

Introduction

This handbook contains updates based on the 11-19-2007 Collective Bargaining Agreement between Ford Motor Company and the UAW.

Unless specifically noted, this book describes benefit programs for Active UAW-represented hourly employees of Ford Motor Company hired or rehired before November 19, 2007.

This handbook does NOT apply to Active UAW represented hourly employees hired or rehired on or after November 19, 2007 or UAW hourly retirees. Information for them is provided separately.

Your handbook is divided into sections — one for each benefit program and one section to describe administrative and ERISA information. (also included in some of the separate sections) Once you turn to the section in which you're interested, look for information using:

- The table of contents with page numbers for that section
- The overview page with the major points of that plan
- An in-depth explanation with a summary of each plan
- Examples and tables with an easy-to-understand summary of certain plan features

If you cannot find the answers to your benefits questions in this handbook, call the NESC or contact your local UAW Benefits Representative.

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Introduction

Highlights

Your employee benefits are important for you and your family. They are described in this handbook.

Benefits are a valuable part of your compensation as a Ford employee represented by the UAW.

You and your dependents may be eligible for the benefit programs negotiated by Ford Motor Company and the UAW (see Volumes II, III and IV of the UAW-Ford Collective Bargaining Agreement). The following chart outlines each of the benefit programs, as well as the requirements you must meet to be eligible for those benefits. Refer to the sections within your handbook for complete information.

This handbook contains an explanation of your employee benefits based on the documents, policies and negotiated Agreements by which these benefits are provided. If there is any difference between the Plan texts, negotiated Agreements and this handbook, the Plan texts and negotiated Agreements always will govern.

The Company reserves the right to end, suspend or amend these 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.

In certain cases, employees may be eligible for some – but not all - benefits in this handbook. If someone receives this handbook in error, it does not make them eligible for benefits.

Benefit Program	Description	Eligibility
Health Care Plan	For bargaining unit employees, provides hospital, surgical, medical, prescription drug, dental, vision care, and hearing aid coverages.	First day of the month after acquiring seven months of seniority
Life and Disability Insurance	Provides financial protection in case of disability or death	Regular full-time employees
Retirement Plan	Pays a monthly benefit when you retire, based on type of retirement, date of retirement and years of credited service	Participation is automatic for employees
Supplemental Unemployment Benefit (SUB) Plan	Provides income benefits if you are laid off	Employees with one year of seniority who: <ul style="list-style-type: none"> • Are on a qualifying layoff • Have reported at a state employment office, if required • Are in an AutoSUB state or have applied for Regular Benefits either in person or by mail • Qualify for a Regular Benefit of at least \$2
UAW-Ford Legal Services Plan	Provides certain legal services for covered matters such as will preparation, house closings, adoption, and divorce	Full-time employees 90 days after date of hire
Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	Offers you an opportunity to save and invest on a pre-tax or after-tax basis	Employees on the active employment roll three months after initial date of hire
Profit Sharing Plan	Provides additional income (in the form of check, TESPHE or Ford Interest Advantage contributions) based on Company profits	Full-time employees who have been hired by December 31 of the plan year
Ford Interest Advantage	Provides you another opportunity to invest	All employees
Dependent Care Assistance Plan	Allows you to make pre-tax contributions into an account that reimburses you for eligible dependent care expenses	All full-time employees

What do you do if you have questions about your benefits?

When you have a benefits question, you may be able to find the answer in this handbook and benefits bulletins posted in your area. If you cannot find the answer to your question from these sources, call the National Employee Services Center (NESC) or contact your local UAW Benefits Representative.

Benefits service from the NESC

The NESC was opened in 1993 to provide improved benefit service for you and your family. The Personnel Benefits Representatives receive specialized training that enables them to assist you with your needs. The UAW National Ford Department is represented at the NESC. The goal of the NESC is to provide "Best-In-Class" benefits service by offering:

- Toll-free phone access
- Experts to handle complex cases
- Simplified processing
- Fewer forms and faster service
- Personal service and benefits counseling

Comments and suggestions for improving service should be sent to the Quality Coordinator, National Employee Services Center, P.O. Box 6214, Dearborn, Michigan 48121.

The NESC cannot assist you with your leave of absence, except to answer questions related to your health care eligibility. You must contact your local hourly personnel office to initiate or close a leave of absence, or to address any employment termination for an expired medical leave.

How do you call the NESC?

To reach the NESC system call 1-800-248-4444.

Personnel Benefits Representatives are available Monday through Friday from 9:00 a.m. to 4:00 p.m. (Eastern Time), except on Company holidays.

Convenient account access

The Fidelity Service Center for Ford Motor Company generally provides 24-hour access to TESPHE account information and permits a variety of transactions to be initiated, toll-free, from any touch-tone telephone. Fidelity representatives are available 15½ hours a day from 8:30 a.m. to midnight (Eastern Time) on business days.

You can manage your TESPHE account almost entirely over the phone with the Fidelity Service Center or through Fidelity's Internet access www.netbenefits.fidelity.com. Forms will not be necessary for most transactions.

To use the Fidelity Service Center, you will need to establish a PIN (personal identification number). The first time you call Fidelity, you will be asked to establish your PIN.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Your Benefits Service Directory

Here is a quick directory for assistance with your benefits questions:

For this information:	Call:
Health Care Plan <ul style="list-style-type: none"> Health care claims, dependent status or benefit coverage To add or delete dependents or for problems that cannot be resolved with your Health Care Plan 	The number on your Health Care Plan I.D. card NESC: 1-800-248-4444 Or email : nesc@ford.com
Life Insurance Program <ul style="list-style-type: none"> Company-provided coverage UNICARE Optional Group life insurance, Mutual of Omaha dependent group life insurance, 1 or optional accident insurance To file a death claim 	UNICARE 1-313-336-5550 or 1-800-843-8184 Mutual of Omaha 1-847-299-9393 or 1-800-742-8215 NESC: 1-800-248-4444 Or email: nesc@ford.com
Disability Program <ul style="list-style-type: none"> To file claims or ask about accident and sickness and extended disability benefits 	UNICARE 1-800-572-1581 or 1-313-336-5550
Retirement Plan	NESC: 1-800-248-4444 Or email: retire@ford.com
Supplemental Unemployment Benefit (SUB) Plan	Your local hourly personnel office
UAW-Ford Legal Services Plan	Your local legal services plan office (see legal section of this handbook for a listing)
Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	Fidelity Service Center 1-800-544-3333 1-508-787-9902 (from overseas call collect) 1-800-847-0348 (TDD phone line for the hearing impaired)
Profit Sharing Plan <ul style="list-style-type: none"> Eligible pay problems All other matters 	Your local hourly personnel office NESC: 1-800-248-4444
Ford Interest Advantage (FIA) Account <ul style="list-style-type: none"> Account status/interest Enrollment/packages FIA Payroll deduction information only 	1-800-462-2614 1-800-580-4778 1-800-426-2888
Other Personnel Matters Address changes, Anniversary Awards, U.S. Savings Bonds, United Way, vehicles, FERA, suggestions, education programs, vacation, direct deposit of paycheck, tax withholding of wages, and leaves of absence	Local hourly personnel office
Dependent Care Assistance Plan	WageWorks 1-877-924-3967
Personal Protection Plan Auto and home insurance	Marsh@WorkSolutions - 1-800-523-2359

An overview: How your benefits work together

	Health Care Plan	Life and Disability	Retirement Plan	SUB Plan
If you are working for the Company	Provides benefits for covered hospital, surgical, medical, prescription drug, dental, vision care and hearing aid expenses	Provides protection of: <ul style="list-style-type: none"> Life and Accidental Death and Dismemberment Insurance Survivor Income Benefits Accident and Sickness Benefits Extended Disability Benefits Safety Belt User Benefits Optional Employee Group Life Insurance (employee-paid) Optional Dependent Group Life Insurance (employee-paid) optional Accident Insurance (employee-paid) 	You earn credit toward a pension based on hours for which you receive pay from the Company.	Not applicable
If you are on an approved medical leave	Coverages continue for the greater of: <ul style="list-style-type: none"> A period equal to your years of seniority at disability The period during which you receive Extended Disability Benefits 	Accident and Sickness Benefits provide a benefit for up to 52 weeks; Extended Disability Benefits may provide a monthly benefit after Accident and Sickness Benefits end. Other coverages may continue based on your years of seniority.	Participation continues and service credits accrue for a limited period; Disability Retirement may be available.	Not applicable
If you are laid off	Coverages continue for the greater of a period of time determined by: <ul style="list-style-type: none"> Your years of seniority on last day worked before layoff The period during which you receive Extended Disability Benefits 	Certain coverages continue for the greater of a period of time determined by: <ul style="list-style-type: none"> Your years of seniority on last day worked before layoff Your eligibility for SUB on last day worked before layoff Your receipt of Extended Disability Benefits Accident and Sickness Benefits may be reinstated if you become disabled during a qualified layoff under the SUB Plan and are eligible for a Regular Benefit under the SUB Plan while insured for Life Insurance.	Participation continues and service credits accrue for a more limited period, provided you retain your seniority. (Special rules for GIS may apply, however.)	Provides: <ul style="list-style-type: none"> Regular Benefits Short Week Benefits Lump-sum Separation Payment
If you retire	Coverage continues for you, your spouse or same-sex domestic partner and your eligible dependents. *** On or after 1-1-2010 retiree healthcare will be provided by the UAW Retiree Benefits Trust (VEBA)	Life Insurance coverage continues in full (paid by Ford) until age 65. At age 65, reduced amounts of Life Insurance may continue for the rest of your life in a "Continuing Group Life Insurance" amount	If vested, you may receive a monthly pension based on your Benefit Class Code, date of retirement, and years of credited service.	Your eligibility ends.
If you die	Coverage may continue for your spouse and eligible dependents.	Life Insurance is paid to your beneficiary, based on your base hourly rate. If you have a survivor, he or she may be eligible for Transition and Bridge Survivor Income Benefits. If you die as the result of an accident, your beneficiary also may receive a benefit under the Accidental Death and Dismemberment Insurance Plan.	If vested and a survivorship option is in effect, your surviving spouse may receive a benefit.	Participation ends.

An overview: How your benefits work together

	UAW-Ford Legal Services Plan	TESPHE	Profit Sharing Plan	Dependent Care Assistance Plan
If you are working for the Company	Provides certain legal services for covered matters such as will preparation, house closings, adoption and divorce.	Offers on a pre-tax or after-tax basis savings and investment opportunities.	Provides additional income based on Company profits.	You must enroll to participate; mid-year changes are allowed if you experience a qualifying life event.
If you are on an approved medical leave	Coverage continues.	Contributions are suspended. In some instances, accounts may be paid upon request.	Your Profit Share is based on a formula that generally excludes compensation received while on approved medical leave.	Participation ends. Claims may be submitted for services received while in active status.
If you are laid off	Coverage continues for 18 months.	Contributions are suspended. Distribution is made after you reach age 65, if you so elect otherwise, distribution will begin at age 70½. You may request earlier distribution at or after termination.	Your Profit Share is based on a formula that generally excludes compensation received while on layoff.	Participation ends. Claims may be submitted for services received while in active status.
If you retire	Coverage continues.	Contributions end. You may request distribution of all or part of your account at or after termination. You may elect distribution when you reach age 65, or you may elect to leave your assets in the Plan, otherwise distribution will begin at age 70½.	Participation ends. You receive a Profit Share based on eligible pay earned to date of your retirement.	Participation ends. Claims may be submitted for services received while in active status.
If you die	Coverage may continue for your eligible spouse and eligible dependents. Under some conditions, coverage for covered dependents and surviving spouses not otherwise eligible shall continue only until the end of the sixth month following the month in which the employee or surviving spouse dies.	Your account is paid to your beneficiary as provided under the Plan. If your beneficiary is your surviving spouse, the spouse may elect to retain the account.	Your Profit Share, based on eligible pay earned to date of your death, is paid to your beneficiary.	Participation ends. Claims may be submitted for services received while in active status.

Health Care Plan

An Overview

This section of your handbook answers these questions:

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Health Care Plan - Overview

An Overview: Your Health Care Plan

Your Health Care Plan, which includes Hospital - Surgical-Medical-Prescription Drug-Dental-Vision Care-Hearing Aid coverages, provides important protection for you, your spouse and your eligible dependents.

Your health care benefits cover most health-related expenses. As an hourly Ford employee represented by the UAW, you may be eligible for the following categories of health care coverage:

- Hospital-Surgical-Medical
- Prescription Drug
- Dental
- Vision Care
- Hearing Aid

More details follow.

One of the general primary objectives of the Company in conjunction with the UAW is to provide you with access to quality health care services. The Company is not a health care provider and it will not be responsible for any liability stemming from the care you or your dependents receive from a specific health care provider. Nothing in this handbook (or any other explanation of benefits provided to you by or on behalf of the Company) should be considered a representation as to the quality of specific health care services you or your dependents will receive from a particular provider.

BCBS National PPO Plan / and Alternative Plans

In most areas of the country, hospital-surgical-medical coverage is available under alternative health care plans. In some areas, dental coverage is available under alternative dental care plans.

The alternatives to the BCBS National PPO Plan and the BCBS Dental Plan are as follows:

Alternatives to the:

National PPO Plan	Dental Plan
HMO (Health Maintenance Organization)	DHMO (Dental Health Maintenance Organization)
PPO (Preferred Provider Organization)	

Brief descriptions of the National PPO and alternative plan options available are presented below.

National PPO Plan

The National PPO Plan Is a Preferred Provider Plan, which pays for a greater part of covered expenses if a preferred (network) provider is used.

If you are enrolled in the BCBS National PPO Plan, you must use National PPO in-network hospitals, physicians, and pharmacies to receive the maximum benefits payable under the plan. If you use out-of-network National PPO Plan providers, you will be required to pay an additional 10% co-insurance for covered services.

Refer to the “What is the National PPO Plan” in the Hospital-Surgical-Medical Coverage section of this handbook for additional information regarding National PPO Plan provisions.

HMO (Health Maintenance Organization)

When you join an HMO, most of your health care is covered in full, when services are provided by the physicians affiliated with the HMO Plan you choose. The HMO usually is associated with specific hospitals. The doctor you choose will coordinate all of your health care needs. You usually can choose a different physician for each member of your family. HMOs generally cover office visits and put a great deal of emphasis on preventive care such as immunizations, allergy testing, well-baby care, and physical exams. Services received outside the HMO network of providers are not covered unless preauthorized by the Plan or in an emergency.

PPO (Preferred Provider Organization)

When you join a PPO, you may receive care from any physician affiliated with the Plan. A PPO also gives you the option of receiving medical services from a doctor or hospital not affiliated with the Plan, but you will be responsible for paying more of the costs yourself. PPOs generally provide partial coverage (but less than HMOs) for office visits and preventive care from affiliated providers.

Standard Dental Plan

You may select any licensed dentist, and he or she is reimbursed by the Plan for covered services. The Traditional Dental Plan generally pays a percentage of the approved amount for covered procedures, up to an annual dollar maximum (or a lifetime maximum for orthodontics). In addition, when you receive services from a DenteMAX provider, the cost you pay is often less.

DHMO (Dental Health Maintenance Organization)

If there is a DHMO available in your area, you may choose coverage under the DHMO regardless of which Medical Plan you choose. If you choose a DHMO, you must receive your dental care from a dentist who is affiliated with that Dental Plan. A DHMO generally pays all or most of the cost for covered procedures from affiliated dentists with more favorable (or even no) dollar maximums than under the Traditional Dental Plan.

NOTES

Health Care Plan

Eligibility for Health Care Coverage

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Health Care Plan –

Eligibility for Health Care Coverage – EMPLOYEE

Who is eligible for health care coverage?

You, your spouse or same-sex domestic partner and your dependent children may be eligible for Company-paid coverages, if you are an hourly employee represented by the UAW hired or rehired before November 19, 2007.

How do I enroll when first eligible

You will be sent enrollment information approximately two (2) months prior to your initial eligibility date. You should make your medical and dental plan elections two (2) months prior to your effective date. This will allow the health care plans sufficient time to send you your identification cards prior to your effective date of coverage.

Your medical election automatically determines your prescription drug, vision and hearing aid coverage's. You do not need to separately enroll.

Coverage for Yourself Only

To elect coverage for yourself only, please call the Automated Telephone System (VRU) at 1-800-333-7444. The Automated Telephone System is open 24 hours a day/365 days a year.

Coverage for Yourself and Eligible Dependents

Review the eligibility requirements under “Eligible for Health Care Coverage” to ensure that your dependents are eligible. To elect coverage for yourself and eligible dependents, please call the NESC at 1-800-248-4444 to make your election.

You will need to provide the following information:

- Full name
- Social Security number
- Birth date

Transfer from salaried to hourly employment or vice-versa

If you transfer from salaried to hourly employment or vice-versa, call the NESC at 1-800 248-4444 and a Human Resource Associate will assist you regarding your enrollment options and the enrollment process.

- Under certain circumstances, you may choose to continue your group (Ford) health care coverage.
- Refer to the “Other Health Care Plan Information” section for detailed information on when you can pay to continue coverage or convert your coverage to an individual policy.

When can I change my medical and dental plan elections?

You may change your plan elections during any month of the year.

Under the Hourly Rolling Enrollment system, there is no longer a specific enrollment period. You may change your medical and/or dental plan elections during any month of the year (provided 12 months have elapsed since your last change) and you are eligible for coverage.

To make a change, call the Automated Telephone System (VRU) at 1-800-333-7444 and follow the prompts to change your medical and/or dental elections. The Automated Telephone System is open 24 hours a day / 365 days a year. You will receive a confirmation statement in the mail anytime you make a change through the Automated Telephone System. Your election takes effect on the 1st day of the 2nd month following your election.

Hourly Rolling Enrollment	
If you call during the month of:	Your election takes effect on:
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

Once you make a change to your medical and/or dental plan, you must wait 12 months to make another change. Certain limited changes are allowed during the 12-month period. You must call the NESC to determine if a change is allowable.

You also may call the Automated Telephone System at 1-800-333-7444 to:

- Cancel a pending election made within the same month
- Review a pending election made within the same month
- Hear who your current medical provider and dental provider are
- Request plan benefit summaries

When coverage is continued

If you are on an approved medical leave of absence, health care coverage for you, your spouse and your eligible dependents continues while you are away from work for up to the greater of:

- A period of time equal to the number of years of seniority you had when you left
- The period of time during which you receive Extended Disability Benefits

If you are on a FMLA leave of absence, health care coverage for you, your spouse and your eligible dependents continue while you are away from work for the duration of the FMLA leave. For additional information on FMLA, please refer to "What are my rights under the Family and Medical Leave Act (FMLA) of 1993?" in the Administrative, ERISA and Family and Medical Leave Act of 1993 Information section of this handbook.

If you are on a qualifying layoff under the Ford-UAW Supplemental Unemployment Benefit (SUB) Plan, health care coverage for you, your spouse and your eligible dependents continues for the greater time period either from the schedule below:

Your years of seniority on the last day you worked prior to layoff	Number of months coverage will be provided without cost to you
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	10
6 but less than 10	12
10 and over	24

OR

- One full calendar month of layoff (up to 24 months) for each full four weeks of Regular Benefits to which your Credit Units as of October 29, 1990 (or as of the last day worked prior to layoff in the event the 1987 SUB Plan is reinstated prior to your layoff) entitle you based on your seniority and the Credit Unit Cancellation Base under the provisions of the 1987 SUB Plan

OR

- The period of time during which you receive Extended Disability Benefits

When your months of continued coverage are up, you may continue coverage for up to 12 consecutive months by making payments for coverage.

When coverage ends

Generally, health care coverage's (except dental coverage) end the last day of the month following the month you were last at work.

- If you terminate your employment or are discharged, all your health care coverage's (except dental coverage) end on the last day of the month in which your employment is terminated (or as of the employment termination date when administratively feasible).
- If you have a grievance pending to protest your termination, all of your health care coverage's end the last day of the month after the month in which you are discharged. You may, however, continue coverage after Company-paid coverage terminates by paying the cost while the grievance is pending.
- If you go on leave of absence (other than a medical leave or FMLA leave), all of your health care coverages (except dental coverage) end the last day of the month following the month in which you leave. If you wish, you may continue health care coverage (except dental coverage) during the leave for up to twelve consecutive months by making payments for coverage.

Dental coverage usually ends the last day of the month in which you leave.

- If you terminate your employment, dental coverage ends the last day you work.
- If you have a grievance pending to protest your termination, coverage ends the last day of the month following the month in which you last worked.

You may continue your dental coverage by paying the cost if there is a grievance pending or if you are on an approved local Union leave.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

When must I remove my dependent from coverage?

You are responsible for notifying the NESC to remove a dependent from your Company-paid coverage as soon as they no longer meet the eligibility requirements.

If and when your circumstances change causing a dependent to lose eligibility, call the NESC at 1-800-248-4444 and remove your ineligible dependent.

- Removing dependents when they lose eligibility will eliminate any action by the Company to recover any health care claims or premiums incurred by an ineligible dependent.
- You can also get information about self-pay continuation of coverage options.

Refer to the "Other Health Care Plan Information; When may I continue my coverage under COBRA" section of this handbook for information about self-pay continuation of coverage options.

Benefit Overpayment Recovery

If the Plan determines that your act (such as adding a person not eligible under the Plan) or omission (for example, failing to remove a person no longer eligible under the Plan) results in or contributes to an overpayment under this Program, you will be sent written notice from the Company and you must repay the amount of overpayment.

- If repayment is not made within 60 days following the date of the written notice, the Company has the right, in accordance with and subject to any limitations under applicable federal laws, to make, or arrange to have made, deductions for recovering such overpayments from any present or future compensation or benefits payable under the Ford H-S-M-D-D-V Program which are or become payable to you.
- Deductions for such overpayments will not exceed \$100 per paycheck except in cases of fraud or willful misrepresentation.

Health Care Plan

Eligibility for Health Care Coverage - DEPENDENTS

Dependent Types

The following pages list the dependent types and explain the eligibility guidelines for each dependent type. Please be sure to read each category to find plan requirements for:

- Eligibility for health care
- Enrollment and Effective dates
- Termination of your dependent's health care

You will need to provide the following information for each dependent

- Full name
- Social Security number
- Birth date

Spouse

Common-Law Spouse

Same-Sex Domestic Partner

Children Under the Age of 19

Children 19 to 24 years of age

Children Covered by a Qualified Medical Child Support Order

Principally Supported Dependents (for example a grandchild, niece or nephew)

Children by Legal Guardianship

Children of Same-Sex Domestic Partners Under the Age of 19

Children of Same-Sex Domestic Partners 19 to 24 years of age

Totally and Permanently Disabled Dependents

Sponsored Dependents

Spouse

Your spouse is eligible for coverage, if you are eligible for and enrolled in a health care plan offered by the Company.

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of a spouse. The NESC will inform you of any required documentation for proving eligibility for a spouse you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- Coverage for your spouse is effective on the same day as your coverage, or later, on your marriage date.

Your identification card

Once you and your spouse are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your spouse.

Termination

Your spouse's eligibility for coverage ends on the earliest to occur of:

- The date your coverage ends
- The date of a final decree of divorce
- The date your marriage is annulled
- The last day of the month following the month in which you die unless:
 - ◊ You were retired or eligible to retire at the time of your death and your spouse is eligible for a surviving spouse benefit under the Ford-UAW Retirement Plan
 - ◊ Your surviving spouse is eligible to receive Bridge Survivor Income Benefits from the Life and Disability Insurance Program (or would be eligible except that your surviving spouse was age 60 or older at the time of your death), Company-paid coverage (other than dental and vision) continues for the following continuation period:
 - 24 months following the month in which you die if your death occurs on or after October 25, 1999, and prior to January 1, 2004, or if your death occurs on or after January 1, 2004, and you have less than 10 years of credited service under Company retirement plans at the time of your death
 - 30 months following the month in which you die if your death occurs on or after January 1, 2004, and you have 10 or more years of credited service under Company retirement plans at the time of your death
- The date your surviving spouse remarries if your death is the result of an occupational injury caused solely by employment with the Company
- The date your surviving spouse is not enrolled in Medicare Part B coverage
- The date of your spouse's or surviving spouse's death
- The date your spouse or surviving spouse no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible spouse.

Refer to the "Other Health Care Plan Information; When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Common-Law Spouse

Your common-law spouse is eligible for coverage, if the relationship is recognized by the laws of the state in which you reside, provided you meet the requirements for documentation of the status as may be necessary by law and required by the Company.

States permitting common law marriages:

Alabama
Colorado
District of Columbia
Florida (before 01/01/1968)
Georgia (before 01/01/1997)
Idaho (before 01/01/1996)
Indiana (before 01/01/1958)
Iowa
Kansas
Michigan (before 1957)
Montana
Ohio (before 10/11/1991)
Oklahoma
Pennsylvania
Rhode Island
South Carolina
Texas
Utah

Not every state permits or recognizes common law marriages. If you enter into a common law marriage in one of the state listed above that still permit common law marriages to take place, the marriage is likely to be recognized in other states which do not permit common law marriages to occur.

Enrollment and Effective Dates

Coverage for a common-law spouse is effective on the latest to occur of the effective date of your coverage, or the date of a valid enrollment and receipt by the Company of any necessary supporting documentation.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your common-law spouse. The NESC will inform you of any required documentation for proving eligibility for a common-law spouse you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.

Your identification card

- Once you and your common-law spouse are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your common-law spouse.

Termination

- Your common-law spouse's eligibility for coverage ends on the earliest to occur of:
 - The date your coverage ends
 - The date of a final decree of divorce
 - The date your marriage is annulled
 - The last day of the month following the month in which you die unless:
 - ◇ You were retired or eligible to retire at the time of your death and your spouse is eligible for a surviving spouse benefit under the Ford-UAW Retirement Plan
 - ◇ Your surviving spouse is eligible to receive Bridge Survivor Income Benefits from the Life and Disability Insurance Program (or would be eligible except that your surviving spouse was age 60 or older at the time of your death), Company-paid coverage (other than dental and vision) continues for the following continuation period:
 - 24 months following the month in which you die if your death occurs on or after October 25, 1999, and prior to January 1, 2004, **or** if your death occurs on or after January 1, 2004, and you have less than 10 years of credited service under Company retirement plans at the time of your death
 - 30 months following the month in which you die if your death occurs on or after January 1, 2004, and you have 10 or more years of credited service under Company retirement plans at the time of your death
 - The date your surviving spouse remarries if your death is the result of an occupational injury caused solely by employment with the Company
 - The date your surviving spouse is not enrolled in Medicare Part B coverage
 - The date of your spouse's or surviving spouse's death
 - The date your spouse or surviving spouse no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Same-Sex Domestic Partners

Your same-sex domestic partner is eligible for coverage if the relationship is recognized by the laws of the state in which you are enrolled, provided you meet requirements for documentation of the status as may be necessary by law and required by the Company.

The two states that recognize same-sex marriages are California and Massachusetts.

Your same-sex domestic partner will be eligible for coverage if all the following criteria are met:

- You are eligible for and enrolled in a health care plan offered by the Company
- You and your partner are the same-sex
- You have shared a continuous committed relationship with each other for no less than six months, intend to do so indefinitely, and have no such relationship with any other person
- You are jointly responsible for each other's financial obligations
- You reside in the same household
- You are not related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of your state of residence
- You reside in a state where marriage between persons of the same-sex is not recognized as a valid marriage by the state, or if residing in a state that recognizes same-sex unions, have entered into such union as recognized by the state
- You and your partner are over age 18, of legal age, and legally competent to enter into a contract
- Neither of you is married to a third party
- If same-sex marriages or other forms of same-sex unions become a legal option in the state in which you reside, a legal marriage or other such legal union is required to establish or retain eligibility for Company-paid health care coverage for your same-sex domestic partner

If the non-employee same-sex domestic partner is not your legal Federal tax dependent, the fair market value of the coverage provided for your partner will be imputed (taxable) income to you and reported on your IRS form W-2 each year and also included in your pay check.

Enrollment and Effective Dates

Coverage for your same-sex domestic partner is effective the later of the effective date of your coverage, or the date your affidavit is signed and notarized, provided that you notified the Company 30 days from the date the affidavit is notarized. Otherwise, coverage is effective on the later of the effective date of your coverage or the first of the month following the date the NESC receives your completed affidavit and any required documentation.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your same-sex domestic partner. The NESC will inform you of any required documentation for proving eligibility for a same-sex domestic partner you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.

Coverage for your same-sex domestic partner is effective:

- The later of the effective date of your coverage, or the date your affidavit is signed and notarized, provided that you notified the Company within 30 days from the date the affidavit is notarized.
- Otherwise, coverage is effective on the later of the effective date of your coverage or the first of the month following the date the NESC receives your completed affidavit and any required documentation.

Your identification card

Once you and your same-sex domestic partner are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your same-sex domestic partner.

Termination

Your same-sex domestic partner shall lose eligibility on the earliest to occur of:

- The date your coverage ends
- The date the relationship ends
- The last day of the month following the month in which you die unless:
 - ◊ You were retired or eligible to retire at the time of your death (not including your eligibility for a deferred vested benefit) and if hired on or after September 30, 1996, you had at least ten years of credited pension service, in which case your same-sex domestic partner qualifies for continued coverage

- ◊ Your surviving same-sex domestic partner is eligible to receive Bridge Survivor Income Benefits from the Life and Disability Insurance Program (or would be eligible except (i) he/she was age 60 or older at the time of your death, or (ii) you died on or after August 1, 2000 and before September 29, 2003 Company-paid coverage (other than dental and vision) continues for the following continuation period:

- 24 months following the month in which you die if your death occurs on or after August 1, 2000, and prior to January 1, 2004, and you have less than 10 years of credited service under Company retirement plans at the time of your death
- 30 months following the month in which you die if your death occurs on or after January 1, 2004, and you have 10 or more years of credited service under Company retirement plans at the time of your death

- The date your same-sex domestic partner marries or enters into a same-sex domestic partnership if your death is the result of an occupational injury caused solely by employment with the Company
- The date of your partner's death
- The date your partner no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Children Under the Age of 19

Your children are eligible for coverage if you are eligible and enrolled for coverage, and they meet all of the following requirements:

Relationship

"Children" include:

- Your natural child
- Your stepchild
- You or your spouse's legally adopted child
- A child placed for legal adoption under the age of 18
- A legally adopted child
- In the event of your death your spouse's child is eligible if that child was eligible to be enrolled prior to your death

Age

The child must be newborn through 18 years of age

Residency

- The child must reside with you as a member of your household
- If not a member of your household, you must be legally responsible for providing health coverage for the child through a court order, divorce decree, or other Qualified Medical Child Support Order (QMCSO)
- Students are considered to be living with you while they are away at school, if they return home when school is not in session

Tax Dependent

- You must claim an exemption for the child on your Federal Income Tax return
- The dependency requirement will be waived if you, the primary enrollee, are legally responsible to provide health care coverage for the child through a court order, divorce decree, or other Qualified Medical Child Support Order (QMCSO).

Marital Status

Children must be unmarried

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of your child under the age of 19. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- A child may not be covered by more than one Ford employee or retiree.

- Coverage for a child under the age of 19 is effective on the later of the effective date of your coverage, the date they first meet the eligibility criteria, or in the case of:
 - ◊ Birth - The date of birth
 - ◊ Legal Adoption - The date of placement in your household or petition for adoption, whichever occurs earlier, or the date the assumption and retention of a legal obligation for total or partial support
 - ◊ Stepchild - The date the child becomes a member of your household
 - ◊ Court Order, Divorce, or other Qualified Medical Child Support Order (QMCSO) - The date of the court order, divorce decree, or other QMCSO

Your identification card

Once you and your children are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

Your child will lose eligibility for coverage on the earliest to occur of:

- The date your coverage ends
- The date the child no longer resides with you
- The date the child ceases to be dependent upon you or your spouse as defined in Section 151 of the Internal Revenue Code for Federal Income Tax purposes (except a totally and permanently disabled dependent may earn up to \$10,000)
- The date of marriage of the child
- The last day in the calendar year in which the child becomes age 19, except in the case of a totally and permanently disabled child
- The date your surviving spouse's coverage ends
- The date you or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information; When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Children 19 to 24 Years of Age

Your children are eligible for coverage if you are eligible and enrolled for coverage, and he or she meets all of the following requirements:

Relationship

"Children" include:

- Your natural child
- Your stepchild
- A child placed for legal adoption under age 18
- A legally adopted child
- In the event of your death, your spouse's child is eligible if that child was eligible to be enrolled prior to your death

Age

- Dependent children will be removed from coverage at age 19 unless the employee, retiree or surviving spouse responds to a written notification to continue coverage
- A child is eligible between the ages of 19 and the end of the calendar year in which they turn age 24 effective January 1, 2009 – age 25 until then, if they qualify as a full-time student as defined by the Internal Revenue Code and they meet the Company's eligibility requirements, or has been determined to be totally and permanently disabled by the Plan Administrator (Company)
- Coverage may also be continued beyond the end of the year the child becomes age 19 (24 for a child who is a full-time student) if the child has been determined to be totally and permanently disabled

Residency

- The child must reside with you as a member of your household
- Students are considered to be living with you while they are away at school, if they return home when school is not in session

Tax Dependent

You must claim an exemption for the child on your Federal Income Tax return.

Marital Status

Children must be unmarried

Full-Time Student Status

Effective January 1, 2009, dependents between the ages of 19 and the end of the year they reach 24 (25 until 2009) must qualify as a full-time student as defined by the school and meet all other Company dependent eligibility requirements. This does not apply if your dependent has been determined by the Company to be totally and permanently disabled.

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of your child 19 to 24 years of age. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee or retiree.

Coverage for a child 19 to 24 years of age is effective on the later of the effective date of your coverage, the date they first meet the eligibility criteria, or in the case of:

Stepchild

The date the child becomes a member of your household

Your identification card

Once you and your children are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

Your child shall lose eligibility for coverage on the earliest to occur of:

- The date your coverage ends
- The date of marriage of the child
- The date the child no longer resides with you
- The date the child is no longer a full-time student
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date your 24-year-old dependent exceeds the Federal Income Tax earnings limitation
- The last day in the calendar year in which the child becomes age 24 (effective January 1, 2009), except in the case of a totally and permanently disabled child
- The date your surviving spouse's or surviving same-sex domestic partner's coverage ends
- The date you or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Children who are covered by a Qualified Medical Child Support Order ("QMCSO")

The Ford Health Plan must follow the provisions of a Qualified Medical Child Support Order (called a "QMCSO"). A QMCSO is a judgment, decree or order from a court or administrative agency (that the Ford health plan determines meets all QMCSO requirements) requiring a Ford health plan participant to provide coverage to a child under a state domestic relations law (such as a divorce judgment) or a law relating to child support (such as a National Medical Support Notice issued by a state child support agency).

As Plan Administrator, Ford determines whether a court or agency order meets the requirements for a QMCSO. For a copy of the Ford Health Plan QMCSO procedures, write to:

Ford Motor Company
National Employee Services Center
Attn: QMCSO Coordinator
FMC-NESC
P.O. Box 7162
Dearborn, MI 48121

A court or agency order will not be a QMCSO unless the child that is subject to the order meets the following requirements:

Relationship

"Children" include the employee's:

- Natural Child
- Legally Adopted Child

Age

The child must not have graduated from high school or attained age 18, whichever occurs later, but in no instance after age 19 and six months

Residency

There is no residency requirement when you, the primary enrollee, are legally responsible to provide health care coverage for the child through Qualified Medical Child Support Order (QMCSO)

Dependency

There is no dependency requirement if you, the primary enrollee, are legally responsible to provide health care coverage for the child under a Qualified Medical Child Support Order (QMCSO)

Dependents for which you are legally responsible to provide health care coverage through a paternity order **MUST** be claimed as an exemption for Federal Income Tax purposes. A court order, QMCSO, or divorce decree **MUST** be provided in order to provide health care coverage for the dependent.

Marital Status

Children must be unmarried

Enrollment and Effective Dates

The effective date of coverage for a Court Order, Divorce Decree or other QMCSO dependent will be the 1st of the month following the receipt of the court documents.

Call the NESC at 1-800-248-4444 to initiate the enrollment of your QMCSO child. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage,

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee or retiree.

Your identification card

Once you and your children are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

Your QMCSO child will lose eligibility for coverage the date:

- Your coverage ends
- The child graduates from high school or attains age 18, whichever occurs later, but in no instance after age 19 and six months
- The qualified legal requirement to provide health care coverage has terminated or the qualified legal requirement to provide health care coverage no longer meets the Plan requirements
- The child no longer meets any other eligibility requirements of the Plan

Principally Supported Dependents

If a principally supported dependent is on your coverage **prior to 11/19/2007**, that child will be deemed to be grandfathered as long as they continue to meet all other Company eligibility requirements. If that child loses eligibility or is terminated from your coverage during an audit you will be unable to reinstate the child to coverage unless you obtain "legal guardianship" of the child. These dependents are not eligible for coverage if your spouse or your same-sex domestic partner claims them.

Relationship

The child must be related to you by blood or marriage

- Grandchildren
- Nieces
- Nephews
- Siblings

Age

- Dependent children will be removed from coverage at age 19 unless the employee, retiree of surviving spouse responds to a written notification to continue coverage
- A child is eligible between the ages of 19 and (effective January 1, 2009) the end of the calendar year in which they turn age 24, if they qualify as a full-time student as defined by the school and they meet the Company's eligibility requirements, or has been determined to be totally and permanently disabled by the Plan Administrator (Company)

Residency

The child **must** reside with you as a member of your household.

Tax Dependent

You must claim an exemption for the child on your Federal Income Tax return.

Marital Status

Children must be unmarried

Full-Time Student Status

Effective January 1, 2009, dependents between the ages of 19 and the end of the year they reach 24 (25 until 2009) must qualify as a full-time student as defined by the school and meet all other Company dependent eligible requirements. This does not apply if your dependent has been determined by the Company to be totally and permanently disabled.

Enrollment and Effective Dates

Effective 11/19/2007, no further enrollments are allowed for Principally Supported dependents.

Termination

Your principally supported dependent will lose eligibility for coverage on the earliest to occur of:

- The date the Company terminated the child's coverage because you did not comply with an audit and prove the child's eligibility for coverage
- The date of marriage of the child
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date the child no longer meets the residency requirement
- The date the child is no longer a full-time student (for dependents age 19 to 24) (effective January 1, 2009)
- The last day in the calendar year in which the child becomes age 24 (effective January 1, 2009), except in the case of a totally and permanently disabled child
- The date your coverage ends, except that in the case of your death, coverage for the dependent child will end on the last day of the month following the month in which you die (unless the child is eligible for coverage as a dependent child of an eligible Surviving Spouse in which case the child's coverage ends when the Surviving Spouse is no longer eligible for coverage)
- The date you or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Children by Legal Guardianship Under the Age of 18

A child by Legal Guardianship is eligible for coverage if you are eligible and enrolled for coverage, and the child meets all of the following requirements:

Relationship

A child by legal guardianship will be limited to children who are related by blood (up to and including second degree relatives) to the primary enrollee or the primary enrollee's current spouse. A child by legal guardianship is eligible until 18 years of age, not graduation high school. The dependent children that are eligible as "legal guardianship dependents" are:

- Brother, Sister, Half-Brother and Half-Sister
- Grandson and Granddaughter
- Niece and Nephew

If a principally supported dependent is on your coverage prior to 11/19/2007, that child will be deemed to be grandfathered and must meet all other Company dependent eligibility criteria. If that child loses eligibility or is terminated from your coverage during an audit, you will be unable to reinstate the child to coverage unless you obtain "legal guardianship". These dependents are not eligible for coverage if your spouse or your same-sex domestic partner claims them.

Age

The child must be newborn to 18 years of age

Residency

- The child must reside with you as a member of your household
- Students are considered to be living with you while they are away at school, if they return home when school is not in session

Tax Dependent

You must claim an exemption for the child on your Federal Income Tax return

Marital Status

Children must be unmarried

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of your child by legal guardianship. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee or retiree.
- Coverage for a child by legal guardianship is effective on the later of the effective date of your coverage or the date of petition for guardianship and residence.

Your identification card

Once you and your child by legal guardianship are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

Your child by legal guardianship shall lose eligibility for coverage on the earliest to occur of:

- The date your coverage ends
- The date the child no longer resides with you
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date of marriage of the child
- The day in the calendar month in which the child becomes age 18, except in the case of a totally and permanently disabled child
- The last day of the month the enrollee's legal guardianship of the child is terminated
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Children of Same-Sex Domestic Partner Under the Age of 19

The children of your same-sex domestic partner are eligible for coverage if you are eligible and enrolled for coverage, and they meet all of the following requirements:

Relationship

The child is related to your same-sex domestic partner by birth, legal adoption, or placement for legal adoption for a child under 18 years of age.

Age

The child must be newborn through 18 years of age

Residency

- The child must reside with you as a member of your household
- Students are considered to be living with you while they are away at school, if they return home when school is not in session

Tax Dependent

You **must** claim an exemption for the child on your Federal Income Tax return

Marital Status

Children must be unmarried

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of the children of your same-sex domestic partner under the age of 19. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee or retiree.

Coverage for the children of your same-sex domestic partner under the age of 19 is effective on the later of the effective date of your coverage, or the date your affidavit is signed and notarized provided that you notified the Company within 30 days from the date the affidavit is notarized.

Otherwise, coverage is effective on the later of the effective date of your coverage or the first of the month following the date the NESC receives your completed affidavit and any required documentation.

Your identification card

Once you and the child of your same-sex domestic partner are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

The child of your same-sex domestic partner will lose eligibility for coverage on the earliest to occur of:

- The date of marriage of the child
- The date the child no longer meets the residency requirement
- The date the child no longer meets the dependency requirement
- The date your coverage ends, except that in the case of your death, coverage for the dependent child will end on the last day of the month following the month in which you die
- The date you or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information; When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Children of Same-Sex Domestic Partner 19 to 24 Years of Age

The children of your same-sex domestic partner are eligible for coverage if you are eligible and enrolled for coverage, and they meet all of the following requirements:

Relationship

The child is related to your same-sex domestic partner by birth, legal adoption, or placement for legal adoption for a child under 18 years of age.

Age

- Dependent children will be removed from coverage at age 19 unless the employee, retiree or surviving spouse responds to a written notification to continue coverage
- A child is eligible between the ages of 19 and the end of the calendar year in which they turn age 24 (effective January 1, 2009 – age 25 until then), if they qualify as a full-time student as defined by the Internal Revenue Code and they meet the Company's eligibility requirements, or has been determined to be totally and permanently disabled by the Plan Administrator (Company)
- Coverage may also be continued beyond the end of the year the child becomes age 19, 24 for a child who is a full-time student, if the child has been determined to be totally and permanently disabled

Residency

- The child **must** reside with you as a member of your household
- Students are considered to be living with you while they are away at school, if they return home when school is not in session

Tax Dependent

You **must** claim an exemption for the child on your Federal Income Tax return

Marital Status

- Children must be unmarried

Full-Time Student Status

Effective January 1, 2009, dependents between the ages of 19 and the end of the year they reach 24 must qualify as a full-time student as defined by the school and meet all other Company dependent eligible requirements. This does not apply if your dependent has been determined by the Company to be totally and permanently disabled.

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of the children of your same-sex domestic partner 19 to 24 years of age. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage
- A dependent may not be covered by more than one Ford employee or retiree

Coverage for the children of your same-sex domestic partner 19 to 24 years of age is effective on

- The later of the effective date of your coverage, or the date your affidavit is signed and notarized provided that you notified the Company within 30 days from the date the affidavit is notarized.
- Otherwise, coverage is effective on the later of the effective date of your coverage or the first of the month following the date the NESC receives your completed affidavit and any required documentation.

Your identification card

Once you are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

The child of your same-sex domestic partner 19 to 24 years of age will lose eligibility for coverage on the earliest to occur of:

- The date of marriage of the child
- The date the child ceases to be dependent upon you for Federal Income Tax purposes
- The date the child no longer meets the residency requirement
- The date the child is no longer a full-time student
- The last day in the calendar year in which the child becomes age 24, except in the case of a totally and permanently disabled child (in the event coverage for a totally and permanently disabled child is continued, eligibility for such coverage will end as of the last day of the month in which the child ceases to be totally and permanently disabled)
- The date your coverage ends, except that in the case of your death, coverage for the dependent child will end on the last day of the month following the month in which you die
- The date you or your same-sex domestic partner, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Totally and Permanently Disabled Children

Totally and permanently disabled is defined by having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity which can be expected to result in death or be of long-continued or indefinite duration.

Coverage will not be reinstated for a child who:

- First becomes totally and permanently disabled after the end of the calendar year in which age 25 is attained (age 24 and full-time student status is attained effective January 1, 2009) **or**
- Was eligible for coverage as a totally & permanently disabled child, recovers, and, after so disabled **or**
- Was not eligible for coverage at the time of the disability.

A child shall not be deemed to be "totally and permanently disabled" if he or she is engaged in regular employment or occupation of remuneration or profit which exceeds \$10,000 annually.

Your child shall be eligible for coverage if you are eligible and enrolled for coverage, he or she is deemed to be totally and permanently disabled by the Plan (Company) and meet all of the following requirements:

Relationship

"Children" include:

- Your natural child
- Your stepchild
- A child of your same-sex domestic partner
- A child placed for legal adoption under age 18
- A legally adopted child
- In the event of your death your spouse's child is eligible if that child was eligible to be enrolled prior to your death

Age

- The child must be deemed to be totally and permanently disabled prior to the end of the year they reach the age of 25 (age 24 and full-time student status is attained effective January 1, 2009)
- Coverage will not be reinstated for a child who first becomes totally and permanently disabled after the end of the calendar year in which age 25 is attained (age 24 and full-time student status is attained effective January 1, 2009) or who was eligible for coverage as a totally & permanently disabled child, recovers, and, after so disabled or who was not eligible for coverage at the time of the disability

Residency

The child **must** reside with you as a member of your household

Tax Dependent

- You must claim an exemption for the child on your Federal Income Tax return
- A child shall not be deemed to be "totally and permanently disabled" if the child is engaged in regular employment or occupation of remuneration or profit which exceeds \$10,000 annually

Marital Status

Children must be unmarried

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of the totally and permanently disabled child. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage.
- A dependent may not be covered by more than one Ford employee or retiree.

Coverage for totally and permanently disabled children is effective on the later of the effective date of your coverage or the date they first meet the eligibility criteria.

Your identification card

Once you and your totally and permanently disabled children are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage for you and your eligible dependents.

Termination

Your totally and permanently disabled child shall lose eligibility for coverage on the earliest to occur of:

- The date they are deemed no longer to be totally and permanently disabled by the (Company) Plan Administrator
- The marriage date of the child
- The date the child ceases to be dependent upon you or your spouse for Federal Income Tax purposes and/or earns more than \$10,000 per year from regular employment
- The date the child no longer meets the residency requirement
- The date the court order, divorce decree or other Qualified Medical Child Support Order (QMCSO) ordering you to provide health care coverage has expired
- The date you or your spouse, or the order of a court of competent jurisdiction, terminates the legal obligation for total or partial support for a child who met the criteria for placement for adoption under OBRA 93
- The date a child over age 25 (age 24 effective January 1, 2009) is no longer totally and permanently disabled
- The date of the child's death
- The date the child no longer meets any other eligibility requirements of the Plan

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Optional Sponsored Dependent Coverage

You may obtain optional employee-paid medical and prescription drug coverage (but not dental and vision) for certain eligible dependents through the Sponsored Dependent Program. The employee will pay the full cost of the coverage for sponsored dependents.

Your Sponsored Dependent is eligible for coverage if you are eligible and enrolled for coverage, and meet all of the following requirements:

Relationship

"Sponsored Dependents" include:

- A dependent parent of an employee, retiree or employee's spouse
- An unmarried child or stepchild of an enrollee who resides with the enrollee, but is not eligible as a dependent child
- A blood relative who does not qualify as a dependent by legal guardianship
- A non-relative (such as a fiancée) whom resides with you and is claimed as an exemption on your Federal Income Tax returns

Age

There is no age requirement

Residency

- The sponsored dependent **must** reside with you as a member of your household
- The sponsored dependent **must** be a resident of the United States for at least one full year, when applicable, prior to being enrolled for such coverage and be legally entitled to remain in the United States indefinitely before becoming eligible for coverage

Tax Dependent

You **must** claim an exemption for the sponsored dependent on your Federal Income Tax return.

Enrollment and Effective Dates

Call the NESC at 1-800-248-4444 to initiate the enrollment of your Sponsored Dependent. The NESC will inform you of any required documentation for proving eligibility for any dependent you enroll for coverage.

- Failure to furnish any required documentation will result in denial of coverage
- A sponsored dependent may not be covered by more than one Ford employee or retiree

Coverage for Optional Sponsored Dependents is effective on:

- The later of the effective date of your coverage or the first day of the month following the month of receipt by the Company of any supporting documentation required by the Company to prove eligibility.
- The effective date of coverage for a sponsored dependent previously enrolled as such, and whose coverage as a sponsored dependent was discontinued, is the first day of the sixth month following the month in which a valid enrollment is completed

Your identification card

Once you and your sponsored dependent are eligible and enrolled for coverage, you will receive identification (ID) cards from the plans you enroll in. These cards should be presented to health care providers as confirmation of coverage. Sponsored dependents will receive their own ID cards. For more information on ID cards, see the "Health Care Claims" section.

Termination

Your sponsored dependent will lose eligibility for coverage on the earliest to occur of:

- The last day of the month in which the sponsored dependent ceases to meet the eligibility requirements shown above
- The last day of the month preceding the month for which a required contribution was due but not paid
- The date your coverage ends, except that in the case of your death, coverage for the sponsored dependent will end on the last day of the month following the month in which you die, unless the coverage is continued by your eligible Surviving Spouse
- The date of your sponsored dependent's death

If and when any of the above circumstances occur, call the NESC at 1-800-248-4444 and remove your ineligible dependent(s).

Refer to the "Other Health Care Plan Information, When may I continue my coverage under COBRA", section of this handbook for information about self-pay continuation of coverage options.

Health Care Plan

Hospital-Surgical-Medical Coverage

This section of your handbook answers these questions:

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Health Care Plan - Hospital-Surgical-Medical Coverage

What is The National PPO Plan?

The Traditional Hospital-Surgical-Medical Plan is called the National PPO Plan and continues to be administered by Blue Cross Blue Shield (BCBS).

The National PPO Plan has an in-network benefit level and an out-of-network benefit level.

In-Network benefit level

If you receive covered services from an in-network BCBS National PPO Plan provider, there are no payment changes to the benefit plan.

To determine whether your physician participates in the BCBS National PPO Network, you may call Blue Cross Blue Shield at 1-800-810-2583, or search the BCBS website at <http://www.bcbs.com/healthtravel/finder.html> for information.

Out-of-Network benefit level

If you receive covered services from an out-of-network BCBS National PPO Plan provider, you will be required to pay an additional 10% co-insurance for those covered services. The most you will pay for the 10% out-of-network co-insurance is \$250 per person or \$500 per family, each calendar year.

- In addition, if you use an **out-of-network** BCBS National PPO Plan provider who is also a **non-participating** provider with the BCBS Traditional Plan, you may be responsible for any changes above the BCBS maximum allowable payment amount.
- If, however, you receive covered services from an **out-of-network** BCBS National PPO Plan provider who is a **participating** provider with the BCBS Traditional Plan, covered charges will be subject to the 10% out-of-network co-insurance, but you should not be balance-billed for charges above the BCBS maximum allowable payment amount (and if you are balance billed in this case, you are not responsible to pay those additional charges above the BCBS maximum allowable amount.)

Mental Health & Substance Abuse Program

Coverage for psychiatric care and substance abuse treatment is unchanged; active employees should continue to utilize the Managed Care Psychiatric and Substance Abuse Program. Refer to “How does the Managed Care Program Work?” later in this section for additional information.

If You have Medicare

BCBS enrollees who have Medicare are included in the National PPO Plan. If you are an active employee with Medicare and your UAW-Ford coverage is primary, you are subject to the 10% out-of-network co-insurance.

If Medicare is your primary carrier (meaning Medicare pays first), covered charges are not subject to the 10% co-insurance for out-of-network services under the Ford Plan.

Out-of-Network referrals

Covered referrals can be made only by in-network BCBS National PPO Plan providers. If your in-network PPO provider refers you to an out-of-network provider and obtains approval from BCBS, covered approved services from the out-of-network provider will be paid at the in-network benefit levels.

Services received out-of-network without an approved referral are subject to the 10% out-of-network coinsurance. You may also be responsible for any charges above the BCBS maximum allowable payment amount, if the provider does not participate with the BCBS Traditional Plan.

Important notes

Throughout the rest of this health care section, reference to “the Plan” means the information stated applies to the BCBS National PPO Plan.

All claim examples and coverage descriptions in this section assume that National PPO enrollees are utilizing in-network National PPO Plan providers.

How does Hospital-Surgical-Medical coverage work?

Hospital-Surgical-Medical benefits cover most medically necessary health care services for you and your eligible dependents.

Note: BCBS National PPO in-network and out-of-network benefit levels may apply.

Hospital-Surgical-Medical benefits are provided for covered hospital, surgical and medical expenses for you and your eligible dependents. Covered services include hospital room and board charges, along with customary hospital-related services and supplies and some outpatient and home care services. Surgical-Medical benefits cover the maximum allowable payment as defined below, for physicians' services, surgery, tests and most other health-related expenses.

Information relating to your eligibility for Hospital-Surgical-Medical coverage is provided in the "Eligibility for Health Care Coverage" section of this handbook.

Maximum allowable payment

Reimbursement is based on the lower of the providers charges or the BCBS maximum allowable payment for a covered service.

The predetermination feature (prior authorization)

Your Hospital-Surgical-Medical coverage has a special feature, "predetermination." Predetermination determines whether hospital admission is appropriate. Once the hospital admission is approved, an appropriate length of stay is established and your physician and the hospital will be notified. Your covered charges then will be paid according to your plan's provisions.

The predetermination feature requires physicians and hospitals, not you, to notify and obtain approval from the claims processor before non-emergency hospitalization can occur. Emergency admissions must be reported within 24 hours by providers. Predetermination is not required for a maternity admission.

While you are in the hospital, the length of your stay will continue to be reviewed.

If you have been notified that predetermination approval for hospitalization has been denied but you elect to be hospitalized, you will pay 20% of your covered hospital expenses, the first \$100 of your physician expense and 20% of the remaining covered physician expenses up to a calendar year maximum of \$750 per individual or \$1,500 per family. After this amount is reached, covered services are paid according to your plan's provisions for the remainder of that calendar year.

If you are admitted to the hospital but are not notified that your hospital admission has been denied, you will not be held responsible for the extra predetermination charges in the paragraph above incurred for covered services. You will be held harmless from the provider's errors of commission or omission.

The voluntary second surgical opinion feature

Note: *BCBS National PPO in-network and out-of-network benefit levels may apply.*

The second opinion program is strictly voluntary, and is described as follows.

The voluntary second surgical opinion feature is designed to enhance quality of care and to reduce unnecessary inpatient surgery. This feature provides you and your eligible dependents with additional information on the risks and benefits of the surgery as well as available treatment alternatives.

When you and your eligible dependents are faced with covered surgery, a second surgical opinion may help you decide:

- If an operation is necessary
- If a different treatment is more appropriate

If you decide to seek a voluntary second surgical opinion, benefits will be provided under the Plan for the cost of the second opinion, including the physician's consultation and any necessary x-ray and laboratory tests. When the second opinion does not agree with the first, a third opinion also is covered under the Plan. Non-surgical medical consultations also are covered under the Plan when recommended by the second opinion physician because of medical complications which may affect your surgery.

Second and third opinions are covered only when they relate to covered surgeries that take place in an inpatient or outpatient hospital setting, or approved ambulatory surgery facility. They are covered only when performed by a M.D., D.O., D.P.M. or oral surgeon. Second and third opinions are not covered when performed by a Chiropractor, Psychologist or Dentist. Also, the second and third opinions cannot be sought from the physician who performed your initial diagnosis.

BCBS National PPO Plan members must utilize in-network PPO providers for surgical opinions to be paid at 100% of the maximum payment allowed under the plan. Opinions performed by out-of-network PPO providers will be subject to the 10% out-of-network co-insurance amount. You may also be responsible for any charges above the BCBS maximum payment allowed when you utilize an out-of-network PPO provider who does not participate with the BCBS Traditional Plan.

No matter what the second or third opinions are, you're still free to choose whether or not to have the surgery. Even if the second opinion states that surgery is unnecessary, your Hospital-Surgical-Medical coverage still provides benefits for the surgery, as long as the surgery is a covered procedure.

The case management feature

Another feature of your Hospital-Surgical-Medical coverage is "case management." Case management is a process of substituting alternative, non-hospital care for traditional inpatient care. The alternative care may consist of covered services and, in addition, services over and above present coverage such as private duty nursing in the home to allow patients who would otherwise be confined to a hospital to live a more normal life within the family setting. The primary objective of case management is to design alternative treatment plans that maintain or improve the quality of life while providing more cost effective care.

You and your eligible dependents can participate in the case management program if the patient has remaining health care benefit eligibility and the patient and the attending physician agree to the alternative treatment plan prior to implementation. Participation in the plan is voluntary. You may elect to return to your regular health care coverage at any time (assuming such health care benefits have not been exhausted).

What hospital-related services are covered?

Generally, when you or your eligible dependents are confined in a hospital, most services are covered. Benefits also are paid for approved outpatient care.

Hospital coverage as an inpatient

Hospital benefits are paid under the plan for covered services for up to 365 days while you or your eligible dependents are confined in a hospital. Up to 45 of the 365 days are covered for treatment of a mental or nervous condition or pulmonary tuberculosis. A new 365-day or 45-day period begins when you have not been in the hospital or a similar facility (e.g., a skilled nursing facility, a day or night care center or residential substance abuse treatment facility) for 60 consecutive days.

Note: BCBS National PPO in-network and out-of-network benefit levels may apply.

Covered services include:

- Semiprivate room and board charges, including all regular daily services. Charges for a private room are covered at the hospital's standard rate for a semiprivate room, unless you need a private room for intensive care or isolation. If you choose a private room, you pay the amount over the semiprivate room rate
 - Hospital services and supplies, including general nursing care, meals and special diets
 - Intensive care
 - Drugs and medicines
 - Oxygen and gas therapy
 - Use of operating rooms, other surgical treatment rooms and delivery rooms
 - Anesthesia given by a qualified hospital employee
 - Certain blood services and their administration, including whole blood and packed red blood cells
 - Hemodialysis when provided by a qualified hospital
 - Dressings and casts
 - Physical and electroshock therapy provided by the hospital
 - Use of the hospital's radium, cobalt and radioactive isotopes
- Chemotherapy and its administration, including most oral chemotherapy and drug injections, but not experimental chemotherapy drugs (similar chemotherapy administered in the physician's office or the patient's home also is covered)
 - Use of durable medical equipment, as described in the "What benefits are provided for durable medical equipment?" section
 - X-rays, two-dimensional echocardiography EKGs, and digital subtraction angiography
 - Prosthetic appliances
 - Laboratory services
 - Intermittent positive breathing therapy
 - Rehabilitation care
 - Pulmonary function evaluation
 - Hyperbaric oxygenation
 - Psychological testing administered by a qualified hospital employee
 - Skin bank, bone bank and soft tissue bank
 - Costs for human organ transplants, including:
 - ◊ Locating, evaluating, removing, preserving and transplanting human organs and tissues
 - ◊ Care of potential and actual donors, to the extent not covered by any other medical plan
 - Maternity care (including routine nursery care of newborns)

Maternity and Newborn Infant Health Coverage

Consistent with the "Newborns' and Mothers' Health Protection Act of 1996" (NMHPA), in connection with childbirth for a covered mother or newborn child, your coverage does not restrict benefits to, or require authorization for, any hospital length of stay of less than:

- 48 hours following vaginal delivery
- 96 hours following caesarean delivery

Of course, the mother and physicians may decide on a shorter stay if appropriate, and all other Plan provisions are unchanged. Alternative plans, such as HMOs and PPOs, follow the same rule as well.

Hospital coverage as an outpatient

Note: BCBS National PPO in-network and out-of-network benefit levels may apply.

The benefits listed above in the “Hospital coverage as an inpatient” section are covered under your plan’s benefit structure when you receive them on an outpatient basis from a hospital when ordered by the attending physician, except:

- Medications are covered only when dispensed and used in the hospital in connection with the use of operating or surgical treatment rooms, anesthesia or physical therapy.
- Laboratory services are covered only when used with outpatient surgery, emergency treatment or treatment of accidental injuries or when received within 72 hours of a hospital admission.
- Up to 60 treatments per calendar year (per condition) are covered for outpatient physical therapy in a hospital or **approved physical therapy facility**.^{*} The limit may be renewed after surgery or a distinct aggravation of the original condition. The outpatient physical therapy benefit includes coverage for separately billed speech, hearing and functional occupational therapy (whether or not provided in conjunction with physical therapy).
- A separate series of 60 treatments also may be available for speech therapy to treat congenital and severe developmental speech disorders for children under age six. Benefits may be paid after attainment of age six for continuous treatment which began prior to age six up to the 60-visit limit. To qualify, therapy must not be available through a public agency.
- The Hourly Outpatient Physical Therapy Program in Michigan only is administered by TheraMatrix. The program provides necessary services through a managed care program for eligible hourly employees and their eligible dependents (including eligible sponsored dependents) enrolled in the National PPO in Michigan and Blue Preferred Plus PPO plans. The program is designed to provide accessible services in a managed care environment while providing cost savings. Please see the “What benefits are provided for the TheraMatrix Outpatient Physical Therapy Program?” section of this handbook for additional details on the TheraMatrix Outpatient Physical Therapy Program **in Michigan**.
- Outpatient observation bed care is covered under your plan’s benefit structure when it meets Plan criteria.

Infusion therapy is covered under your plan’s benefit structure in the hospital outpatient department (or the physician’s office) in accordance with Plan criteria.*

Some outpatient services are provided outside of the hospital in a physician’s office or another facility (e.g., a skilled nursing facility). Information relating to these benefits is explained in the following sections: “What surgical and medical services are covered?”; “What benefits are provided for treatment at a skilled nursing facility?”; “What benefits are provided for coordinated home care?”; “What benefits are provided for psychiatric care and substance abuse treatment under the MCP?”

* Call your claims processor to verify if a facility or planned treatment is approved.

Outpatient services for covered surgery at an Ambulatory Surgical Facility (ASF) or Freestanding Ambulatory Surgical Center (FASC) **approved by the Plan are covered**. To be approved by the Plan, an ASF or FASC must meet certain licensing, accreditation, and similar criteria, and also satisfy Plan standards which may consider whether more facility capacity is needed in a given area. Check with the Plan before you are treated at such a facility to find out if it is an approved facility.

Outpatient hospital charges related to dental services are covered under the Hospital-Surgical-Medical plan based on Control Plan guidelines for enrollees with special needs (e.g., Down’s Syndrome, autism, spastic conditions), medical conditions that are marginally controlled, or dental conditions that may adversely impact their medical conditions (e.g., uncontrolled diabetes with periodontal disease). Charges for the actual dental services will continue to be paid by your dental plan.

Following documentation of no measurable signs of healing, following at least 30 days of standard wound therapy, up to 60 hospital outpatient hyperbaric oxygenation treatments per condition per calendar year are covered for conditions which are covered by Medicare and which meet criteria established by the Control Plan. Treatment must be administered in a chamber and for the treatment of wounds and must be used in addition to standard wound care. Continued treatment with hyperbaric oxygen therapy is not covered if measurable signs of healing have not been documented within any 60-day period of treatment (within any 30-day period for diabetic wounds).

Ambulance services

Effective January 1, 2008, the benefit for ambulance services will include ambulance treatment when treatment is performed by qualified ambulance personnel in lieu of transportation to a hospital.

Ambulance services are a covered benefit under the following conditions:

- Ambulance services must be medically necessary
- The provider of the ambulance service must meet Medicare criteria for approval

Ground transportation between facilities

A physician must prescribe services which necessitate use of ground ambulance transportation between facilities.

Ambulance benefits are provided for local ground transportation within the greater metropolitan area when the need for services arises and for purposes of:

- Transferring (one-way or round trip) of a hospital inpatient, or patient seen in the emergency room, to another local hospital when a lack of needed treatment facilities, equipment or staff physicians exists at the first hospital, or
- Transporting (one-way or round trip) of a hospital inpatient to a non-hospital facility for examination with a covered CAT, MRI or PET scan and the following conditions are met:
 - ◇ The services are not available in the hospital where the member is inpatient and are not available in a closer local hospital, and
 - ◇ The free-standing facility providing the treatment is approved by any applicable state planning agency or comparable approval process

Emergency transportation: ground / air /water

Benefits for emergency transportation services are provided for ground, air and water ambulances. Services are covered for emergency transportation for:

- Transporting a patient one-way from the scene of an emergency incident to the nearest available facility qualified to treat the patient.
- Transporting a patient one-way or round trip from the home to the nearest available facility qualified to treat the patient.
- Medical emergency/accidental injury patients are provided one-way transportation from the home to the facility. The return trip following stabilization is not covered.
- Home-bound patients are provided round trip transportation from the home to the facility and back when medically necessary and when other means of transportation could not be used without endangering the patient's health.

Coverage at nonparticipating hospitals

If you are covered by the National PPO Plan, some special hospitalization rules apply. Most hospitals in the United States are described as "participating" by Blue Cross. A participating hospital is a facility that is approved by Blue Cross and receives full payments from Blue Cross for covered services.

If you are enrolled in the National PPO Plan and you are admitted to a nonparticipating hospital, hospital coverage will pay up to a maximum benefit of:

- \$250 a day toward covered hospital services (including \$20 for ancillary services) you receive as an inpatient in an acute care hospital
- \$15 per day for services in other than an acute care hospital (e.g., a mental health facility) and
- \$35 for each condition for services received on an outpatient basis
- Emergency services immediately following a serious (e.g., life threatening) bodily injury or medical emergencies are covered, not to exceed the average amount paid to nonparticipating hospitals within the Plan area

You should find out which of your local hospitals participates in Blue Cross before you need emergency hospital care. Blue Cross or the facility can tell you if it is "participating." Please see 'What is the National PPO Plan' at the beginning of this section for information on Blue Cross in-network and out-of-network coverage.

What surgical and medical services are covered?

Surgical-Medical benefits cover many surgical and medical services you and your eligible dependents receive.

Note: BCBS National PPO in-network and out-of-network benefit levels may apply.

Your Surgical-Medical benefits cover the maximum allowable payment amount for certain medical and surgical services which include:

- General inpatient care for medical and non-pulmonary tubercular conditions by the physician rendering the service for hospital bed patients for an unlimited number of days
 - Surgical fees for all generally accepted operative and cutting procedures, including laser surgery for covered procedures necessary for the diagnosis and treatment of diseases, injuries, fractures, dislocations and reconstructive surgery for the following:
 - ◊ The correction of conditions resulting from accidental injuries or traumatic scars
 - ◊ The correction of congenital anomalies
 - ◊ Reconstructive plastic surgery to correct deformities resulting from medically necessary surgery due to malignancy or fibrocystic disease and reconstructive surgery when there is a visual impairment
 - Physician services to donors and potential donors for medically recognized human organ or tissue transplants to the extent not covered by any other medical plan
 - Heart, heart-lung, lung, pancreas and liver transplants, up to a \$25,000 limit on physicians' and surgeons' fees
 - Assistant surgical physicians' fees for certain procedures, if an intern, resident or staff physician is not available
 - Necessary surgical, medical or obstetrical consultation by another physician, if requested by the physician in charge of your case when you are an inpatient
 - Delivery of a child or children, necessary pre- and post-natal care and routine laboratory services in connection with normal maternity care
- Routine medical care of the newborn and a separate benefit for initial inpatient examination of the newborn when provided by:
 - ◊ A physician other than the delivering physician
 - ◊ The physician who administered the anesthesia during delivery
 - Charges for anesthesia and its administration in connection with surgical, medical or obstetrical care when administered by a physician other than the one in charge of the case
 - General anesthesia services when performed and billed directly by a nurse anesthetist where legally permitted
 - Continuous passive motion (CPM) will be covered after knee surgery if initiated within the first 48 hours following surgery, and utilized a maximum of 20 days immediately following surgery
 - Physicians' services for hemodialysis
 - Therapeutic radiological services, if necessary for the treatment of an illness or injury
 - Physicians' services to administer chemotherapy
 - Pulmonary function tests provided in accordance with Control Plan criteria for location of service, including the hospital outpatient and physician office setting
 - CAT scans and MRI services are covered benefits when ordered by a physician, and performed on approved equipment
 - Diagnostic X-rays, laboratory and pathology tests when related to diagnosis of an illness or injury (miniature plates, screening procedures and diagnostic X-rays related to a routine physical exam are not covered)
 - PAP smear tests performed once every 12 months unless prescribed more frequently by a licensed physician for one of the following medical conditions:
 - ◊ Previous surgery for a vaginal, cervical or uterine malignancy
 - ◊ Presence of a suspect lesion in the vaginal, cervical or uterine areas
 - ◊ A positive PAP smear leading to surgery and requiring post-operative PAP smear

- Routine mammography screening and Magnetic Resonance Imaging (MRI) Breast Screening in accordance with guidelines established by the American Cancer Society as follows:
 - ◊ A baseline mammogram at age 40
 - ◊ A mammogram every one to two years between ages 40 through 49 depending on risk factors and physician recommendation
 - ◊ A mammogram once each year after age 50 is attained
 - ◊ Enrollees determined to be at increased risk for breast cancer based on family history (1st degree family member), genetic factors or previous breast cancer are eligible to undergo annual mammography examinations beginning at age 25.
 - ◊ An annual MRI breast screening (along with a mammogram) if the person has at least one of the following conditions:
 - A BRCA1 or BRCA2 mutation
 - A 1st degree relative (parent, sibling, child) with a BRCA1 or BRCA2 mutation, even if they have not been tested.
 - Lifetime risk of breast cancer scored at 20-25% or greater, based on one of several accepted risk assessment tools that look at family history and other factors
 - Had radiation treatment to the chest between ages 10 and 30
 - Has Li-Fraumeni Syndrome, Cowden Syndrome, or Bannayan-Riley-Ruvalcaba Syndrome, or may have one of these syndromes based on a history in a 1st degree relative
- PSA (Prostate-Specific Antigen) screening testing once each calendar year for enrollees ages forty (40) and older provided the test is performed in accordance with guidelines established by the American Cancer Society. PSA tests used to confirm a diagnosis of cancer or to track the progress of the disease, and to determine the effectiveness of their treatment being given will continue to be covered regardless of age. A second screening within the same calendar year will be provided if the first PSA test indicates a PSA level of 4.0 or higher.
- Proctoscopic examinations with biopsy; after you reach age 40, proctoscopic examinations without a biopsy are covered once every three years
- Flexible Sigmoidoscopy, Barium Enema and Colonoscopy: One (1) flexible sigmoidoscopy or one (1) barium enema every 5 years, or one colonoscopy every 10 years, beginning at age 50.
- Enrollees determined to be at increased risk for colorectal cancer based on family history or genetic factors, are eligible to undergo colonoscopy and/or flexible sigmoidoscopy and fecal occult blood examinations every 2 years as of age 25, and annually as of age 40
- Fecal Occult Blood Test or Fecal Immunochemical Test: one (1) test per year, beginning at age 50.
- Cancer Antigen screening test (CA-125) is covered:
 - ◊ Once per calendar year for those enrollees age 25 and older with family history of ovarian cancer (1st degree family member)
 - ◊ At the time of diagnosis of ovarian cancer, and up to three follow-up tests per calendar year to determine the effectiveness of therapy
 - ◊ Up to twice per calendar year for those who have been diagnosed with ovarian cancer and who are in clinical remission
- Hepatitis C (HCV) screening is provided if an enrollee is at risk or when signs or symptoms may indicate a Hepatitis C infection
- Total Serum Cholesterol with Low Density Lipoprotein (LDL) Test: coverage is provided for one test every five years, beginning at age 20
- Procedures that require a physician's expertise for injection, implantation, insertion, fitting and removal of covered contraceptives
- Cosmetic bonding of eight front teeth for children age eight through the end of the calendar year in which they become age 19 because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of three consecutive years

Your Surgical-Medical benefits also cover the maximum allowable payment for:

- Physical therapy for non-Medicare enrollees, in an office setting by a physician or an independent physical therapist (but not a chiropractor) participating with or approved by the Plan, and subject to treatment limits together with outpatient hospital-based therapy
- Physician services during covered hospital outpatient observation bed care
- Administration of rabies vaccines necessitated by recent exposure to a rabid or potentially rabid animal. Regardless of where initial treatment is performed, follow-up treatments may be performed in a physician's office or a hospital outpatient setting
- One flu shot per calendar year, administered in accordance with Plan criteria.
- Enrollees are covered for immunizations as recommended by the Centers for Disease Control Advisory Committee on Immunization Practices and for the cost of separately billed charges for administering the injection of covered immunizations, but not any related office visit charges. (For BCBS National PPO members, these services are covered in-network only.) Covered immunizations and vaccinations include those used to prevent the following disease or conditions:
 - ◇ Tetanus
 - ◇ Pertussis
 - ◇ Poliomyelitis
 - ◇ Hepatitis A and
 - ◇ Meningococcal disease (e.g., meningitis)
- Well-baby care services as defined by the Control Plan up to six visits prior to age two. (Covered in-network only for BCBS National PPO members.)
- In-network office visits for BCBS National PPO members will be regarded as a covered service, but with a 100% member co-pay. Office visit charges paid by the member will not apply to the \$250 individual or \$500 family annual out-of-pocket maximum described earlier in this section.
- Effective March 1, 2008, if the HMO or Alternative PPO the employee was enrolled in is no longer offered to the hourly active UAW population and no other HMO or alternative PPO plan is available in that geographic area, the Hourly National PPO will provide, effective with the date the HMO or alternative PPO plan ceases to be available, five office visits per eligible enrolled contract (family) per benefit year at a co-payment of \$25 per visit.

Generally, most services you will need in the event of an emergency are covered by Hospital-Surgical-Medical benefits.

Benefits are provided for treatment of accidental injuries and certain health-threatening or disabling medical emergencies. A "health-threatening" or disabling medical emergency is a condition that:

- Could place your health in danger or cause significant impairment of bodily functions
- Requires professional medical attention and treatment
- Has symptoms which occur suddenly and unexpectedly
- Is treated within 72 hours of the time the condition started
- Has signs or symptoms, verified by a physician at the time of treatment, confirming the health-threatening or disabling condition

Benefits are provided in full for hospital emergency room services in participating hospitals *only* if your condition is a medical emergency or accidental injury. Physicians' services for the initial examination and treatment also are covered wherever administered. Follow-up care is not covered under the emergency benefit.

What benefits are provided for treatment at a skilled nursing facility?

Benefits are paid if you receive care from an approved skilled nursing facility (sometimes referred to as a convalescent or long-term illness care facility).

In some situations, your physician may find it appropriate to discharge you from the hospital and transfer you to a skilled nursing facility for further treatment. Or your physician may admit you directly into an approved skilled nursing facility without prior hospitalization, if it is an appropriate site for treatment.

If you receive services from a skilled nursing facility, Hospital-Surgical-Medical benefits will be provided for:

- Semi-private room and board charges and related services
- A maximum number of physicians' visits equal to two visits per week

Benefits for general conditions are provided for up to 730 days or two days for every one day of unused hospital care. For example, if you are admitted to a skilled nursing facility after spending 100 days in the hospital, you can receive benefits for up to 530 days while you are in the skilled nursing facility.

A new 730-day period begins when you have not been in the hospital, a skilled nursing facility, a day or night care center or residential substance abuse treatment facility for 60 consecutive days.

No benefits are provided for custodial care or treatment of tuberculosis.

What benefits are provided for coordinated home care?

If you receive care at home, instead of a hospital or other facility, certain services are covered.

Under certain circumstances, your physician, with your approval, may have you receive continuing care from an approved home health care agency (if one is available in your area), if you are discharged early from a hospital or other approved facility. Your physician also may recommend that you receive home health care services without prior hospitalization.

Hospital-Surgical-Medical benefits are provided for up to three home care visits for each remaining hospital or convalescent care day as long as you remain medically eligible. Charges for the following services received during a home care visit are covered:

- Necessary nursing care
- Drugs, supplies, laboratory tests and other related services
- Necessary services of a part-time health aide employed by the agency
- Physical therapy and speech therapy

These benefits are available only through an **approved** home health care agency. Custodial care and physicians' visits to your home are not covered.

Home care kidney machines

Hospital-Surgical-Medical benefits cover the use of an artificial kidney machine in your home for hemodialysis treatment. Included are reasonable and necessary expenses for supplies and for installing and maintaining the equipment.

If you use such a machine, you may be eligible for Medicare benefits, regardless of your age. Your local Social Security office has more information.

Infusion therapy

Infusion therapy covered in the hospital outpatient and physician's office may also be covered under the coordinated home care when approved in accordance with Plan criteria.

What benefits are provided for hospice care?

Hospital-Surgical-Medical benefits are available for hospice care in approved programs in most locations.

Focusing on the patient and the patient's family as the unit of care, Hospital-Surgical-Medical benefits are available for hospice care through approved hospice care programs in most locations for persons having a life expectancy of six months or less. Participation in the program is voluntary and requires concurrence of the attending physician.

Generally, five levels of care are provided by the hospice care program:

- Routine home care to maintain the terminally ill patient at home
- Continuous home care for periods of crisis where predominantly skilled continuous care is necessary to manage the patient's acute medical symptoms
- Inpatient respite care in an approved inpatient facility to provide caring family members or other persons caring for the patient a short period of relief
- General inpatient care for pain control or acute or chronic symptom management of the patient
- Nursing home care with hospice support for hospice patients who are medically stable but unable to return home because no primary care support is available

Hospice care programs within specific areas will be based on available resources. Consequently, hospice care coverage may differ between areas. Contact the Health Care Plan in which you are enrolled for coverage available in your area and to determine any lifetime maximum benefit amount.

Note: *If you anticipate meeting the limit, you may request to be admitted into the Case Management Program.*

What is Coordinated Disease Management?

If you are a non-Medicare, UAW-Ford member with coverage through the BCBS National PPO Plan, you may be eligible to participate in this program.

This program may pay alternative benefits to members who participate in disease management with Healthy Highway (LifeMasters). The CDM program is administered by BCBSM. Coordinated Disease Management (CDM) is a voluntary and confidential program for members with illnesses such as:

- Heart disease
- Diabetes
- Asthma

which caused a hospital stay or two or more emergency room visits in the last twelve months.

CDM can work with the physician you are already seeing. It can help you and your physician by:

- Developing treatment plans and
- Providing access to necessary healthcare services and educational programs

If you meet the eligibility criteria and decide to participate, here is what happens:

- You are assigned a nurse care manager (a registered nurse) to help you and your physician coordinate your care
- Your nurse care manager contacts you to ask questions about your health, medications, etc.
- Your nurse care manager talks to your physician
- Your nurse care manager works with you and your physician to design a personal treatment plan based on your diagnosis, risk factors, and health care needs
- You begin receiving services

The CDM program may cover services in addition to the benefits ordinarily covered by your health plan. Depending on your personal needs, your treatment plan may include:

- Primary physician (up to 4 visits)
- Specialist (up to 2 visits)
- Cardiac rehabilitation (up to 18 visits)
- Diabetic educational classes
- Supervised exercise classes
- Nutritional counseling

and more

If you are interested in CDM (Coordinated Disease Management), please call its toll free number to learn more:

1-800-768-6787

Participants are encouraged to complete the CDM program. Most participants complete the CDM Program in 6 to 12 months, depending on factors such as their customized (specific) goals. However, a member can stop participating at any time and continue to receive regular Plan benefits. Any extra benefits provided through CDM will stop once a member leaves the CDM program.

What is Healthy Highway?

If you are a non-Medicare, UAW-Ford member enrolled in the BCBS National PPO Plan you may be eligible to participate in this program.

Healthy Highway (formerly Continuum of Care) is a voluntary and confidential total health management program, which supports the entire care continuum from those who are well to those with chronic conditions. If you are interested in more information on the Healthy Highway Program please call 1-888-441-2525 or you can log into their website <http://healthyhighway.online.staywell.com>.

What is Complex Care Management?

If you are a non-Medicare, UAW-Ford member enrolled in the BCBS National PPO Plan you may be eligible to participate in this program.

Note: BCBS National PPO in-network benefit levels may apply.

Complex Care Management is a voluntary and confidential program for BCBS National PPO members facing a serious illness. Facing a serious illness can be frightening and confusing. The Complex Care Management program is designed to:

- Provide you with health care information and support you and your family in your decision making process.
- Act as your advocate and educate you about treatment options so that you can make informed decisions about which treatments are right for you.
- Act as a central point of contact to coordinate medical services.
- Ease the burden of managing a complex illness, allowing you to focus on the most important thing — your health.
- Help you maintain control of the care you receive.
- Work with your physicians to coordinate treatment.

The Complex Care Management Program is administered by Blue Cross and Blue Shield of Michigan and Alere (formerly Paradigm Health, Inc.).

To learn more about the Complex Care Management Program, please contact Alere toll free at 1-877-233-1694.

What benefits are provided for durable medical equipment?

Hospital-Surgical-Medical benefits are generally provided for durable medical equipment covered by Medicare Part B and certain other equipment.

If you are enrolled in the BCBS National PPO Plan with or without Medicare you are covered under the UAW-Ford National DME and P&O SUPPORT Program.

The UAW-Ford National DME (durable medical equipment and P&O (prosthetic & orthotic) SUPPORT Program provides convenient access to quality products and skilled professional care through a national network for persons whose physical condition requires using in-home DME, respiratory or certain hyperalimentation services.

For services that are not provided in a hospital or other facility setting, the SUPPORT Program will generally cover all medically necessary DME covered services when they are arranged for by the SUPPORT Program. You are required to have a prescription from your physician to obtain services or equipment.

Generally, DME benefits pay for a wide range of non-hospital durable medical equipment services including those approved by Medicare Part B as approved by the Company-Union Committee or as collectively bargained. Examples of durable medical equipment covered by Medicare Part B are as follows:

- Hospital beds and related equipment
- Equipment used to increase mobility
- Certain bathroom aids and therapeutic equipment
- Oxygen and breathing apparatus
- Health monitoring devices
- Repair (but not routine maintenance) of approved equipment
- Certain nutritional tube feedings

The following are examples of additional equipment also covered by the Program:

- Type I portable insulin infusion pumps and blood sugar monitoring devices for diabetics
- Blanket supports
- Neuromuscular stimulators
- Electromagnetic bone growth stimulators
- Positional transportation chairs

- Pressure gradient supports when prescribed for circulatory insufficiency conditions to promote and restore normal fluid circulation in the extremities and when prescribed to enhance and prevent scarring of burn patients
- Phototherapy (bilirubin) light with photometer, for infants under the age of one who have a diagnosis of hyperbilirubinemia
- Special features which are necessary to adapt otherwise covered equipment for use by children
- Continuous passive motion (CPM) devices for use on elbow and shoulder after surgery and after a total knee replacement. CPM will be covered after surgery if initiated within the first 48 hours following surgery, and utilized a maximum of 20 days immediately following surgery.
- Automatic external defibrillator with integrated electrocardiogram analysis
- Intermittent limb compression device and accessories

Out-of-Network services

If covered services are ordered from a provider outside of the SUPPORT network, the SUPPORT Program will pay 80% of the maximum payment amount (this is the approved amount for covered services). You will be responsible for the remaining 20% of the maximum payment up to an annual \$500 out-of-pocket maximum. After you have met your annual out-of-pocket maximum, the SUPPORT Program will reimburse you 100% of the maximum fee payment allowed for covered services. Also you may be responsible for paying the difference between the actual amount billed by the out-of-network provider and the maximum payment amount. This difference may be substantial. In order to avoid or limit out-of-pocket costs, you or the out-of-network provider should call the SUPPORT Program to determine if the services are covered, the approved payment allowed, and amount of the provider's bill for which you may be responsible.

Note: *SUPPORT Program co-pays do not apply toward BCBS National PPO co-pay maximums.*

Customer service information

You or your provider may call 1-800-831-0999 to obtain services or to ask questions. One call coordinates all of your SUPPORT Program care. Services are provided 24 hours a day, seven days a week.

What benefits are provided for prosthetic and orthotic appliances?

Hospital-Surgical-Medical benefits are provided for prosthetic and orthotic appliances approved by Medicare Part B and certain other items.

The UAW-Ford National DME and P&O SUPPORT Program provides convenient access to quality products and skilled professional care through a national network for persons whose physical condition requires prosthetic & orthotic (P&O) appliances.

For covered appliances, the SUPPORT Program will generally cover all medically necessary P&O covered appliances when they are arranged for by the SUPPORT Program. You are required to have a prescription from your physician to obtain services or equipment.

A prosthetic or orthotic "appliance" is, generally, artificial equipment needed to replace a nonfunctioning or missing part of the human body. Appliances prescribed by your physician are covered at the hospital's charge or the maximum payment allowed if billed by another provider. The expense for replacing, repairing, fitting, and adjusting a device also is covered with certain limits.

To be a covered benefit, prosthetic and orthotic appliances, including external appliances and excluding experimental or research appliances or devices, must be payable by Medicare Part B and approved by the Company-Union Committee or as collectively bargained.

In addition, the following items are covered subject to any stated conditions and to the other provisions of the Health Care plan and this section, even if not Medicare approved:

- Any style of orthopedic footwear, other than a basic oxford, when the shoes are an integral part of a covered brace
- All orthopedic shoe inserts, arch supports and shoe modifications, used with a shoe that is attached to a covered brace

- Individually fitted arch supports used with a shoe that is not attached to a brace. Coverage is limited to arch supports that are prescribed in writing by a physician for an orthopedic, neuromuscular, vascular or insensate foot condition approved by the Control Plan (excluding flat feet) that has failed to respond to a course of appropriate conservative treatment (e.g., physical therapy, injections, anti-inflammatory medications), or when prescribed arch supports as part of post surgical care. Once administratively feasible, all arch supports must be obtained from a provider approved by the UAW-Ford National DME and P&O SUPPORT Program. No additional payment will be made for separately billed charges for fitting the arch support. Adult enrollees are eligible for replacement arch supports only if received more than 36 months after receipt of the most recent previous arch support for the same condition for which benefits were payable under this plan. Arch supports for children may be replaced after 12 months if required by growth of the child
- Wigs are covered for enrollees who lose their hair as a result of undergoing chemotherapy or radiation therapy. Up to \$250 is available to cover the wig, wig stand and tape in the first year, and up to \$125 is available in subsequent years

Generally, prosthetic and orthotic appliances must be furnished through facilities approved by the SUPPORT Program.

To obtain service, you or the provider must call 1-800-831-0999; one call coordinates all of your SUPPORT Program care. Services are provided 24 hours a day, seven days a week. You are required to have a prescription from your physician to obtain services or equipment.

Out-of-Network services

If covered services are ordered from a provider outside of the SUPPORT network, the SUPPORT Program will pay 80% of the maximum payment amount (this is the approved amount for covered services). You will be responsible for the remaining 20% of the maximum payment up to an annual \$500 out-of-pocket maximum. After you have met your annual out-of-pocket maximum, the SUPPORT Program will reimburse you 100% of the maximum fee payment allowed for covered services. Also you may be responsible for paying the difference between the actual amount billed by the out-of-network provider and the maximum payment amount. This difference may be substantial. In order to avoid or limit out-of-pocket costs, you or the out-of-network provider should call the SUPPORT Program to determine if the services are covered, the approved payment allowed, and amount of the provider's bill for which you may be responsible.

Note: SUPPORT Program co-pays do not apply toward BCBS National PPO co-pay maximums.

Customer service information

You or your provider may call 1-800-831-0999 to obtain services or to ask questions. One call coordinates all of your SUPPORT Program care. Services are provided 24 hours a day, seven days a week.

What benefits are provided for mastectomy?

Surgery, reconstruction and prostheses following a mastectomy are covered.

Note: BCBS National PPO in-network and out-of-network benefit levels may apply.

Consistent with the “Women’s Health and Cancer Rights Act of 1998,” your benefits cover a member who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy.

While the other benefits of the Plan apply as well, coverage specifically includes:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas

Coverage is subject to all other plan provisions and requirements. If you choose an HMO or PPO, it will cover these services subject to its plan provisions and requirements.

What benefits are provided for under the TheraMatrix Outpatient Physical Therapy Program?

If you live in Michigan and are enrolled in the BCBS National PPO or Blue Preferred Plus PPO, outpatient physical therapy benefits are provided under the Outpatient Physical Therapy Program administered by TheraMatrix. Affected members will **not** receive a separate ID card for TheraMatrix and should continue to use their present BCBS ID card for all covered services.

The TheraMatrix program applies **only** to outpatient physical therapy services. Outpatient functional, occupational, speech and language therapy services will continue to be provided through the BCBS National PPO or Blue Preferred Plus PPO medical plans under the medical plan’s regular benefit provisions.

The TheraMatrix Program covers up to 60 outpatient physical therapy treatments for each non-chronic condition per plan year. The limit may be renewed following surgery or a definite aggravation of the condition that initially required the therapy. Outpatient physical therapy services under the TheraMatrix Program are also coordinated with any separately billed speech, language and/or function occupational therapy services when calculating the 60 treatments per calendar year (per condition) limitation.

The Plan will cover up to 10 treatments each plan year for chronic conditions, and these 10 treatments will also count toward the 60-treatment limit.

Outpatient physical therapy benefits are covered under the TheraMatrix Program as follows:

TheraMatrix In-Network Benefit Level

Covered outpatient physical therapy services provided by TheraMatrix participating network providers are covered in full. There are no out-of-pocket costs to covered members when medically necessary services are rendered by TheraMatrix network providers.

Contact TheraMatrix at 1-888-638-8786 to find a TheraMatrix network provider near you to avoid out-of-pocket expenses.

TheraMatrix Out-of-Network Benefit Level

Covered outpatient physical therapy services obtained from providers who are not in the TheraMatrix network are **not covered at all**, except in the following situations:

- If there are no TheraMatrix network providers within 25 miles of your home, covered outpatient physical therapy services will be paid at the in-network benefit level. You must contact TheraMatrix at **1-888-638-8786** prior to treatment so that TheraMatrix can arrange for you to see a provider to avoid out-of-network penalties.
- If you are traveling outside Michigan, or will be out of Michigan for an extended period, and require medically necessary outpatient physical therapy you **MUST** contact TheraMatrix at **1-888-638-8786**. TheraMatrix will arrange for you to see an out-of-area provider with no out-of-network penalty.

Be sure to contact TheraMatrix for any questions regarding current or planned future outpatient physical therapy treatment, or with questions regarding the Program in general.

How does the Managed Care Program (MCP) for psychiatric care and substance abuse treatment work?

You and your eligible dependents receive full benefits when services are authorized by the Central Diagnostic and Referral Agency, and you receive treatment from a participating provider.

If you are an active employee enrolled in the BCBS National PPO benefits for psychiatric care and substance abuse treatment are provided through a managed care, limited provider program. The Managed Care Program (MCP) is designed to improve the quality of care and facilitate access to appropriate providers. The Central Diagnostic and Referral Agencies (CDR) under the Employee Support Services Program are the case managers. Generally, to receive full benefits, you are required to use the CDR for the following services:

- Assessment
- Differential diagnosis
- Treatment plan development
- Referral to a provider
- Follow-up for after care

Blue Cross and Blue Shield of Michigan (BCBSM) is responsible for initial assessment and referral for emergency and out-of-area care, and performs the utilization review function for the program.

Under certain circumstances, you may receive full benefits without first visiting the CDR. For example; you may go directly to a mental health provider who participates with the MCP. In addition, you may receive full benefit coverage in hospital emergency cases or when you use your own personal physician under conditions that may be considered appropriate.

Generally, to receive full benefits, all covered services rendered in the care and treatment of psychiatric and substance abuse conditions must be received from participating providers. The panel of providers may include the following types of facilities and providers:

Facilities

- Hospitals
- Outpatient facilities
- Detoxification facilities
- Residential care facilities
- Day care and night care facilities
- Halfway houses
- Skilled nursing facilities

Providers

- Psychiatrists
- Ph.D. Psychologists
- Masters degreed and licensed psychiatric social workers
- Clinical nurse specialists with advanced training in adolescent or adult mental health nursing

If you are enrolled in an alternative plan (HMO or PPO), you are encouraged to use the CDR to obtain an assessment, differential diagnosis and a recommended treatment plan as well.

What benefits are provided for psychiatric care and substance abuse treatment under the MCP?

Hospital-Surgical-Medical benefits are provided for psychiatric care and substance abuse treatment for up to 45 days in a hospital or residential facility. Certain outpatient psychiatric or substance abuse care also is covered.

Benefits received from participating providers

The following psychiatric and substance abuse benefit coverages will be provided under the MCP if you are enrolled in the BCBS National PPO Plan, receive services authorized by the CDR (or the Administrator for emergency and out-of-area care) and receive treatment from a participating provider:

- **Inpatient care.** Benefits for inpatient treatment of a psychiatric or substance abuse condition are paid in full for up to 45 days of care, including any necessary detoxification days. The 45 days are renewable when you have been out of facility care for a continuous period of sixty (60) days. This 60-day provision applies to hospital and any residential facilities.
- **Outpatient care.** Hospital-Surgical-Medical coverage provides up to 35 visits per calendar year for psychiatric care and 35 visits per calendar year for substance abuse treatment. There are no lifetime visit limits. The first 20 outpatient visits, whether for psychiatric care or substance abuse treatment, are paid in full. For visits 21-35, if services are provided for substance abuse treatment, benefits also are paid in full. However, for visits 21-35 for psychiatric care, the Plan covers 75%; you pay 25% of Program costs. Visits with the CDR for an initial assessment, diagnosis and referral, or for short-term problem solving do not count against the annual 35-visit limit.
- **Other benefits.** Program benefits also include:
 - ◇ Up to 90 visits to a night care or day care treatment facility for psychiatric care; each visit reduces the number of remaining inpatient days by one-half day
 - ◇ A lifetime maximum benefit of 120 days in a halfway house; no more than 90 days are provided in any one calendar year
 - ◇ Psychological testing when approved by the CDR as medically necessary or when authorized by BCBSM as medically necessary in an emergency or out-of-area situation

Benefits received from nonparticipating providers

- Benefits can be fully covered when received from non-participating providers in the following situations:
 - ◇ Full plan benefits may be provided if you are referred to a nonparticipating provider outside of the panel network by the CDR
 - ◇ Under certain situations, full benefits may be provided even though you did not visit the CDR initially. To receive full Plan payment in cases of an emergency or where you may be out-of-area, your attending provider must call BCBSM within 24 hours of providing initial care. BCBSM may then approve the initial care and refer your case to the appropriate CDR for case management. When the CDR, in consultation with your attending provider, determines it is appropriate, you may be referred to a participating provider. In certain situations after consultation with BCBSM, the CDR may judge it appropriate to treat your nonparticipating provider as a participating provider for your case
 - ◇ If you receive outpatient psychiatric care directly from a physician general practitioner, M.D. or D.O., the provider will receive full reasonable payment for the initial service if the provider contacts BCBSM within 24 hours of providing such service. BCBSM will approve payment for the initial service and refer the case to the appropriate CDR. Up to two additional visits may be approved by the CDR if it and the physician general practitioner agree upon the necessity of care. If continuing care is needed, the CDR will facilitate transfer of your care to another provider
- If you receive psychiatric care services from non-participating providers other than as described above, you will receive the following reduced benefits:
 - ◇ For inpatient services in a general acute care hospital, the Plan pays \$160 per day plus \$20 per day for ancillaries; in a psychiatric hospital, the Plan pays \$15 per day
 - ◇ For physician (either M.D. or D.O.) services for psychiatric care provided on an inpatient or outpatient basis, the Plan pays 50% of the reimbursement that would be made to a participating physician under the MCP
 - ◇ No benefits are payable for services received from nonparticipating, non-physician providers, such as psychologists or social workers
- If you receive substance abuse services from nonparticipating providers (whether physicians or non-physicians), no benefits are payable except as described above in cases of emergency or where you are referred by the CDR

What Hospital-Surgical-Medical services are not covered?

No benefits are paid for the Hospital-Surgical-Medical services below.

Hospital-Surgical-Medical benefits provided under the National PPO Plan (BCBS) do not cover certain services. These services include but are not limited to:

- Admissions and treatment before your coverage starts
- Hospitalization principally for dental care or other dental services, except for multiple extractions or removal of unerupted teeth under general anesthesia for hospital patients when another hazardous medical condition exists, except for dental treatment within a hospital on an outpatient setting based on Control Plan guidelines, for enrollees with special needs (e.g., Down's Syndrome, autism, spastic conditions), medical conditions that are marginally controlled, or dental conditions that may adversely impact their medical conditions (e.g., uncontrolled diabetes with periodontal disease)
- Custodial or domiciliary care (care that doesn't require continuous skilled medical or nursing services)
- Care, services, supplies or devices which are experimental or research in nature; Federal Drug Administration (FDA) approval does not necessarily mean a procedure or supply has been removed from the plan's experimental list
- Routine physical exams, premarital, pre-employment or preschool exams, similar exams or tests not directly related to a diagnosis except for preventive services as outlined in the surgical medical services section of this manual.
- Admission and treatment for weight reduction or diet control unless plan criteria are met
- Outpatient care for regular treatment of chronic conditions which require repeated visits, except as specifically provided for psychiatric conditions, drug and alcohol abuse and hemodialysis
- Outpatient psychiatric services for mental disorders which are not expected to improve with treatment or services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation
- Hospitalization principally for observation or diagnostic evaluation, diagnostic X-rays, laboratory tests or physical therapy
- Surgical-medical or other professional charges for sterilization reversals of either sex, or for abortion, except when medically necessary
- Removal of corns, calluses, and clavus and nail trimming
- Removal of wax from ear
- Services or supplies available under public plans or programs such as Workers' Compensation
- Services or supplies furnished in a United States government hospital not operated for the public at large, or elsewhere at government expense
- Surgery for cosmetic or beautifying purposes, except that reconstructive surgery for the following is covered:
 - ◊ The correction of conditions resulting from accidental injuries or traumatic scars
 - ◊ The correction of congenital abnormalities or
 - ◊ Reconstructive plastic surgery to correct deformities resulting from medically necessary surgery due to malignancy or fibrocystic disease and reconstructive surgery when there is a visual impairment
- Chiropractic office visits
- Office visits received outside the BCBS National PPO Network
- For any exclusions with respect to HMO or PPO coverage, contact the individual plan

How does coverage under an HMO or PPO work?

In some areas of the country, you may choose to receive health care from an alternative health maintenance organization (HMO) or preferred provider organization (PPO).

If you live in an area served by an alternative plan such as a “Health Maintenance Organization” (HMO) or “Preferred Provider Organization” (PPO) which is made available by the mutual agreement of Ford and the UAW, you may elect HMO or PPO coverage in place of the BCBS National PPO Plan for Hospital-Surgical-Medical and Prescription Drug coverage. You also may be covered for Vision Care under an HMO or PPO. If you are enrolled in any HMO or PPO which does not provide vision coverage, your vision care provider is SVS Vision Managed Care, Inc.

You may elect an HMO or PPO alternative, if one is available in your area (if you have been enrolled in your current plan for at least 12 months) by calling the Automated Telephone System at 1-800-333-7444.

Health maintenance organizations (HMOs)

When you belong to an HMO, most of your health care is covered in full. In order to receive benefits, you must obtain all of your health care services from the group of physicians, hospitals or other providers affiliated with the HMO, except in the case of an emergency or upon referral by the HMO.

If you are enrolled in an HMO and seeking psychiatric care and or substance abuse treatment benefits, you are encouraged to use the Central Diagnostic and Referral Agencies (CDR) to obtain an assessment, differential diagnosis and a recommended treatment plan as well.

Preferred provider organizations (PPOs) other than BCBS National PPO

In a PPO arrangement, certain participating health care providers, the “preferred providers,” provide health care services. You choose your physician or hospital from a list of those who participate. If you elect to go outside the PPO plan for services, some co-payments are required except for emergency care or for referrals by network providers.

In addition to Hospital-Surgical-Medical benefits, services such as office visits may be covered. You receive full benefits only if you use a physician who participates in the PPO unless your physician refers you to a provider outside the PPO or for emergency care.

For more information about the HMO or PPO option, contact the Automated Telephone System at 1-800-333-7444 to request health care plan benefit summaries. You may contact the HMO or PPO directly for detailed information about the plan.

Health Care Plan

Prescription Drug Coverage

This section of your handbook answers these questions:

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Health Care Plan - Prescription Drug Coverage - National PPO Plan (BCBS) and Blue Preferred Plus PPO Plan (MI only)

Am I covered for my Prescription Drug Expenses?

Prescription Drug coverage is part of the National PPO Plan (BCBS) and Blue Preferred Plus PPO Plan (MI only)

Note: If you are enrolled in an alternate plan this description does not apply to you. Contact your alternate plan for benefit information.

How does Prescription Drug coverage work?

Prescription Drug coverage helps you pay the cost of covered prescription drugs you or your family may need. You, your spouse and your eligible dependents may have prescriptions filled at a participating or non-participating pharmacy or through the home delivery program (Medco By Mail). You pay less if you go through a participating pharmacy, and even less if you go through the home delivery program (Medco By Mail). You also pay less for generic rather than brand name drugs.

What medications are covered?

Prescription Drug benefits cover the initial fill and refills for prescription medications. To qualify, the drug label must read "Rx Only". In addition, injectable insulin, which may not require a prescription, is covered by the plan. Allergy serums which are prescribed for you on an ongoing basis are covered. Also, the retail price or home delivery price of the quantity prescribed must be more than the co-payment amount.

Insulin

Benefits are provided for a one-month supply of disposable syringes and needles for injection of insulin when filled with a one-month supply of insulin, or a three-month supply of disposable syringes and needles for injection of insulin when filled with a three-month supply of insulin, or, if greater, 100 disposable syringes and needles when prescribed with a three-month supply of insulin.

If syringes and needles are ordered or filled on a different date than the insulin, the syringes and needles are not covered. One co-payment applies to the total prescription when insulin, needles and syringes are filled at the same time.

Effective January 1, 2008, insulin was added to the UAW-Ford Mail Order Maintenance Drug List. Review the section on "The Home Delivery Program" later in this section.

Dosage quantities

You can receive up to a 34-day supply of medication if purchased from a retail pharmacy. Through the home delivery prescription drug program (Medco By Mail), you can receive up to a 90-day supply of any covered prescription drugs.

What are the Prescription Drug co-payments?

If you go to a participating retail pharmacy or through the home delivery prescription drug program (Medco By Mail), the co-payments are as follows:

National PPO Plan (BCBS) / Blue Preferred Plus PPO Plan (MI only)			
	Generic	Brand	ED*
Retail Pharmacy:			
Up to a 34-day supply	\$5	\$11	\$16
Home Delivery:			
Up to a 90-day supply	\$10	\$15	\$19

*ED = Erectile Dysfunction Drugs

Who administers the Prescription Drug Benefits?

If you are enrolled in the National PPO Plan (BCBS) or the Blue Preferred Plus PPO Plan (MI only), your prescription drug coverage is administered by Blue Cross and Blue Shield of Michigan (BCBSM) and Medco Health Solutions (Medco). BCBSM and Medco are responsible for drug utilization review functions and quality assurance mechanisms.

Can I go to any retail pharmacy?

To receive the maximum benefits available for retail pharmacies, you must have your prescription filled at a participating pharmacy. To locate a participating pharmacy near your home or workplace or while traveling, call BCBSM Ford/UAW Service Center at 1-800-482-5146 or go to www.medco.com.

When you use a participating retail pharmacy

You must present your BCBS ID card and prescription to the retail pharmacist. You pay a co-payment for each covered prescription or refill. You do not have to submit a claim form when you use a participating pharmacy. Medco will automatically reimburse the participating provider for the remaining cost.

If you or an eligible member needs to take a prescription drug on a long-term basis, you may need to obtain it through home delivery (Medco By Mail). Review the section on “The Home Delivery Program” later in this section.

When you use a non-participating retail pharmacy

You pay the full price (100%) of the prescription at the time of purchase and obtain a receipt. Call the BCBSM Ford/UAW Service Center at 1-800-482-5146 to obtain a claim form. Once received, submit your completed claim form to Medco Health Solutions, Inc., P.O. Box 14711, Lexington, KY 40512. The prescription receipt must be attached to the form. For your records, make a photocopy of your claim and receipt. You will be reimbursed 75% of the allowed amount after deducting the co-payment. You will not be reimbursed for the pharmacy’s retail drug charges above the allowed amount, if applicable.

If your prescription is filled by a physician or dentist

If your prescription is filled at your physician or dentist’s office, or if you receive medication from anyone (other than a pharmacy) licensed to fill prescriptions, you pay the entire cost and file a claim with the claims processor. You will be reimbursed up to the amounts described above for use of a non-participating retail pharmacy.

How does the home delivery program (Medco By Mail) work?

The home delivery program (Medco By Mail) offers you a convenient way to get your prescription medications. You will be able to save money by buying your prescriptions through this mail order program. Under the home delivery program (Medco By Mail) you pay only \$15 to receive up to a 90-day supply of brand or \$10 for up to a 90-day supply of generic or \$19 for up to a 90-day supply of ED instead of paying \$5 (generic) or \$11 (brand-name) or \$16 (ED) at a retail pharmacy for up to a 34-day supply.

For medications included on the UAW-Ford Mail Order Maintenance Drug List, the first three times you fill a prescription on or after January 1, 2004, you may go through a retail pharmacy. Beginning with the fourth fill, you must go through the home delivery program (Medco By Mail) in order to have a maintenance drug covered. Refer to the Home Delivery Maintenance Drug List that follows to check whether your medication falls under this provision. Be careful when you check the list. For questions on a specific medicine, call BCBSM at 1-800-482-5146 or contact your physician.

You also may go through the home delivery program (Medco By Mail) for other long-term medications not on the Maintenance Drug List. This will save you time and money.

Note: The Generic Prescription Drug Program described later in this section also applies to the home delivery program (Medco By Mail) as well as retail.

Follow these steps to get started using the home delivery program (Medco By Mail):

Note: After 3 fills (the initial fill and 2 additional refills), you MUST go through the home delivery program (Medco By Mail) in order for maintenance drugs on the UAW-Ford Mail Order Maintenance Drug List to be covered.

To mail your order:

- Step 1: Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year. Make sure that you have at least a two-week supply on hand. If not, ask your doctor for a prescription for up to a 34-day supply that you can fill at a participating retail pharmacy while you wait for your home delivery prescription to arrive.**
- Step 2: Complete a home delivery order form and attach the original prescription (you may want to retain a copy for your records). You may obtain an order form and envelope by calling Medco at 1-800-778-0735 or BCBSM at 1-800-482-5146. You also can obtain or print a home delivery order form online, once you have registered at www.medco.com, or from your Union Benefit Representative.**
- Step 3: Mail the new prescription in the envelope provided. You may pay the home delivery co-payment by credit card, check, money order, or e-check. E-check is an electronic funds transfer system that automatically deducts your co-payment from your checking account. If you prefer to pay for all of your orders by credit card, you may want to join the Medco automatic payment program. You can enroll by visiting the Medco website, www.medco.com, or by calling Medco toll-free at 1-800-948-8779.**

When you order your prescriptions by mail, your prescriptions are delivered via standard delivery, postage-paid, generally within 8 days from the date you mailed your order.

If you are a first-time visitor to medco.com® please take a moment to register your contract number (located on your BCBS ID card). **Do not enter the letters that appear in front of your contract number. Entering the letters will cause an error and prevent you from registering.** A recent retail or mail order prescription number is also needed to complete the registration.

If your Doctor wants to fax your order:

Step 1: Same as above.

Step 2: Provide your doctor with your contract number located on your BCBS ID card. Ask your doctor to call 1-888-327-9791 for instructions on how to fax a prescription. Afterward, you may wish to call Medco at 1-800-778-0735 and verify that your doctor's fax was received. You will be billed later for your order.

When your doctor faxes your prescription, your prescriptions are generally delivered within 5 to 8 days from the date your doctor faxes the prescription.

Note: *Only your doctor's office is permitted by law to fax your prescriptions to Medco.*

For questions about your home delivery prescription (such as order status, account balance or shipment information), call Medco at 1-800-778-0735.

How are maintenance drugs covered?

"Maintenance drugs" are certain prescription drugs taken regularly, over a long period, for conditions such as high blood pressure, arthritis diabetes, and asthma. Effective January 1, 2004, maintenance drugs listed on the UAW-Ford Mail Order Maintenance Drug List will no longer be covered when dispensed by a retail pharmacy in 100-unit and 200-unit dosages, if greater than a 34-day supply.

Maintenance drugs on the list will only be covered if obtained through the home delivery program (Medco By Mail), after you have filled a prescription three times on or after January 1, 2004, at a retail pharmacy. If you continue to fill the prescription at a retail pharmacy after the first 3 fills, you will be responsible for the entire cost of the medication. You may, however, continue to get short-term prescription drugs (for example, antibiotics) and other prescription drugs not on the maintenance drug list from retail pharmacies.

You may receive up to a 90-day supply* at each fill through the home delivery prescription drug program (Medco by Mail).

Prescription drugs may be added to or removed from the UAW-Ford Mail Order Maintenance Drug List from time to time by mutual agreement of the UAW and the Company.

Refer to the table on the next page to help determine whether your prescription drug(s) are on the UAW-Ford Mail Order Maintenance Drug List.

Be careful when you check the UAW-Ford Mail Order Maintenance Drug List later in this section. A drug may have other names that are not listed. For questions to determine if a specific medicine is on the UAW-Ford Mail Order Maintenance Drug List, call BCBSM at 1-800-482-5146.

*Medco will fill the prescription with the quantity as written by your doctor, up to a maximum of 90-day supply. (Subject to application of pharmacy management tools described in the next section)

What are the Pharmacy Management Tools for Select Medications?

Coverage management tools help bring greater patient safety by protecting against potentially dangerous dosing that does not meet FDA-approved guidelines or national physician best practice guidelines. Some medications, for example, are not covered unless you receive prior authorization through a coverage review. Medco must review prescriptions for these medications with your doctor before they can be filled under your plan, since more information than what is on a prescription is needed. The review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

The following coverage management tools (a.k.a. Drug Tools or RX Tools) will apply for those enrolled in the National PPO or Blue Preferred Plus PPO (MI only) Plans. You will receive future notification if a program or tool applies to a prescription that you and/or your eligible dependents attempt to fill:

- **Prior authorization:** This program requires that you obtain prior approval through a coverage review. The review will determine whether your plan covers your medication.
- **Step therapy/preferred coverage review:** These programs allow for coverage of certain medication only when the patient has first tried another "first-line" medication or therapy.
- **Authorization for additional quantity of medication:** For some medication, your plan covers a limited quantity within a specified period of time. A coverage review may be available to request additional quantities of these medications. Please note that Medco By Mail does not automatically initiate a coverage review process for additional quantities. You or your doctor would need to initiate this request by calling Medco at 1-800-753-2851. Medco will send you and your doctor written notification of the decision.
- **Dose optimization:** For certain medications, this program lets patients take one pill a day at a higher dose instead of two pills a day of a lower dose.

For information on specific drugs impacted by the pharmacy management tools, contact the BCBSM Service Center at 1-800-482-5146.

To begin a coverage review, contact Medco at 1-800-753-2851

**UAW-Ford
Mail Order Maintenance Drug List
As of January 2008**

BRAND NAME (Examples)	GENERIC NAME	BRAND NAME (Examples)	GENERIC NAME
Accolate	Zafirlukast	Diuril	Chlorothiazide
Accupril	Quinapril HCL	Dyazide / Maxzide	HCTZ / Triamterene
Accuretic	Quinapril / HCTZ	Dymelor	Acetohexamide
Aceon	Perindopril	Dynacirc	Isradipine
Activella	Estradiol / Norethindrone	Dyrenium	Triamterene
Actonel	Risedronate	Ec-Naprosyn	Naproxen
Actonel with Calcium	Risedronate / Calcium carbonate	Eldepryl	Selegiline HCL
Actos	Pioglitazone	Enablex	Darifenacin Hydrobromide
Adalat CC	Nifedipine	Enduron	Methyclothiazide
Advicor	Lovastatin / Niacin	Esclim	Estradiol Transdermal
Aggrenox	Dipyridamole / Aspirin	Estrace	Estradiol
Aldactazide	Spirolactone/HCTZ	Estraderm	Estradio Transdermal
Aldactone	Spirolactone	Estratab	Estrogens (Esterified)
Aldomet	Methyl dopa	Estratest	Methyltest;Estrog., Estd.
Alora	Estradiol Transdermal	Estratest H.S.	Methyltest, Estrog., Estd.
Altace	Ramipril	Euthroid / Thyrolar	Liotix
Altoprev	Lovastatin XL	Evista	Raloxifene
Alupent	Metaproterenol Sulfate	Xforge	Amlodipine / Valsartan
Amaryl	Glimepiride	Exna	Benzthiazide
Anaprox	Naproxen Sodium	Femhrt	Ethinyl Estradio / Norethindrone
Ansaid	Flurbiprofen	Femring	Estradiol Transdermal
Apresoline	Hydralazine	Flomax	Tamsulosin HCL
Aricept	Donepezil	Fosamax	Alendronate
Armour Thyroid	Thyroid	Fosamax Plus D	Alendronate/Cholecalciferol
Artane	Trihexyphenidyl	Glucophage	Metformin HCL
Atacand	Candesartan	Glucotrol	Glipizide
Atacand HCT	Candesartan / HCTZ	Glucotrol XL	Glipizide
Avalide	Irbesartan / HCTZ	Glucovance	Glyburide / Metformin
Avandamet	Rosiglitazone/Metformin	Glynase	Glyburide (micronized)
Avapro	Irbesartan	Glyset	Miglitol
Avodart	Dutasteride	Humalog / Humulin	Insulin
Benemid	Probenecid	Hydrodiuril	Hydrochlorothiazide
Benicar	Olmesartan	Hygroton	Chlorthalidone
Benicar HCT	Olmesartan / HCTZ	Hytrin	Terazosin HCL
Betimol	Timolol Maleate drops	Hyzaar	Losartan / HCTZ
Betoptic	Betaxolol HCL drops	Iletin	Insulin
Blocadren	Timolol Maleate	Imdur	Isosorbide Mononitrate
Boniva	Ibandronate Sodium	INH	Isoniazid
Brethine	Terbutaline Sulfate	Inderal	Propranolol HCL
Bumex	Bumetanide	Inderide	Propranolol / HCTZ
Caduet	Amlodipine / Atorvastatin	Indocin	Indomethacin
Calan / Isoptin / Verelan	Verapamil HCL	Innopran XL	Propranolol HCL
Capoten	Captopril	Ismo	Eplerenone
Capozide	Captopril/HCTZ	Isoptin	Isosorbide Mononitrate
Cardene	Nicardipine HCL	Isordil / Sorbitrate	Verapamil HCL
Cardizem	Diltiazem HCL	Janumet	Isosorbide Dinitrate
Cardura	Doxazosin Mesylate	Januvia	Sitagliptin / Metformin
Cardura XL	Doxazosin Mesylate	Kaon	Sitagliptin
Catapres	Clonidine HCL	Kay Ciel / Slow K / K-Dur	Potassium Gluconate
Cenestin	Estrogens, Conjugated	K-Lyte CL	Potassium Chloride
Climara	Estradiol Transdermal	K-Tab	Potassium Chloride
Climara Pro	Estradiol/Levonorgestrel	Kerlone	Betaxolol HCL
Clinoril	Sulindac	Lanoxin	Digoxin
Clorpres	Clonidine/Chlorthalidone	Lantus	Insulin Glargine
Cogentin	Benzotropine Mesylate	Lasix	Furosemide
Combipatch	Estradiol/Norethindrone	Lescol	Fluvastatin Sodium
Comtan	Entacapone	Levothroid / Synthroid	Levothyroxine Sodium
Coreg	Carvedilol	Lexxel	Enalapril / Felodipine
Corgard	Nadolol	Lipitor	Atorvastatin Calcium
Covera HS	Verapamil HCL	Lodine	Etodolac
Cozaar	Losartan Potassium	Loniten	Minoxidil
Crystodigin	Digitoxin	Lopid	Gemfibrozil
Cytomel	Liothyronine Sodium	Lopressor	Metoprolol Tartrate
Detrol	Tolterodine Tartrate	Lotensin	Benazepril HCL
Detrol LA	Tolterodine Tartrate	Lotensin HCT	Benazepril / HCTZ
Diabeta	Glyburide	Lotrel	Amlodipine / Benazepril
Diabinese	Chlorpropamide	Lovaza	Omega-3 Acid Ethyl Esters
Diamox	Acetazolamide	Lozol	Indapamide
Dilantin	Phenytoin Sodium	Mavik	Trandolapril
Diovan	Valsartan	Mevacor	Lovastatin
Diovan HCT	Valsartan / HCTZ	Miacalcin	Calcitonin
Ditropan	Oxybutynin Chloride	Micardis	Telmisartan
Ditropan XL	Oxybutynin Chloride	Micardis HCT	Telmisartan / HCTZ

BRAND NAME (Examples)	GENERIC NAME	BRAND NAME (Examples)	GENERIC NAME
Micro-K	Potassium Chloride	Theolair-SR	Theophylline
Micronase / Diabeta	Glyburide	Tiazac	Diltiazem HCL
Midamor	Amiloride HCL	Timoptic	Timolol Maleate
Minipress	Prazosin HCL	Tolinese	Tolazamide
Mirapex	Pramipexole	Toprol XL	Metoprolol Succinate
Mobic	Meloxicam	Trandate	Labetalol HCL
Moduretic	Amiloride / HCTZ	Tricor	Fenofibrate
Monopril	Fosinopril Sodium	Uniphyl	Theophylline
Motrin	Ibuprofen	Univasc	Moexipril HCL
Mysoline	Primidone	Uroxatral	Alfuzosin HCL
Namenda	Memantine HCL	Vaseretic	Enalapril Maleate / HCTZ
Naprelan	Naproxen Sodium	Vasotec	Enalapril Maleate
Naprosyn	Naproxen	Velosulin	Insulin
Naqua	Trichlormethiazide	Vesicare	Solifenacin Succinate
Naturetin	Bendroflumethiazide	Visken	Pindolol
Neptazane	Methazolamide	Vivelle	Estradiol Transdermal
Niacor	Niacin	Vivelle-Dot	Estradiol Transdermal
Niaspan	Niacin, Long Acting	Voltaren	Diclofenac Sodium
Nitrobid / Nitrostat	Nitroglycerin	Welchol	Colesevelam
Nitro-Dur	Nitroglycerin Transderm	Zaroxolyn	Metolazone
Normodyne / Trandate	Labetalol HCL	Zebeta	Bisoprolol Fumarate
Norpace	Disopyramide	Zestoretic / Prinzide	Lisinopril / HCTZ
Novolog / Novolin	Insulin	Zestril / Prinivil	Lisinopril
Norvasc	Amoldipine Besylate	Zetia	Ezetimibe
Nydrazide	Isoniazid	Ziac	Bisoprolol / HCTZ
Ogen / Ortho-est	Estropipate	Zocor	Simvastatin
Orinase	Tolbutamide	Zyflo	Zileuton
Ortho-Prefest	Estradiol / Norgestimate	Zyloprim	Allopurinol
Paser	Para-Aminosalicylic Acid		
Pavabid	Papaverine HCL		
Persantine	Dipyridamole		
Phenytek	Phenytoin Sodium		
Plavix	Clopidogrel		
Plendil	Felodipine		
Pletal	Cilostazol		
Prandin	Repaglinide		
Pravachol	Pravastatin Sodium		
Pravigard PAC	Pravastain / Aspirin		
Precose	Acarbose		
Premarin / Estratab	Estrogens (Conj. or Estd.)		
Premarin w / Methyltest	Methyltest, Estrog., Conj		
Premphase / Prempro	Estrogen, Con / M-Progest Acetate		
Prinivil	Lisinopril		
Prinzide	Lisinopril / HCTZ		
Procan / Pronestyl	Procainamide HCL		
Procardia / Procardia XL	Nifedipine		
Proscar	Finasteride		
Proventil / Ventolin	Albuterol Sulfate		
Provera	Medroxyprogesterone Acetate		
PTU	Propylthiouracil		
Questran	Cholestyramine /Sucrose		
Questran Light	Cholestyramine/Aspartame		
Quinaglute	Quinidine Gluconate		
Quinidex	Quinidine Sulfate		
Ranexa	Ranolazine		
Relafen	Nabumetone		
Relion Insulin	Insulin		
Renese	Polythiazide		
Requip	Ropinarole		
Sectral	Acebutolol HCL		
Serpasil	Reserpine		
Sinemet	Carbidopa / Levodopa		
Singulair	Montelukast Sodium		
Sorbitrate	Isosorbide Dinitrate		
Starlix	Nateglinide		
Sular	Nisoldipine		
Tarka	Trandolapril / Verapamil		
Tekturna	Aliskiren		
Tenex	Guanfacine HCL		
Tenoretic	Atenolol / Chlorthalidone		
Tenormin	Atenolol		
Teveten	Eprosartan		
Teveten HCT	Eprosartan / HCTZ		
Theo-24	Theophylline		
Theo-Dur / Slo-Phyllin	Theophylline		

How does the Generic Prescription Drug Program Work?

Note: The Generic Prescription Drug Program applies to the home delivery program (Medco By Mail) as well as the retail program.

The Generic Prescription Drug Program is designed to require the use of generic drugs. Generic equivalent drugs provide the same potency and effectiveness as brand-name drugs.

At retail pharmacies and through the home delivery program (Medco By Mail), where legally permissible, your pharmacist will automatically dispense generic equivalent drugs in place of brand name drugs when a generic exists. You will receive the generic drug, and pay the generic co-payment instead of the brand-name co-payment.

If your physician prescribes a specific drug for which there is no generic available, you get the brand-name drug, and pay the brand-name co-payment.

If **YOU** request a brand-name drug for which there is a generic available, you will get the brand-name drug. However, you will be responsible for the generic co-payment, **PLUS** the full cost difference between the brand and generic drug.

If **YOUR DOCTOR** prescribes a brand-name drug when a generic drug equivalent is available, and your doctor indicates on your prescription that a generic drug is not permitted (for example, by writing DAW, Dispense as Written), then for your first prescription fill, you will pay the brand-name drug co-payment, plus up to \$10 of the cost difference between the brand-name and generic drug. Your doctor will need to request a review if you need to continue receiving this drug. See box below for further information.

Should your doctor feel there are special circumstances for which you need the brand-name drug, ask your doctor to request a review by calling Medco at 1-800-841-5409. Medco will send you and your doctor written notification of the decision. If your review is approved, you will receive authorization to purchase the brand-name drug for the brand-name drug co-payment for as long as you remain on that medication. If your review is approved, you will also receive a refund on the most recent fill for the cost difference that you paid in excess of the brand-name co-payment. If the review is not approved, you must pay the generic co-payment, plus the full difference in cost between the brand-name and generic drug for all future refills. For additional information see "What are the New Claims and Appeal Procedures for Health Care Plans" and "Voluntary Level of Appeal" in the Health Care Claims section of the handbook.

What Prescription Drug services, supplies and medications are not covered?

Under the National PPO Plan (BCBS) and Blue Preferred Plus PPO Plan (MI only), the following services, supplies and medications are not a covered benefit:

- Drugs for which the provider's charge is less than the applicable co-payment
- Drugs requiring a prescription by state but not by federal law
- Covered drugs which are consumed entirely at the time and place where the prescription is written*
- Non-prescription contraceptive medication, devices, appliances, or supplies
- Reusable syringes and needles, multi-use syringes and disposable needles
- Charges for administering a covered drug*
- Charges for more than a 34-day supply of a covered drug through a retail pharmacy, except for certain insulin and syringes and for medications pre-packaged in supplies greater than 34 by the manufacturer
- Charges for more than a 90-day supply of a drug filled through the prescription drug home delivery program (Medco by Mail)
- Charges for more refills than your physician or dentist specifies or refills after a year from the original date the prescription was written.
- Charges for medication furnished on an inpatient or outpatient basis, if the charge is covered by any other health care coverage
- Medication provided under Workers' Compensation or other government plans (If you are enrolled in the Medicare Part D prescription drug plan, you are ineligible for prescription drug coverage with the Company while enrolled in Medicare Part D).
- Medication prescribed by a non-licensed provider
- Drugs which are not medically necessary
- Investigational or experimental drugs
- Medications received before you or your dependent was covered under the Plan or after coverage ends
- Maintenance drugs filled at a retail pharmacy after receiving the same prescription drug at the same therapeutic strength three times at a retail pharmacy
- All non-sedating antihistamines

- All vitamins and minerals with the exception of:
 - Prenatal vitamins for females under the age of 49
 - Vitamin D derivatives prescribed to treat renal disease
 - Vitamin K prescribed for bleeding conditions
 - Long-acting Niacin for treating heart conditions
 - Potassium Chloride

*Certain items may be covered under your medical/surgical program

How to contact BCBSM/Medco:

On the Internet—www.medco.com

- Order and track the status of your Medco By Mail refills.
- Download mail order forms.
- Request envelopes.
- Check prescription coverage and pricing.
- Request order forms and envelopes.
- Locate an in-network retail pharmacy.

By phone

You can reach BCBSM/Medco at the numbers listed below.

Member Services

BCBSM Ford Service Center—For questions about the Prescription Drug Program, such as benefits, co-pays, and eligibility, Active Employees can call 1-800-482-5146.

Medco By Mail—For questions about your Medco By Mail prescriptions, such as order status, account balance or when and how an order was shipped, call 1-800-778-0735.

Braille

To request braille labels for mail-order prescriptions, call 1-800-778-0735.

Health Care Plan

Dental Coverage

This section of your handbook answers these questions:

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Health Care Plan - Dental Coverage

How does Dental coverage work?

The Traditional Dental benefits are provided for most dental services.

Traditional Dental benefits cover most dental services for you, your spouse or eligible same-sex domestic partner, and your eligible dependents. Benefits are paid at 100%, 90% or 50% of the covered expense (up to the allowed amount); depending on the service you receive. You do not have to satisfy a deductible. The maximum dental benefit payable in a calendar year effective January 1, 2008 is \$1,850 for each individual.

Most orthodontic services are covered at 50%. There is a lifetime maximum of \$2,200 for orthodontia for each covered person under age 19 effective January 1, 2008 with a maximum of \$2,000.00 applicable to covered dental expenses for services provided prior to January 1, 2008.

Payments for covered dental services related to the repair of accidental injury to sound natural teeth due to a sudden unexpected impact from outside the mouth will not count against the annual benefit limit or the lifetime orthodontic limit. Regular co-payments will be required for all such services.

Information relating to your eligibility for Dental coverage is provided in the "Eligibility for Health Care Coverage" section.

Covered Expenses

Covered dental expenses are the "allowable amounts" that a dentist charges for services and supplies which are "necessary" for treatment of a dental condition customarily employed for treatment of that condition, and which are rendered in accordance with accepted standards of dental practice.

If you have a dental problem that can be treated in more than one way, the procedure that provides a cost-effective, professionally satisfactory result is covered.

Are dental services covered in an outpatient hospital setting?

Refer to the "Hospital-Surgical-Medical Coverage" section for information on dental services received at an outpatient hospital setting.

What Dental services are covered?

Expenses for dental services are covered at 100%, 90% or 50% of the Allowable Amount.

Services covered at 100%

These services are paid at 100% of the allowable amount:

- Routine oral exams and cleaning and scaling, but not more than twice for each covered person during any calendar year
- Four cleanings per calendar year if you have a documented history of periodontal disease
- One topical application of fluoride, provided that such treatment is only for enrollees under 15 years of age unless a specific dental condition makes such treatment necessary
- Space maintainers to replace prematurely lost teeth for covered children under age 19 (coverage will terminate the end of the day immediately preceding the covered child's 19th birthday)
- Emergency treatment to relieve dental pain
- Fabrication of fluoride trays and fluoride treatment applications for cancer patients undergoing radiation therapy of the head and neck.

Services covered at 90%

These services are paid at 90% of the allowable amount:

- Dental X-rays, including full mouth X-rays once each period of five consecutive calendar years, supplementary bitewing X-rays once in any calendar year for enrollees age 14 and younger; and once every two years for enrollees age 15 and older, and such other dental X-rays as required for the diagnosis of a specific treatment
- Extractions
- Oral surgery
- Fillings made of amalgam, silicate, acrylic, synthetic porcelain and composites to restore diseased or accidentally injured teeth
- General anesthetics and intravenous sedation when necessary and used with oral or dental surgery
- Periodontics and treatment of other gum or mouth tissue diseases
- Endodontics, including root canal therapy
- Injection of antibiotics by the attending dentist
- Repair or recementing of crowns, inlays, onlays, bridgework and dentures; or relining or rebasing dentures more than six months after installation, but not more than once in any period of 36 consecutive months
- Inlays, onlays, gold fillings or crown restorations but only when a tooth, as a result of extensive caries or fractures, cannot be restored with the filling materials described above
- Replacement of crowns more than three (3) years after installation of an initial or replacement crown if the crown has been damaged and cannot be made serviceable, or if there is recurrent decay under the existing crown or decay at a crown-to-natural-tooth margin that cannot be repaired by a direct-fill restoration
- Oral brush biopsy up to two (2) times per year per member over the age of 18.

Services covered at 50%

These services are paid at 50% of the allowable amount:

- Initial installation of fixed bridgework, including inlays and crowns as abutments
- Initial installation of partial or full removable dentures, including any attachments and adjustments during the six (6) months after installation.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework if:
 - The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed
 - The existing denture or bridgework cannot be made serviceable and, if installed under this Plan, at least five years have passed since its installation
 - The existing denture is an immediate temporary denture and replacement of a permanent denture occurs within 12 months of the first installation of the immediate temporary denture
- Orthodontia (teeth straightening), as described in the “What is paid for orthodontia?” section and

Services covered under Hospital-Surgical-Medical coverage

- Benefits are provided under Hospital-Surgical-Medical coverage for cosmetic bonding of eight front teeth for children age eight through the end of the calendar year in which they become age 19 if required because of severe staining, but not more frequently than once in any period of three consecutive years.

What is the Enhanced Traditional Dental Plan?

The Enhanced Traditional Dental Plan is a nationwide dental provider network.

The Enhanced Traditional Dental Plan offers a nationwide dental provider network through an agreement between Blue Cross Blue Shield and DenteMax. When you receive services from a DenteMax provider, your out-of-pocket expenses will be lower than those you would incur if you received services from a non-DenteMax provider.

The DenteMax Preferred Provider Network is a network of over 48,000 dentists in 50 states who have agreed to accept a discounted fee as full payment for covered services. Use of the DenteMax Network is voluntary, but you may save money if you use a DenteMax dentist. There is no commitment required, family members can switch back and forth at will. Since the DenteMax dentist accepts less for covered services, your co-payment amounts will be lower, and you will not be billed for the balance of the charges above the DenteMax approved amount. This schedule is typically 10-30% below the average charges of non-DenteMax dentists. You also save money because DenteMax provides a higher level of coverage for certain services. For example:

	Traditional	DenteMax
Fillings	90%	100%
Root Canals	90%	100%
Gum Treatments	90%	100%
Extractions	90%	100%
Bridgework	50%	70%
Dentures	50%	70%
Orthodontics	50%	60%

You can save hundreds of dollars on many procedures by using a DenteMax provider (refer to the Enhanced Traditional Dental Plan Letter of Understanding in Volume IV of the UAW-Ford Collective Bargaining Agreement for additional information).

Built-in Predetermination

The DenteMax enhanced dental program requires predetermination for complex or expensive services (\$200 or more).

However, if a DenteMax dentist neglects to predetermine the covered service with BCBSM, you will not be responsible for the higher amount. For example, if a network dentist installed a crown without predetermining the case prior to treatment and BCBSM determined that a filling was an acceptable form of treatment, you would be responsible for only the co-payment for a filling, not the balance for the crown.

Traditional dental benefits remain the same if you use a non-network DenteMax dentist. You can still save money if you use a participating dentist who has agreed to accept Blue Cross Blue Shield's maximum payment amount for covered services. However, you should always ask your dentist if he or she participates with DenteMax because using a DenteMax dentist will save you additional money and stretch your annual and lifetime maximums.

Finding a DenteMax Network dentist is easy

There are over 48,000 generalist and specialist DenteMax network dentists nationwide. Ask your current dentist if he/she is in the DenteMax network. If the dentist is not in the network, you may locate a network dentist or nominate your dentist by submitting the dentist's name, address and phone number by calling:

DenteMax at 1-800-752-1547

If you wish to locate a DenteMax dentist near where you live or work, please refer to the DenteMax Dental Provider directory from your Union Benefit Representative. You may also find a list of DenteMax providers at www.dentemax.com or by calling them at 1-800-752-1547.

What is paid for orthodontia?

For eligible persons under age 19, Traditional Dental benefits are paid at 50% (60% for DenteMax) of covered orthodontic services, up to an annual maximum per covered person.

Orthodontia is a special part of your Dental benefits. Benefits are provided for teeth-straightening programs for eligible persons, as long as continuous treatment begins before age 19.

Dental benefits are paid at 50% of the allowable amount for all covered services relating to orthodontic treatment, up to a \$2,200 lifetime maximum per covered person effective January 1, 2008 with a maximum of \$2,000 applicable to covered dental expenses for services provided prior to January 1, 2008. "Orthodontic treatment" includes preventive and corrective treatment of dental irregularities resulting from injury or the abnormal growth and development of teeth.

Covered services include:

- Diagnostic procedures and treatment, including oral exams related to orthodontia
- Surgical therapy
- Appliance therapy
- Functional/myofunctional therapy (when related to surgical therapy)

When is a treatment plan necessary?

A "treatment plan" must be filed in advance if charges are expected to be \$200 or more.

If the estimated charges are less than \$200 or if emergency care is involved, your dentist need not obtain a predetermination of benefits, as described below. Once the work is completed, a claim form must be submitted.

If treatment of planned dental work is expected to be \$200 or more, your dentist will need to file a predetermination of benefits or "treatment plan" with the claims processor before treatment begins—unless emergency care is necessary. The claims processor then can authorize payments before your dentist begins work, and you will know in advance exactly how much your Dental coverage will pay.

A treatment plan works as follows:

- Your dentist decides what treatment is needed and describes it on the appropriate form, along with an estimate of treatment charges. This form is available from the claims processor
- You and your dentist then will be notified what portion of the total expenses will be paid by your Dental coverage. The claims processor will take into account any alternatives that may be used to accomplish the same result
- After the dental work is complete, you or your dentist should send the claim back to the claims processor for payment
- If a treatment plan is required but not submitted in advance, the claims processor reserves the right to determine the benefits payable, taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

What Dental services are not covered?

Under the Traditional Plan, no benefits are paid for the dental services below.

Under the Traditional Plan, certain dental expenses are not covered. These include:

- Benefits payable by your other Health Care coverages
- Work not done by a dentist, except scaling and cleaning of teeth and topical application of fluoride by a licensed dental hygienist under a dentist's supervision
- Veneers for crowns or pontics on teeth, other than the 10 upper and lower anterior teeth
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- Prosthetic devices (including bridges), crowns, inlays, onlays and their fitting, if you were not covered when they were ordered or if they are not installed or delivered within 60 days after the day your coverage ends
- Replacement of lost, missing or stolen prosthetic devices
- Failure to keep a scheduled visit with the dentist
- Replacement or repair of an orthodontic appliance
- Charges for services which are compensated under Workers' Compensation
- Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage
- Charges for services or supplies, which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist
- Charges for services or supplies which do not meet accepted standards of dental practice and that are considered experimental
- Services or supplies received as a result of war, declared or undeclared
- Services or supplies furnished or payable by any government or governmental agency, or any governmental program or law under which you could be covered, unless payment is legally required
- Duplicate appliances
- Charges for completion of any insurance forms
- Sealants and oral hygiene and dietary instruction

- A plaque control program
- Implantology
- Services or supplies for periodontal splinting

How does coverage under an alternative Dental plan work?

In some areas of the country, you may choose to receive Dental coverage through an alternative dental plan.

If you live in an area served by an alternative dental plan which is approved by Ford and the UAW, you may elect Dental coverage under that plan in place of the Traditional Plan's coverage.

With the Hourly Rolling Enrollment system, there is no longer a specific enrollment period. You may change your dental plan election during any month of the year (provided 12 months have elapsed since your last change).

To make a change, call the Automated Telephone System at 1-800-333-7444 and follow the prompts to change your dental election. The Automated Telephone System is open 24 hours a day / 365 days a year. You will receive a confirmation statement in the mail anytime you make a change through Automated Telephone System. Your election takes effect on the 1st day of the 2nd month following your election.

For detailed information on the availability of and the coverage provided by an alternative dental plan, contact the Automated Telephone System to request benefit summaries and determine which plans you are eligible to choose from. Detailed information related to the plan can be provided by the dental carrier. The benefit summaries include the phone number to the carrier.

Refer to the section "Eligibility for Health Care Coverage" for more details on changing your election.

Health Care Plan

Vision Care Coverage

This section of your handbook answers these questions:

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Health Care Plan - Vision Care Coverage

Am I covered for my Vision Care Expenses?

If you are enrolled in the National PPO for health care coverage, or in a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) that does not provide Vision Care coverage, this section describes your Vision Care Program. If you are enrolled in an HMO or PPO that provides vision care coverage, your HMO or PPO will mail you information on your vision care coverage.

Information relating to your eligibility for Vision Care coverage is provided in the "Eligibility for Health Care coverage" section of this handbook.

Who administers the Vision Care Program?

SVS Vision Managed Care, Inc. insures Vision Care benefits and provides a network consisting of SVS Vision and other affiliated providers (the "Network"). You and your eligible dependents receive the most comprehensive vision care expense coverage when you receive services from a Network provider. You generally incur greater out-of-pocket expenses when you obtain services from a non-Network provider.

What expenses are covered under the program when services are provided by a Network provider?

The following expenses are covered when services are obtained from a network provider.

**SCHEDULE 1
NETWORK PROVIDER SCHEDULE**

Services:	Coverage:
Vision testing exam	Full Coverage
Reexamination (by an ophthalmologist)	\$45
Regular lenses: (glass or plastic) <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal • Special (lenticular, aspheric, etc.) 	Full Coverage
Lens Options: <ul style="list-style-type: none"> • Tints equal to Rose 1 and 2 • Scratch resistant coating for those age 13 and under • Lenses more than 65 millimeters in diameter 	Full Coverage
Frames <ul style="list-style-type: none"> • Standard frames • Designer frames 	Full Coverage \$40
Contact lenses (instead of eyeglasses) <ul style="list-style-type: none"> • Not medically necessary <ul style="list-style-type: none"> ○ Hard or soft contact lenses \$75 ○ Professional fees (fitting and follow-up) \$40 • Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by an M.D. or O.D., includes professional fees and contact lenses 	Up to \$350

Is there a warranty on lenses and/or frames obtained from a Network provider?

Most lenses or frames received from a Network provider are under warranty for two years. (There is a one-year warranty for rimless frames.) The warranty begins the day you receive your lenses and/or frames and works according to a point system.

During the two-year warranty period (or one-year period for rimless frames), a total of 10 replacement points are provided for services received. When any eyeglass part is repaired or replaced, the point value of the replaced part, as described below, will be subtracted from the total number of points remaining.

10 Replacement Points	
Each lens	2 points
Each temple	2 points
Frame front	2 points

Broken parts must be submitted to qualify for this replacement plan. Scratched lenses are not covered. If you use all 10 replacement points before the end of the warranty period, you will be responsible for paying any additional repair or replacement costs. For more information on the warranty, call SVS's toll-free number: 1-800-225-3095.

How do I obtain services from a Network provider?

Contact a Network provider for an appointment and let them know that you are an hourly UAW-Ford employee with SVS coverage. To obtain the location of the nearest Network provider, call this toll-free number: 1-800-225-3095.

Can I visit an ophthalmologist?

Normally, you will be seen by a Doctor of Optometry for your vision examination. If you prefer, or if your optometrist suggests, you may have an ophthalmologist perform your vision exam. You may choose any licensed ophthalmologist. You will be reimbursed for the exam based on the following Schedule 2 coverage levels (regardless of where you live or where your ophthalmologist is located).

If you have your vision exam performed by an optometrist, your optometrist may refer you to an ophthalmologist for medical reasons. Your reexamination by an ophthalmologist is covered if performed by a Network provider within 60 days from the date of your initial examination. You may receive partial coverage under the following "Schedule 2" if you go to a non-Network provider, and you live more than 25 miles from a Network provider. (For those residing within 25 miles of a Network provider, referral must be made by a Network provider.)

What expenses are covered under the program when services are provided by a non-Network provider and I live more than 25 miles from a Network provider?

If you live more than 25 miles from a Network provider, and you choose to receive services from a non-Network provider, you will be reimbursed up to the lesser of the actual charge or the following amounts:

**SCHEDULE 2
NON-NETWORK PROVIDER SCHEDULE
LIVE MORE THAN 25 MILES FROM A
NETWORK PROVIDER**

Services	Coverage
Vision testing examination	\$45
Reexamination (by an ophthalmologist)	\$45
Regular lenses: (glass or plastic)	
• Single vision	\$59
• Bifocal	\$79
• Trifocal	\$99
• Special (lenticular, aspheric, etc.)	\$99
Lens Options:	\$0
• Tints equal to Rose 1 and 2	
• Scratch resistant coating for those age 13 and under	
• Lenses more than 65 millimeters in diameter	
Frames (standard or designer frame)	\$49
Contact lenses (instead of eyeglasses)	\$89
• Not medically necessary; Including hard or soft contact lenses and professional fees (fitting and follow-up)	\$200
• Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by M.D. or O.D. including professional fees and contact lenses	

What expenses are covered under the program when services are provided by a non-Network provider and I live within 25 miles of a Network provider?

If you live within 25 miles of a Network provider, and you choose a non-Network provider, you will be reimbursed up to the lesser of the actual charge or the following amounts:

**SCHEDULE 3
NON-NETWORK PROVIDER SCHEDULE
LIVE WITHIN 25 MILES OF A NETWORK
PROVIDER**

Services	Coverage
Vision testing examination	\$0
Reexamination (by an ophthalmologist)	\$0
Regular lenses: (glass or plastic)	
<ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal • Special (lenticular, aspheric, etc.) 	\$13
Lens Options:	\$0
<ul style="list-style-type: none"> • Tints equal to Rose 1 and 2 • Scratch resistant coating for those age 13 and under • Lenses more than 65 millimeters in diameter 	
Frames (standard or designer frame)	\$13
Contact lenses (instead of eyeglasses)	\$37
<ul style="list-style-type: none"> • Not medically necessary; Including hard or soft contact lenses and professional fees (fitting and follow-up) • Medically necessary to achieve 20/70 in better eye or to correct keratoconus, irregular astigmatism, or irregular corneal curvature as diagnosed by M.D. or O.D. including professional fees and contact lenses 	\$52.50

What expenses are covered if I have an emergency and I can't get to a Network provider?

If you have an emergency and you are unable to reach a Network provider, you may receive covered emergency services from a non-Network provider (subject to Program limits). For this purpose, an "emergency" is considered a permanent visual impairment of such nature that failure to replace lost or broken lenses and/or frames could jeopardize your safety or well-being. You will be reimbursed up to the amounts listed under "Schedule 2".

What limitations apply to the Vision Care Program?

Program benefits are limited to:

- One vision testing examination in any period of 12 months plus one referral when medically necessary to an ophthalmologist for re-examination within 60 days from the date of initial examination. For those residing within 25 miles of a Network provider, referral must be made by the Network provider.
- One pair of lenses and frames or contact lenses in any period of 24 months.
- Children to the end of the calendar year in which they become sixteen years of age, who are diagnosed as having severe, progressive myopia (i.e., nearsightedness with myopia of 2.00 diopters or greater and progressing at the rate of 1.00 diopter or more per year in the meridian of greatest change) who have a change of 1.00 diopter or more during the preceding 12 months, will be eligible for appropriate corrective lenses (but not frames) payable by the Program. If a covered person has received lenses or frames for which benefits were payable under the program, benefits will be payable for lenses or frames only if received more than 24 months after receipt of the most recent lenses or frames for which benefits were payable under the program.
- If you (or your eligible dependent) are insulin-dependent diabetics and if a change of .5 diopter or 10 degree axis occurs during the preceding 12 months, you may receive one pair of new lenses on an annual basis at the new prescription (but not frames).
- In order to receive these benefits, insulin-dependent enrollees must provide a letter from their personal physician to the optometrist or ophthalmologist, stating they (or their eligible dependent) are insulin-dependent. For those enrolled in an HMO or PPO plan and who are covered under the SVS Program, the annual eye exam will be provided at an HMO or PPO location as a plan benefit and the lenses, if necessary, would be obtained from an SVS location as a SVS plan benefit.
- When eligible for lenses, and until the enrollee's thirteenth birthday, coverage will be provided for scratch-guard coating on plastic lenses when received from a Network provider. Scratch-guard coating will be covered under the Program not more frequently than once every two calendar years.

What expenses are not covered under the Vision Care Program?

This Vision Care Program does not provide coverage for any of the following services or procedures:

- Visual training, orthoptics, visual therapy for learning disorders, low vision aids, aniseikonic lenses, aphakic lenses (if for condition of surgical aphakia) and tonography
- Medical or surgical treatment (these benefits may be provided by your Hospital-Surgical-Medical coverage)
- Drugs or any other medication not administered for the purpose of a vision testing exam
- Vision testing exams, lenses or frames provided for any condition, disease, ailment or injury arising out of and in the course of employment
- Vision testing exams, lenses or frames ordered before you were eligible or after coverage terminated
- Lenses or frames which are not necessary according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by your physician or optometrist
- Charges for vision testing exams, lenses or frames if covered by a government health care program
- Charges for vision testing exams, lenses or frames which are payable under any other group coverage
- Lenses or frames ordered while coverage is in effect but delivered more than 60 days after coverage terminates
- Charges which exceed the reimbursement levels stated above or which otherwise exceed Plan benefits

Health Care Plan

Hearing Aid Coverage

This section of your handbook answers these questions:

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Health Care Plan - Hearing Aid Coverage

How does Hearing Aid coverage work?

Under the National PPO Plan (BCBS), benefits are provided for hearing aid service when obtained from participating providers.

Under the National PPO Plan (BCBS), benefits are provided for audiometric exams, hearing aid evaluations, hearing aids and replacement ear molds for children up to age seven, when services are obtained from participating providers. If necessary, the same benefits will be provided again after 36 months have passed since your last examination for a hearing problem. Up to four replacement ear molds are covered annually for children up to age three and up to two for children ages three to seven.

Information relating to your eligibility for Hearing Aid coverage is provided in the "Eligibility for Health Care coverage" section.

For benefits to be paid, Hearing Aid services must be obtained from a participating provider. Your claims processor has a list of participating providers and suppliers.

What Hearing Aid expenses are covered?

Effective January 1, 2008, an allowance of up to \$2,000 every three (3) years will be provided for each eligible enrollee for the acquisition cost and dispensing fee to purchase hearing aids and ear molds, as applicable, plus replacements, adjustments and repairs as required.

For the initial hearing aid payable under this Plan or for a person under age 18, you must first obtain a medical examination of the ear by a physician. This physician's examination is not a covered benefit.

To receive benefits you must obtain:

- **An audiometric exam** performed by a participating physician or audiologist to measure the extent of hearing loss. An "audiometric" exam measures hearing acuity or sharpness. This exam must be performed after or in conjunction with a physician's most recent medical exam of the ear if for an initial hearing aid or for a person under age 18 and must result in a determination that a hearing aid would compensate for the loss of hearing. The lesser of the billed charge or the allowed amount for this exam is covered.
- **A hearing aid evaluation test** to prescribe the make and model of the hearing aid which will best improve your hearing. This test must be performed by a participating physician or audiologist when indicated by the most recent audiometric exam.

Effective October 1, 2007, hearing aid coverage pays up to \$139 for this test. Beginning in 2008, the amount will be adjusted on October 1 of each year to reflect increases in the Consumer Price Index. Your claims processor can tell you how much the coverage currently pays for the hearing aid evaluation test.
- **A hearing aid prescription filled and fitted** by a participating dealer. A prescription from the participating physician or audiologist is required when a hearing aid is purchased.

If the initial exam reveals that the hearing loss may be corrected by ear surgery, that surgery could be covered by Hospital-Surgical-Medical benefits. See the “Hospital-Surgical-Medical coverage” section for more details.

To be covered, your audiometric and evaluation test must be performed by a participating physician or licensed audiologist. “Physician” means an otologist, otolaryngologist or otorhino-laryngologist who is certified to perform a medical examination of the ear to determine whether you have a loss of hearing acuity.

An “audiologist” is a person who has an advanced college degree in audiology or speech pathology, is certified by the American Speech-Language-Hearing Association and is qualified in the state where he or she practices.

You should present your health care identification card to the participating provider at the time covered services are obtained. Participating providers will bill your claims processor directly for covered services.

What Hearing Aid expenses are not covered?

Under the National PPO Plan (BCBS), no Hearing Aid benefits are paid for the services below.

Certain hearing aid-related services are not covered. These include:

- Services and equipment obtained from non-participating providers
- Medical or surgical treatment (this may be covered by your Hospital-Surgical-Medical benefits)
- Drugs or other medications (this may be covered by your Prescription Drug benefits)
- Audiometric exams and hearing aid evaluation tests performed and hearing aids ordered before coverage becomes effective or after coverage ends, unless a hearing aid is prescribed before coverage ends and is delivered and fitted within 60 days
- Replacement of lost or broken hearing aids
- Replacement parts for, and repairs of, hearing aids once the \$2,000.00 allowance for an individual enrollee has been utilized during any period of 36 consecutive months.
- Eyeglass-type hearing aids, to the extent the charge for such hearing aids exceeds the standard covered hearing aid expense
- The cost for more than one audiometric exam, one hearing aid evaluation test and one \$2,000.00 allowance for hearing aids and/or ear molds for an individual enrollee during any period of 36 consecutive months
- Audiometric exams, hearing aid evaluation tests and hearing aids that are not necessary, do not meet accepted standards of practice or are not recommended by a physician or for any other condition other than the loss of hearing acuity.
- In the case of an initial hearing aid or any hearing aid for a person under age 18, charges for hearing aid evaluation tests and hearing aids which are not recommended or approved by a physician
- Experimental services or supplies
- Services provided under Workers’ Compensation or other government plans
- Services or supplies provided in a United States government hospital not operated for the general public

NOTES

Health Care Plan

Pilot Programs

This section of your handbook answers these questions:

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Health Care Plan - Pilot Programs

What is a pilot program?

In some areas of the country, part of your Health Care coverage may be provided through a pilot program.

From time to time, Ford and the UAW may agree to implement "pilot programs" with the goal of providing high quality, cost effective care.

The following lists the pilot programs now in effect. The National Employee Services Center can advise you if a pilot program is in effect in your area.

What pilot programs are in effect?

Two pilot programs are in effect in certain areas of the country:

- Cardiac Rehabilitation program for Michigan employees with National PPO (BCBS) plan coverage
- Long Term Care Pilot Program for grandfathered employees only, at the Louisville Assembly and Kentucky Truck plants and their eligible dependents who were enrolled in the program as of November 19, 2007. This pilot program is closed to any new enrollees but will continue for the grandfathered employees until funding is exhausted.

Health Care Plan

Health Care Claims

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Health Care Plan - Claims

Who processes health care claims?

Your health care claims generally are processed by a claims processor. If you are covered under the National PPO Plan (BCBS) the claims processors that apply to you are listed below. If you have coverage through an alternative or pilot plan (e.g., a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Dental HMO), your claims will be processed through those organizations.

Health Care Coverage:	Location:	Your Claims Processor is:
Hospital-Surgical-Medical Hearing Aid National PPO Plan (BCBS)	All states	Blue Cross and Blue Shield
Prescription Drug	All states	Blue Cross and Blue Shield Michigan/ Medco Health
Dental	All states	Blue Cross and Blue Shield Michigan
Vision Care	Any state or the District of Columbia unless enrolled in an HMO or PPO plan that provides vision care	SVS Vision Managed Care Inc.
Outpatient Physical Therapy	Michigan Only	BCBS (TheraMatrix)
Durable Medical Equipment	All States	Wright & Filippis (SUPPORT Program)

See the “Administrative, ERISA, and Family Medical Leave Act of 1993 Information” section of this handbook for the address and telephone numbers of these claims processors.

Explanation of benefits

Whenever a National PPO Plan (BCBS) claim is processed, you will receive an Explanation of Benefits (EOB) from your claims processor giving information about the service and benefits paid.

If you have a question about your EOB, contact the appropriate claims processor at the address shown on the statement or the telephone number on the back of your ID card.

Discretion to Determine Benefits

The National PPO claims processors have been delegated full power and authority by the Plan Administrator to administer the H-S-M-D-D-V (Hospital-Surgical-Medical-Drug-Dental-Vision) Program and to interpret its provisions including, but not limited to, discretionary authority to determine entitlement to Program benefits. Ford, as Plan Administrator, determines the eligibility of employees and dependents to participate in the Plan.

What is the identification card used for?

You present your identification card to most health care providers.

Generally, you will receive one card for yourself and another for your spouse. You may get additional cards if necessary. Contact the health care plan in which you are enrolled for information on how to obtain additional cards.

Your cards identify the group (Ford-UAW) through which you are enrolled for health care. The National PPO Plan (BCBS) and most HMOs and PPOs issue identification cards. Present your card when you, your spouse or an eligible dependent requires health care services. When you present your card, you may be asked to show additional identification.

If your identification cards are lost or stolen, contact the health care plan in which you are enrolled immediately. Only you, your spouse and your covered dependents are permitted to use the cards. Any attempt to misuse your health care identification card may be a violation of law. Misuse also may subject you to disciplinary action by your employer, including discharge. It is a felony in most states to lend your health care card to anyone not listed on your insurance coverage and to knowingly enroll people or retain persons on your contract who do not meet the Program's eligibility rules. For example, ex-spouses must be removed from your coverage immediately upon divorce.

See the "Eligibility for Health Care Coverage" Section of this handbook for more information on eligibility.

How are health care claims filed?

Different claims procedures apply to each coverage in the Health Care Plan.

Most claim forms are available from your provider. If your provider does not have the appropriate claim form, contact your claims processor.

BCBS National PPO Plan Hospital-Surgical-Medical

If you receive Hospital-Surgical-Medical services from an **in-network** BCBS National PPO Plan provider, the provider will bill BCBS directly for covered services. You are not required to file a claim. After claims are paid, you will receive an Explanation of Benefits (EOB) showing what was paid.

If you receive services from an out-of-network BCBS National PPO Plan provider who is participating with BCBS the provider will bill BCBS directly for covered services. You are not required to file a claim. After claims are paid, you will receive an Explanation of Benefits (EOB) showing what was paid.

If your claims processor is Blue Cross and Blue Shield and you receive services from either an out-of-network provider who is not participating with BCBS, OR you receive Hearing Aid services, follow these steps:

- Verify whether the provider will submit a claim to BCBS directly on your behalf. If not, have the provider fill out the provider's section, then complete your portion and submit the claim form to the local office of your claims processor. Be sure to enclose your itemized bills or statements along with cash register receipts, cancelled checks, money order stubs or a paid receipt. Also be sure to keep copies of the claim form, bills and receipts. The originals will not be returned to you.
- You will be paid directly for covered services and will receive an Explanation of Benefits (EOB) showing how much was considered and paid.

Durable Medical Equipment and Prosthetic and Orthotic Appliances (DME and P&O)

When you obtain covered DME and P&O services from a SUPPORT network provider under the Ford National DME and P&O Program, no claim forms are necessary and you will not receive a bill.

For services that are not provided in a hospital or other facility setting, the SUPPORT Program will generally cover all medically necessary DME covered services when they are arranged for by the SUPPORT Program.

If services are performed by a provider outside the SUPPORT network, submit a claim or itemized bill to the SUPPORT Program, UAW / Ford National DME and P&O Program, P.O. Box 82060, Rochester, MI 48308-2060, 1-800-831-0999.

TheraMatrix Out-Patient Physical Therapy in Michigan Only

Covered outpatient physical therapy services provided by TheraMatrix participating network providers are covered in full under the National PPO.

There are no out-of-pocket costs to covered enrollees when services are received from TheraMatrix network providers.

There are no prior authorization requirements. The member needs only to ensure the provider being utilized is a TheraMatrix Physical Therapy Network (TPTN) provider, by contacting TheraMatrix. However, if the member is outside of Michigan, reference information can be found below.

Outpatient physical therapy services that are obtained from providers who are not in the TheraMatrix network are not covered.

If you are traveling outside of Michigan and Outpatient Physical Therapy is medically necessary contact TheraMatrix for arrangements to see an out-of-area provider with no out-of-network penalty.

For additional information contact TheraMatrix at 1-888-709-5186 or for provider information you can also go to www.theramatrix.com.

Prescription Drug coverage

When you obtain prescription drugs from the Blue Cross and Blue Shield/Medco Program or one of its affiliated providers, no claim forms are required, (although prior authorization is required as described in the “Health Care Plan - Prescription Drug Coverage” section of this handbook, and other “Pharmacy Management Tools” also described there may apply)

If you elect to receive services from a nonparticipating pharmacy obtain a prescription receipt and submit with a claim form to Blue Cross and Blue Shield/Medco. You will be reimbursed for covered expenses. See the “Health Care Plan - Prescription Drug Coverage” section of this handbook for additional information.

Dental coverage

To receive benefits under the Traditional Dental Plan, a claim form must be filed with your claims processor.

Generally, your provider will file a claim for you. If he or she doesn't, you will need to file the claim. On the claim form, you decide whether to have payment made to you or your dentist.

Remember, if dental expenses are expected to be \$200 or more, your dentist should file a “treatment plan” before dental work begins. See the “Health Care Plan - Dental Coverage” Section of this handbook for additional information.

If you are enrolled in a Dental HMO, you will not have to complete claim forms.

Vision Care coverage

If you or your dependent receives Vision Care services from an SVS Network provider, no claim forms are required. If you or your dependent elects to receive services from a non-Network provider, claim forms are required. You may obtain a claim form from SVS Vision Managed Care, Inc., (1-800-225-3095 or www.svsvision.com), or your UAW Benefits Representative. Submit your completed claim form, along with your itemized receipt, to SVS Vision Managed Care, Inc., P.O. Box 464, Mt. Clemens, MI 48046-0464. You will be reimbursed up to the amounts described in the “Health Care Plan - Vision Care Coverage” section of this handbook.

What are the Claims and Appeal Procedures for the National PPO (BCBS) Plan?

This section describes the health care plan claims and appeals procedures for the National PPO plan that have been implemented in compliance with the Department of Labor's (DOL's) new regulations governing how health care plans process claims and handle appeals. This section also describes the inquiry procedures. Information on plans other than the National PPO (BCBS) plan should be provided to you by those alternative plans. If you are in an alternate plan and have questions, contact the alternative plan directly.

The DOL regulations mandate that claim and appeal procedures include specific time frames. Ford Motor Company's health care Plan claims and appeals procedures were developed and are administered in compliance with the Department of Labor's (DOL's) regulations. These regulations establish different requirements for how all group health plans must process claims and handle appeals rather than the rules that apply to other kinds of welfare benefits and pension benefits. The regulations mandate specific time frames for:

- You to make various types of health care claims
- Your claims to be processed by a health plan
- You to appeal what the DOL calls "adverse benefit determinations" of a health claim (which are essentially claim denials or limitations), and
- A health plan to respond to your appeal.

Under the health plan claim and appeal procedures, claims include the following types:

- ***Pre-Service Claims*** – a claim where receipt of the benefit is conditioned, in whole or part, on receiving approval in advance of obtaining medical care (for example, a requirement to get approval before any non-emergency hospitalization).
- ***Urgent Claims*** – A Pre-Service claim, where the otherwise applicable time limit for determining a claim or hearing an appeal
 - ◇ Could seriously jeopardize the claimant's life, health or ability to regain maximum function, or
 - ◇ Would (in the opinion of a physician with knowledge of the claimant's condition) subject the claimant to severe pain that cannot be adequately managed without the proposed care or treatment.

- ***Post Service Claims*** – Any claim that is not a Pre-Service or Urgent Claim (that is, a typical health care claim, where services are obtained and then payment requested).

Note: There are also time limits on the amount of time a health plan has to process your claim:

- Urgent Pre-Service Claims - Plans have 72 hours to provide you with an adverse benefit determination on a pre-service claim.
- Non-urgent Pre-Service Claims - Plans have up to 15 calendar days to provide you with an adverse benefit determination on a non-urgent pre-service claim. This time frame can be extended by 15 calendar days.
- Post-Service Claims - Plans have up to 30 calendar days to provide you with an adverse benefit determination on a post service claim. This time frame can be extended by 15 calendar days.

Note: If another person will be representing you (family member, friend or union representative), you must complete and submit an Auto Claim Inquiry/Appeal Form (CIF) authorizing that person to act on your behalf. You may contact your health care plan's customer service department for a copy of the authorization form.

If you have a question about your benefit coverage on a claim, you can submit a verbal or written inquiry to your health care plan. An appeal may be submitted without a prior inquiry.

While health care plans will handle claims for benefit coverage, eligibility-only appeals that are not related to a claim for benefit coverage will be handled by Ford at the NESC. The DOL regulations apply to any appeal involving a claim for benefits. The regulations do not apply to determination of eligibility that are not attached to a claim for benefits.

Appeals

You may appeal an adverse benefit determination within 190 calendar days from the date of notification. The notification date generally is the date of the Explanation of Benefits (EOB) you receive from your health care plan. The appeal must be in writing and should be submitted to the address shown on the EOB for appeals. Please include your contract and group number, daytime phone, service date(s), and any documentation supporting your appeal, including a copy of the EOB form. If another person will be representing you, you must submit a written form authorizing that person to act on your behalf. Please contact your health care plan's Customer Service Department or your UAW Benefits Representative for a copy of the authorization form. The timing for response differs for urgent and non-urgent appeals.

- Urgent Pre-Service Appeals - Plan must notify claimant of decision within 72 hours of receiving an urgent pre-service appeal.
- Non-Urgent Pre-Service Appeals - Plan must notify claimant of decision within 30 calendar days of receipt of a non-urgent pre-service appeal.
- Non-Urgent Post-Service Appeals - Plan has up to 60 calendar days to provide a written response.

Voluntary Level of Appeal

Ford has established an additional, voluntary level of appeal, after the DOL-required appeal process has been exhausted. You may submit a Voluntary Appeal to Ford if you are dissatisfied with the health care plan's determination of your appeal. You should send the Voluntary Appeal with a copy of all previous correspondence (including a copy of the health care plan appeal response) and all available supporting documentation to the National Employee Service Center, Health Care Voluntary Appeals, and P.O. Box 6214, Dearborn, Michigan 48121-6214. The voluntary appeal level has no timing requirements mandated by DOL. However, the Company and the UAW have agreed to the following timing for the Voluntary Appeal process:

- Timing for submitting Voluntary Appeal: The enrollee or his or her authorized representative has 60 calendar days from the date of the health care plan's denial to request a voluntary appeal for pre-service and post-service non-urgent services.
- Pre-service urgent response time: The Company has 25 calendar days from the date the request is received to respond to a request for a voluntary appeal.
- Pre-service and post-service non-urgent response time: The Company has 60 calendar days from the date the request is received to respond to a request for a voluntary appeal.

Note: *If you are not satisfied with your National PPO Plan (BCBS), Dental, Hearing, Prescription Drug, SUPPORT Program or TheraMatrix Outpatient Physical Therapy Program Plan's response to your DOL appeal, you may either (1) submit a voluntary appeal to Ford and then initiate a civil action in the appropriate court if you are still not satisfied, or (2) submit a voluntary appeal at the same time as civil action or (3) immediately initiate a civil action without using the voluntary appeal process.*

***Health Maintenance Organizations (HMO),
Dental Health Maintenance Organizations
(DHMO), Fully Insured Preferred Provider
Organization (PPO), and the SVS Vision
Managed Care Program***

Each HMO, DHMO, fully insured PPO, and the SVS Vision Managed Care Program has an appeal process in place. Please contact the customer service department of your plan for detailed information about their appeals process and the timing requirements, or refer to the Plan's Explanation of Benefits (EOB) for more information.

Note: *The National PPO Plan (BCBS) and Blue Preferred Plus PPO Claims and Appeals process (including the voluntary level of appeal) described above in this section does not currently apply to HMOs, DHMOs, or fully insured PPOs. In the event this changes in the future, you will be notified in writing.*

See the "Administrative, ERISA, and Family Medical Leave Act of 1993 Information" section of this handbook for certain rights under ERISA.

NOTES

Health Care Plan

HIPAA Privacy Practices

This section of your handbook answers these questions:

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HIPAA Privacy Practices

Is my health care information kept private under HIPAA?

NOTICE OF PRIVACY PRACTICES UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This Notice describes how medical information about you may be used and disclosed by your insurance company or Ford and how you can get access to this information and its uses. Please review it carefully.

Ford provides its employees and Medicare/non-Medicare retirees/surviving spouses and their eligible dependents a number of benefits, including hospital, surgical, medical, prescription drugs, dental and others. This Notice applies to employees and retirees/surviving spouses and their eligible dependents who participate in the following health care plans, referred to below as “Group Health Plans”:

BCBS National PPO Plan - Hospital-Surgical-Medical-Drug-Hearing-Dental Plan for Hourly Employees

Preferred Provider Organizations (Michigan only at this time)

Health Maintenance Organizations (HMO)

Note: Depending on the circumstances, the term “Group Health Plans” as used in this Notice may mean multiple Group Health Plans or a single Group Health Plan.

Also note that employees and retirees/surviving spouses and their eligible dependents who choose to receive benefits through a Health Maintenance Organization (HMO), fully-insured Preferred Provider Organization (PPO) or other fully-insured plan will receive a Notice of Privacy Practices related to those benefits directly from those insurers.

Group Health Plans maintain the confidentiality of your medical information related to your Group Health Plan coverage. This Notice describes the Group Health Plans’ legal duties and privacy practices with respect to that information. This Notice also describes your rights and the Group Health Plans’ obligations regarding the use and disclosure of your medical information.

The Group Health Plans are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, to maintain the privacy of your Protected Health Information (PHI). PHI is the information created or received by or on behalf of the Group Health Plans that identifies you or which, on a reasonable basis, could be used to identify you and includes:

Information that relates to your past, present, or future physical or mental health or condition;

The provision of health care to you; or

The past, present, or future payment for the provision of health care to you.

This information may be maintained or transmitted either electronically or in any other form or medium.

Please note that your medical file located at any Ford medical office (i.e., the Plant Medical) is not considered PHI and thus is not subject to this Notice. However, while this excluded area is not subject to HIPAA, there is other legislation and/or Company safeguarding procedures, as well as the “Confidentiality of Health Care Information” letter located in Volume IV of the Collective Bargaining Agreement between the UAW and Ford Motor Company, to maintain appropriate levels of confidentiality.

“Minimum Necessary” requirements apply to the uses and disclosures of your PHI. Use and disclosure is limited to the amount of information reasonably necessary to accomplish the intended purpose (i.e., for group health plan administration).

How the Group Health Plans may use or disclose your health information

For treatment

While the Group Health Plans generally do not use or disclose PHI for treatment, they are permitted to do so if necessary, and will disclose PHI for treatment in connection with the Healthy Highway Program.

For payment

The Group Health Plans may use and disclose your PHI to others to facilitate payment for treatment and services. For example, the Group Health Plans may provide information to a provider or a third-party payor, such as an insurance company, regarding amounts that are covered under the Group Health Plans. The information may identify you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations

The Group Health Plans may use and disclose your PHI for operational purposes. For example, your PHI may be disclosed to certain employees of the Group Health Plans, or third parties retained or hired by the Group Health Plans, for customer service, enrollment, due diligence, quality improvement, business planning, and cost management. This information may identify you, your diagnosis, and treatment or supplies used in the course of treatment.

Plan sponsor

The Group Health Plans may disclose PHI to Ford Motor Company, for health care operation purposes. At no time will the Group Health Plans disclose information for employment-related actions or decisions.

Within Ford, information can only go to certain individuals, namely those located at the NESC, on an as-needed basis. These individuals have been trained and certified in HIPAA.

Required by law

The Group Health Plans may use and disclose information about you as required by law. For example, the Group Health Plans may disclose information:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect, or domestic violence pursuant to legal authority; or
- To assist law enforcement officials in their law enforcement duties as required by law.

Other permitted uses and disclosures

While the Group Health Plans generally do not use or disclose PHI for the following purposes, the Group Health Plans may disclose PHI:

- To a health oversight agency (such as Medicare or Medicaid);
- For government functions (for reasons of national security);
- To avert a serious health or safety threat;
- For post-mortem identification; or
- To comply with Workers' Compensation laws.

Other issues

Other uses and disclosures will be made only with your written authorization. You may revoke the authorization in writing, except to the extent that the Group Health Plans have relied on your authorization.

Your health information rights under HIPAA

You have the right to:

- Request a restriction or limitation on the Group Health Plans' use or disclosure of your PHI for payment or health care operations purposes as set forth above. You also have the right to request a limit on the PHI the Group Health Plans disclose about you to someone who is involved in your care or the payment of your care. The Group Health Plans are not required to agree to your request. If the Group Health Plans do agree, the Group Health Plans will comply with your request unless the information is needed to provide you with emergency treatment.
- Obtain a paper copy of the Notice of Information Practices upon request.
- Inspect and copy your PHI that is contained in the records maintained, used, collected or disseminated by the Group Health Plans. Usually, this includes the medical and billing records maintained by the Group Health Plans, but does not include psychotherapy notes to which the Group Health Plans may have access. (You may be charged for the costs of copying, mailing, or other supplies directly associated with your request).

- Request an amendment to your PHI if you believe the PHI the Group Health Plans have about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Group Health Plans. The Group Health Plans may deny your request for amendment if:
 - ◊ Your request is not in writing, or it does not include a reason to support the request;
 - ◊ Or the PHI to which your request refers:
 - Was not created by the Group Health Plans, unless the person or entity that created the PHI is no longer available to make the amendment;
 - Is not part of the medical information, enrollment, payment, claims adjudication or management records kept by the Group Health Plans;
 - Is not part of the information you would be permitted to inspect or copy; or is accurate and complete.
- Request the Group Health Plans to communicate with you about your PHI in a certain manner or at a certain location. For example, you may request that the Group Health Plans contact you only at home and not at work. The Group Health Plans will accommodate all reasonable requests if you clearly state that you are requesting a confidential communication because you feel that disclosure could endanger your life. You must make sure your request specifies how or where you wish to be contacted.
- Receive an accounting of disclosures made of your PHI, except those based on an authorization for treatment, payment or health care operations.

Personal or designated representatives

You may exercise your Health Information Rights under HIPAA through a personal or designated representative. Your personal or designated representative will be required to produce evidence of authority (i.e., authorization form or other legal authority) to act on your behalf before being given access to your PHI or being allowed to take any action for you. Copies of an authorization form can be obtained from the National Employee Services Center and/or from a Union Benefit Representative.

The Group Health Plans can deny your personal or designated representative access to PHI in order to protect people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Complaints

You may complain to the Group Health Plans and to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of the Group Health Plans

The Group Health Plans are required to:

- Maintain the privacy of PHI.
- Provide you with this Notice of their legal duties and privacy practices with respect to PHI.
- Abide by the terms of this Notice.
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.
- Accommodate reasonable requests to communicate PHI by alternative means or at alternative locations.

The Group Health Plans reserve the right to change their information practices and to make the new provisions effective for all protected PHI they maintain. Revised Notices will be made available to you through the Group Health Plan.

State law may provide for additional protection of your health information. Please contact the person identified below for more information. The UAW-Ford Collective Bargaining Agreement, Volume IV, "Confidentiality of Health Care Information" also provides protection on confidentiality of medical information.

Contact information

If you have any questions, complaints or wish to exercise any of your Health Information Rights under HIPAA as described herein, contact:

Enrollment Information

National Employee Services Center (NESC)
 P.O. Box 6214
 Dearborn, MI 48121-6214
 1-800-248-4444

Claims and Billing - Contact your health care plan carrier directly.

No change to plans

Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Group Health Plans. You should refer to the Group Health Plans documents for complete information regarding any rights or obligations you may have under the Group Health Plans.

Health Care Plan

Important Medicare Information

This section of your handbook answers these questions:

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Health Care Plan - Important Medicare Information

IMPORTANT MEDICARE INFORMATION FOR FORD MEDICARE-ELIGIBLE RETIREES AND SURVIVING SPOUSES

The purpose of this section is to provide you with important information regarding Medicare and to explain how enrollment in Medicare affects your benefits under the BCBS National PPO Plan after your retire.

Late enrollment in Medicare B may cause your surviving spouse to be responsible for substantial medical costs and may result in Medicare late enrollment penalties. For surviving spouses, failure to enroll in Medicare Part B may result in loss of eligibility for coverage under the medical plan.

Action Required

If you will be covered under the National PPO Plan (BCBS) [protected, Modified or Catastrophic] after you retire, please read this material explaining Medicare enrollment requirements.

What is Medicare?

Medicare is our country's health insurance program for the elderly and disabled.

Medicare has two parts:

- Medicare Part A - Hospital Insurance. Most people are not required to pay for Part A.
 - ◇ Medicare Part A helps pay for hospital stays, very limited skilled nursing care, some home health care and hospice care.
 - ◇ Medicare Part A does **not** cover long-term nursing home care or most prescription drugs.
- Medicare Part B - Medical Insurance. Most people pay a monthly premium for Part B which is adjusted each year by the Centers for Medicare and Medicaid Services (CMS).
 - ◇ Medicare Part B helps pay for doctor's services, X-rays, diagnostic tests, ambulance services and outpatient hospital care.

Who is eligible for Medicare?

Most people age 65 or older, who are citizens or permanent residents of the United States, are eligible for Medicare based on their own (or their spouse's) employment history.

Before age 65, you are eligible for Medicare if you have been receiving Social Security disability benefits for 24 months.

If you have end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant), you may be eligible for Medicare at any age.

Does Medicare cost anything?

In almost all cases, there is no cost to you or your spouse for Medicare Part A. A Medicare tax deduction for Part A was taken from your or your spouse's paychecks during the years you worked.

There is, however, a monthly premium (cost) for Medicare Part B; this premium is adjusted annually by Centers for Medicare and Medicaid Services (CMS).

How do I enroll in Medicare Part A?

If you are receiving Social Security Benefits at age 65, you will automatically be enrolled in Medicare Part A, at no cost to you. Prior to your 65th birthday, you will receive a Medicare I.D. card in the mail.

If you have been receiving Social Security Disability Benefits for 24 months or longer, you will automatically be enrolled in Medicare Part A at no cost to you.

If you misplace your Medicare card, you can request a new card from Social Security by calling 1-800-772-1213.

NOTE: *If you are age 65 or older and retired, and not receiving a Social Security check, you must enroll for Medicare Part A. Enrollment is not automatic at age 65 unless you are receiving Social Security Benefits. You can enroll at your local Social Security Administration Office, by calling 1-800-772-1213, or online at www.ssa.gov. Please note that if you delay your enrollment and you receive medical services, you may be responsible for all or most of the charges which Medicare Part A would have paid.*

How does my retiree medical coverage coordinate with Medicare Part A?

The health care plan first determines what it would pay if you had no other coverage. The plan then subtracts Medicare benefits and pays the difference. As long as you are eligible for Medicare Part A and are not actively working, your health care claims will be paid under the assumption that you are enrolled in Medicare Part A. Your health care plan benefits will be reduced for any benefits that are available under Part A whether or not you are actually enrolled. As long as you are enrolled in Medicare, your total level of benefits will not change because of your Medicare coverage. Only the source of payment will change.

Medicare and the health care plan do not cover all your health care costs. In some cases, the health care plan will cover costs not covered by Medicare. For example, most covered prescription drugs will continue to be paid by your health care plan. For those charges that are covered by your health care plan, but not Medicare, the plan will pay without considering your Medicare coverage.

What will happen if I do not present my Medicare I.D. card to the doctor or hospital?

If you are eligible for Medicare Part A, the medical plan will check to see if Medicare has paid its share before processing your claim.

Any services that would have been paid by Medicare Part A will be rejected by your health care plan. This will cause a delay in payments to your providers and may require you to work with your provider to submit the claim to Medicare. For example, if you were admitted to a hospital as an inpatient and you did not present your Medicare I.D. card, your coverage would pay only the Medicare Part A deductible amount. You would be responsible for working with your provider to submit the balance of the hospital bill to Medicare.

How do I enroll in Medicare Part B?

You are automatically eligible for Medicare Part B if you are eligible for Medicare Part A.

If you are receiving a Social Security benefit and are eligible for Medicare coverage, you were enrolled automatically in Medicare Parts A and B at the same time.

NOTE: *Although you may have previously declined Medicare Part B coverage, you do not have the option to decline Medicare Part A as long as you continue to receive a Social Security benefit.*

The premium for Medicare Part B is deducted from your Social Security check.

What is the Special Age 65 Benefit?

A Special Age 65 Benefit is payable to retirees and surviving spouses, who are at least age 65, receiving a retirement benefit (other than deferred vested), are eligible for health care and enrolled in Medicare Part B. Active employees with End Stage Renal Disease and employees in receipt of disability benefits are also eligible to receive this special benefit, provided they are enrolled in Medicare Part B.

If you are eligible, the Special Age 65 Benefit will be included in your pension check.

Your spouse is not eligible for the Special Age 65 Benefit. However, your surviving spouse will be eligible for the Special Age 65 Benefit when you die, if he or she receives a survivor pension benefit and is enrolled in Medicare Part B when eligible.

In some circumstances, you may be eligible to receive a Special Age 65 Benefit before you are age 65. You must apply for this benefit. You must be enrolled in Medicare Part B to receive this benefit.

For more information, refer to the Medicare Information Table at the end of this section.

How do I apply for Special Age 65 Benefit?

You will be provided with application instructions when you retire.

What happens if I do not enroll in Medicare Part B?

If you decide not to take Medicare Part B when first eligible, should you choose to enroll later, the monthly premium cost to you for Medicare Part B will go up by 10% of the Medicare Part B premium cost for each 12-month period that you could have been enrolled. The health plan will not reimburse you for this penalty.

If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll.

The BCBS National PPO Plan does not pay for some services that would be covered by Medicare Part B, such as office visits.

If you are a surviving spouse who is age 65 or older, you will lose health care coverage until you enroll in Medicare Part B.

Why should my spouse and dependents enroll in Medicare Part B?

If your spouse is age 65 or older, and is not enrolled in Medicare Part B when you die, he or she will not be eligible for the health care coverage until he or she is enrolled in Medicare Part B. Since the Medicare Part B open enrollment period is from January 1 to March 31 of each year, and the coverage does not become effective until July 1, this could leave your spouse with no coverage other than Medicare Part A for an extended period of time.

If you are not actively working and you have a spouse or a dependent that is not yet age 65 but is eligible for Medicare, Medicare will be their primary insurance coverage when they enroll.

Additionally, the health plan does not pay for some services that would be covered by Medicare Part B, such as office visits. Enrollment in Medicare Part B may reduce your total out-of-pocket health care expenses.

Where do I go if I have questions about Medicare?

The Social Security Administration and Medicare are available to answer your questions at the following:

The Social Security Administration Office
1-800-772-1213

Online at www.ssa.gov

Medicare
1-800-MEDICARE (1-800-633-4227)

Medicare online at www.medicare.gov

If I am eligible for Medicare, how does the Ford Medicare enrollment policy apply to me?

Medicare Information Table

Employment Status	Is Medicare Part A required?	Is Medicare Part B required?	Eligible for Ford Special Age 65 Benefit?	How are my benefits coordinated with Medicare?
You are actively working for the Company	No	No	No	The Ford health care plan will continue to be the primary payer of eligible health care expenses and Medicare will be the secondary payer (if you are enrolled) as long as you are actively working.
You are actively working for the Company AND you have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)	Yes, when first eligible*	No	Yes. An employee with End Stage Renal Disease who is enrolled in Medicare Part B is eligible to receive the Special Age 65 benefit towards the Medicare Part B premium. You must apply for this benefit.	The Ford health care plan will continue to be the primary payer of eligible health care expenses for an initial 30-month coordination period. At the end of the 30 months, Medicare becomes the primary payer.
You are on a leave/layoff and have been off work for six months	Yes, when first eligible*	No	Yes. An employee who is receiving Ford's UAW disability benefits and is enrolled in Medicare Part B is eligible to receive the Special Age 65 benefit towards the Medicare Part B premium. You must apply for this benefit.	If you have been off from work for more than six months and you are enrolled in Medicare, Medicare becomes the primary payer of eligible health care expenses for you and any of your Medicare eligible dependents (if they are enrolled in Medicare).
You are retired, disabled and under age 65	Yes, when first eligible*	No	Yes. You may be eligible to receive the Special Age 65 Benefit before you are age 65. You must be enrolled in Medicare Part B to receive this benefit. You must apply for this benefit.	Medicare becomes the primary payer of eligible health care expenses for you and any of your dependents enrolled in Medicare when you retire.

** Members who are eligible for Medicare Part A, whether or not they are actually enrolled, will have all benefits available under the Ford health care plan reduced to the extent payment or benefit is available or would be available under Medicare Part A.*

Medicare Information Table (Continued)

Employment Status	Is Medicare Part A required?	Is Medicare Part B required?	Eligible for Ford Special Age 65 Benefit?	How are my benefits coordinated with Medicare?
You are retired and age 65 or older	Yes, when first eligible*	No	Yes. The Special Age 65 benefit is payable to retirees, who are at least age 65, enrolled in Medicare Part B and receiving Ford's UAW retirement benefits (other than a deferred vested benefit). You must be enrolled in Medicare Part B to receive this benefit. You must apply for this benefit.	Medicare becomes the primary payer of eligible health care expenses for you and any of your dependents enrolled in Medicare when you retire.
You are a surviving spouse	Yes, when first eligible*	Yes, at age 65	Yes. The Special Age 65 benefit is payable to surviving spouses who are enrolled in Medicare Part B and receiving Ford's UAW retirement benefits (other than a surviving spouse benefit payable as a deferred vested benefit). You must apply for this benefit.	Medicare is the primary payer of eligible health care expenses for Medicare eligible surviving spouses.

**Members who are eligible for Medicare Part A, whether or not they are actually enrolled, will have all benefits available under the Ford health care plan reduced to the extent payment or benefit is available or would be available under Medicare Part A.*

NOTES

Health Care Plan

Other Health Care Plan Information

*This section of your handbook
answers these questions:*

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Health Care Plan - Other Health Care Plan Information

How does the Health Care Plan coordinate with other group health care plans?

If you or a covered dependent is covered by another group health care plan, your Health Care Plan coordinates with that plan.

Your Health Care Plan may be coordinated with other group health care plans to which you or your eligible dependents belong. This means that all plans together pay no more than 100% of allowable expenses for you or your dependents. An “allowable expense” is any expense covered at least in part by one of the plans.

When a health care claim is made, benefits are coordinated as follows:

- The primary plan pays benefits first, without regard to any other plan
- The secondary plan pays benefits so that the total benefits paid will not be greater than your allowable expense
- No plan pays more than it would without the coordination provision.

A plan without a coordinating provision always is the primary plan. If all plans have a coordinating provision, benefits will be coordinated as follows:

- The plan covering the patient as an employee, rather than as a dependent, will be the primary plan
- If the patient is a dependent covered by more than one plan, the plan of the employee whose birthday occurs first in the calendar year is primary. If the birthdays are the same day, the plan that has covered the dependent for a longer period of time is primary

If you are separated or divorced, however, the plans pay in this order:

- The plan of the parent with responsibility for health care is primary, if the court has established one parent as financially responsible for health care
- The plan of the parent with custody of the child
- The plan of the stepparent married to the parent with custody of the child
- The plan of the parent that does not have custody of the child

When a determination cannot be made, the plan that has covered the patient for a longer period of time is primary, unless the patient is retired, laid off or the dependent of a retired or laid-off employee. In this case, the plan covering the patient is primary.

The Health Care Plan will pay the benefits explained in this section when it is the primary plan. When it is the secondary plan, it will pay the difference between benefits paid from the primary plan and the benefits explained in the “Hospital-Surgical-Medical coverage” section of this handbook. It’s important to indicate on your claim form if you have any other insurance coverage so that each pays the correct amount.

Coordination of benefits does not apply to other group coverage where you or a member of your family is paying one-half or more of the cost or to non-group coverage which is privately purchased.

How does the Health Care Plan coordinate with medical coverage through auto insurance?

The Plan also coordinates with personal injury protection coverage in those states with no-fault auto insurance laws. Benefits under this plan are secondary to no-fault auto insurance coverage.

How does the Health Care Plan coordinate with Medicare coverage?

When you or your spouse are age 65 or older or disabled or have End Stage Renal Disease and you are still working for Ford, you may have coverage under both the Health Care Plan and Medicare.

When you or your spouse are age 65 or older, are still working for Ford and you or your spouse are eligible for Medicare, the Health Care Plan automatically will continue to be the primary payor of eligible Health Care expenses. You or your spouse are not required to enroll in Medicare while you are an active employee. However, if you do enroll, Medicare in most cases will be the secondary payer. If you are enrolled in Medicare because of age or disability, Ford is the primary payor. If you are enrolled in Medicare and have End Stage Renal Disease, after thirty months of Medicare participation, Medicare becomes the primary payer. Your claims should be submitted to your claims processor first and then to Medicare for complementary benefits. Medicare provides some additional benefits under Part B such as office visits which are not paid by the National PPO Plan (BCBS) and Blue Preferred Plus PPO Plan.

When Medicare becomes primary, for example when you retire, Ford coverage will pay only the balance over what Medicare would pay if you are enrolled.

Hospital, surgical and medical benefits are coordinated while covered by both Ford and Medicare. Ford prescription drug, dental, vision care and hearing aid benefits are not affected by Medicare.

Refer to the section "Important Medicare Information" for further details.

How does USERRA (Uniformed Services Employment and Reemployment Rights Act) affect me?

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based plan coverage for you and your dependents for up to 24 months while in the military.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed; generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

When may the Plan recover benefits that were paid?

Right of Recovery/Subrogation

If benefits are paid under the Plan for an injury or condition caused by the actions of another person, the Plan may be entitled to recover payment from another insurance company, third party, or you if payment has been made to you by another insurance company or third party. This right of recovery is called Subrogation.

The Company has hired a subrogation administrator for the National PPO Plan (BCBS) and Blue Preferred Plus PPO Plan. The Subrogation Administrator will review certain claims when there is an indication that an injury or condition may have been the result of an accident.

If you are contacted by the subrogation administrator on behalf of the Company, you are required to complete any incident reports sent to you and provide copies of any documents requested.

In the event you fail to repay the Plan for payment made to you by another insurance company or third party, the Plan may offset future benefit payments by withholding payment until the entire amount due is reimbursed.

Additionally, the Plan's rights shall not be reduced by reason of the make-whole doctrine.

When may I continue my coverage under the “cash pay” rules?

You may continue coverage for yourself and your dependents after Company-paid coverage ends by paying the Plan’s cash pay rate under certain circumstances.

For example, if you are laid-off, you may continue hospital, surgical, medical, prescription drug, vision and hearing aid coverages (but not dental coverage) during a layoff without a break in seniority for up to 12 months after your Company-paid coverage ends.

If you go on an approved leave of absence (other than for disability), you may continue your hospital, surgical, medical, prescription drug, vision care and hearing aid coverages for up to 12 months by paying the Plan’s cash pay rate.

Certain categories of surviving spouses may pay the Plan’s cash pay rate to continue hospital, surgical, medical, prescription drug and hearing aid coverage (but not dental or vision care coverage) after Company-paid coverage ends for themselves and dependents who were eligible or sponsored at the time of your death.

“Cash-pay” coverage may only be continued as long as the surviving spouse is eligible to receive survivor income benefits under the Group Life and Disability Insurance part of the program (including for this purpose, a surviving spouse whose Survivor Income Benefit is not payable because she is receiving (Mother’s Insurance Benefits under Social Security). A surviving spouse who would be eligible for Bridge Survivor Income Benefits except that such spouse is age 60 or older may cash-pay to continue coverage until the end of the month in which the spouse reaches age 65.

If you are not eligible for continued Company-paid coverage, but have the option of continuing coverage under Company cash-pay rules by paying 100% of the full group rate for a certain period of time, you may choose between continuing coverage under Company cash-pay rules or under COBRA rules, **but not both**.

When may I continue my coverage under COBRA?

If you are not eligible for Company-paid continuation of coverage, you may be eligible to continue coverage at your own expense.

In addition to the Company’s continuation of coverage provisions as described in other parts of this section, you and your dependents may be entitled to continue individual health care coverage at your own expense under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. COBRA is a federal law that gives certain eligible participants the right to temporarily continue health care coverage at group rates. If you or a covered family member should become ineligible for Company-paid coverage because of what COBRA calls a “Qualifying Event” (described below), you may be able to continue your coverage at 102% of group rates for a limited period of time (note that this information is intended only as a summary of the COBRA law; eligibility, etc., under the law will be determined at the time you apply).

NOTE: Each individual covered under your contract has a separate individual right to COBRA continued coverage.

Qualifying Events — employees

If you are an active employee covered by the Company’s group health care plan, COBRA provides that you may continue Ford coverage at your own expense if you lose it because of:

- The termination of your employment (for any reason other than gross misconduct on your part)
- A reduction in your hours of employment
- You fail to return to work at the conclusion of a FMLA leave of absence

Qualifying Events — spouses

If you are the spouse of an active employee covered by the Company’s group health care plan, COBRA provides that you may continue Ford coverage at your own expense if you lose Company-paid coverage because of:

- A termination of the employee’s employment (for reasons other than gross misconduct)
- A reduction in the employee’s hours of employment
- The death of the employee
- Divorce or legal separation from the employee

Qualifying Events — dependent children

In the case of a dependent child of an active employee covered by the Company's group health care plan, COBRA provides that the child may continue Ford coverage at his/her own expense if he/she loses Company-paid coverage because of:

- The termination of the employee's employment (for reasons other than gross misconduct)
- A reduction in the employee's hours of employment
- The death of the employee
- The divorce or legal separation of the parents
- The child ceasing to be a "dependent child" as defined in the Company's group health care plan

Notification of Qualifying Events

The covered employee, spouse or dependent child who wishes to elect to continue coverage at his/her own expense under COBRA must notify the NESC at 1-800-248-4444 within 60 days of the following qualifying events:

- Divorce or legal separation
- A dependent child ceasing to be a "dependent child" as defined in the Company's group health care plan
- Death, if it results in loss of coverage
- Failure to provide the notice will eliminate your right to elect continued coverage under COBRA.
- For other Qualifying Events (termination of employment or reduced hours of employment), your employer will notify the COBRA Coordinator within 30 days.

COBRA Coordinator Responsibility

Upon receipt of appropriate notice of the occurrence of a Qualifying Event, the Ford COBRA Coordinator will, within 14 days, send an election notice to those individuals eligible to elect to continue coverage. If you wish to continue group health care coverage under COBRA, you must return a completed election form to the COBRA Coordinator within 60 days of the date the COBRA Coordinator sent you the election form, or the date coverage stops, whichever is later. If you do not choose to continue coverage, your Company's group health care coverage will end according to the provisions of that Plan.

Your cost

Your cost to continue health care coverages under COBRA will be 102% of the full group rate in effect at the time continued coverage begins. Cost-of-coverage information will be provided by the COBRA Coordinator if a Qualifying Event occurs. If the group rate changes, you will be required to pay the revised amount. You are not required to make any COBRA payment until 45 days after the date on which you make the initial election to continue coverage. However, you will be required to pay for your coverage retroactively to the date the Company-paid coverage ended.

For those who are eligible, as described later, for such additional coverage because you are determined by the Social Security Administration to have been disabled (as defined by the Social Security Act) before the first 60 days of continuation coverage has elapsed, the cost to continue coverage for an additional 11 months for qualified beneficiaries is 150% of the full group rate for the 11 months of COBRA coverage following your initial 18 months of coverage (which was paid at 102% of the full group rate).

Effect of Company continuation provisions on COBRA

Under the Company's health care plans, provisions exist for continuing Company-paid coverage for a period of time after you stop working, for example, when you are on a qualifying layoff. Periods of Company-paid continuation of coverage following a qualifying event will be counted as part of your COBRA continuation period. Please consult the above section of this handbook for specific details on Company-paid continuation provisions.

Whether or not you continue your coverage under COBRA, you may convert to the individual coverage offered by your claims processor within 30 days of the time your COBRA coverage ends. See "Can I convert my coverage to an individual policy?" in this section for more information on conversion coverage.

Health Care Provision

If you or your eligible dependents elect to continue your health care coverage under COBRA, it will be identical to the coverage you were eligible for before the Qualifying Event. You may choose to continue coverage under any or all of the following three categories of coverage:

- Hospital, surgical, medical, prescription drug and hearing aid
- Vision care
- Dental

You may choose any combination of these plans, provided you were enrolled in the coverage before the qualifying event. You are also eligible to change plans at any time after being enrolled in a plan for 12 months. Generally, if at the time of the Qualifying Event you had group medical coverage and coverage under separate plans, such as vision or dental plans, you are eligible to continue those plans too, but you are not required to do so. If some coverages stop while others continue at Company expense, you may elect, and pay for, only those coverages that are no longer Company-paid.

If you are not eligible for continued Company-paid coverage, but have the option of continuing coverage under Company cash-pay rules by paying 100% of the full group rate for a certain period of time, you may choose between continuing coverage under Company cash-pay rules or under COBRA rules, **but not both**.

Second Qualifying Event

If you or your dependents lost Ford coverage because of your termination of employment or reduction in hours, you or your dependents may continue the coverage for 18 months. However, if you are continuing coverage for 18 months and a second Qualifying Event occurs that would cause your spouse or dependent children to lose coverage (i.e., death of the employee or retiree, divorce or legal separation, a child ceasing to be a “dependent child”), the COBRA continuation period is expanded so that they may continue coverage on their own COBRA contract for a maximum of 36 months measured from the date of the first event.

If you or anyone in your family is determined by the Social Security Administration (SSA) to have been disabled under the Social Security Act before the 60th day of COBRA coverage and you notify the NESC (National Employee Service Center) at 1-800-248-4444 within 60 days of the later of (1) the SSA’s determination and (2) the date on which a qualifying event occurs, and in all cases before the expiration of the 18 month COBRA continuation period, you and your family members may be

eligible for COBRA coverage for a maximum of 29 months rather than 18 months.

If you are subsequently determined by SSA to no longer be disabled under the Social Security Act, you must notify the NESC at 1-800-248-4444 within 30 days of the SSA’s determination.

Termination of COBRA coverage

You also should be aware that health care coverage continued under COBRA will be terminated before the end of the 18 or 36 month period for any of the following reasons:

- Failure to make the required payment on time
- Obtaining coverage under any other group health care plan, after your COBRA election which does not contain any exclusion or limitation with respect to any preexisting condition of the covered beneficiary
- Eligibility for Medicare
- Voluntary cancellation of coverage

The Company no longer provides group health care coverage to any of its employees or retirees

Once coverage under COBRA has been terminated, it will not be reinstated.

For additional information

If you have any questions about COBRA, contact the designated COBRA Coordinator, UNICARE Life and Health Insurance Company, P.O. Box 6067, Dearborn, Michigan 48121-6067. Phone: (313) 336-2351 or 1 (800) 843-8184. UNICARE does not insure or act as plan administrator (as defined by ERISA) for this program but does provide the administrative service for Ford.

Will continuation of coverage be available to my same-sex domestic partner if he or she is no longer eligible under the Ford Plan (due to a qualifying event)?

Yes. Ford has made “cash pay” continuation coverage under the Ford group medical plans available for purchase by former same-sex domestic partners in such situations for a limited time (generally up to 36 months) at group rates. Same-sex domestic partners do not qualify for COBRA coverage under the federal government’s regulations covering COBRA continuation of coverage. Instead, the Company offers COBRA-like “cash pay” continuation of coverage with eligibility rules and payment arrangements similar to COBRA coverage for same-sex domestic partners who no longer qualify for coverage. Contact the NESC at 1-800-248-4444 to obtain detailed rules.

You or your former same-sex domestic partner must notify the NESC at 1-800-248-4444 within 60 days of the date the same-sex domestic partnership terminates. Otherwise, your former same-sex domestic partner will lose the opportunity to purchase “cash pay” continuation coverage.

Will continuation of coverage be available to the children of my same-sex domestic partner when they cease to meet the eligibility criteria?

Yes. COBRA continuation coverage will be available as explained above when the children no longer meet the eligibility criteria of the Ford plan (for example, when they marry, when they no longer reside in your household, when they are no longer principally dependent on you or when they reach age 25) or when the employee loses eligibility.

Company-paid coverage will stop on the day in which the dependent no longer meets the eligibility criteria. You must notify the NESC within 60 days from the date the dependent no longer meets the Ford eligibility criteria. Otherwise, the opportunity to purchase continuation coverage will be lost.

Can I convert my coverage to an individual policy?

In addition to the Company “cash pay” rules and COBRA continuation provisions, you or your covered dependents also have the option of converting your group medical coverage to an individual plan when you:

- Cease active employment
- Reach the end of the period allowed under your Company’s health care continuation provisions
- Stop paying for COBRA coverage

Your coverage may be converted to an individual policy without proof of good health if you do so within 30 days of the time your Company’s health care coverage or COBRA coverage stops. The coverage to which you convert and the rates may not be identical to the Company’s plan. Prescription drug, hearing aid, vision and dental coverages may not be converted. Check with your medical plan claims processor about the availability of conversion coverage.

NOTE: To convert to an individual policy, contact your carrier within 30 days of when coverage stops.

May I obtain a Certificate of Creditable Coverage for credit against another (non-Ford) plan's Preexisting Condition Clause?

If you become covered under another group health care plan, coverage under the Ford Health Care Plan may count toward satisfying any preexisting condition clause contained in the new plan. For example, if your new health care plan excludes coverage for certain pre-existing conditions for six months, and you had Ford coverage for a total of three months, you may present a Certificate of Creditable Coverage from Ford to reduce the exclusionary period to three months.

Without evidence of creditable coverage, you may be subject to a preexisting condition for up to 12 months (18 months for late enrollees) after your enrollment date in your new, non-Ford coverage, depending on that Plan's terms.

You will be provided a Certificate of Creditable Coverage, free of charge, from the Ford Health Care Plan when:

- You lose coverage under the Plan
- You become entitled to elect COBRA continuation coverage
- Your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

The Ford Health Care Plan does not contain a pre-existing condition clause.

NOTES

Life and Disability Insurance Program

After an overview of the Life and Disability Insurance Program, this section of your handbook answers these questions:

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Life and Disability Insurance Program

An overview: the Life and Disability Insurance Program

The Life and Disability Insurance Program provides important financial protection for you and your family if you die, become disabled or terminally ill.

If you die, become disabled or terminally ill, you or your family has financial protection through the Life and Disability Insurance Program. Through the Program, you may be eligible for:

- **Life Insurance**—paying a benefit if you die or become terminally ill
- **Accidental Death and Dismemberment Insurance**—paying a benefit to you if you suffer a covered dismemberment, or to your beneficiary if you die as the result of an accident
- **Survivor Income Benefits**—providing monthly income to your eligible survivors after you die
- **Optional Group Life Insurance Benefits**—paying a benefit if you have enrolled in this coverage to your beneficiary in the event of your death
- **Dependent Group Life Insurance Benefits**—paying a benefit to you if you have enrolled in this coverage and a covered dependent dies
- **Optional Accident Insurance Benefits**—paying a benefit if you have enrolled in this coverage: to you if you suffer a covered dismemberment or if a covered dependent dies as the result of an accident; to your beneficiary if you die as the result of an accident; to your covered dependent who suffers a covered dismemberment
- **Safety Belt User Benefits**—paying a \$15,000 benefit if you or another covered participant dies as a result of an automobile accident while wearing a qualified passenger restraint
- **Accident and Sickness Benefits**—providing a weekly benefit for up to 52 weeks if you are injured or sick and unable to work
- **Extended Disability Benefits**—providing a monthly benefit after Accident and Sickness benefits end, if you are totally disabled and unable to work

Naming a beneficiary - For some benefits, you will be asked to name a beneficiary-the person you want to receive your insurance if you die. You may change any beneficiary you have named at any time.

Who is eligible and what are the basic coverage details?

Eligibility

You are eligible for the following benefits under the Life and Disability Insurance Program if you are represented by the UAW under the Collective Bargaining Agreement effective November 19, 2007 and hired before November 19, 2007 as a Regular Full-Time employee.

When coverages begin

Your coverages become effective as shown here:

Your Situation	Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits	Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance	Safety Belt User Benefit Program	Accident and Sickness and Extended Disability Benefits
You are hired or rehired	Date of hire or rehire	First day of the month following the date you are employed and enroll for this employee-paid benefit	First day of the 8 th month following the date you are employed	First day of the 6 th month following the date you are employed
You are reinstated	Date of your reinstatement (for any coverage in effect at the time you terminated prior Ford Employment)			
You return from military service	Date of your reinstatement If you are placed on layoff (rather than reinstated), Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages become effective on the date you are laid off.			

If you are absent from work due to sickness or injury on the day your coverage ordinarily would start, coverage will begin on the first day you return to active work.

How your benefits are determined

Your Survivor Income Benefits, Safety Belt benefits, Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance are fixed dollar amounts, as described later in this section. Your Life Insurance, Accidental Death and Dismemberment Insurance, Accident and Sickness benefits* and Extended Disability Benefits* are based on your base hourly rate on the last day you worked preceding your death or disability or, if higher, the rate determined in the following section. (This is your base hourly rate before any contributions to the Tax-Efficient Savings Plan for Hourly Employees.) Your base hourly rate does not include shift differentials, overtime, cost-of-living allowance or other extras.

Certain rules, however, apply:

In this situation:	Your benefits are based on:
You are under an incentive plan	Your average straight-time hourly earnings (not including shift differentials, overtime, cost-of-living allowance or other extras) during the four pay periods you worked immediately preceding the January 1, April 1, July 1 and October 1, or if higher, the greater of the scheduled amounts applicable to you as described in the "If your base hourly rate changes" section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability
You are assigned a lower-rated job because of an occupational injury resulting in a reduction in pay	Your base hourly rate at the time of injury, while you are at work and receiving weekly Workers' Compensation or, if higher, the greater of the scheduled amounts applicable to you as described in the "If your base hourly rate changes" section on the last two dates on which Coverage Bracket changes took effect, immediately preceding death or disability

If your base hourly rate changes

The level of your Life Insurance and disability benefits coverage changes if a change in your base hourly rate puts you into a new "coverage bracket."

Specifically:

If you receive a change in pay effective:	You are in a new coverage bracket on:	The change in your coverage will take effect on:
October 2-January 1	January 1	February 1
January 2-April 1	April 1	May 1
April 2-July 1	July 1	August 1
July 2-October 1	October 1	November 1

If you are absent from work due to sickness or injury on the day your change in coverage is due to take effect, the change won't take effect until the day you return to work.

Your cost

Under the UAW-Ford Agreement, the Company pays the full cost of your Life Insurance, Accidental Death and Dismemberment Insurance, Survivor Income Benefits, Safety Belt User Benefits, Accident and Sickness Benefits and Extended Disability Benefits coverages:

- For any months you receive pay from the Company
- For certain months when you are away from work

For certain other months when you are away from work, you may continue coverage beyond the period for which the Company pays the cost by paying a monthly contribution. (The "What happens if I stop working or my employment changes for any reason?" section has more details.)

Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance are voluntary. If you choose to enroll, you pay a monthly premium for coverage.

***NOTE: For accident and sickness benefits and extended disability benefits, if you become disabled again for an old accident or illness without having returned to work for three (3) consecutive months, the benefits will be the amount you would have received under a continuation of your prior claim.**

What are Life Insurance benefits?

If you die while insured, your beneficiary may receive a Life Insurance benefit. If you become terminally ill, you may be eligible to receive a benefit. Any benefit amount is based on your base hourly rate.

Taxation of Group Life Insurance

Federal law requires that employers report to the Internal Revenue Service (IRS) the "imputed income" of certain employer-paid benefits, including Life Insurance that exceeds \$50,000 and the Survivor Income Benefit. Imputed income represents the value of "in kind" compensation not actually received as wages but having value to the employee. The income is subject to Federal, Social Security and Medicare (FICA), state, and local taxes and is reportable on an employee's or retiree's Form W-2 in box 12C. It will also appear on the first paycheck in December for December wages.

The amount of imputed income is determined based on:

- Life Insurance amount, and
- Value of Survivor Income Benefit as determined by spouse's or qualified same sex domestic partner's age, employee's years of credited service under the Retirement Plan, and age of youngest dependent.

Benefit amount upon death prior to age 65

If you are under age 65 and die from any cause while insured, your beneficiary will receive the Life Insurance amount shown here for your coverage bracket:

Life Insurance Code	If your base hourly rate is: ¹ (Coverage Bracket)	Your Life Insurance is:
1J	Up to but less than \$14.30	\$32,500
1I	\$14.30 but less than \$14.65	\$33,500
1H	\$14.65 but less than \$15.00	\$34,000
1G	\$15.00 but less than \$15.35	\$35,000
1F	\$15.35 but less than \$15.70	\$36,000
1E	\$15.70 but less than \$16.05	\$36,500
1D	\$16.05 but less than \$16.40	\$37,500
1C	\$16.40 but less than \$16.75	\$38,000
1B	\$16.75 but less than \$17.10	\$38,500
1A	\$17.10 but less than \$17.45	\$39,500
A	\$17.45 but less than \$17.80	\$40,500
B	\$17.80 but less than \$18.15	\$41,000
C	\$18.15 but less than \$18.50	\$42,500
D	\$18.50 but less than \$18.85	\$43,000
E	\$18.85 but less than \$19.20	\$44,000
F	\$19.20 but less than \$19.55	\$44,500
G	\$19.55 but less than \$19.90	\$45,500
H	\$19.90 but less than \$20.25	\$46,500
I	\$20.25 but less than \$20.60	\$47,000
J	\$20.60 but less than \$20.95	\$47,500
K	\$20.95 but less than \$21.30	\$48,500
L	\$21.30 but less than \$21.65	\$49,000
M	\$21.65 but less than \$22.00	\$50,000
N	\$22.00 but less than \$22.35	\$50,500
O	\$22.35 but less than \$22.70	\$51,500
P	\$22.70 but less than \$23.05	\$52,500
Q	\$23.05 but less than \$23.40	\$53,000
R	\$23.40 but less than \$23.75	\$54,000
S	\$23.75 but less than \$24.10	\$54,500
T	\$24.10 but less than \$24.45	\$55,500
U	\$24.45 but less than \$24.80	\$56,500
V	\$24.80 but less than \$25.15	\$57,000

Life Insurance Code	If your base hourly rate is: ¹ (Coverage Bracket)	Your Life Insurance is:
W	\$25.15 but less than \$25.50	\$58,000
X	\$25.50 but less than \$25.85	\$58,500
Y	\$25.85 but less than \$26.20	\$59,500
Z	\$26.20 but less than \$26.55	\$60,500
AA	\$26.55 but less than \$26.90	\$61,000
BB	\$26.90 but less than \$27.25	\$62,000
CC	\$27.25 but less than \$27.60	\$62,500
DD	\$27.60 but less than \$27.95	\$63,500
EE	\$27.95 but less than \$28.30	\$64,500
FF	\$28.30 but less than \$28.65	\$65,000
GG	\$28.65 but less than \$29.00	\$66,000
HH	\$29.00 but less than \$29.35	\$67,500
II	\$29.35 but less than \$29.70	\$68,000
JJ	\$29.70 but less than \$30.05	\$69,000
KK	\$30.05 but less than \$30.40	\$70,000
LL	\$30.40 but less than \$30.75	\$70,500
MM	\$30.75 but less than \$31.10	\$71,500
NN	\$31.10 but less than \$31.45	\$72,000
OO	\$31.45 but less than \$31.80	\$72,500
PP	\$31.80 but less than \$32.15	\$73,000
QQ	\$32.15 but less than \$32.50	\$74,000
RR	\$32.50 but less than \$32.85	\$75,000
SS	\$32.85 but less than \$33.20	\$75,500
TT	\$33.20 but less than \$33.55	\$76,500
UU	\$33.55 but less than \$33.90	\$77,000
VV	\$33.90 but less than \$34.25	\$78,000
WW	\$34.25 but less than \$34.60	\$79,000
XX	\$34.60 but less than \$34.95	\$79,500
YY	\$34.95 but less than \$35.30	\$80,500
ZZ	\$35.30 but less than \$35.65	\$81,000
2A	\$35.65 but less than \$36.00	\$82,500
2B	\$36.00 but less than \$36.35	\$83,500
2C	\$36.35 but less than \$36.70	\$84,500
2D	\$36.70 but less than \$37.05	\$85,000
2E	\$37.05 but less than \$37.40	\$86,000
2F	\$37.40 and over	\$86,500
1** <i>If an employee is under an incentive plan, coverage is based upon average straight time hourly earnings.</i>		

The above amounts will be reduced by any amount of insurance paid prior to your death due to terminal illness.

If you last worked before November 19, 2007, your Life Insurance amount is shown in the Collective Bargaining Agreement in effect when you last worked.

Benefit amount after age 65

When you reach age 65, your Life Insurance will be gradually reduced if you are insured, but not below a Continuing Group Life Insurance amount if you are eligible for that coverage.

If you are insured at age 65, as a retiree, the reduction each month after age 65 is 2% of the amount in force at age 65.

If you are insured after age 65 other than as a retiree, your Life Insurance will increase as shown in the table if your base hourly rate increases. Your insurance, however, will be reduced by 2% of that insurance amount for each month you are over age 65. Nevertheless, until age 70, your insurance will not be reduced below 65% of the amount that was in force at age 65, adjusted to reflect any pay increases you may have received after that age. At age 70, your insurance will not be reduced below 50%. Further reductions are made at age 75, 80 and so on.

If you become insured after age 65, your Life Insurance will be determined as shown in the table, reduced by 2% of that amount for each month you are over age 65, as though you had been insured since age 65. Nevertheless, your insurance will not be reduced below the amounts described above as long as you have Company-paid coverage beyond age 65, other than as a retiree.

Continuing Group Life Insurance amount

If you are insured at age 65 and have 10 or more years of credited service under the Retirement Plan, your Life Insurance is continued by the Company at a reduced level until you die.

The level of your Continuing Group Life Insurance amount is determined in the following manner:

Your Continuing Group Life Insurance amount	=	Your Life Insurance in force at age 65 or later (based on your last day worked)	x	1½ %	x	Your years of credited service under the Retirement Plan.
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The minimum amount of Continuing Group Life Insurance is the greater of 15% of Life Insurance in force at age 65 (with 10 years of credited service) or \$5,000. If the amount of Life Insurance in force at age 65 is less than \$5,000 and you do not return to work thereafter, the Continuing Group Life Insurance is the amount of Life Insurance in force at age 65 or \$500, whichever is greater.

An example:

If your base hourly rate is \$25.60, your Life Insurance benefit as an active employee under age 65 would be \$58,500.

Assume you go on a medical leave of absence at age 63 with 23 years of credited service under the Retirement Plan. You then are away from work on medical leave until age 65 when you retire on a Normal Retirement.

Your Life Insurance while you were on medical leave would continue at the level in effect on your last day worked—\$58,500. When you retire at age 65, your Life Insurance would start reducing at the rate of 2% per month (\$1,170) until it reaches a Continuing Group Life Insurance amount of \$20,182.50.

The Continuing Group Life Insurance amount is based on:

Your Life Insurance on the last day worked	x	1½ %	x	23 years of credited service under the Retirement Plan
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How your benefits are paid

As soon as satisfactory proof of your death is submitted to the insurer, your Life Insurance benefit will be paid to your beneficiary(ies). If \$10,000 or more is payable to a beneficiary, an interest paying money market account will be established by the insurer. A beneficiary may withdraw the account balance at any time. Additional information will be provided to your beneficiary in the event of your death.

At your death, the insurer may deduct up to \$5,000 from the benefit—to be paid to any person or persons who have incurred burial expenses on your behalf.

The insurer will not distribute any of the benefit if the death claim is in dispute or litigation or where the beneficiary or guardian does not agree with such distribution.

Naming a beneficiary

You may name a beneficiary you want to receive your Life Insurance. You have the right to name the beneficiary of your choice—and to change that beneficiary at any time by notifying the insurer.

Your beneficiary will be the last designation indicated on the insurer's records. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment.

If an employee names more than one primary beneficiary and a primary beneficiary predeceases the employee, the full death benefit upon the death of the employee is paid to the remaining primary beneficiaries.

If your last named beneficiary dies before you do, or if no beneficiary designation is in effect at your death, your Life Insurance will be paid, in this order, to:

- Your surviving spouse or qualified same sex domestic partner
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)

If there are no such survivors, your Life Insurance will be paid to the executor or administrator of your estate.

Be sure to update your beneficiary designation on file with the insurer. If you do not, your benefit could be delayed or paid to someone other than the person you want to receive the benefit.

Life Insurance is not assignable, unless the assignment is made in writing and consented to by the insurer in writing.

Benefit If You Become Terminally Ill

You may elect to receive a portion of your Life Insurance proceeds, up to 50% of coverage, if you become terminally ill. "Terminal illness" means an injury or sickness expected to result in death within one year without any reasonable prospect of recovery as determined by the insurer.

The amount of Life Insurance remaining in force will be reduced by the amount paid. This option does not apply to individuals who:

- Are cash paying for Life Insurance while a grievance is pending, or while on layoff or leave of absence
- Are permanently and totally disabled individuals who have drawn on their Life Insurance benefits
- Have irrevocably assigned their Life Insurance, or
- When all or a part of Life Insurance is to be paid to a former spouse as a part of the divorce decree

What are Accidental Death and Dismemberment Benefits?

If you suffer certain dismemberments or die as the result of an accident (including presumption of accidental death due to disappearance, or death due to exposure to the elements as a result of an accident), Accidental Death and Dismemberment Insurance pays a benefit if you are insured at the time of the injury and at the time of the loss.

Benefit amount

If you are insured for Accidental Death and Dismemberment Insurance, you are covered for two types of benefits:

- **Death benefits.** If you die while insured as the result of an accidental bodily injury within two years after the injury occurred, your beneficiary will receive an accidental death benefit. The benefit equals one half of the Life Insurance amount in force. This amount is paid in addition to your Life Insurance benefit.
- If your base hourly rate is \$25.60, for instance, you are eligible for a Life Insurance benefit of \$58,500. You are also eligible for an accidental death benefit of \$29,250 if your death is accidental.
- **Dismemberment benefits.** Accidental Death and Dismemberment Insurance also pays a benefit if you suffer a covered dismemberment or loss of sight as a result of an accidental bodily injury within two years of the injury. The benefit you receive will be a percentage of your Life Insurance benefit—depending on the nature of your loss:

Loss	Accidental Death and Dismemberment Benefit
Accidental death including presumption of accidental death due to disappearance, or death due to exposure to elements as a result of an accident, or accidental loss of more than one of the following: hand, foot or sight of an eye	Equal to ½ Life Insurance in force (3 times Life Insurance if accidental death is job related)
Accidental loss of one of the following: hand, foot or sight of an eye	Equal to ¼ Life Insurance in force

Loss of a hand or foot means loss by severance at or above the wrist or ankle joint; and loss of sight of an eye means total and irrecoverable loss of sight.

If you file a dismemberment claim, the insurer reserves the right to examine you while a claim is pending—at its expense—as often as it may reasonably require. (In the case of an accidental death, the insurer also reserves the right to conduct an autopsy, if permitted by law.)

Maximum benefits

Total payment for losses from a single accident cannot be more than one-half of your Life Insurance benefit, unless you die as a result of a job-related accident. In that instance, the benefit paid will be three times the scheduled amount of the Accidental Death and Dismemberment Benefit. Your beneficiary will receive this benefit if your death results:

- From accidental bodily injuries caused solely by your employment with the Company
- Solely from an accident in which the cause and results are unexpected and definite as to time and place

Some losses are not covered

Accidental Death and Dismemberment Insurance does not pay benefits for any loss caused by:

- An act of war
- Self-destruction or intentionally self-inflicted injury
- Disease, or bodily or mental infirmity—or medical or surgical treatment of that condition
- Any infection (except infection caused by an external visible wound sustained in an accident)
- Your act of aggression, participation in a felonious enterprise or illegal use of drugs

How your benefits are paid

As soon as satisfactory proof is submitted to the insurer, your accidental death benefit will be paid to your beneficiary(ies). If \$10,000 or more is payable to a beneficiary, an interest paying money market account will be established by the insurer. A beneficiary may withdraw the account balance at any time. Additional information will be provided to your beneficiary in the event of your death.

Accidental dismemberment benefits will be paid in a lump sum only—as soon as satisfactory proof of your loss is received by the insurer.

Beneficiary

Accidental death benefits are paid to the beneficiary of your Life Insurance.

Accidental dismemberment benefits are paid to you.

What are Survivor Income Benefits?

If you have one or more survivors, they may be eligible for Survivor Income Benefits—first Transition benefits; then, in some cases, Bridge benefits.

Transition Survivor Income Benefits

If you die while covered for Survivor Income Benefits, your eligible survivor will receive a monthly Transition benefit for up to 24 months. Payments will begin on the first day of the month after you die and continue for the next 23 months as long as there is at least one eligible survivor. If on the first day of any month after your death there is no eligible survivor, no benefit will be paid for that or any subsequent month.

If you last worked on or after November 19, 2007, the monthly Transition benefit is \$700. The benefit is reduced to \$375 if your eligible survivor is entitled to receive one of the following Social Security benefits:

- Unreduced old-age (retirement) benefits
- Survivor benefits not reduced for age
- Disability benefits

For months in which two or more eligible survivors share a benefit, each survivor's share is computed as a fraction of the benefit that would be paid to him or her as a sole survivor, according to his or her own eligibility for Social Security benefits.

The amount of monthly Transition Survivor Income Benefit for a survivor of an employee who last worked prior to November 19, 2007 remains unchanged.

Your eligible survivors

Survivor Income Benefits are paid:

- First, to your eligible surviving widow, widower, or qualified same sex domestic partner (Class A or B)
- Next, if you do not have an eligible surviving widow or widower, or qualified same sex domestic partner, to your eligible surviving children, divided equally (Class C)
- Finally, if you do not have an eligible widow, widower, qualified same sex domestic partner or child, to your eligible surviving parents, divided equally between the two (Class D)

The eligibility requirements for a survivor are:

Survivor classes	At the time of your death	At the time a benefit is payable
A. Widow or qualified same sex domestic partner, whether or not remarried	Married to you for at least one year	Living
B. Widower or qualified same sex domestic partner, whether or not remarried	Married to you for at least one year	Living
C. Children	<ul style="list-style-type: none"> •Unmarried and under age 21 •Unmarried, legally residing with you and dependent on you at the time of your death: -Either under age 25 -Totally and permanently disabled 	Living and still satisfying the eligibility requirements at the time of your death
Children include:	Natural-born children born prior to the first of the month following your death, legally adopted children, or children for whom legal adoption proceedings were undertaken or stepchildren who resided with you at your death In certain circumstances, unmarried children of a qualified same sex domestic partner	
D. Father or mother by blood or adopting parent	You were providing at least 50% of support during calendar year immediately preceding your death	Living

Qualified same sex domestic partners are eligible for benefits if they are determined to be qualified for at least one year. Qualified same sex domestic partner status must be demonstrated when filing a claim.

Bridge Survivor Income Benefits

If you have an eligible spouse or qualified same sex domestic partner, he or she may qualify for additional Bridge Survivor Income Benefits at the end of the Transition Survivor Income Benefits period. Your spouse or qualified same sex domestic partner is eligible if:

- He or she has not remarried and
- He or she was at least 45 years old at the time you died or his or her age at your death (rounded to the nearest 1/12) plus your years of credited service under the Retirement Plan totals 55 or more
- He or she was eligible to receive 24 Transition Benefit payments

If your spouse or qualified same sex domestic partner is eligible, he or she will receive a monthly Bridge benefit of \$700, if you last worked on or after November 19, 2007, until the earliest of:

- Death
- Remarriage/new qualified same sex domestic partner
- Reaching age 62 or
- Reaching age 62 and one month, provided your spouse or qualified same sex domestic partner is:
 - ◇ Not eligible to receive a Social Security Widow's or Widower's benefit during that additional month
 - ◇ Not eligible for a survivor benefit under the Retirement Plan
 - ◇ Eligible to receive and has applied for a reduced Social Security old-age (retirement) benefit that first will be paid during the second month following his or her 62nd birthday
- Reaching an age when full Widow's or Widower's insurance benefits are available under the Social Security Act, as amended

No additional Survivor Income Benefits will be payable for any month a widow or widower is eligible (because of the care of a child) to receive Social Security Mother's Insurance benefits or comparable benefits for a Father.

The amount of monthly Bridge Survivor Income Benefit for a survivor of an employee who last worked prior to November 19, 2007 remains unchanged.

Waiver of benefits

When it's to your surviving spouse's **advantage** to waive Survivor Income Benefits, he or she may do so by completing the insurer's form. The waiver will take effect on the first day of the second month after the waiver is received by the insurer or, if later, at the beginning of the period covered by the waiver.

Survivor Income Benefits will not be payable for any period covered by the waiver. Any month in which a Transition benefit is not paid because of a waiver, however, still will be counted for purposes of determining the 24-month Transition Benefit payment maximum.

Your eligible surviving spouse may revoke the waiver by completing the appropriate form furnished by the insurer.

Attachment of benefits

To the extent permitted by applicable law, monthly Survivor Income Benefits shall not be subject to attachment or other encumbrance or subject to the debts or liability of any eligible survivor.

What are Safety Belt User Benefits?

If you, your surviving spouse, qualified same sex domestic partner or an eligible dependent dies as a result of an automobile accident while wearing a qualified passenger restraint, a \$15,000 benefit may be paid.

Eligibility

If you, your surviving spouse, qualified same sex domestic partner or eligible dependents have Company-paid benefits under the Health Care Plan, you and your eligible dependents are covered participants in the Safety Belt User Benefit Program.

Benefit amount

If you or another covered participant dies as a result of bodily injury caused solely by an automobile accident that occurs while the participant is properly using a qualified passenger restraint, the Program pays \$15,000. The accident must occur in the United States or Canada and death must occur within 365 days of the accident's date.

The Program pays only one \$15,000 benefit for each eligible person who dies as a result of a covered automobile accident.

A passenger restraint qualifies for purposes of the Program as long as it is:

- An unaltered seat belt or lap and shoulder restraint installed by the automobile manufacturer or provided by the manufacturer—and installed by an authorized dealer of that manufacturer
- If the covered participant is a child, a restraint that has been approved by the National Highway Traffic Safety Administration and is:
 - ◇ Properly secured
 - ◇ Used as recommended for children of like age and weight

For purposes of the Program, an automobile is a conventional, private passenger land motor vehicle. Automobiles include:

- Vans
- Four-wheel-drive vehicles
- Self-propelled motor homes
- Trucks with a factory-rated load capacity of 2,800 pounds or less

Automobiles do not include:

- Custom-made specialty vehicles
- Vehicles such as:
 - ◊ Motorcycles
 - ◊ Dune buggies
 - ◊ Snowmobiles and
- Vehicles used for:
 - ◊ Farming
 - ◊ Commercial business
 - ◊ Military business
 - ◊ Racing
 - ◊ Any type of competitive speed event

Some deaths aren't covered

The Program won't pay benefits for deaths of a covered participant caused by:

- An act of war
- Self-destruction or intentionally self-inflicted injury while sane or insane
- Disease or bodily or mental infirmity, or medical or surgical treatment of that condition
- Any infection (except infection caused by an injury sustained in a covered automobile accident) or
- An act of aggression or participation in a felonious enterprise by the covered participant.

Beneficiary

You are the beneficiary if you are living. If you die before the covered participant, the benefit will be paid, in this order, to:

- Your surviving spouse or qualified same sex domestic partner
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)

If there are no such survivors, the benefits will be paid to the estate of the deceased covered participant.

What are Optional Group Life Insurance benefits?

You may buy Optional Group Life Insurance coverage to supplement the Life Insurance coverage paid for by the Company.

Eligibility

You are eligible for Optional Group Life Insurance on the first day of the month following the month you are employed.

If you enroll within the 31-day period following your eligibility date or within the 31-day period following marriage or acquisition of a child, you won't have to provide evidence of your good health for coverage up to \$200,000.

When coverage begins

Your Optional Group Life Insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Optional Group Life Insurance	First day of the month following your hire or rehire date for coverage up to \$200,000. If applying for an amount greater than \$200,000, evidence of good health is required. If evidence of good health is approved, coverage above \$200,000 will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
During the 31-day period after your eligibility date	First day of the month following your enrollment for coverage up to \$200,000. If applying for an amount greater than \$200,000, evidence of good health is required. If evidence of good health is approved, coverage above \$200,000 will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

During the 31-day period following marriage or acquisition of a child or children by birth or adoption	Once you have provided satisfactory proof that such family change has taken place and if coverage elected is \$200,000 or less, coverage is effective the first day of the month following receipt of proof of family change. If applying for an amount greater than \$200,000, evidence of good health is required. If evidence of good health is approved, coverage above \$200,000 will begin on the later of the first day of the month following the date the insurer approves such evidence of good health or receipt of proof of family change. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
After the 31st day following eligibility date	Evidence of good health is required for any coverage amount. Once you have provided your satisfactory evidence of good health, coverage is effective the first day of the month after the insurer approves that evidence. You must be actively at work on that date, otherwise coverage is effective on the first day worked thereafter.
During Open Enrollment	If the employee enrolls during open enrollment, coverage is effective (1) for guaranteed coverage amounts (coverage amounts as specified in the open enrollment where evidence of good health is not required), the first of the month following enrollment, or (2) for amounts requiring evidence of good health, the first of the month following the date the insurer approves coverage. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

For the insurance to become effective, you must be actively at work on the date the insurance would otherwise become effective. If you are not then actively at work, the insurance becomes effective on the date you return to active work, provided you still are eligible.

Benefit amount

You may elect one of the following schedules of Optional Group Life Insurance:

	Amount of Life Insurance
Schedule 1	\$ 10,000
Schedule 2	\$ 20,000
Schedule 3	\$ 30,000
Schedule 4	\$ 40,000
Schedule 5	\$ 50,000
Schedule 6	\$ 75,000
Schedule 7	\$ 100,000
Schedule 8	\$ 125,000
Schedule 9	\$ 150,000
Schedule 10	\$ 175,000
Schedule 11	\$ 200,000
Schedule 12	\$ 225,000
Schedule 13	\$ 250,000
Schedule 14	\$ 275,000
Schedule 15	\$ 300,000
Schedule 16	\$ 400,000
Schedule 17	\$ 500,000

Changing your coverage amounts

You may change your Optional Group Life Insurance amount if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Increase your coverage amount because you have married or acquired a child or children by birth or adoption during the 31-day period preceding enrollment for increased coverage	Once you have provided satisfactory proof that such family change has taken place during the 31-day period immediately prior to such enrollment, coverage up to \$200,000 is effective the 1 st of month following receipt of proof of the family change. If you apply for an amount greater than \$200,000, evidence of good health is required. If evidence of good health is approved, coverage above \$200,000 will begin on the first day of the month following the date the Insurer approves such evidence or receives proof of the family change if later. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

Increase your coverage amount for any reason other than (1) a family change as described above, or (2) open enrollment	Evidence of good health is required for all coverage. Once you have provided your satisfactory evidence of good health, coverage is effective the first day of the month after the insurer approves that evidence. You must be actively at work on that date, otherwise on the first day worked thereafter.
Decrease your coverage	First day of the month after the last month for which you made required contributions for coverage at the higher amount.
Increase your coverage amount during Open Enrollment	If the employee enrolls during Open Enrollment, coverage is effective (1) for guaranteed coverage amounts (coverage amounts as specified in the open enrollment where evidence of good health is not required), the 1 st of the month following enrollment, or (2) for amounts requiring evidence of good health, the first of the month following the date the insurance insurer approves coverage. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked.

Your contributions

Optional Group Life Insurance is voluntary. If you enroll for this coverage, you will have to pay a monthly premium in advance. The required monthly contributions for each \$1,000 of Optional Life Insurance are based on your age. The following rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

ACTIVE EMPLOYEE CONTRIBUTION RATES

Employee's age*	Monthly contribution for each \$1,000 of insurance: After 1-1-08
Less than 30	\$0.042
30-34	\$0.059
35-39	\$0.075
40-44	\$0.115
45-49	\$0.206
50-54	\$0.395
55-59	\$0.576
60-64	\$0.979
65-69	\$1.877
70-74	\$3.129
75-79	\$4.770
80-84	\$6.842
85-89	\$9.852
90-94	\$13.839
95 & over	\$23.458

RETIRED EMPLOYEE CONTRIBUTION RATES

Retiree's age*	Monthly contribution for each \$1,000 of insurance: After 1-1-08
Less than 30	\$0.044
30-34	\$0.061
35-39	\$0.078
40-44	\$0.120
45-49	\$0.215
50-54	\$0.411
55-59	\$0.600
60-64	\$1.020
65-69	\$1.955
70-74	\$3.800
75-79	\$5.793
80-84	\$8.312
85-89	\$11.973
90-94	\$16.816
95 & over	\$28.501

* *When the employee/retiree attains a birthday which places them in a higher age bracket, the monthly contribution will change on the first day of the calendar month next following the month in which such birthday occurs.*

Premiums are payable in advance through payroll deductions for each month of coverage.

If you cease active employment, payroll deductions will be discontinued and you must make your premium contributions directly to the insurer to continue coverage. If you do not make premium contributions, your coverage will terminate. **The insurer will not advise you of payments due.**

Some examples

If after 12-31-07 you are age 42 and you want \$40,000 of Life Insurance (Schedule 4), your monthly contribution would be \$4.60. That is:

$$\begin{aligned} \$40,000 \div \$1,000 &= 40 \\ 40 \times \$0.115 &= \$4.60 \end{aligned}$$

If after 12-31-07 you are age 50 and you want \$75,000 of Life Insurance (Schedule 6), your monthly contribution would be \$29.63. That is:

$$\begin{aligned} \$75,000 \div \$1,000 &= 75 \\ 75 \times \$0.395 &= \$29.63 \end{aligned}$$

Naming a beneficiary

You may name a beneficiary you want to receive your Optional Group Life Insurance. You have the right to name the beneficiary of your choice—and to change that beneficiary at any time by notifying the insurer. It is important to name a beneficiary for Optional Group Life Insurance even though you want the beneficiary to be the same as the beneficiary you have named for your Company-paid Life Insurance.

Your beneficiary will be the last designation indicated on the insurer's records. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment.

If your last named beneficiary dies before you do, or if no beneficiary designation is in effect at your death, your insurance will be paid, in this order, to:

- Your surviving spouse or qualified same sex domestic partner
- Your surviving children (divided equally among them)
- Your surviving mother or father (or to both equally)

If there are no such survivors, your insurance will be paid to the executor or administrator of your estate.

Be sure to update your beneficiary designation on file with the insurer. If you do not, your benefit could be delayed or paid to someone other than the person you want to receive the benefit. Remember to update your beneficiary designations on both your Company-paid and Optional Group Life Insurance.

How benefits are paid

The Optional Group Life Insurance may be paid as soon as satisfactory proof of your death is submitted to the insurer or you may elect to receive up to 80% of your life insurance proceeds if you become terminally ill.

The amount of life insurance paid will be reduced by the amount of the life insurance paid out under the Accelerated Benefits provision.

Accelerated Benefits for Terminal Illness

The Accelerated Benefits provision is provided for terminally ill employees insured under the Optional Group Life Insurance Program. A terminal illness is one in which life expectancy is less than 12 months.

A terminally ill employee or their legal representative may request a one-time lump sum payment of up to 80% of their Optional Group Life Insurance amount in advance of their death by submitting the request for such payment to the insurer. The insurer will determine if the benefit is payable.

The Accelerated Benefits provision is not available if:

- the employee has irrevocably assigned Group Life benefits under the program
- all or part of Optional Group Life benefits are to be paid to a former spouse as part of a divorce agreement
- All or part of Optional Group Life benefits are to be paid to a former qualified same sex domestic partner as part of a court order/divorce agreement.

The amount of coverage that remains in force will be reduced by the amount paid out under the Accelerated Benefits provision. The amount of Optional Group Life Insurance that may be converted in accordance with the Conversion Privilege provision of the program will be reduced by the amount of accelerated benefit paid. Additionally, premium payments must continue to be paid on the full amount of Optional Group Life Insurance for which the employee was enrolled.

Assignment

Optional Group Life Insurance may be assigned if the assignment is made by you in writing and the insurer consents in writing.

What are Dependent Group Life Insurance Benefits?

You may buy Dependent Group Life Insurance coverage, if you wish—to cover your spouse, qualified same sex domestic partner, and unmarried, dependent children. If your covered spouse, qualified same sex domestic partner, or dependent dies from any cause, a benefit will be paid to you.

Eligibility

You are eligible for Dependent Group Life Insurance on the first day of the month following the month you:

- Are employed
- Are insured for Life Insurance under the Life and Disability Insurance Program
- Have at least one “eligible dependent,” as defined by the Plan

If you enroll within the 31-day period following your eligibility date, you will not have to provide evidence of good health for your dependents’ coverage up to \$75,000 for your spouse or qualified same sex domestic partner or for coverage up to \$30,000 for your child.

Your eligible dependents

For purposes of Dependent Group Life Insurance benefits, your eligible dependents are your spouse, qualified same sex domestic partner and unmarried dependent children over 14 days of age. Dependent children include:

- Your children by birth, legal adoption or legal guardianship while they legally reside with and are dependent on you
- Your spouse’s or qualified same sex domestic partner’s children who are:
 - ◊ In your spouse’s or partner’s custody
 - ◊ Dependent on your spouse or partner
 - ◊ Residing with you
- Children as defined above who do not reside with you but are your legal responsibility for the provision of health care

- Children who reside with and are related to you by blood or marriage—for whom you provide principal support as defined by the Internal Revenue Code and who:
 - ◊ Were reported as dependents on your most recent income tax return
 - ◊ Qualify in the current year for dependency tax status

Children are included until the end of the calendar year in which they reach age 25. Children will be covered, however, regardless of age if they are totally and permanently disabled, provided that after the end of the calendar year a child reaches age 19, that child:

- Is dependent on you according to the Internal Revenue Code
- Legally resides with you and is a member of your household
- Your child is “totally and permanently” disabled as long as the disability:
 - ◊ Is a medically-determinable physical or mental condition
 - ◊ Keeps your child from engaging in substantial gainful activity
 - ◊ Is expected to result in death or to be of long-continued or indefinite duration

If your spouse or qualified same sex domestic partner also is eligible for this coverage, only one of you may enroll your children as dependents.

When coverage begins

Your dependents' insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Dependent Group Life Insurance	First day of the month following your hire or rehire date for coverage up to \$75,000/\$30,000. If applying for an amount greater than \$75,000/\$30,000, evidence of good health is required. If evidence of good health is approved, coverage above \$75,000/\$30,000 will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
During the 31-day period after your dependent eligibility date	First day of the month following your enrollment for coverage up to \$75,000/\$30,000. If applying for an amount greater than \$75,000/\$30,000, evidence of good health is required. If evidence of good health is approved, coverage above \$75,000/\$30,000 will begin on the first day of the month following the date the insurer approves such evidence. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
After the 31st day following your dependent eligibility date	Evidence of good health is required for any coverage amount. Once you have provided your satisfactory evidence of your dependents good health, coverage is effective the first day of the month after the insurer approves the evidence of good health; provided you are actively at work on that date, otherwise on the first day worked thereafter.

If you enroll:	Coverage will begin on this date:
During Open Enrollment	First of the month following the enrollment for guaranteed coverage amounts (coverage where evidence of good health is not required) or for amounts requiring evidence of good health, the first of the month following the date the insurer approves the evidence of good health. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
Increase your coverage amount because you have married or acquired a child or children by birth or adoption during the 31-day period preceding enrollment for increased coverage	Once you have provided satisfactory proof that such family change has taken place during the 31-day period immediately prior to such enrollment, coverage up to \$75,000/\$30,000 is effective the first of the month following receipt of proof of the family change. If you apply for an amount greater than \$75,000/\$30,000, evidence of good health is required. If evidence of good health is approved, coverage above \$75,000/\$30,000 will begin on the first day of the month following the date the insurer approves such evidence or receives proof of the family change if later. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

For the insurance to become effective, you must be actively at work on the date the insurance would otherwise become effective. If you are not then actively at work, the insurance becomes effective on the date you return to active work, provided you still are eligible.

Benefit amount

As an active employee, you have fourteen levels of coverage to choose from:

BENEFIT AMOUNT

	Your Spouse or Qualified Same Sex Domestic Partner	Each Child
Option I	\$5,000	\$2,000
Option II	\$10,000	\$4,000
Option III	\$15,000	\$6,000
Option IV	\$20,000	\$8,000
Option V	\$25,000	\$10,000
Option VI	\$30,000	\$12,000
Option VII	\$35,000	\$14,000
Option VIII	\$40,000	\$16,000
Option IX	\$50,000	\$20,000
Option X	\$60,000	\$24,000
Option XI	\$75,000	\$30,000
Option XII	\$100,000	\$40,000
Option XIII	\$125,000	\$50,000
Option XIV	\$150,000	\$60,000

Changing your coverage amounts

You may change your Dependent Group Life Insurance amounts if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Increase your dependents' coverage amounts (later than 31 days following dependents eligibility date)	Evidence of good health is required for any coverage amount. Once you have provided satisfactory evidence of your dependents' good health coverage will begin the first day of the month after the insurer approves that evidence..You must be actively at work on that date for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.
Decrease your dependents' coverage amounts	First day of the month after the last month for which you made required contributions for coverage at the higher amount.
During Open Enrollment	First of the month following the enrollment period for guaranteed coverage amounts (coverage where evidence of good health is not required) or, for amounts requiring evidence of good health, the first of the month following the date the insurer approves the evidence of good health. You must be actively at work for coverage to become effective, otherwise coverage is effective on the first day worked thereafter.

Your contributions

Dependent Group Life Insurance is voluntary. If you enroll for this coverage, you will have to pay a monthly premium. Regardless of the number of dependents you have, your premium is based on your age and the amount of coverage you select.

Dependents of Employees, Retirees, and Surviving Spouses and Qualified Same Sex Domestic Partners of Deceased Employees or Retirees Monthly Rates. The following rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

Monthly Rates per \$1,000 of Insurance (Effective 1-1-2008)		
Employee's or Retiree's Age	Dependents of Employees	Dependents of Retirees, Surviving Spouses and Qualified Same Sex Domestic Partner of Employee or Retiree
Under 30	\$.077	\$.80
30-34	\$.098	\$.102
35-39	\$.123	\$.128
40-44	\$.171	\$.178
45-49	\$.246	\$.256
50-54	\$.374	\$.390
55-59	\$.593	\$.618
60-64	\$.856	\$.892
65-69	\$1.428	\$1.488
70-74	\$2.186	\$2.349*
75-79	\$3.164	\$3.403**
80-84	\$4.350	\$4.672**
85-89	\$5.725	\$6.155**
90-94	\$7.384	\$7.931**
95 and over	\$9.669	\$10.389**

*For dependents of retirees, surviving spouses and qualified same sex domestic partners of deceased employees and retirees, maximum coverage is 75% of scheduled insurance amount in force on last day employee or retiree worked.

**For dependents of retirees, surviving spouses and qualified same sex domestic partners of deceased employees and retirees, maximum coverage is 37.5% of scheduled insurance amount on last day the employee or retiree worked.

Premiums are payable in advance through payroll deductions for each month of coverage.

If you cease active employment, payroll deductions will be discontinued and you must make your premium contributions directly to the insurer to continue coverage. If you do not make premium contributions, your dependent coverage will terminate. **The insurer will not advise you of payments due.**

Beneficiary

You are your covered dependents' beneficiary for purposes of Dependent Group Life Insurance.

Provision of Continuation of Coverage for Survivors of Deceased Employees

A Surviving Spouse or Qualified Same Sex Domestic Partner of an employee who, at the time of death, was enrolled for dependent coverage may continue coverage for themselves and the eligible enrolled dependents by notifying the insurer and paying the required premium within 31 days of the employee's death. The required premium will be based on the age of the Surviving Spouse or Qualified Same Sex Domestic Partner. The amount of coverage may not exceed the amount in force at the time of the employee's death but may be decreased.

Continuation of coverage for dependents shall terminate automatically at the earliest of the date of expiration of the period to which the last premium payment made is applicable or the date immediately preceding the date a dependent ceases to qualify as a dependent.

If a Spouse or Qualified Same Sex Domestic Partner is insured as an employee under the Optional Group Life Insurance Plan and as a dependent under the Dependent Group Life Insurance Plan, the surviving employee has the option to continue coverage as either an employee or a surviving spouse/qualified same sex domestic partner, but not both.

How benefits are paid

Death

The insurance will be paid to you in a lump sum as soon as satisfactory proof of your dependent's death is submitted to the insurer.

The amount of Life Insurance paid will be reduced by the amount of the Life Insurance paid out under the Accelerated Benefits provision.

Accelerated Benefits for Terminal Illness

The Accelerated Benefits provision is provided for terminally ill spouses or qualified same sex domestic partners insured under the Dependent Group Life Insurance Program. (The Accelerated Benefits provision is not available for children.) A terminal illness is one in which life expectancy is less than 12 months. A terminally ill spouse or qualified same sex domestic partner or their legal representative may request a one-time lump sum payment of up to 80% of their Life Insurance amount in advance of their death by submitting a request for such payment to the insurer. The insurer will determine if the benefit is payable. The Accelerated Benefits provision is not an option for insured dependent children.

The Accelerated Benefits provision is not available if the spouse or qualified same sex domestic partner has irrevocably assigned Group Life benefits under the program.

The amount of coverage that remains in force will be reduced by the amount paid out under the Accelerated Benefits provision. The amount of Dependent Group Life Insurance that may be converted in accordance with the Conversion Privilege provision of the program will be reduced by the amount of accelerated benefit paid. Additionally, premium payments must continue to be paid on the full amount of Dependent Group Life Insurance.

What are Optional Accident Insurance Benefits?

Optional Accident Insurance Benefits (Employee Paid coverage) are benefits you may choose to purchase for coverage that will be paid in addition to the Accident Insurance coverage that is paid for by the Company.

Eligibility

You are eligible for Optional Accident (Employee Paid) Insurance on the first day of the month following the month of employment, providing you are insured for Company-paid Life Insurance under the Group Life and Disability Insurance Program.

You may purchase this benefit for yourself (Employee Coverage), or your spouse, qualified same sex domestic partner and eligible dependents (Family Coverage).

When coverage begins

Your Optional Accident Insurance coverage will take effect:

If you enroll:	Coverage will begin on this date:
On or before the day you are eligible for Optional Accident Insurance	First day of the month following your eligibility date
After your eligibility date	The first day of the month next following the date of enrollment or change

For the insurance to become effective, you must be actively at work on the date the insurance would otherwise become effective. If you are not then actively at work, the insurance becomes effective on the date you return to active work, provided you still are eligible.

Amount of Insurance

Coverage must be purchased in units of \$10,000. You may buy a principal sum of up to ten (10) times annual base pay, rounded to the next \$10,000, up to a maximum benefit of \$500,000.

Loss of life or a bodily injury

If you sustain an accidental bodily injury which results in one of the following losses within 365 days of the accident, the following schedule applies:

Loss*	Amount of Accident Insurance
Loss of life	The Principal Sum
Loss of both hands or both feet	The Principal Sum
Loss of one hand and one foot	The Principal Sum
Loss of the entire sight of both Eyes	The Principal Sum
Loss of speech and hearing	The Principal Sum
Loss of the entire sight of one eye and one hand or foot	The Principal Sum
Loss of one hand or one foot	One-Half of the Principal Sum
Loss of the entire sight of one eye	One-Half of the Principal Sum
Loss of speech or hearing	One-Half of the Principal Sum
Loss of thumb and index finger (of the same hand)	One-Quarter of the Principal Sum

*“Loss”, used with reference to hand or foot, means complete severance through or above the wrist or ankle joint; as used with reference to eye, means irrecoverable loss of the entire sight thereof; as used with reference to speech and hearing, means entire and irrecoverable loss of speech or hearing and as used with reference to thumb and index finger, means complete severance through or above metacarpophalangeal joints.

If you elect Family Coverage, both you and eligible family members are insured; your spouse or qualified same sex domestic partner is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

Benefits under this provision will not be paid under any circumstances for more than one of the losses, the greatest, sustained by you or your covered family member as the result of any one injury.

Paralysis Benefits

If you sustain an accidental bodily injury that results in permanent paralysis within 365 days of the accident, the following schedule applies:

Quadriplegia	The Principal Sum
Paraplegia/Triplegia	Three-Quarters of the Principal Sum
Hemiplegia/Uniplegia	One-Half of the Principal Sum

If you elect Family Coverage, your spouse or qualified same sex domestic partner is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

If you sustain an accidental bodily injury that results in a permanent paralysis within 365 days of the accident and less than the Principal Sum is payable by reason of such loss and you thereafter suffer a greater loss as a result of the same accidental bodily injury within such 365 day period following the accident, the excess benefit amount will be payable.

Comatose Benefit

If you sustain an accidental bodily injury that results in lapse into a comatose state within 365 days of the accident, a benefit equal to one percent (1%) of the Principal Sum shall be payable on the 32nd day of the coma and each month thereafter for a maximum of 100 months, or until death, if earlier, at which time any balance would be paid. If you regain consciousness, benefits shall cease and coverage for Optional Accident Insurance would resume only upon re-enrollment and payment of premiums.

If you elect Family Coverage, your spouse or qualified same sex domestic partner is covered for an amount equal to fifty percent (50%) of your coverage and each other eligible dependent is covered for ten percent (10%) of your coverage.

Special Education Benefit

If Family Coverage has been elected and you die as a result of a covered accident, an additional benefit in the amount of up to six percent (6%) of the Principal Sum (subject to a maximum of \$7,000/per year, effective January 1, 2004 for covered accidents occurring on or after that date) will be paid for each eligible dependent child enrolled within 365 days of your death as a full-time student in an accredited college or university.

This benefit is payable annually for a maximum of four consecutive years, provided the eligible child consecutively continues his/her education as a full-time student. Benefits beyond the first year require evidence that the child has successfully completed all academic requirements of the prior school year.

No payment will be made for room, board, or other living, traveling, or clothing expenses.

If there is no dependent child who qualifies, an additional benefit of \$1,000 will be paid to the beneficiary.

Special Child Care Center Benefit

If Family Coverage is elected, upon the death of you or your insured spouse or your qualified same sex domestic partner from a covered accident, the beneficiary will receive an additional benefit in the amount of six percent (6%) of the Principal Sum (subject to a maximum of \$7,000/per year, effective January 1, 2004 for covered accidents occurring on or after that date) for up to four years for each eligible dependent child under the age of 13 enrolled (or who becomes enrolled within 90 days) in a qualified child care center.

If there is no dependent child who qualifies, an additional benefit of \$1,000 will be paid to the employee's beneficiary.

Spousal Occupational Training Expense

If Family Coverage is elected and you die as a result of a covered accident, a surviving spouse or qualified same sex domestic partner who participates in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not have sufficient qualification otherwise, will be reimbursed for expenses actually incurred up to 6% of the Principal Sum (subject to a maximum of \$7,000 effective January 1, 2004 for covered accidents occurring on or after that date).

To be reimbursed, such expenses must be reasonable and necessary and must be incurred within three (3) years of the date of the death. No payment will be made for room, board, or other living, traveling, or clothing expenses.

Common Disaster Benefit

If Family Coverage is elected and you and your insured spouse, or qualified same sex domestic partner suffer a loss of life in the same covered accident, or separate covered accidents which occur within 48 hours of each other (common disaster), the amount payable by reason of your spouse's or qualified same sex domestic partner's death will equal the amount payable by reason of your death. The common disaster benefit for you and your insured spouse or qualified same sex domestic partner will not exceed \$1,000,000.

Repatriation Benefit

For losses occurring on or after January 1, 2004, if an insured employee or retiree or, if Family Coverage is elected, a covered spouse, qualified same sex domestic partner or dependent child, sustains a loss of life as a direct result of a covered accident, both the accident and death occurring at a distance of 100 miles or more from the deceased person's principal residence, reimbursement up to a maximum benefit of \$5,000 will be made for the expenses incurred for preparation of the body and its transportation to the city of his/her principal residence.

Continuation of coverage for surviving spouse or qualified same sex domestic partner

If an employee's or retiree's coverage ends due to their death, a covered spouse or qualified same sex domestic partner may continue coverage for themselves and dependent children by paying the required premium.

For enrolled survivors, coverage is provided at no cost for the first 12 months from the date of the employee's death.

The elected coverage for the surviving spouse or qualified same sex domestic partner may be continued until age 65, at which time they will be allowed to convert coverage to the Retiree Plan. Eligible dependents who are enrolled at the time of conversion to the Retiree Plan may also be covered, provided they continue to meet eligibility requirements and pay the applicable premium.

Coverage will terminate if the spouse or qualified same sex domestic partner remarries or establishes a new qualified same sex domestic partner or for non-payment of the required premium.

Seat Belt Benefit

If Family Coverage is elected, and you, your surviving spouse, qualified same sex domestic partner or an eligible dependent dies as a result of an automobile accident while wearing a qualified passenger restraint, up to \$10,000 is payable for each member whose life is lost.

A passenger restraint qualifies for purposes of the Program as long as it is:

- An unaltered seat belt or lap and shoulder restraint installed by the automobile manufacturer or provided by the manufacturer and installed by an authorized dealer of that manufacturer
- If the covered participant is a child, a restraint that has been approved by the National Highway Traffic Safety Administration and is:
 - ◊ Properly secured
 - ◊ Used as recommended for children of like age and weight

For purposes of the Program, an automobile is a conventional, private passenger land motor vehicle. Automobiles include:

- Vans
- Four-wheel drive vehicles
- Self-propelled motor homes
- Trucks with a factory-rated load capacity of 2,000 pounds or less

Automobiles do not include:

- Custom-made specialty vehicles
- Vehicles such as:
 - ◊ Motorcycles
 - ◊ Dune buggies
 - ◊ Snowmobiles and
- Vehicles used for:
 - ◊ Farming
 - ◊ Commercial business
 - ◊ Military business
 - ◊ Racing
 - ◊ Any type of competitive speed event

Exclusions

The policy doesn't cover loss caused or contributed by:

- Suicide or self-destruction or any attempt thereat, whether sane or insane
- Bodily infirmity, sickness or disease
- Medical or surgical treatment (except medical or surgical treatment necessitated only due to an injury)
- War, declared or undeclared, or any act of war except while you are outside the United States and Puerto Rico on Company assignment or while your insured dependents are outside the United States and Puerto Rico because of your assignment, provided, however, that a member of an Organized Reserve Corps or National Guard Unit is covered during short periods of training or participation in public ceremonies
- Injury sustained while serving in the armed forces of any country, for which period premiums will be refunded
- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft; this policy covers riding as a passenger, but not as an operator or crew member, in or on, boarding or unloading from any aircraft having a current and valid airworthiness certificate or any transport type aircraft operated by the Military Airlift Command (MAC) of the United States of America or by any similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world; persons who are not members of the operating crew of any aircraft, who are engaged in testing, measuring, calibrating and similar operations, shall be considered passengers and not crew members
- You or your insured dependent's act of aggression, participation in a felonious enterprise or illegal use of drugs

Changing your coverage amounts

You may change your Optional Accident Insurance amount if you choose. Your change in coverage will take effect as shown here:

If you elect to:	The change will take effect:
Increase your coverage amount	The first day of the month following the date of change, provided you are actively at work on that date, otherwise on the first day worked thereafter
Decrease your coverage amount	First day of the month after the last month for which you made required contributions for coverage at the higher amount whether or not you are actively at work on that day

Your contributions

Optional Accident Insurance is voluntary. If you enroll for this coverage, you will have to pay a monthly premium in advance. The following rates are subject to change, if necessary, by mutual agreement between the Company and the Union:

- The required monthly contribution for each \$10,000 is \$.28 for Employee Coverage and \$.48 for Family Coverage.
- Premiums are payable in advance through payroll deductions for each month of coverage.
- If you cease active employment, payroll deductions will be discontinued and you must make your premium contributions directly to the insurer to continue coverage. If you do not make premium contributions, your coverage will terminate. **The insurer will not advise you of payments due.**

Some examples

You want \$40,000 of Employee Coverage; your monthly contribution would be \$1.12. That is:

$$\begin{aligned} \$40,000 \div \$10,000 &= 4 \\ 4 \times \$0.28 &= \$1.12 \end{aligned}$$

You want \$150,000 of Family Coverage; your monthly contribution would be \$7.20. That is:

$$\begin{aligned} \$150,000 \div \$10,000 &= 15 \\ 15 \times \$0.48 &= \$7.20 \end{aligned}$$

Your eligible dependents for Family Coverage

For purposes of Optional Accident Insurance benefits, your eligible dependents are your spouse, qualified same sex domestic partner and unmarried dependent children. Dependent children include:

- Your children by birth, legal adoption or legal guardianship—while they legally reside with and are dependent on you
- Your spouse's or qualified same sex domestic partner's children who are:
 - ◊ In your spouse's or partner's custody
 - ◊ Dependent on your spouse or partner
 - ◊ Residing with you
- Children as defined above who do not reside with you but are your legal responsibility for the provision of health care
- Children who reside with and are related to you by blood or marriage—for whom you provide principal support as defined by the Internal Revenue Code and who:
 - ◊ Were reported as dependents on your most recent income tax return
 - ◊ Qualify in the current year for dependency tax status

Children are included until the end of the calendar year in which they reach age 25. Children will be covered, however, regardless of age if they are totally and permanently disabled, provided that after the end of the calendar year a child reaches age 19, that child:

- Is dependent on you according to the Internal Revenue Code
- Legally resides with you and is a member of your household

Your child is "totally and permanently disabled" as long as the disability:

- Is a medically-determinable physical or mental condition
- Keeps your child from engaging in substantial gainful activity
- Is expected to result in death or to be of long-continued or indefinite duration

If your spouse or qualified same sex domestic partner also is eligible for this coverage, only one of you may enroll your children as dependents.

Naming a beneficiary and how benefits are paid

If you die as a result of accidental death while insured for Optional Accident Insurance, the amount of the insurance in force will be paid to the person or persons you designated as beneficiary.

Your beneficiary will be the last designation indicated on the insurer's records. If the insurer makes a payment on account of your death before receiving the notice of change, however, the insurer will not be liable for another benefit payment. When the insurer receives notice of a beneficiary change, the change takes effect on the date the notice was signed even though the insurer may receive the notice of change after your death.

If your last named beneficiary dies before you do, or if no beneficiary is in effect at your death, the Optional Accident Insurance will be paid to your surviving spouse or qualified same sex domestic partner, if living; if not living, equally to your surviving children; if none survive, to either your mother or father, or to both equally if both survive; if there are no such survivors, to your estate.

If your covered spouse or qualified same sex domestic partner or other covered dependent dies as a result of an accident while insured for Optional Accident Insurance, the amount of such insurance in force on account of the dependent shall be paid in a lump sum to you (the employee is the beneficiary for Optional Accident Insurance). Your insurance certificate shall set forth the procedure for payment of insurance in case a covered dependent dies after your death.

All other benefits are payable to the injured person suffering the loss.

How do I file a claim or appeal a denied claim for Basic Life, Accidental Death & Dismemberment, Survivor Income Benefit, Safety Belt, or Optional benefits?

Before you or your beneficiary can receive benefits, you must file a proper claim.

Claiming Life, Accidental Death & Dismemberment, Survivor Income or Safety Belt Benefits

You or your beneficiary should make a claim as soon as possible in the event of death or dismemberment.

To begin the process for a death claim, your family or beneficiary will need to provide copies of the death certificate certified by the governmental unit maintaining the record.

Death certificates usually are kept on file in the Department of Health of the city or county where death occurred. You may contact that office directly to obtain the number of death certificate copies you need. Usually, only certain members of the immediate family may obtain these copies.

The funeral home director might obtain the death certificate copies for your family.

To file a claim for Basic Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt or Survivor Income Benefits, contact:

UNICARE Life and Health Insurance Company
Dearborn Service Center
P.O. Box 2090
Dearborn, Michigan 48123-2090
1-800-843-8184

To file a claim for Optional Group Life Insurance, Dependent Group Life Insurance or Optional Accident Insurance Benefits, follow these steps:

1. Contact the insurer directly:
Ford Hourly Optional Insurance Plan
Suite 116
2720 South River Road
Des Plaines, Illinois 60018
(847) 299-9393
1-800-742-8215
2. Complete the notice of claim form obtained from the insurer. Then return the form and a certified copy of the death certificate to the insurer.
3. You may receive a form requesting additional information from the insurer.

After the insurer receives a claim for benefits, the insurer will review the claim and notify you or, if applicable, your beneficiary of its decision to approve or deny the claim.

You or your beneficiary will receive the written notification within a reasonable period, not to exceed 90 days from the date the insurer received your claim. You or your beneficiary may be notified of a required extension within the original 90 day period if there are special circumstances. The additional review period is also 90 days.

If a claim for benefits is denied in whole or in part, the written notification will include:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision(s) on which the denial is based;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the Plan's review * procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, if your claim is denied after an appeal.

*To Request a review (appeal) of a claims decision, you or your beneficiary must submit your request in writing to the appropriate insurer (for Company paid coverage or optional coverages). Such requests should be submitted to the address of the insurer indicated in the Summary of Administrative Information at the end of this section.

What if an appeal is denied for Life Insurance, Accidental Death & Dismemberment, Safety Belt User or Survivor Income Benefits?

This section contains a description of the procedures for seeking review of a denied claim for Company paid Life Insurance, AD&D, Safety Belt User or Survivor Income Benefits.

In the event that the insurer denies a claim for Life Insurance, accidental death or dismemberment, safety belt user or survivor income benefits, a claimant may request reconsideration/appeal of your claim. You should write the insurer within 60 days of your receipt of denial. Unless the insurer requests additional information in a timely manner, you will be notified of the insurer's decision within 60 days after your letter is received. If your request for reconsideration/appeal is denied, you may:

1. Request a review upon appeal by written application to the Ford Group Life and Disability Appeal Committee (Committee);
2. Review pertinent documents; and
3. Submit issues and comments in writing within sixty (60) days after the claimant receives the written notification of denial of the appeal.

The UAW will appoint three members and alternate members to the Committee. Three additional members of the Committee are appointed by the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services.

Address appeal requests to:

Ford Motor Company
P.O. Box 3139
Melvindale, MI 48122-0139
Attn: UAW-Ford Group Life and Disability
Committee

The request for appeal should clearly indicate the reason(s) why you or your beneficiary think your claim should not have been denied. You are encouraged to submit copies of any additional documents, records, information or comments you think have a bearing on your claim.

Since a committee is reviewing the appeal, it will be considered at the Appeal Committee's next regularly scheduled meeting. If it is filed within thirty (30) days of the next meeting, a decision by the Appeal Committee shall be made by the date of the second meeting after receipt of the claimant's request for review. Under special circumstances an extension of time for processing may be required, in which case a decision shall be rendered by the date of the third meeting.

If an extension is required because information is incomplete, the review period will be adjusted from the date the notice was sent to the date the complete information is received. If an extension is needed, you will receive a written notice before the extension period begins.

Written notice of a decision will be made no later than five (5) days after the decision has been made by the Appeal Committee. Your notice will include the final decision and the specific reasons for denial and reference to pertinent Plan provisions on which the denial is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The notice will also advise you of your right to bring a civil action under ERISA following an adverse benefit determination of appeal. No legal action may be brought until after the claims and appeals procedures have been exhausted. No legal action can be taken later than two years after the claim accrues.

Denial of other insurance claims

In the event that a claim for benefits under Dependent Group Life, Optional Group Life, or Optional Accident is denied, the insurer responsible for providing such benefits shall handle the initial claim and any requests for review of the denial according to the applicable claims procedures and policies of the insurer. The Appeal Committee shall have no responsibility to review any such claims or denials of any such claims by the insurer.

What are Accident and Sickness Benefits?

Accident and Sickness benefits can replace a portion of your pay for up to 52 weeks of illness, injury or pregnancy-related disability.

Eligibility for benefits

You are eligible for Accident and Sickness benefits if you:

- Become wholly and continuously disabled by an accidental bodily injury, sickness or pregnancy while covered for Accident and Sickness benefits
- Cannot perform all duties of your job
- Furnish the claims processor with written notice and satisfactory proof of your disability on a timely basis
- Are under a physician's care
- Are confined for treatment in an alcohol or drug abuse facility qualifies as being under a physician's care, as long as:
 - ◊ The facility is an inpatient residential, day treatment or outpatient substance abuse treatment facility approved for benefits under the Health Care Plan and medical oversight is compliant as described below. *
 - ◊ The physician-director of the facility, or a physician-consultant selected by the facility, certifies your disability based on information and recommendation furnished by the therapist supervising your therapy; a certifying physician must be a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) as described below. *

* For Mental Health and/or Substance abuse claims, under a physician's care can include treatment from a legally licensed Clinical Psychologist (PhD) for a maximum of 30 days following the start of your disability period. However, if your disability extends beyond 30 days, treatment with a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who specializes in psychiatry is required for benefit eligibility to continue. Compliance with the prescribed treatment plan is required to maintain benefit eligibility.

Please refer to the Mental Health and Substance Abuse section for further guidelines and timeframes.

Claims processor

UNICARE Life and Health Insurance Company is presently the claims processor under an administrative services agreement with the Company.

Benefit amount

Your weekly Accident and Sickness benefits are determined according to your base hourly rate:

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Weekly Accident and Sickness Benefits are:
1J	Up to but less than \$14.30	\$340
1I	\$14.30 but less than \$14.65	\$345
1H	\$14.65 but less than \$15.00	\$355
1G	\$15.00 but less than \$15.35	\$365
1F	\$15.35 but less than \$15.70	\$375
1E	\$15.70 but less than \$16.05	\$380
1D	\$16.05 but less than \$16.40	\$390
1C	\$16.40 but less than \$16.75	\$400
1B	\$16.75 but less than \$17.10	\$405
1A	\$17.10 but less than \$17.45	\$415
A	\$17.45 but less than \$17.80	\$425
B	\$17.80 but less than \$18.15	\$430
C	\$18.15 but less than \$18.50	\$440
D	\$18.50 but less than \$18.85	\$450
E	\$18.85 but less than \$19.20	\$455
F	\$19.20 but less than \$19.55	\$465
G	\$19.55 but less than \$19.90	\$475
H	\$19.90 but less than \$20.25	\$480
I	\$20.25 but less than \$20.60	\$490
J	\$20.60 but less than \$20.95	\$500
K	\$20.95 but less than \$21.30	\$505
L	\$21.30 but less than \$21.65	\$515
M	\$21.65 but less than \$22.00	\$525
N	\$22.00 but less than \$22.35	\$530
O	\$22.35 but less than \$22.70	\$540
P	\$22.70 but less than \$23.05	\$550
Q	\$23.05 but less than \$23.40	\$555
R	\$23.40 but less than \$23.75	\$565
S	\$23.75 but less than \$24.10	\$575
T	\$24.10 but less than \$24.45	\$585

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Weekly Accident and Sickness Benefits are:
U	\$24.45 but less than \$24.80	\$590
V	\$24.80 but less than \$25.15	\$600
W	\$25.15 but less than \$25.50	\$610
X	\$25.50 but less than \$25.85	\$615
Y	\$25.85 but less than \$26.20	\$625
Z	\$26.20 but less than \$26.55	\$635
AA	\$26.55 but less than \$26.90	\$640
BB	\$26.90 but less than \$27.25	\$650
CC	\$27.25 but less than \$27.60	\$660
DD	\$27.60 but less than \$27.95	\$665
EE	\$27.95 but less than \$28.30	\$675
FF	\$28.30 but less than \$28.65	\$685
GG	\$28.65 but less than \$29.00	\$690
HH	\$29.00 but less than \$29.35	\$700
II	\$29.35 but less than \$29.70	\$710
JJ	\$29.70 but less than \$30.05	\$715
KK	\$30.05 but less than \$30.40	\$725
LL	\$30.40 but less than \$30.75	\$735
MM	\$30.75 but less than \$31.10	\$740
NN	\$31.10 but less than \$31.45	\$750
OO	\$31.45 but less than \$31.80	\$760
PP	\$31.80 but less than \$32.15	\$765
QQ	\$32.15 but less than \$32.50	\$775
RR	\$32.50 but less than \$32.85	\$785
SS	\$32.85 but less than \$33.20	\$795
TT	\$33.20 but less than \$33.55	\$800
UU	\$33.55 but less than \$33.90	\$810
VV	\$33.90 but less than \$34.25	\$820
WW	\$34.25 but less than \$34.60	\$825
XX	\$34.60 but less than \$34.95	\$835
YY	\$34.95 but less than \$35.30	\$845
ZZ	\$35.30 but less than \$35.65	\$850
2A	\$35.65 but less than \$36.00	\$860
2B	\$36.00 but less than \$36.35	\$870
2C	\$36.35 but less than \$36.70	\$875
2D	\$36.70 but less than \$37.05	\$885
2E	\$37.05 but less than \$37.40	\$895
2F	\$37.40 and over	\$900

If you last worked before November 19, 2007, your Accident and Sickness benefits are shown in the Collective Bargaining Agreement in effect when you last worked.

If you are absent from work for part of a week, your Accident and Sickness benefits are based on one-fifth of the weekly benefit for each regular workday of disability (where state laws permit).

Special provisions apply to employees at operations utilizing three crew or alternate production schedules. In those instances, the benefit for each regular workday of disability will be an amount calculated in accordance with the agreement with the union for operation of an alternative work schedule at the plant at which the employee works.

If you have less than one year of seniority as a regular full time employee, your Accident and Sickness benefits will be 75% of the weekly benefit amount for periods of disability occurring prior to the date one year of seniority is attained, subject to reduction for other benefits (as described in the proceeding "Other sources of benefits" section).

When benefits begin

If you have an accident, your Accident and Sickness benefits begin the first day of disability. If you are absent from work due to sickness, pregnancy, or an accident which occurred more than one year prior to the present disability, benefits begin on the eighth day you are disabled, or on the first day:

- That you are hospitalized at least 18 consecutive hours, or that the hospital charges you for room and board
- Of treatment for alcohol or substance abuse in a residential facility approved for such treatment or
- After the day you have an outpatient surgical procedure for which you are entitled to at least \$25 in benefits under the H-S-M Program

Any day you work less than four hours due to your accident or sickness is considered a day of disability.

When benefits end

For one continuous period of disability, Accident and Sickness benefits end when you are able to return to work or after the lesser of:

- 52 weeks
- A period equal in duration to your service (on the date the disability began) since your most recent date of hire or rehire

Regardless of your length of service, your Accident and Sickness benefits can continue for up to 52 weeks, if:

- ◊ You still are hospitalized for the same disability at the end of this period
- ◊ You are receiving lost-time benefits under Workers' Compensation or other laws providing benefits for job-related accidents or sickness—because of your employment. (These do not include benefits for dismemberment)

Successive periods of disability

You may be absent due to the same or related disabilities for several periods of time. Successive periods of absence due to the same or related disabilities are considered one continuous disability unless:

You are employed in:	AND	Before another absence:
California or New Jersey		You are back to work for 2 or more consecutive weeks
All Other Locations		You are back to work for 3 consecutive months or more

You will be considered to have returned to work if you work 4 or more hours on each working day (where state laws permit).

If a new illness or accident disables you after you have returned to work, you can make a new claim for benefits. You can also make a new claim for benefits if an old accident or illness disables you again after your return to work, as described above.

If you become disabled again for an old accident or illness without having returned to work for three consecutive months or more, the benefits shall be the amount you would have received under a continuation of the prior claim.

Other sources of benefits

Your Accident and Sickness benefits may be affected by other benefits you receive:

If You Are Receiving:	Effect on Your Accident and Sickness Benefits:
Unemployment Compensation	<p>You are not entitled to Accident Sickness benefits while:</p> <ul style="list-style-type: none"> You are eligible for unemployment benefits under any unemployment compensation law You are entitled to unemployment benefits, but rejected or waived your right to receive them
Workers' Compensation	<p>Your Accident and Sickness benefits are reduced by the amount of any lost-time Workers' Compensation benefits to which you are entitled. Accident and Sickness benefits are not payable for an occupational disability if you have waived your rights to Workers' Compensation benefits. Your Accident and Sickness benefits will <i>not</i> be reduced if you are receiving Workers' Compensation for:</p> <ul style="list-style-type: none"> A dismemberment The 100% loss of use of a body member A work-related, permanent partial disability unrelated to the disability for which you are applying for benefits
Social Security	<p>Accident and Sickness benefits will be reduced by the weekly equivalent (one monthly benefit equals 4.33 weekly benefits) of any disability benefit or old-age (retirement) benefit (except for Social Security old-age benefits reduced because of age) and payable for the same period of disability.</p> <p>Any benefits paid to you prior to a Social Security determination, which are later determined not to be payable because of Social Security award, are an overpayment which must be repaid. If not repaid within 30 days, future Accident and Sickness (and Extended Disability Benefits if necessary) will be suspended until the overpayment is recovered.</p>

If You Are Receiving:	Effect on Your Accident and Sickness Benefits:
California State Disability Compensation	Accident and Sickness benefits will be reduced by State Unemployment Compensation Disability Benefits for which you are eligible—whether or not you have rejected or waived your rights to those benefits.
New York and New Jersey State Disability Benefits	Accident and Sickness benefits are at least equal to the benefits required by State Law.
Holiday pay or other pay received from the Company	Accident and Sickness benefits are not payable for any day you are entitled to holiday pay or receive pay for at least a regular work day (defined as 8 hours or the hours you are scheduled to work under an alternate work schedule). If you receive pay for less than a regular work day (as defined above), the total of the pay you receive and the disability benefits payable cannot exceed the number of hours you work in a regular day (as defined above) multiplied by your base hourly rate.

Subrogation

If your disability is the result of an event that creates a legal liability in another person or entity and you seek to recover economic or compensatory damages through legal or other action against that person or entity, the Company may initiate or join the action to recover the cost of the benefits paid to you by the plan. If you recover monies, economic or compensatory through personal injury action, the payments can be offset from the disability benefit. You must notify the Company or UNICARE in the event you initiate legal action to enforce your right to recovery from another party.

How do I initiate a disability claim and request a conditional medical leave of absence?

To report a disability claim and also request a conditional medical leave of absence, call UNICARE at this toll free number: 1-877-HRLY-MLA (1-877-475-9652) within 5 days from your last day of work. Your call will initiate both your disability claim at UNICARE and the medical leave of absence process with your work location.

Once your conditional medical leave of absence has been initiated based on your call to the toll free number, your local medical department will be your primary contact for the medical leave process. You will be required to supply your work location with proper medical justification for your medical leave once your request has been submitted via the toll free number. The required medical information must be supplied to your work location via a 5166 form **within 14 days of your last date of work**. Your medical leave will remain in a conditional status until the medical information is provided. If you fail to provide the required medical information to justify your medical leave of absence, you will be subject to loss of seniority through the 5-day quit process.

Once your disability claim has been initiated following your call, you and your physician will be responsible for ensuring that UNICARE is provided with the medical information necessary to determine eligibility for Accident and Sickness Benefits (and Extended Disability Benefits). To expedite the processing of your claim, you should have your physician call UNICARE regarding your case as soon as possible at 1-800-572-1581. In order to process your claim, UNICARE must also receive a signed copy of the notice of application for benefits form. UNICARE will make a claim determination within 21 days of your claim filing date. You are encouraged to supply all of the necessary information to UNICARE within this timeframe to avoid payment delays. Official deadlines for submitting this information are outlined in the next section.

At the time of your call, please be prepared to supply UNICARE with the following information:

- Your last day of work
- The name, address and phone number of your treating physician(s)

UNICARE will verify your last day of work with the Company along with your rate of pay and tax withholding information. If you know in advance that you will be absent due to medical reasons (for example, if you have a scheduled operation), you can call UNICARE with this information ahead of time.

After you initiate your disability claim and your conditional medical leave of absence with this phone call, UNICARE will mail you a package with all the information you need to certify your claim with UNICARE and justify your medical leave of absence with your work location.

Once your claim is established, you may call UNICARE toll free at 1-800-572-1581 if you have any questions or if you would like to obtain a claim status.

If you have any questions regarding your medical leave you must contact your work location.

Requirements for Notice and Proof of Claim

As indicated in the previous section, notice of your medical leave request is required by the Company within 5 days of your last date of work. For purposes of claim filing, you must provide written notice of claim to UNICARE within 20 days after you become disabled, or as soon as is reasonably possible. If you follow the process described in the previous section, you will satisfy the claim filing provision.

Proof of your injury or sickness also must be provided to UNICARE within 90 days after the end of your covered disability.

If you fail to furnish this proof within the time required, your claim will not be honored unless:

- It was not reasonably possible for you to give such proof within the time required
- You provide the proof as soon as reasonably possible and, in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required

Mental Health and Substance Abuse Claims

If you are diagnosed with a Mental Health and/or Substance Abuse (MHSA) condition you must obtain treatment from a legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a specialist in psychiatry for any disability extending beyond thirty (30) days. If you fail to obtain treatment from a psychiatrist before expiration of the 30 day period, your Accident and Sickness Benefits (and Extended Disability Benefits) will be terminated.

Treatment from a legally licensed clinical psychologist (PhD) during the first 30 days of your disability will qualify for purposes of benefit eligibility. The 30 day period is calculated from your first date of disability as determined by your provider or from the date your MHSA condition is first diagnosed.

If your claim is reopened due to a recurrence of a MHSA condition, you must obtain treatment from a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who specializes in psychiatry within 14 days of your most recent last date of work. You must be back to work for 3 or more consecutive months in order to qualify for a new claim if you are disabled for the same or related condition.

If you are disabled for a non-MHSA condition and you subsequently develop a MHSA condition, you must seek treatment with a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who specializes in psychiatry within 30 days of the diagnosis.

If you have previously sought treatment and disability certification for a MHSA condition and recover, but have not actually returned to work due to a secondary condition, you must seek treatment with a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who specializes in psychiatry within 14 days of recurrence of your MHSA condition.

Compliance with the treatment plan prescribed by your healthcare provider is required in order to maintain eligibility for Accident and Sickness Benefits (or Extended Disability Benefits).

If you do not seek treatment with a legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who specializes in psychiatry within the timeframes described above, you will not be eligible for Accident and Sickness Benefits (or Extended Disability Benefits).

Physical examination

UNICARE has the right to have you examined by an impartial medical examiner, at its expense, while your Accident and Sickness claim is pending or being paid. Failure to report for an examination without good cause will result in denial of your claim and termination of Accident and Sickness Benefits.

The results of the examination by an appropriate medical specialist are final and binding. Accident and Sickness Benefits will be terminated if you are found able to work or able to work with restrictions by the examiner. You must report to your work location for assessment following such determination.

If the medical examiner determines that you are able to work and you do not report to your work location to return to work following the examination, H-S-M-D-D-V coverage will be discontinued the first day of the second month following the examination date. H-S-M-D-D-V coverage will not be reinstated until you return to work.

Mileage reimbursement for Impartial Medical Examination (IME)

If an IME is scheduled for you at a location farther than 40 miles one-way (or the distance you drive to work, if greater) from your residence, you can request reimbursement from UNICARE at a rate of 48.5 cents per mile for actual miles driven from your residence to the IME physician's office and back using the most direct route available. You should request mileage reimbursement before your appointment. Mileage reimbursement will be made after you have kept your appointment with the IME examiner.

Application for Social Security Disability Benefits

Accident and Sickness and Extended Disability Benefits are reduced by the weekly equivalent of any Social Security Disability Insurance Benefits (SSDIB) you are entitled to receive. You are expected to comply with the Social Security Disability Benefit assessment, application and advocacy process as described below.

Initial Assessment for Social Security Disability Insurance Benefits

If you have a serious or prolonged disability:

You will receive a form from the claims processor, UNICARE, during your 24th week of absence to be completed by your physician.

The completed physician form must be returned to UNICARE before expiration of the 28th week of your absence.

If your physician indicates on the form that you will not be disabled for longer than 12 months, no additional follow up will be required at that time.

If your physician indicates on the form that you will be disabled for more than 12 months, or the completed physician statement is not received by UNICARE by the 30th week of your absence, your claim will be referred to a social security advocate.

What is the Social Security Advocacy Process?

Claims expected to last 12 or more months or otherwise determined to be suitable for the Social Security process will be assessed by a Social Security advocate. If the Social Security advocate determines that an application for SSDIB is appropriate, you will be required to comply with any directions provided by the Social Security advocate.

You will receive notification from UNICARE regarding your responsibilities under this process and detailing the services that will be provided to you free of charge from the Social Security advocate.

The initial SSDIB application process must be completed within 45 days of the notification to avoid a presumed SSDIB offset. Your Accident and Sickness and Extended Disability benefits will be reduced by a presumed SSDIB amount if you do not complete the process within the timeline provided.

If at any time you are asked to supply UNICARE or the Social Security advocate with an authorization for the release of Social Security information and fail to do so within 30 days of the request, a presumed offset of SSDIB will be applied effective as of the first of the month following the 30 day period.

If at any time you are not compliant with the Social Security advocate, it will be presumed that your SSDIB should have commenced at the time of your SSDIB application

Non-compliance includes but is not limited to:

- Failure to sign and submit the reimbursement agreement (account sweep) for purposes of collection of a retroactive award of SSDIB
- Failure to complete and return forms or supply required medical information
- Failure to cooperate with the Social Security advocate or follow instructions
- Failure to complete the initial application appeal, reconsideration process, etc.

Additional Information about the Social Security Disability Insurance Process

You must apply, as instructed by the Social Security advocate, for reconsideration or appeal if you have been denied SSDIB upon your initial application. You may also be required by the Social Security advocate to submit a second application for SSDIB and exhaust all levels of appeal with the Social Security Administration, up to and including review by an Administrative Law Judge. If you fail to cooperate with any additional steps recommended by the Social Security advocate, your Accident and Sickness and Extended Disability benefits will be reduced by a presumed SSDIB amount effective as of the date of the original SSDIB application.

Please be aware that your claim for Accident and Sickness or Extended Disability Benefits can be referred to the Social Security advocate at anytime benefits are pending.

Applying for Social Security Disability Insurance Benefits on Your Own

The Social Security advocacy process is provided at no cost to you. If you choose to pursue application for SSDIB on your own you must notify the claims processor, UNICARE, of this action. Proof of application for SSDIB must be provided to UNICARE within 30 days of your application. You are required to supply UNICARE with the SSDIB award/denial information within 30 days of the determination by the Social Security Administration. Failure to provide SSDIB award or denial information to UNICARE will result in a presumed offset and your Accident and Sickness and/or Extended Disability Benefits will be reduced.

Waiver of benefits

If you have one or more years of seniority, you may waive irrevocably any right to Accident and Sickness benefits for any period of disability by completing a waiver form furnished by the claims processor. Accident and Sickness benefits shall not be payable for any period of disability covered by such a waiver.

Reinstatement of Accident and Sickness benefits during layoff

Your Accident and Sickness benefits will be reinstated if you:

- Become wholly and continuously disabled while on a qualifying layoff as defined in the 1999 Ford-UAW Supplemental Unemployment Benefit Plan (SUB Plan), are found to be medically disabled by the plant physician upon recall from a qualifying layoff, or are certified by your physician to be unable to return to work because of disability, and
- Are insured for Life Insurance, and
- Are eligible for a Regular Benefit under the SUB Plan or have been employed by another employer immediately before becoming disabled

If you wish to receive benefits, you must submit notice and proof of your claim to UNICARE within the time limits described above.

With respect to each week for which a benefit is claimed, you also must:

- Be unable to perform all duties of your job
- Be under the care of a physician (as defined in the Accident and Sickness benefits section) and
- Be otherwise eligible to receive a benefit under the SUB Plan or, if the 1987 SUB Plan is reinstated, have to your credit at least a Credit Unit under the 1987 SUB Plan

If you were receiving Regular Benefits under the SUB Plan immediately before you became disabled, Accident and Sickness benefits will begin on the first day following the last day a Regular Benefit was payable to you. If you were not receiving Regular Benefits, Accident and Sickness benefits will begin on the first day of qualifying disability.

Benefits will not continue after you cease to satisfy the disability requirements. If, however, you remain on qualifying layoff under the SUB Plan, benefits are payable for remaining days in the same week (as defined in the SUB Plan) for which you do not receive a Regular Benefit.

Reinstated Accident and Sickness benefits will not be paid for any week in which:

- You receive an Accident and Sickness benefit (see the "What are Accident and Sickness benefits?" section for more details) or an Extended Disability Benefit or
- If the 1987 SUB Plan is reinstated, the Credit Unit Cancellation Base under the SUB Plan is below the applicable dollar amount at which a SUB benefit is payable according to your seniority

Your Reinstated Accident and Sickness benefits will be reduced by the amount of any disability benefit you receive for the same week under a plan paid in whole or in part by another employer.

Reinstated Accident and Sickness benefits are governed by the applicable Accident and Sickness benefits provisions described earlier.

What are Extended Disability Benefits?

If your disability continues beyond the period you are entitled to receive Accident and Sickness benefits, Extended Disability Benefits may provide monthly payments for an extended period of time.

Eligibility for benefits

You are eligible for Extended Disability Benefits if:

- You are covered for Accident and Sickness benefits
- Your disability continues beyond the period that you were eligible for Accident and Sickness benefits and
- You are totally disabled, which means:
 - ◊ You are not engaged in any regular occupation or employment for remuneration or profit, and
 - ◊ You are prevented by bodily injury or disease from engaging in any regular occupation or employment with the Company at the plant or plants where you have seniority

Claims processor

UNICARE Life and Health Insurance Company is presently the claims processor under an administrative services agreement with the Company.

UNICARE Phone Number: 1-800-572-1581

Benefit amount

Your maximum Extended Disability Benefits are determined according to:

- Your base hourly rate on your last day of work, and
- Your number of years of credited service under the Retirement Plan or your number of years of participation under the Life and Disability Insurance Program

If you have less than 10 years of credited service under the Retirement Plan and less than 10 years of participation in the Life and Disability Insurance Program, your monthly benefit is shown in Column I. If you have 10 or more years of credited service or 10 or more years of participation in the Life and Disability Insurance Program, your monthly benefit is shown in Column II. For AAI employees, years of credited service under the Retirement Plan and years of participation in the Life and Disability Insurance Program include relevant time at Ford and at AAI.

The Extended Disability Benefits shown in the table below will be reduced by the amount of benefits from other sources for which you are eligible:

Insurance Code	BENEFIT AMOUNT: If your base hourly rate is: (Coverage Bracket)	Your Monthly Extended Benefits are:	
		(I) Less than 10 years	(II) 10 or more years
1J	Up to but less than \$14.30	\$1250	\$1370
1I	\$14.30 but less than \$14.65	\$1280	\$1405
1H	\$14.65 but less than \$15.00	\$1310	\$1440
1G	\$15.00 but less than \$15.35	\$1340	\$1475
1F	\$15.35 but less than \$15.70	\$1370	\$1505
1E	\$15.70 but less than \$16.05	\$1405	\$1540
1D	\$16.05 but less than \$16.40	\$1435	\$1575
1C	\$16.40 but less than \$16.75	\$1465	\$1610
1B	\$16.75 but less than \$17.10	\$1495	\$1640
1A	\$17.10 but less than \$17.45	\$1525	\$1675
A	\$17.45 but less than \$17.80	\$1560	\$1710
B	\$17.80 but less than \$18.15	\$1590	\$1745
C	\$18.15 but less than \$18.50	\$1620	\$1780
D	\$18.50 but less than \$18.85	\$1650	\$1810
E	\$18.85 but less than \$19.20	\$1680	\$1845
F	\$19.20 but less than \$19.55	\$1710	\$1880
G	\$19.55 but less than \$19.90	\$1745	\$1915
H	\$19.90 but less than \$20.25	\$1775	\$1950
I	\$20.25 but less than \$20.60	\$1805	\$1980
J	\$20.60 but less than \$20.95	\$1835	\$2015
K	\$20.95 but less than \$21.30	\$1865	\$2050
L	\$21.30 but less than \$21.65	\$1900	\$2085

BENEFIT AMOUNT:		Your Monthly Extended Benefits are:	
Insurance Code	If your base hourly rate is: (Coverage Bracket)	(I) Less than 10 years	(II) 10 or more years
M	\$21.65 but less than \$22.00	\$1930	\$2120
N	\$22.00 but less than \$22.35	\$1960	\$2150
O	\$22.35 but less than \$22.70	\$1990	\$2185
P	\$22.70 but less than \$23.05	\$2020	\$2220
Q	\$23.05 but less than \$23.40	\$2055	\$2255
R	\$23.40 but less than \$23.75	\$2085	\$2290
S	\$23.75 but less than \$24.10	\$2115	\$2320
T	\$24.10 but less than \$24.45	\$2145	\$2355
U	\$24.45 but less than \$24.80	\$2175	\$2390
V	\$24.80 but less than \$25.15	\$2205	\$2425
W	\$25.15 but less than \$25.50	\$2240	\$2460
X	\$25.50 but less than \$25.85	\$2270	\$2490
Y	\$25.85 but less than \$26.20	\$2300	\$2525
Z	\$26.20 but less than \$26.55	\$2330	\$2560
AA	\$26.55 but less than \$26.90	\$2360	\$2595
BB	\$26.90 but less than \$27.25	\$2395	\$2630
CC	\$27.25 but less than \$27.60	\$2425	\$2660
DD	\$27.60 but less than \$27.95	\$2455	\$2695
EE	\$27.95 but less than \$28.30	\$2485	\$2730
FF	\$28.30 but less than \$28.65	\$2515	\$2765
GG	\$28.65 but less than \$29.00	\$2550	\$2795
HH	\$29.00 but less than \$29.35	\$2580	\$2830
II	\$29.35 but less than \$29.70	\$2610	\$2865

BENEFIT AMOUNT:		Your Monthly Extended Benefits are:	
Insurance Code	If your base hourly rate is: (Coverage Bracket)	(I) Less than 10 years	(II) 10 or more years
JJ	\$29.70 but less than \$30.05	\$2640	\$2900
KK	\$30.05 but less than \$30.40	\$2670	\$2935
LL	\$30.40 but less than \$30.75	\$2700	\$2965
MM	\$30.75 but less than \$31.10	\$2735	\$3000
NN	\$31.10 but less than \$31.45	\$2765	\$3035
OO	\$31.45 but less than \$31.80	\$2795	\$3070
PP	\$31.80 but less than \$32.15	\$2825	\$3105
QQ	\$32.15 but less than \$32.50	\$2855	\$3135
RR	\$32.50 but less than \$32.85	\$2890	\$3170
SS	\$32.85 but less than \$33.20	\$2920	\$3205
TT	\$33.20 but less than \$33.55	\$2950	\$3240
UU	\$33.55 but less than \$33.90	\$2980	\$3275
VV	\$33.90 but less than \$34.25	\$3010	\$3305
WW	\$34.25 but less than \$34.60	\$3045	\$3340
XX	\$34.60 but less than \$34.95	\$3075	\$3375
YY	\$34.95 but less than \$35.30	\$3105	\$3410
ZZ	\$35.30 but less than \$35.65	\$3135	\$3445
2A	\$35.65 but less than \$36.00	\$3165	\$3475
2B	\$36.00 but less than \$36.35	\$3195	\$3510
2C	\$36.35 but less than \$36.70	\$3230	\$3545
2D	\$36.70 but less than \$37.05	\$3260	\$3580
2E	\$37.05 but less than \$37.40	\$3290	\$3615
2F	\$37.40 and over	\$3320	\$3645

If you last worked before November 19, 2007, your Extended Disability Benefits are shown in the Collective Bargaining Agreement in effect when you last worked.

Benefits payable for less than a full month are prorated—based on the ratio of calendar days of eligibility to total calendar days in the month.

If you become disabled again for an old accident or illness without having returned to work for three consecutive months or more, the benefits shall be the amount you would have received under a continuation of the prior claim.

Other sources of benefits

Other sources of benefits are:

- Benefits under any retirement plan for Company employees
- Lost-time benefits under Workers' Compensation laws or other laws providing benefits for occupational injury or disease, including lump-sum settlements (excluding specific allowances for loss, 100% loss of use of a body member, or permanent partial disability payments for a work-related disability unrelated to the disability for which Extended Disability Benefits are payable)
- Disability or old-age (retirement) primary Social Security benefits to which you are entitled (except for retirement benefits reduced because of your age at the time you receive them); this includes any similar benefits arising from future legislation, and
- Benefits under any state or federal law providing benefits for lost time because of disability, except benefits for total disability due to pneumoconiosis

Extended Disability Benefits are reduced by the amounts you receive from other sources. To determine the amounts paid from other sources, those benefits paid on a weekly or lump-sum basis are converted to monthly amounts (by multiplying the weekly amount by 4.33).

Subrogation

If your disability is the result of an event that creates a legal liability in another person or entity and you seek to recover economic or compensatory damages through legal or other action against that person or entity, the Company may initiate or join the action to recover the cost of the benefits paid to you by the plan. If you recover monies, economic or compensatory through personal injury action, the payments can be offset from the disability benefit. You must notify the Company or UNICARE in the event you initiate legal action to enforce your right to recovery from another party.

Offset for Social Security Disability Insurance benefits

Your Extended Disability Benefits (EDB) are reduced by any Social Security Disability Insurance Benefits you are entitled to receive. Please refer to the Application for Social Security Disability Insurance Benefits section for more information on the social security advocacy process, your role and responsibilities.

Offset for benefits from the Ford-UAW Retirement Plan

After you have received EDB for 24 months, your EDB will be reduced by the amount of retirement benefit for which you are presumed to be eligible if you have not previously applied for benefits under the Ford-UAW Retirement Plan, or if you applied for retirement benefits but have not yet received a determination on your application. This provision does not apply to you if you applied for retirement benefits and received a determination on your application prior to the twenty-fourth month. The amount deducted from your EDB based on presumed eligibility for retirement benefits will be paid to you if you provide evidence that your application for retirement benefits was denied, unless the reason for the denial was your refusal to accept vocational rehabilitation services. If you apply for Retirement Plan benefits after the twenty-fourth month of your eligibility for EDB and your application is approved, the amounts deducted prior to the scheduled effective date of the retirement will not be paid to you.

After Extended Disability Benefits begin, any increases in the amount of other benefits mentioned above will not affect the amounts payable from Extended Disability Benefits—unless the increase represents an adjustment in the benefit originally determined.

You may be required to verify the amounts of your income from other sources while you are eligible for Extended Disability Benefits.

Duration of benefits

The duration of benefits is based on your years of seniority or, for AAI employees, your combined years of AAI and Ford service, and your last day worked before disability began:

Extended Disability Benefits Will Continue

If:	Until:
You have 10 or more years of seniority on the date disability began	Your recovery or attainment of age 65, whichever is sooner
You have less than 10 years of seniority on the date disability began	The sooner of your recovery, attainment of age 65, or minus the number of full months of seniority at the onset of disability, minus the number of weeks for which you are entitled to receive Accident and Sickness benefits

For purposes of determining the maximum period of monthly Extended Disability Benefits, a month in which benefits are partially or wholly offset by benefits from other sources is counted as a full month. A month during which you engage in some gainful occupation or employment for which you are not reasonably qualified by education, training or experience also is counted as a full month.

For those employees who have less than 10 years of seniority when the disability commenced, the total number of months during any previous period of eligibility for Extended Disability Benefits, regardless of whether the disability was for the same or a related condition, will reduce the maximum number of monthly benefit payments which you are eligible to receive.

If you become disabled at or after the age of 60, and are otherwise eligible for Extended Disability Benefits (EDB), benefits will continue for the length of your disability, not to exceed five years.

Benefits may be suspended

Extended Disability Benefits will be suspended for the period of your return to work if:

- Your return to work is not effective to qualify you for a new period of Accident and Sickness benefits, or
- You engage in some gainful occupation or employment for which you are reasonably qualified by education, training or experience

Work determined to be primarily for training under a recognized program of vocational rehabilitation will not disqualify you for Extended Disability Benefits.

UNICARE may require you to provide proof that you have no other employment. If this information is not provided, benefits will be suspended until such information is provided and it is determined that you did not engage in gainful occupation or employment.

If your Extended Disability Benefits are discontinued because you no longer satisfy the disability requirement, and within two weeks of the date of such discontinuance and before you return to work with the Company, you again become disabled so as to satisfy the disability requirements, monthly Extended Disability Benefits will be resumed.

Special Medicare benefit

If you are an Extended Disability Benefits recipient enrolled in voluntary Medicare coverage (Part B), you will receive the following special benefit:

Starting this date:	Your Monthly Special Benefit is the lesser of the generally applicable Medicare Part B Premium or this amount
January 1, 1999	\$45.50
January 1, 2000	\$61.50
January 1, 2004	\$76.20

Special Medicare benefit payments will begin on the first day of the month after the month you notify the claims processor that you have enrolled for Part B coverage. If you already are receiving a special benefit for your Part B payments through the Retirement Plan or Health Care Plan, however, you will not receive duplicate payments.

Special Medicare payments are paid along with Extended Disability Benefits. If you do not receive an Extended Disability Benefit payment because other benefit sources exceed the monthly Extended Disability Benefit amount, you still will receive this special payment.

Physical examination

UNICARE has the right to have you examined by an impartial medical examiner, at its expense, while your Extended Disability Benefit claim is pending or being paid. Failure to report for an examination without good cause will result in denial of your claim and termination of Extended Disability Benefits.

The results of the examination by an appropriate medical specialist are final and binding. Extended Disability Benefit will be terminated if you are found able to work/able to work with restrictions by the examiner. You must report to your work location for assessment following such determination.

If the medical examiner determines that you are able to work and you do not report to your work location to return to work following the examination, H-S-M-D-D-V coverage will be discontinued the first day of the second month following the examination date. H-S-M-D-D-V coverage will not be reinstated until you return to work.

Mileage reimbursement for Impartial Medical Examination (IME)

If an IME is scheduled for you at a location farther than 40 miles one-way (or the distance you drive to work, if greater) from your residence, you can request reimbursement from UNICARE at a rate of 48.5 cents per mile for actual miles driven from your residence to the IME physician's office and back using the most direct route available. You should request mileage reimbursement before your appointment. Mileage reimbursement will be made after you have kept your appointment with the IME examiner.

Waiver of benefits

You may waive irrevocably your right to receive Extended Disability Benefits for any period of disability by completing a waiver form furnished by the claims processor. No Extended Disability Benefits shall be payable for any period of disability covered by such waiver.

Claiming disability benefits

To file a claim for Accident and Sickness or Extended Disability Benefits, follow these steps:

1. Your claim should be reported directly to:
UNICARE Life and Health Insurance Company
Dearborn Service Center
P.O. Box 4479
Dearborn, Michigan 48126
1-877-HRLY-MLA (1-877-475-9652)
2. If you are employed in California and become disabled, you must apply for State Unemployment Compensation Disability Benefits.

Will taxes be withheld from my disability benefits?

Yes, taxes will be withheld from all disability payments just as they are from your paychecks.

Withholding will be based on your current exemption status on record with the Company. When your exemption status is not available, the withholding amounts will be determined as if you were single and claiming zero exemptions until the claims processor is provided with a valid Form W-4.

If you wish to change your exemption status while you are receiving disability benefits, you may contact the claims processor regarding the submission of updated Form W-4. Changes submitted to the claims processor will take effect as soon as possible for future benefits only. Your exemption status will be obtained from the Company payroll records each time you file a claim. For that reason, you must submit Form W-4 changes for each claim if you desire a different level of tax withholding than appears on Company payroll records. Any Form W-4 changes that are submitted to the claims processor will not affect your Company payroll records.

Your disability benefits also will be reduced by the amount of any applicable court order directing the Company to withhold from your wages or benefits. Court orders for dependent support, bankruptcy, tax levies, garnishment, etc. which are on file with payroll services or served directly upon UNICARE will apply to your disability benefits. The amount withheld will be sent by UNICARE to the court involved. An explanation of withholding will be included on your disability benefit draft.

What if a claim for Accident and Sickness or Extended Disability Benefits is denied?

This section contains a description of the procedures for seeking review of a denied claim.

If a claim for benefits is denied in whole or in part, you should receive written notification within forty-five (45) days of the date that the claim is received. If the Plan Administrator requires more time to review your claim, determination may be delayed up to an additional two (2) thirty (30) day extensions. You will receive notice of the delay which will include the reasons for delay and the date a final decision can be expected. In all cases, a final decision will be reached, and you will be notified within one hundred and five (105) days after the Plan Administrator receives your claim for benefits.

Your first level of appeal is a review of the denied claim by the Plan Administrator.

Review of denial by the Plan Administrator

If a claim is denied, you will receive a written notice. The notice will explain the reason for the denial, refer to the specific Plan provision or provisions on which the denial is based, describe what additional information, if any, is necessary to consider a further appeal, and describe how to appeal your claim.

In the event of a denial, you may request a first level appeal review by the Plan Administrator by submitting an appeal in writing. Your request for review must be submitted within one hundred eighty (180) days after you receive the written notification of denial of the claim. Within forty-five (45) days following receipt of your appeal letter, the Plan Administrator will notify you of their decision. Special circumstances may require an extension of additional forty-five (45) days for processing. If your claim has been denied, the notice will describe the specific reasons for the denial.

In all cases, a final decision will be reached, and you will be notified in writing after your written request for a review is received by the Plan Administrator.

First level appeals should be addressed to:

UNICARE Life and Health Insurance Company
Dearborn Service Center
P.O. Box 4479

Dearborn, Michigan 48126

Review of denial of the appeal by the Committee

In the event that the Plan Administrator denies the appeal of a claim, you may request further review of your claim by submitting your request for appeal in writing to the UAW-Ford Group Life and Disability Appeal Committee. The procedures and time limits for reviewing the appeal are the same as the appeal to the Plan Administrator as listed on the previous page.

The UAW will appoint three members and alternate members to the Committee. Three additional members of the Committee are appointed by the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services.

Address appeal requests to:

Ford Motor Company
P.O. Box 3139

Melvindale, MI 48122-0139

Attn: UAW-Ford Group Life and Disability
Committee

The request for appeal should clearly indicate the reason(s) why you think your claim should not have been denied by the Plan Administrator. You are encouraged to submit copies of any additional documents, records, information or comments you think have a bearing on your claim.

You will be notified of the outcome of your appeal in writing, within forty-five (45) days from the date the written notice is received, unless special circumstances require an extension of additional forty-five (45) days for processing. Your notice will include the final decision and the specific reasons to support the decision. No legal action may be brought until after the claims and appeals procedures have been exhausted. No legal action can be taken later than two years after the claim accrues.

The following information may apply to both Life and Disability coverages.

What happens if I stop working or my employment status changes for any reason?

If you stop working, are away from work or your employment status changes to an ineligible status, Life Insurance and Disability benefits coverages will be affected.

Depending on the reason you stop working, the Company may pay for certain coverages for you or may allow you to continue certain coverages under the Life & Disability Program as described in this section. Additionally, you or your dependents upon loss of coverage or eligibility under the Life and Disability Program may be eligible to apply to continue coverage outside of the Ford Life and Disability Program. For more information, see the following section "When does coverage end under the Life and Disability Program?"

Converting to an individual policy

If you leave the Company or no longer are eligible for coverage, you can convert Life, Survivor Income Benefits, Optional Life and Dependent Life within 31 days of the time coverage ends to any individual Life Insurance policy then customarily issued by the insurer except term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of your Life Insurance in force when you left the Company, including Survivor Income Benefits.

Accidental Death and Dismemberment and Optional Accident are not convertible to an individual policy.

If you quit or are discharged

If your employment is terminated because of a quit or discharge, your Life, Accidental Death and Dismemberment, Disability and Survivor Income Benefit coverage terminates as of the date you quit or are discharged. If, however, you are discharged and have a grievance pending to protest your loss of seniority, coverage for Life Insurance will continue to the end of the month you were discharged and up to two additional months. Coverage for disability benefits terminates as of the date you quit or are discharged.

If your employment is terminated for failing to report or overstaying leave, your coverage terminates as of the end of the month in which seniority is broken.

Life Insurance and Survivor Income Benefits coverages remain in effect for 31 days following your termination of coverage. (See the "What are the Life Insurance Benefits?" and "What are Survivor Income Benefits?" sections for more details.)

If you are laid off

If you are laid off, all your coverages will continue for one month after the month in which you are laid off.

If you are a returning veteran and are placed on layoff instead of being reinstated, your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits will continue at no cost to you for the rest of the month in which you are placed on layoff. (A returning veteran is an employee applying for re-employment who would be entitled to reinstatement as a military service veteran under the Collective Bargaining Agreement.)

If you have one or more years of seniority, your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits may continue for a longer period of time, at no cost to you, during a layoff meeting the conditions of the Supplemental Unemployment Benefits Plan (Article I, Section 3). You will receive these additional coverages for the greater of:

- The number of months (up to 24 months) for which you are eligible based on your years of seniority on your last day worked before layoff (or the date placed on layoff if you are a returning veteran) according to this table:

If your year(s) of seniority on the last day worked before layoff were:	Coverage will be provided for up to this number of months at no cost to you:
Less than 1	0
1 but less than 2	2
2 but less than 3	4
3 but less than 4	6
4 but less than 5	8
5 but less than 6	10
6 but less than 10	12
10 and over	24

OR

- One full calendar month of layoff (up to 24 months) for each full 4 weeks of Regular Benefits to which your Credit Units as of the last day worked prior to layoff entitle you based on your seniority and the Credit Unit Cancellation Base under the provisions of the 1987 SUB Plan.

If, after your last day worked before layoff, you are credited with Credit Units under the SUB Plan, the Credit Unit Cancellation Base as of the date you are entitled to be credited with Credit Units, will be used.

If you remain on layoff beyond the period of time for which coverage is provided at no cost, you may continue coverage for up to an additional 12 months. To do so, you will be required to make monthly contributions. The contribution amount is based on your base hourly rate and your level of coverage at the time your employment terminated.

Additionally, to continue any optional coverages during layoff, you must make your premium payments directly to the insurer.

If you become eligible for reinstated Accident and Sickness benefits during layoff, the Company will provide Life and Accidental Death and Dismemberment Insurance and Survivor Income Benefits while you are eligible to receive Extended Disability Benefits after receipt of reinstated Accident and Sickness benefits.

If you are on a medical leave of absence

If you cease active work because of a disability, all of your coverages will continue up to a period of time equal to your seniority when your absence began. If you remain continuously and totally disabled beyond that time, you can continue Life Insurance and Accidental Death and Dismemberment Insurance coverages by making monthly contributions.

If your absence is due to pregnancy, the Company will continue all your coverages through the month following the month of delivery. If your disability continues beyond that time, your coverages also will continue as for any other disability.

Additionally, to continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

If you are on a non-medical leave of absence

If you go on an approved non-medical leave of absence (except while serving as International Union Representative), all of your coverages for Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits will continue for the first full month of your leave. You may continue coverage beyond that time up to the end of your approved leave by making monthly contributions.

If you go on an approved Union Leave of Absence while serving as an International Union Representative, you may continue your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages by making monthly contributions.

Additionally, to continue any optional coverages during a leave, you must make your premium payments directly to the insurer.

If you retire

If you take early or special early retirement under the Retirement Plan, the Company will continue your full Life Insurance and Accidental Death and Dismemberment Insurance coverages until you reach age 65. After you reach age 65, your Life Insurance will be continued at a reduced level until you die.

If you take disability retirement under the Retirement Plan, the Company will continue your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits until you reach age 65. After you reach age 65, your Life Insurance will be continued at a reduced level until you die.

If you are uninsured and retire under the Retirement Plan before age 65, the following applies. If you do not return to work from layoff or leave of absence, you will become insured on the first day of the month following the month you broke seniority, due to that retirement, for the same coverages you otherwise would have been eligible to receive at the time of your retirement, in the amount you had in force while last working. The Company will continue those coverages for you until you reach age 65, at which time your Life Insurance will be continued at a reduced level (as described in the "Continuing Group Life Insurance amount" section).

See the "What are Life Insurance benefits?" section for details on coverage after you reach age 65.

If you terminate employment between ages 60 and 65

If you terminate employment for any reason except retirement between ages 60 (or prior to that age if you still are insured at age 60) and 65 and you had at least five years of creditable service under the Retirement Plan at age 60, you may continue your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages under the Program until you reach age 65 by making monthly contributions. If, however, you are terminated for total and permanent disability, the Company will pay the cost for you.

If you have a grievance pending

The Company will continue your Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits coverages if you have a grievance pending to protest your disciplinary layoff or your loss of seniority from:

- Discharge
- Failure to report or
- Overstaying leave

Coverage will continue for the month of discharge plus up to two additional months.

To continue coverage after the period in which your loss of seniority or disciplinary layoff occurred, you will need to make monthly contributions.

If you are reinstated or if your disciplinary layoff is reduced after this period, the Company will reimburse you for the continuation payments that the Company would have made had you remained at work.

Disability coverage terminates as of the day your employment terminates.

Your contributions for continuing coverage

Employees are eligible to continue Basic Life, AD&D, SIB, and Disability under Schedule I and Schedule III. Employees are eligible to continue Basic Life, AD&D, and SIB only under Schedule II and IV.

The following charts summarize reasons why your employment may terminate and whether or not your coverage(s) may continue:

Your situation:	The Company continues your coverage for:	You then can contribute according to Contribution Schedule # :
You quit or are discharged	—	—
You have a grievance pending	Month of discharge plus up to two additional months	II
You are laid off	First month (plus additional months for which you may qualify)	II
You are on a leave of absence (except medical or Union leave)	First month	I
You are on a Union leave absence (Local Union)	First month	III
You are on a Union leave of absence (International Union)	Through month in which leave is issued	IV
You are on a medical leave of absence	Length of your absence due to disability but not to exceed period equal to your seniority	II
You take early, normal or special early, retirement with 10 years of service	Entire period	—
You take disability retirement with 10 years of service	Entire period	—
You terminate between ages 60 and 65	—	II

To continue coverage beyond the period for which the Company pays for your coverage, the monthly contribution provided in the following Contribution Schedules I-IV, you are required to pay depends on the coverage bracket you were in as of the last day worked and the kinds of insurance coverage which can be continued.

Contribution Schedule I & II

Insurance Code	If your base hourly rate is: (Coverage Bracket)	Life, AD&D, SIB and Disability Contribution Schedule I	Life, AD&D, and SIB Contribution Schedule II
1J	Up to but less than \$14.30	\$26.36	\$15.75
1I	\$14.30 but less than \$14.65	\$27.22	\$16.25
1H	\$14.65 but less than \$15.00	\$27.65	\$16.75
1G	\$15.00 but less than \$15.35	\$28.51	\$17.25
1F	\$15.35 but less than \$15.70	\$29.37	\$17.75
1E	\$15.70 but less than \$16.05	\$29.80	\$18.00
1D	\$16.05 but less than \$16.40	\$30.66	\$18.50
1C	\$16.40 but less than \$16.75	\$31.09	\$18.75
1B	\$16.75 but less than \$17.10	\$31.52	\$19.00
1A	\$17.10 but less than \$17.45	\$32.38	\$19.50
A	\$17.45 but less than \$17.80	\$33.24	\$20.00
B	\$17.80 but less than \$18.15	\$33.67	\$20.25
C	\$18.15 but less than \$18.50	\$34.96	\$21.00
D	\$18.50 but less than \$18.85	\$35.39	\$21.25
E	\$18.85 but less than \$19.20	\$36.25	\$21.75
F	\$19.20 but less than \$19.55	\$36.68	\$22.00
G	\$19.55 but less than \$19.90	\$37.54	\$22.50
H	\$19.90 but less than \$20.25	\$38.40	\$23.00
I	\$20.25 but less than \$20.60	\$38.83	\$23.25
J	\$20.60 but less than \$20.95	\$39.26	\$23.50
K	\$20.95 but less than \$21.30	\$40.12	\$24.00
L	\$21.30 but less than \$21.65	\$40.55	\$24.25
M	\$21.65 but less than \$22.00	\$41.41	\$24.75
N	\$22.00 but less than \$22.35	\$41.84	\$25.00
O	\$22.35 but less than \$22.70	\$42.70	\$25.50
P	\$22.70 but less than \$23.05	\$43.56	\$26.00
Q	\$23.05 but less than \$23.40	\$43.99	\$26.25
R	\$23.40 but less than \$23.75	\$44.85	\$26.75
S	\$23.75 but less than \$24.10	\$45.28	\$27.00
T	\$24.10 but less than \$24.45	\$46.14	\$27.50
U	\$24.45 but less than \$24.80	\$47.00	\$28.00

Insurance Code	If your base hourly rate is:	Life, AD&D, SIB and Disability Contribution Schedule I	Life, AD&D, and SIB Contribution Schedule II
V	\$24.80 but less than \$25.15	\$47.43	\$28.25
W	\$25.15 but less than \$25.50	\$48.29	\$28.75
X	\$25.50 but less than \$25.85	\$48.72	\$29.00
Y	\$25.85 but less than \$26.20	\$49.58	\$29.50
Z	\$26.20 but less than \$26.55	\$50.44	\$30.00
AA	\$26.55 but less than \$26.90	\$50.87	\$30.25
BB	\$26.90 but less than \$27.25	\$51.73	\$30.75
CC	\$27.25 but less than \$27.60	\$52.16	\$31.00
DD	\$27.60 but less than \$27.95	\$53.02	\$31.50
EE	\$27.95 but less than \$28.30	\$53.88	\$32.00
FF	\$28.30 but less than \$28.65	\$54.31	\$32.25
GG	\$28.65 but less than \$29.00	\$55.17	\$32.75
HH	\$29.00 but less than \$29.35	\$56.46	\$33.50
II	\$29.35 but less than \$29.70	\$56.89	\$33.75
JJ	\$29.70 but less than \$30.05	\$57.75	\$34.25
KK	\$30.05 but less than \$30.40	\$58.61	\$34.75
LL	\$30.40 but less than \$30.75	\$59.04	\$35.00
MM	\$30.75 but less than \$31.10	\$59.90	\$35.50
NN	\$31.10 but less than \$31.45	\$60.33	\$35.75
OO	\$31.45 but less than \$31.80	\$60.76	\$36.00
PP	\$31.80 but less than \$32.15	\$61.19	\$36.25
QQ	\$32.15 but less than \$32.50	\$62.05	\$36.75
RR	\$32.50 but less than \$32.85	\$62.91	\$37.25
SS	\$32.85 but less than \$33.20	\$63.34	\$37.50
TT	\$33.20 but less than \$33.55	\$64.20	\$38.00
UU	\$33.55 but less than \$33.90	\$64.63	\$38.25
VV	\$33.90 but less than \$34.25	\$65.49	\$38.75
WW	\$34.25 but less than \$34.60	\$66.35	\$39.25
XX	\$34.60 but less than \$34.95	\$66.78	\$39.50
YY	\$34.95 but less than \$35.30	\$67.64	\$40.00
ZZ	\$35.30 but less than \$35.65	\$68.07	\$40.25
2A	\$35.65 but less than \$36.00	\$69.36	\$41.00
2B	\$36.00 but less than \$36.35	\$70.22	\$41.50
2C	\$36.35 but less than \$36.70	\$71.08	\$42.00
2D	\$36.70 but less than \$37.05	\$71.51	\$42.25
2E	\$37.05 but less than \$37.40	\$72.37	\$42.75
2F	\$37.40 and over	\$72.80	\$43.00

The rates are subject to change, if necessary, by mutual agreement between the Company and the Union.

Contribution Schedule III. Your contribution is 60¢ per \$1,000 Life Insurance for Life, AD&D, SIB and Disability coverages in addition to \$5.00 a month.

Contribution Schedule IV. Your contribution is 60¢ per \$1,000 Life Insurance for Life, AD&D, and SIB coverages.

Your contributions for the coverages available to you should be mailed to:

UNICARE Life and Health Insurance Company
Dearborn Service Center
P.O. Box 2090
Dearborn, Michigan 48123
(313) 336-5550 or
1-800-843-8184

Payment will be due on the first day of each month for that month's coverage. Payment will be accepted anytime within that month. Late payments are not acceptable, however, and can result in permanent termination of your coverage.

If you return to work from layoff in a month for which you have made payment, you will be reimbursed by UNICARE for that payment.

The insurer will not advise of payments due. Making timely premium payments is your responsibility.

Continuing coverage for Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance

You may continue Optional Group Life Insurance, Dependent Group Life Insurance and Optional Accident Insurance coverage for certain periods when you are not at work while insured for the Basic Life benefit . For more details see the sections "what are Optional Group Life Insurance Benefits?", "What are dependent Group Life insurance Benefits/", and "what are Optional Accident Insurance benefits?"

When does coverage end under the Life and Disability Program?

Coverage will end when you or your dependents are no longer are eligible for coverage under the Program. However, certain coverages may be continued.

An employee or dependent may only continue coverage under one continuation of coverage option. Coverage may not be continued simultaneously under the:

1. The cash pay schedules I, II, III, or IV in the "What Happens If I stop working or my employment status changes for any reason?" found earlier in this section,
2. Dependent Life Insurance "Provision of Continuation of Coverage for Survivors of Deceased Employees",
3. "Conversion Privilege", or
4. "Portability of Coverage Provision"

More information on the continuation of coverage options may be located in the sections referenced above. Conversion and Portability are described in this section. Additionally, continuation of Optional Accident coverage for a surviving spouse/qualified same sex domestic partner is previously referenced in the "What are Optional Accident Insurance Benefits?" section.

The description for each benefit area under the Program section titled "What happens if I stop working or my employment status changes for any reason?" includes a discussion of when Company paid coverage ends and continuation of coverages by self pay. Additionally, Company paid coverages and employee paid coverages including the optional programs under the Life and Disability Insurance Program automatically will end on the earliest of:

- Safety Belt User Coverage will end when eligibility for Company-paid Health Care Plan coverage ends;
- The date the Program terminates;
- The end of the period for which you last made contributions for continuing coverage;
- The end of the month you are transferred within the Company to an ineligible class of employees;
- Unless specifically provided otherwise, the end of the month you stop active work (unless you continue your insurance coverage as described in the "What happens if I stop working or my employment status changes for any reason?" section); or

- The day you quit or are discharged, unless you have a grievance pending to protest your loss of seniority. See "What happens if I stop working or my employment status changes for any reason?" section.
- Dependent Life ends the date on which the employee dies unless the eligible surviving spouse/qualified same sex domestic partner pays for continuation of coverage as a survivor of a deceased employee or eligible surviving spouse/qualified same sex domestic partner or child elects and pays for coverage under the Portability of Coverage Provision or the Conversion option. Coverage may not be continued simultaneously under these options. (See the following sections on Portability and Conversion for more information. Additionally in the previous "What are Dependent Group Life Insurance Benefits" section contains information on "Provision of Continuation of Coverage for Survivors of Deceased Employees".)

Upon loss of coverage, Life Insurance and SIB benefits remains payable during the 31 days following loss of coverage, during which time you are eligible to convert the loss of coverage to an individual policy.

In the event of your death, Dependent Group Life and Optional Accident Insurance may be continued. Coverage will end automatically on the earliest of the following:

- On the date your dependent ceases to be an "eligible dependent"
- On the date your surviving spouse remarries
- On the date your qualified same sex domestic partner marries or enters into a new qualified same sex domestic partner relationship
- On the date of discontinuance of Insurance under the Group Life and Disability Program
- For Optional Accident, after twelve (12) months following the date of your death

Conversion Privilege

If you or your dependents are no longer eligible for coverage, you can convert Life, Survivor Income Benefit, Optional Life and Dependent Life within 31 days of the time coverage ends, to any individual Life Insurance policy then customarily issued by the insurer, except for term insurance. This is done by making application and paying the required premium to the insurer. The maximum amount of the individual policy will be equal to the amount of your Life Insurance in force when you left the Company, including Survivor Income Benefits.

Accidental Death and Dismemberment and Optional Accident are not convertible to an individual policy.

Portability of Coverage Provision

Effective November 19, 2007, an employee, spouse, qualified same sex domestic partner or child who loses coverage under the Optional Group Life or Dependent Group Life Insurance program may elect Life Insurance under the Insurance Portability Provision without providing Evidence of Insurability. To be eligible for portability coverage, a written application must be submitted to the insurer and payment of the first premium made within 31 days after their insurance under the Optional Group Life or Dependent Group Life Insurance program ends.

Benefits for a child insured under Portability provision may be provided by only one parent, not both.

The amount of insurance ported under this provision may not exceed the amount of coverage in effect when coverage under the Optional Group Life or Dependent Group Life Insurance program ended; however, coverage may be for a lesser amount. The amount of insurance under this provision, once elected, may not be increased. Premium rates for portability are age banded and will increase with age, and are set by the insurer. Insurance under the Portability provision will end on the earliest of:

- (a) Employee, Surviving Spouse/Qualified Same Sex Domestic Partner reaches the age limit as specified in the insurance policy
- (b) Failure to pay an applicable premium when due
- (c) Insured receives reinstated coverage under the Optional Group Life or Dependent Group Life Insurance Program
- (d) Insured enters the Armed Forces, National Guard, or Reserves of any state or country on active duty (except for temporary active duty of two weeks or less) if the insurance policy includes this provision
- (e) Child no longer meets the definition of dependent.

What other circumstances might affect benefits?

This section of your handbook has summarized your Life and Disability Insurance Program coverages. Additional circumstances, however, might affect your benefits.

Accident or disability

It is important to remember these things about disability coverage for an accident or sickness:

- The Program covers most disabilities from illness or injury as long as you remain under a physician's care
- If you have two separate or unrelated disabilities not separated by a return to work, you may receive benefits for the second period of disability, as long as you meet certain requirements
- If you are receiving disability benefits from other sources, including Social Security, it's your obligation to let the claims processor know
- If your disability ends, payments stop

Assigning your benefits

You and your beneficiary may assign the death benefit under your Life Insurance, Accidental Death and Dismemberment Insurance and Optional Group Life Insurance by making your assignment in writing with the insurer. Neither you nor your survivors may assign your Survivor Income Benefits, Dependent Group Life Insurance, Optional Accident Insurance, Safety Belt User Benefits, Accident and Sickness Benefits or Extended Disability Benefits.

Certain court orders relating to domestic relations matters could require that your benefits (or a part of your benefits) be paid to someone else—your former spouse, qualified same sex domestic partner or children, for example. This could apply to benefits paid to you as well as to any beneficiary. If the insurer or claims processor determines that the court order qualifies, payments will be made according to the order. As soon as you are aware of any court proceedings which may affect your Life and Disability Insurance Program benefits, contact the National Employee Services Center at 1-800-248-4444.

Attachment of Survivor Income Benefits

To the extent permitted by applicable law, Survivor Income Benefits are not subject to attachment or other encumbrance or subject to the debts or liability of any survivor.

Filing claims

No benefits can be paid until you or your beneficiary files a claim. If you have questions, contact the National Employee Services Center at 1-800-248-4444.

If a disability benefit is overpaid

If a disability benefit is overpaid for any reason, you will receive a written notice that you should repay that amount directly to the claims processor.

If you do not pay that amount promptly, the claims processor has the right to deduct the overpaid amount from future benefit payments. At the claims processor's request, the Company may deduct the overpaid amount from your future paychecks. However, repayment of overpayments caused solely by Company or insurer error is only required if notice is given within one year from the date an overpayment is established.

If you or your beneficiary are incompetent

If you or your beneficiary are incompetent or otherwise incapable of giving a valid release, the insurer or claims processor may withhold payment until a guardian is appointed. In the case of weekly or monthly benefits, payment may be made to any relative by blood or marriage or to any other individual or institution appearing to the insurer or claims processor to have assumed custody of the person. The liability of the insurer or claims processor shall be fully discharged to the extent of such payment.

Summary of Administrative Information

Name:	Plan Number:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Group Life and Disability Insurance Program					
Life Insurance Accidental Death and Dismemberment Insurance, Safety Belt and Survivor Income Benefits	521	Welfare plan providing Life Insurance	The Company pays premiums to the insurer in amounts reflecting the number and amount of claims paid	None	Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt and Survivor Income Benefits are provided by: Group Policy 17-GCC UNICARE Life and Health Insurance Company P.O. Box 2090 Dearborn, Michigan 48123-2090 (313) 336-5550 1-800-843-8184
Accident and Sickness Benefits and Extended Disability Benefits	521	Welfare plan providing disability benefits	Benefits are paid by the Company either directly or through a trust fund established by the Company. If you live in New York or New Jersey, benefits are paid by a insurer.	Comerica Bank 411 West Lafayette Detroit, Michigan 48226 (313) 222-4000 or 1-800-521-1190 (outside Michigan)	Except for employees in New York and New Jersey, Accident and Sickness and Extended Disability Benefits are paid by Ford Motor Company either directly or through a trust fund. Claims are reviewed and approved or provided by: UNICARE Life and Health Insurance Company Dearborn Service Center P.O. Box 4479 Dearborn, Michigan 48126 1-800-572-1581 For employees in New York and New Jersey, benefits are insured by UNICARE (and administered by UNICARE Life and Health Insurance Company) (Group Policy 17-GCC)
Optional Group Life Insurance Plan	521	Welfare plan offering Life Insurance	Participating Employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215
Dependent Group Life Insurance Plan	521	Welfare plan offering Life Insurance for your dependents	Participating Employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215

Summary of Administrative Information

Name:	Plan Number:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Group Life and Disability Insurance Program					
Optional Accidental Insurance Plan	521	Welfare plan offering accident insurance for you and your dependents	Participating Employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215

NOTES

Retirement Plan

After an overview of your benefits from the Retirement Plan, this section of your handbook answers these questions:

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RETIREMENT PLAN

An overview of the Plan

The Ford-UAW Plan provides you with monthly income during your retirement years.

The Plan pays monthly benefits as long as you have at least 5 years of credited service or Employee Retirement Income Security Act (ERISA) service.

You must apply for benefits before any payments from the Plan can begin. To apply, you must contact the NESC at 1-800-248-4444 to obtain an application form 30 to 180 days before you wish benefits to commence. Forms must be signed and dated prior to the retirement effective date and returned to the NESC on a timely basis. Applications signed after the effective date may be made effective the month following signature and may result in a loss of benefits. If you need any information about the Plan, you can call the NESC.

There are four types of retirement under the Plan:

- Normal Retirement
- Regular Early Retirement
- Special Early Retirement
- Disability Retirement

There are different eligibility requirements for each type of retirement.

The Plan also includes provisions under which you may be paid a:

- Temporary Benefit
- Supplemental Allowance

In addition to benefits provided for your retirement years, benefits may be payable to your spouse if you die, as long as you have completed 5 years of Plan service or ERISA Service (10 years if you don't accrue service after 1988).

If you leave the Company before you are eligible to retire and you have completed at least 5 years of Plan service or ERISA Service (10 years if you don't accrue service after 1988), you are eligible for deferred vested benefits.

Effective October 1, 2007, if you have an overpayment balance under the Group Life and Disability Insurance Program, any rate increase and/or lump sum payment paid to you will be reduced by 50% until your Group Life and Disability Insurance Program overpayment equals zero.

What are participation requirements under the Plan?

If you are an hourly employee covered by the Ford-UAW Agreement, you are eligible to participate in the Plan.

You automatically participate in the Plan if you are:

- An hourly Ford employee
- Represented by the UAW under the Collective Bargaining Agreement which became effective November 19, 2007
- If you hire on or after November 19, 2007 under specific job classifications, you are eligible for the Cash-Balance part of this plan, which will be described in more detail in a separate communication

Your participation begins on your hire date. The Company pays the full cost of benefits provided under the Plan.

You do not have any rights to receive benefits under the Plan until you are eligible to retire or you are entitled to receive deferred vested benefits. "Deferred" means your benefits are payable at a later date—in this case, on or after age 55. "Vested" means you've earned a right to receive benefits from the Plan.

What are service credits?

Your service credits are credits used in determining your eligibility for benefits and the benefit amount.

Service credits are used in determining your eligibility and benefit amount. Once the hours for which you received pay in a calendar year are counted, you then are given a full or partial year of credited service under the Plan, based on the table shown below:

Service Credits	
If your hours in a calendar year are:	Your credited service is:
1,615 or more hours	1.0 year
1,445 but less than 1,615 hours	0.9 year
1,275 but less than 1,445 hours	0.8 year
1,105 but less than 1,275 hours	0.7 year
935 but less than 1,105 hours	0.6 year
765 but less than 935 hours	0.5 year
595 but less than 765 hours	0.4 year
425 but less than 595 hours	0.3 year
255 but less than 425 hours	0.2 year
85 but less than 255 hours	0.1 year
Less than 85 hours	None

You earn credited service after March 1, 1950 based on hours for which you receive pay from the Company. An hour for which a premium is paid is counted as only one hour. If you have Company service for employment before March 1, 1950 and were actively employed after that date, you may receive credit for this prior service. If you are affected, the NESCS can provide more information for you. For the period of your service before 1966, your credited service will not be less than your seniority as of December 31, 1965, excluding seniority for military service before Company employment.

You cannot accrue credited service after you have a break in seniority (described later in this section), unless you later reestablish seniority.

You also earn credited service during layoff between January 1, 1951 and January 1, 1968 as well as layoff between January 1, 1974 and January 1, 1990, depending on your seniority on specific dates, if you apply for credited service before your retirement, as shown on the following table:

If you were absent because of layoff in the following calendar years:	And you had at least 5 years seniority as of:
1951-1955	11/19/73
1956-1962	1/1/71
1963-1967	10/1/79
1974-1976	10/1/93
1976-1979	10/1/03
1979-1983	10/1/84 or 10/1/99
1984-1985	10/1/96
1986-1989	10/1/03

You can receive credit for 40 hours for each complete calendar week of layoff multiplied by the applicable percentage shown below:

Seniority on the above dates:	Percent:
20 years or more	100%
15 years but less than 20 years	75%
10 years but less than 15 years	50%
5 years but less than 10 years	25%

If you retire October 1, 2007 or later, your credited service for the period before January 1, 1996 will not be less than your seniority as of December 31, 1995.

You can earn credited service during certain periods when you are not receiving pay from the Company if a break in seniority has not occurred.

- Layoff or Company-approved sick leave if you received pay for at least 170 hours during the year your absence occurred (for years after 1967)
- Layoff or Company-approved sick leave in a second calendar year if your absence continues into a second year and you received pay for at least 170 hours during the year in which your absence began (for years after 1969):
 - ◇ you may receive credit for 40 hours of service per week up to a maximum of 1,530 hours during any single, continuous absence due to layoff or Company-approved sick leave
 - ◇ in addition, you may receive credit during your continuing absence due to layoff (but not Company-approved sick leave) beginning on or after March 1, 1982 up to a maximum of 1,700 hours if you:
 - are at work on or after March 1, 1982
 - have 10 or more years of seniority at the time of layoff and
 - have received service credit of 1,530 hours due to your absence
- Approved Union, credit union or military leave
- Approved pregnancy sick leave between March 1, 1950 and January 1, 1968 (up to a maximum of 0.3 year of credited service during each period of absence), if you apply for it before your retirement, and
- Approved sick leave while receiving Workers' Compensation (if Workers' Compensation benefits are terminated because of a state law that automatically terminates benefits after a certain length of time, or because an employee reaches a maximum medical improvement level, credited service can continue as long as the compensable disability continues)
- Approved leave for up to 8 years to occupy public office at the State or Federal level.
 - ◇ STATE: Governor, Lt. Governor, Attorney General, Auditor, Treasurer, Secretary of State or Legislator.
 - ◇ FEDERAL: President, Vice President or Member of Congress.

Other conditions for which you may receive service credits

Special credited service rules apply if you:

- Have prior service outside the Contract Unit
- Were employed by a foreign subsidiary of the Company
- Were employed on certain job classifications at a Company grey iron foundry
- Were employed in certain departments within the Coke Ovens Operations or Ingot Mold Foundry

If any of these conditions apply to you, you may contact the NESC for information on how your service is counted.

Break in seniority

If you terminate employment in a way that constitutes a break in seniority under the 2007 Collective Bargaining Agreement, you will stop accumulating service even though you might have been accruing it until then and your benefit rate will freeze.

If you have a break in seniority on or after March 1, 1950 and return to work for the Company and regain seniority, all the credited service you had earned before you left the Company will be restored.

If you had a break in seniority before March 1, 1950, the NESC can help you determine whether you may receive service credit for the period before your break.

You may not earn more than 1.0 year of credited service for any calendar year.

What determines your Retirement benefit?

The amount of your monthly Retirement benefit is based on the Benefit Class Code of your job classification, the type of retirement, your retirement date and your credited service.

Your Benefit Class Code is determined by the base hourly rate of the classification you have held for the longest period of time during the 24 months immediately before your last day worked.

There are four Benefit Class Codes. Each job classification is assigned a Benefit Class Code determined by the base hourly rate of the classification, as shown below:

For Job Classifications as of 10/1 /07 with a Maximum Base Hourly Rate of:				
The Benefit Class Code is:	10/1/2007 through 9/30/2008	10/1/2008 through 9/30/2009	10/1/2009 through 9/30//2010	10/1/2010 and after
A	\$28.155 or less	\$28.155 or less	\$28.155 or less	\$28.155 or less
B	\$28.160-\$28.440	\$28.160-\$28.440	\$28.160-\$28.440	\$28.160-\$28.440
C	\$28.445-\$29.630	\$28.445-\$29.630	\$28.445-\$29.630	\$28.445-\$29.630
D	\$29.635 and over	\$29.635 and over	\$29.635 and over	\$29.635 and over

If your job is covered under an incentive job classification, your incentive earnings are included in determining your Benefit Class Code.

Your Benefit Class Code may change because of:

- A promotion
- A transfer
- An increase in the maximum base hourly rate of your job classification

How is your Life Income Benefit calculated?

Your Life Income Benefit is calculated under a formula described here.

Your Life Income Benefit is calculated as follows:

Your Life Income Benefit rate
multiplied by
your years of credited service

Your Life Income Benefit rate is a key factor in determining the amount of your retirement benefit from the Plan, regardless of the type of your retirement.

Once you've determined your Benefit Class Code and the date of your retirement, you can find your Life Income Benefit rate on the table below. The table shows the Life Income Benefit rate initially payable at retirement, as well as the increases occurring during the term of the Agreement.

Your Life Income Benefit Rates for the Following Months Are Shown Here:					
If Your Retirement Date is	And Your Benefit Class Code is:	10/1/07 through 9/1/08	10/1/08 through 9/1/09	10/1/09 through 9/1/10	10/1/10 and After
10/1/07 and later	A	\$52.90	\$53.10	\$53.30	\$53.55
	B	\$53.15	\$53.35	\$53.55	\$53.80
	C	\$53.40	\$53.60	\$53.80	\$54.05
	D	\$53.65	\$53.85	\$54.05	\$54.30

For example

Suppose you are retiring as of January 1, 2008, are age 65 and not married, with 30 years of credited service. Let's also assume the base hourly rate of your job classification at this time is \$28.16.

By looking at the table shown earlier in the section on Benefit Class Codes, you determine that your Benefit Class Code is B.

You then must determine your Life Income Benefit rate. According to the table, your Life Income Benefit rate is \$53.15 as of January 1, 2008.

Your Life Income Benefit from January 1, 2008 through September 1, 2008 is:

$$\$53.15 \text{ times } 30 \text{ years} = \$1,594.50$$

Your Life Income Benefit from October 1, 2008 through September 1, 2009 is:

$$\begin{aligned} & \$53.35 \text{ multiplied by} \\ & 30 \text{ years} = \$1,600.50 \end{aligned}$$

Your Life Income Benefit from October 1, 2009 through September 1, 2010 is:

$$\begin{aligned} & \$53.55 \text{ multiplied by} \\ & 30 \text{ years} = \$1,606.50 \end{aligned}$$

Your Life Income Benefit from October 1, 2010 and later is:

$$\begin{aligned} & \$53.80 \text{ multiplied by} \\ & 30 \text{ years} = \$1,614.00 \end{aligned}$$

What are the four types of Retirement?

The four types of retirement are: Normal, Regular Early, Special Early and Disability Retirement.

There are four types of retirement under the Plan generally applicable to employees who have not broken seniority: Normal Retirement, Regular Early Retirement, Special Early Retirement and Disability Retirement.

Here's a short summary of the eligibility requirements for each type of retirement. The following pages describe each type of retirement in more detail:

Type of Retirement:	Eligibility Requirements:
Normal Retirement	<ul style="list-style-type: none"> Age 65 or older with at least one year of credited service*
Regular Early Retirement	<ul style="list-style-type: none"> Age 55 but less than age 65 with at least 10 years credited service Any age with at least 30 years credited service
Special Early Retirement	<ul style="list-style-type: none"> Age 55 but less than age 65 with at least 10 years credited service and retire under mutually satisfactory conditions Age 50 with at least 10 years credited service and laid off due to certain plant closings. (The date of the layoff and the plant closing both must occur after 10/1/84.)
Disability Retirement	<ul style="list-style-type: none"> Under age 65 At least 10 years of credited service and Totally and permanently disabled for at least 5 months

Generally, although you may otherwise be eligible to retire, your retirement will be deferred if you receive:

- A separation payment under the Voluntary Termination of Employment Program after the end of the allocation period
- A separation payment under the Supplemental Unemployment Benefit Plan
- A GIS Redemption Payment under the Guaranteed Income Stream Benefit Program

Please consult the specific plans described in other sections of this handbook or the 2007 Collective Bargaining Agreement for the periods of time retirement must be deferred.

If you are not eligible for retirement, you may be eligible for deferred vested benefits. Deferred vested benefits are described later in this section.

* *Presently, you must have 10 years of credited service to be eligible for company sponsored post-retirement healthcare and life insurance. Based upon the 2007 Collective Bargaining Agreement, employees with a Ford Service Date prior to November 19, 2007 who meet the eligibility requirements will be provided post-retirement healthcare through a new Voluntary Employee Beneficiary Association (VEBA).*

What is Normal Retirement?

Normal Retirement is a benefit you are eligible to receive at age 65 and after.

Eligibility

You are eligible for Normal Retirement at age 65 if you have seniority and at least one year of credited service. If you are eligible for benefits under the Guaranteed Income Stream (GIS) Benefit Program, you may retain your eligibility for Normal Retirement even though you have incurred a break in seniority.

Your normal retirement date will be the first day of the month after you have reached age 65 and apply for retirement.

If you do not retire when you have reached age 65, you may retire on the first day of any month thereafter by applying for normal retirement.

If you do not apply for normal retirement upon reaching age 65, you will be sent a notice advising that the Plan has suspended your normal retirement benefits as a result of your continued employment. This notice is a U.S. Department of Labor requirement under 29 Code of Federal Regulations Section 2530.203-3. You need not take action nor reply to this communication. Your benefits will continue to be administered under the terms of the Plan as explained in this summary. If you reach age 70½ in 1999 or later, you will have your distribution deferred until retirement. Deferral of your age 70½ distribution will result in an actuarial adjustment when your benefit is paid.

Benefit amount

Your benefits at Normal Retirement may be made up of a Life Income Benefit and a Special Age 65 Benefit. The Special Age 65 Benefit is described later in the “What is the Special Age 65 Benefit?” section.

Survivorship coverage and the related payment methods are described in the “What are your survivorship coverage options?” in this section.

Your Life Income Benefit

Your Life Income Benefit amount is determined using the formula shown in the “How is your Life Income Benefit calculated?” section.

If you return to work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit and Special Age 65 Benefit. You will not, however, earn additional service credits during your reemployment.

An example of monthly normal retirement benefits

Your monthly retirement benefit would be calculated as follows if:

- You are married and retire at age 65 on April 1, 2008 with 30 years of credited service
- Your Benefit Class Code is B
- Your spouse is three years younger than you

At Retirement	
Life Income Benefit	\$1,514.77 ❶
Special Age 65 Benefit	\$ 76.20 ❷
Your Benefit	\$1,590.97
Survivor Benefit	\$ 984.60 ❸

❶ \$53.15 (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,594.50 (\$53.15 x 30) without the Survivorship Coverage.

❷ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or \$76.20. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)

❸ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

What is Regular Early Retirement?

If you meet the eligibility requirements, you can retire before age 65 and receive a Regular Early Retirement benefit under the Plan.

Eligibility

You are eligible for Regular Early Retirement if you:

- Retire between age 55 and 65 and have at least 10 years of credited service
- Retire at any age and have 30 or more years of credited service
- Have seniority when you first meet the age and service requirements

If you are eligible for benefits under the Guaranteed Income Stream (GIS) Benefit Program at age 62 or later, you may retain your eligibility for Regular Early Retirement even though you have incurred a break in seniority.

Benefit amount

Your benefits at Regular Early Retirement may be made up of a Life Income Benefit, a Supplemental Allowance and a Special Age 65 Benefit. The Special Age 65 Benefit is described later in the “What is the Special Age 65 Benefit?” section.

Survivorship coverage and the related payment methods are described in the “What are your survivorship coverage options?” section.

Your Life Income Benefit

Your Life Income Benefit is determined using the formula shown in the “How is your Life Income Benefit calculated?” section. If, however, you are under age 62 when you retire, your benefit will be reduced based on your age when your benefit begins:

Early Retirement Benefit Reduction

Age When Benefit Begins	Percentage of Life Income Benefit Payable	Age When Benefit Begins	Percentage of Life Income Benefit Payable
62 or over	100.0%	51	41.5%
61	93.3%	50	38.3%
60	86.7%	49	35.4%
59	80.8%	48	32.8%
58	75.2%	47	30.4%
57	69.4%	46	28.2%
56	63.5%	45	26.1%
55	57.9%	44	24.3%
54	53.2%	43	22.6%
53	48.9%	42	21.0%
52	45.0%		

If you retire between the ages shown, the percentage of the Life Income Benefit payable will be prorated based on whole months.

To illustrate, if you are not married and are under age 62 when you retire, your Life Income Benefit is calculated as follows:

Your Life Income Benefit rate
multiplied by
your years of credited service
multiplied by
the percentage of your Life Income Benefit payable

Your reduced Life Income Benefit may be restored

If you are not married and retire before age 62, your full Life Income Benefit will be payable beginning at age 62 and one month if at retirement:

- You have at least 30 years of credited service
- Your age and years of credited service added together total at least 85

Supplemental Allowance

You also may receive a Supplemental Allowance until age 62 and one month* if you apply for retirement benefits within five years of the last day you worked for the Company.

There are two types of Supplemental Allowance payable under the Plan—the early retirement supplement (better known as “30 and out”) and the interim supplement. Each supplement type has its own set of eligibility requirements in addition to the general requirements described.

In any case, if you retire and then are reemployed by the Company, your Supplemental Allowance stops during your reemployment.

If you have at least 30 years of credited service, you are eligible to receive an early retirement supplement.

Your early retirement supplement is the amount which, when added to your Life Income Benefit (unreduced for survivorship) and Temporary Benefit (if applicable), will bring your total benefit payable under the Plan up to the amount listed in the table that follows.

Your Total Monthly Benefit Payable (Until Age 62 and One Month*) Under the Plan for the Following Months is shown here:

If Your Retirement Date is	10/1/07 Through 9/1/08	10/1/08 Through 9/1/09	10/1/09 Through 9/1/10	10/1/10 and After
10/1/07 and after	\$3,140	\$3,150	\$3,160	\$3,170

Your early retirement supplement begins when you retire and continues through the month following your 62nd birthday*.

If you are receiving the early retirement supplement and you become eligible to receive a Social Security disability benefit or any other unreduced Social Security benefit, you must contact the Retirement Board office and advise them of the award. The Social Security award reduces your early retirement supplement by the amount of the Temporary Benefit that would have been payable to you if you had retired as a disability retiree under the Plan.

If you have less than 30 years of credited service, you are eligible to receive an interim supplement.

The amount of your interim supplement is:

$$\begin{matrix} \text{Your years of credited service} \\ \text{multiplied by} \\ \text{your interim supplement rate} \end{matrix}$$

Your interim supplement rate depends on your age when you retire. The following table shows the interim supplement rate payable at retirement, as well as the increases occurring during the term of the 2007 Agreement:

Monthly interim supplement rate for Retirements effective 10/1/07 and later				
If You Retire at age	10/1/07 Through 9/1/08	10/1/08 Through 9/1/09	10/1/09 Through 9/1/10	10/1/10 and After
55	\$22.35	\$22.45	\$22.55	\$22.60
56	\$26.35	\$26.50	\$26.60	\$26.70
57	\$31.90	\$32.00	\$32.15	\$32.25
58	\$37.35	\$37.50	\$37.65	\$37.80
59	\$41.65	\$41.85	\$42.00	\$42.20
60-61	\$48.25	\$48.45	\$48.65	\$48.85

If you retire between the ages shown in the table, your interim supplement rate will be prorated based on whole months.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

Your interim supplement begins at retirement and continues through the month following your 62nd birthday*. If you become eligible to receive a Social Security disability benefit or other Social Security benefit not reduced because of your age, you must notify the Retirement Board to stop the interim supplement.

It's important to remember that, even though you may become disabled after you've retired and received payments from the Plan, you cannot switch from Regular Early Retirement to Disability Retirement.

Discharged Employees

A discharged employee under age 62 at the time of discharge is not eligible to receive a Supplemental Allowance.

Maximum monthly benefit

If you retire before you attain age 62 and one month, your total monthly benefit (your Life Income Benefit and any Supplemental Allowance) may not exceed 80% of your monthly base earnings. If your total benefit otherwise would exceed the 80% ceiling, your Supplemental Allowance (but not your Life Income Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to 80% of your monthly base earnings.

Your monthly base earnings equal $173\frac{1}{3}$ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked, plus the cost-of-living allowance in effect on your last day worked.

If you return to work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit and Special Age 65 Benefit (if any). You will not, however, receive a Supplemental Allowance or earn additional service credits during your reemployment.

An example of monthly Regular Early Retirement benefits payable before age 62 with less than 30 years of credited service

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 60 on April 1, 2008 with 24 years of credited service
- Your Benefit Class Code is B and
- Your spouse is three years younger than you.

	At Retirement	At Age 62*	At Age 65
Life Income Benefit	\$1,050.65 ^①	\$1,058.55 ^②	\$1,063.50 ^③
Interim Supplement	\$1,158.00 ^④	—	—
Special Age 65 Benefit	—	—	\$ 76.20 ^⑤
Your Benefit	\$2,208.65	\$1,058.55	\$1,139.70
Survivor Benefit	\$ 682.92 ^⑥	\$ 688.06 ^⑥	\$ 691.27 ^⑥

① \$53.15 (Life Income Benefit rate) x 24 (years of credited service) x 86.7% (early retirement factor) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,105.94 (\$53.15 x 24 x 86.7%) without the Survivorship Coverage.

② \$48.25 (interim supplement rate for retirement at age 60) x 24 (years of credited service).

③ \$53.55 (Life Income Benefit rate) x 24 (years of credited service) x 86.7% (early retirement factor) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,114.27 (\$53.55 x 24 x 86.7%) without the Survivorship Coverage.

④ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or \$76.20. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)

⑤ Equals 65% of the Life Income Benefit amount after applying the early retirement factor and the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

⑥ \$53.80 (Life Income Benefit rate) x 24 (years of credited service) x 86.7% (early retirement factor) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,119.47 (\$53.80 x 24 x 86.7%) without the Survivorship Coverage.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

An example of monthly Regular Early Retirement benefits payable before age 62 with 30 or more years of credited service

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 60 on April 1, 2008 with 30 years of credited service
- Your Benefit Class Code is B
- Your spouse is three years younger than you

	At Retirement	At Age 62*	At Age 65
Life Income Benefit	\$1,302.71 ^①	\$1,526.17 ^②	\$1,533.30 ^③
Early Retirement Supplement	\$1,757.57 ^④	—	—
Special Age 65 Benefit	—	—	\$ 76.20 ^⑤
Your Benefit	\$3,060.28	\$1,526.17	\$1,609.50
Survivor Benefit	\$ 984.60 ^⑥	\$ 992.01 ^⑥	\$ 996.64 ^⑥

- ① $\$53.15$ (Life Income Benefit rate) x 30 (years of credited service) x 86.7% (early retirement factor) minus $\$79.72$ ($\$53.15 \times 30 \times 5\%$) (amount of Survivorship Coverage adjustment based on the unreduced benefit that would be payable if then age 62). The benefit amount would be $\$1,382.43$ ($\$53.15 \times 30 \times 86.7\%$) without the Survivorship Coverage.
- ② $\$53.55$ (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,606.50$ ($\$53.55 \times 30$) without the Survivorship Coverage.
- ③ $\$3,140.00$ (scheduled total benefit amount before age 62) minus $\$1,382.43$ (Life Income Benefit before Survivorship Coverage adjustment) = $\$1,757.57$ Early Retirement Supplement.
- ④ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or $\$76.20$. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)
- ⑤ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment that was or would have been payable at age 62 or death. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.
- ⑥ $\$53.80$ (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,614.00$ ($\$53.80 \times 30$) without the Survivorship Coverage.

An example of monthly Regular Early Retirement benefits payable after age 62

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 62 and one month* on April 1, 2008 with 30 years of credited service
- Your Benefit Class Code is B
- Your spouse is three years younger than you

	At Retirement	At SSA 80% Date	At Age 65
Life Income Benefit	\$1,514.78 ^①	\$1,520.47 ^②	\$1,533.30 ^③
Early Retirement Supplement	\$1,545.50 ^④	—	—
Special Age 65 Benefit	—	—	\$ 76.20 ^⑤
Your Benefit	\$3,060.28	\$1,520.47	\$1,609.50
Survivor Benefit	\$ 984.60 ^⑥	\$ 988.31 ^⑥	\$ 996.64 ^⑥

- ① $\$53.15$ (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,594.50$ ($\$53.15 \times 30$) without the Survivorship Coverage.
- ② $\$53.35$ (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,600.50$ ($\$53.35 \times 30$) without the Survivorship Coverage.
- ③ On the date you are eligible to receive 80% of your full Social Security benefit, your Early Retirement Supplement will be discontinued.
- ④ $\$53.80$ (Life Income Benefit rate) x 30 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,614.00$ without the Survivorship Coverage.
- ⑤ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or $\$76.20$. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)
- ⑥ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49

What is Special Early Retirement?

Special Early Retirement is a benefit paid if you retire under certain circumstances with 10 years of credited service.

Eligibility

You are eligible to receive Special Early Retirement benefits if you:

- Retire when you are between age 55 and 65 and have at least 10 years of credited service
- Retire under mutually satisfactory conditions
- Have seniority immediately before retirement
- Have been laid off due to a plant closing or discontinuance of operations

Beginning October 1, 1984 you also are eligible for Special Early Retirement if you:

- Retire when you are at least age 50 and have at least 10 years of credited service
- Have been laid off because of a plant closing and no other plants are in the same labor market as defined under preferential placement, or beginning October 1, 1987, as defined by the State Employment Security Commission in the state where the plant is located. (Under this provision, the date of the layoff and plant closing both must occur on or after October 1, 1984.)

Benefit amount

Your benefits at Special Early Retirement may be made up of a Life Income Benefit, a Temporary Benefit, a Supplemental Allowance and a Special Age 65 Benefit. The Special Age 65 Benefit is described later in the "What is the Special Age 65 Benefit?" section.

Survivorship coverage and related payment methods are described in the "What are your survivorship coverage options?" section.

Your Life Income Benefit

Your Life Income Benefit is determined using the formula shown in the "How is your Life Income Benefit calculated?" section. There is no reduction in benefits because of age.

Temporary Benefit

A Temporary Benefit also is payable at Special Early Retirement. This benefit begins when you retire and continues through the month following your 62nd birthday*. However, if you become eligible to receive a Social Security disability benefit or other Social Security benefit not reduced because of your age, you must notify the Retirement Board to stop the Temporary Benefit.

Your Temporary Benefit is based on this formula:

Your Temporary Benefit rate
multiplied by
your years of credited service
(up to 30 years)

Your monthly Temporary Benefit rate is based on the date you retire, as shown here, and does not increase during the term of the contract.

If your Retirement date is:	Your Temporary Benefit Rate is:	Your Maximum Monthly Temporary Benefit is:
10/1/07 through 9/1/08	\$50.80	\$1,524.00
10/1/08 through 9/1/09	\$51.00	\$1,530.00
10/1/09 through 9/1/10	\$51.20	\$1,536.00
10/1/10 and later	\$51.40	\$1,542.00

Supplemental Allowance

You also may receive an early retirement supplement if you have at least 30 years of credited service and if your unreduced Life Income Benefit combined with your Temporary Benefit does not exceed the applicable 30-and-out benefit.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

Maximum monthly benefit

If you retire before you have reached age 62 and one month,* your total monthly benefit (Life Income Benefit and any Temporary Benefit, whether payable or not, and Supplemental Allowance) may not exceed 80% of your monthly base earnings.

If your total benefit otherwise would exceed the 80% ceiling, only your Supplemental Allowance (but not your Life Income Benefit or your Temporary Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to 80% of your monthly base earnings.

Your monthly base earnings equal $173\frac{1}{3}$ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked plus the cost-of-living allowance in effect on your last day worked.

If you return to work

If you return to work for the Company after you retire, you will continue to receive your Life Income Benefit, Temporary Benefit and Special Age 65 Benefit (if any). You will not, however, receive a Supplemental Allowance or earn additional service credits during your reemployment.

An example of monthly Special Early Retirement benefits payable before age 62 with less than 30 years of credited service

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 60 on April 1, 2008 with 25 years of credited service
- Your Benefit Class Code is B
- Your spouse is three years younger than you

	At Retirement	At Age 62*	At Age 65
Life Income Benefit	\$1,262.31 ^①	\$1,271.81 ^③	\$1,277.75 ^③
Temporary Benefit	\$1,270.00 ^②	—	—
Special Age 65 Benefit	—	—	\$76.20 ^④
Your Benefit	\$2,532.31	\$1,271.81	\$1,353.95
Survivor Benefit	\$820.50 ^⑤	\$826.68 ^⑥	\$830.54 ^⑥

- ① $\$53.15$ (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,328.75$ ($\$53.15 \times 25$) without the Survivorship Coverage.
- ② $\$50.80$ (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you attain age 62, whichever is earlier*.
- ③ $\$53.55$ (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,338.75$ ($\$53.55 \times 25$) without the Survivorship Coverage.
- ④ $\$53.80$ (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be $\$1,345.00$ ($\$53.80 \times 25$) without the Survivorship Coverage.
- ⑤ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or $\$76.20$. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)
- ⑥ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

What is Disability Retirement?

A Disability Retirement is a benefit that you may be eligible for if you have 10 years of credited service and become totally and permanently disabled.

Eligibility

You are eligible to receive Disability Retirement benefits if you have seniority when you meet the following requirements:

- Are under age 65
- Have at least 10 years of credited service
- Have been totally and permanently disabled for at least five months

Under special circumstances, your surviving spouse may be eligible for the survivor's benefit if you have applied for disability retirement but do not live for the five months normally required for disability retirement. (For additional requirements, see the survivorship section.)

If you are eligible for benefits under the Guaranteed Income Stream (GIS) Benefit Program, you may retain your eligibility for Disability Retirement even though you have incurred a break in seniority.

Definition of disability

You are considered totally and permanently disabled under the Plan if the Retirement Board determines that:

- You have an injury or disease that prevents you from engaging in any regular occupation or employment with the Company at the plant or plants where you have seniority
- You are not engaged in any regular occupation or employment for pay or profit (unless for purposes of rehabilitation)
- Your disability is considered to be permanent and continuous for your lifetime

You will be required to have a medical exam to prove your initial disability. Other medical exams may be required from time to time to prove your continuing disability.

Incapacity resulting from service in the armed forces of any country is not covered by the Plan unless you accumulate at least five years of seniority after separation from military service and before incapacity occurs.

You will not receive a disability retirement benefit in any month you are receiving weekly Accident and Sickness benefits for the entire month under any plan to which the Company has contributed. If you are receiving Accident and Sickness benefits for part of the month, you will be paid a proportionate amount of your Disability Retirement benefit.

Benefit Amount

Your benefits at Disability Retirement may be made up of a Life Income Benefit, a Temporary Benefit, a Supplemental Allowance and a Special Age 65 Benefit. The Special Age 65 Benefit is described later in the "What is the Special Age 65 Benefit?" section.

Survivorship options and related payment methods are described in the "What are your survivorship options?" section.

Your Life Income Benefit

Your Life Income Benefit is determined using the formula shown in the "How is your Life Income Benefit calculated?" section. There is no reduction in benefits because of age.

Temporary Benefit

A Temporary Benefit is payable at Disability Retirement only if you provide evidence that you have applied for Social Security disability benefits and your application was denied.

This benefit begins when you retire and continues through the month following your 62nd birthday,* If you become eligible to receive a Social Security disability benefit or other Social Security benefit not reduced because of your age, your Temporary Benefit stops.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

Your Temporary Benefit is based on this formula:

Your Temporary Benefit rate
multiplied by
your years of credited service
(up to 30 years)

Your monthly Temporary Benefit rate is based on the date you retire, as shown in this table, and does not increase during the term of the contract.

If your Retirement date is:	Your Temporary Benefit Rate is:	Your Maximum Monthly Temporary Benefit is:
10/1/07 through 9/1/08	\$50.80	\$1,524.00
10/1/08 through 9/1/09	\$51.00	\$1,530.00
10/1/09 through 9/1/10	\$51.20	\$1,536.00
10/1/10 and later	\$51.40	\$1,542.00

Supplemental Allowance

You also may receive an early retirement supplement if you have at least 30 years of credited service and if your unreduced Life Income Benefit combined with your Temporary Benefit does not equal the applicable 30-and-out benefit. The Plan assumes you receive a Temporary Benefit even if no Temporary Benefit is payable because you are eligible for Social Security disability benefits.

Any Supplemental Allowance or Temporary Benefit you receive after you become eligible for a Social Security disability benefit or other Social Security benefit not reduced because of your age will be recovered from your future Life Income Benefit. If you notify the Retirement Board within 15 days after your receipt of a retroactive Social Security disability award, the amount of overpayment of any temporary benefit or supplement for the earlier period will be reduced by the attorney fees awarded by Social Security for a successful appeal not exceeding 25% of the award. You will need to pay the Board within 30 days of written notice of the award of the net overpayment, however.

Maximum monthly benefit

If you retire before you have reached age 62 and one month, your total monthly benefit (Life Income Benefit and any Temporary Benefit, whether payable or not, and Supplemental Allowance) may not exceed 80% of your monthly base earnings.

If your total benefit otherwise would exceed the 80% ceiling, only your Supplemental Allowance (but not your Life Income Benefit or your Temporary Benefit) will be reduced by an amount necessary to provide you with a total monthly benefit equal to 80% of your monthly base earnings.

Your monthly base earnings equal $173\frac{1}{3}$ times your highest straight-time hourly rate in effect for you during the 90 calendar days immediately preceding your last day worked plus the cost-of-living allowance in effect on your last day worked.

How long do payments continue?

Disability Retirement benefits end when you no longer meet the requirements for total and permanent disability or when you reach age 65, whichever is earlier. After age 65, you will receive normal retirement benefits. This will be done automatically. You will not be notified of this change.

If you return to work

The Retirement Board of Administration determines if a disability retiree may return to work for the Company. If your disability ends before age 65 and you are approved to return to work, your retirement benefit will stop. You will receive service credits earned both before and after your Disability Retirement, but not during the period of your retirement. Your Disability Benefit will also stop if you are found to be in gainful employment outside the Company.

** or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.*

An example of monthly disability retirement benefits payable at or after age 55 with less than 30 years of credited service

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 60 on April 1, 2008 with 25 years of credited service
- Your Benefit Class Code is B
- Your spouse is three years younger than you.
-

	At Retirement	At Age 62*	At Age 65
Life Income Benefit	\$1,262.31 ^❶	\$1,271.81 ^❷	\$1,277.75 ^❸
Temporary Benefit	\$1,270.00 ^❹	—	—
Special Age 65 Benefit	—	—	\$ 76.20 ^❺
Your Benefit	\$2,532.31	\$1,271.81	\$1,353.95
Survivor Benefit	\$ 820.50 ^❻	\$ 826.68 ^❼	\$ 830.54 ^❾

- ❶ \$53.15 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,328.75 (\$53.15 x 25) without the Survivorship Coverage.
- ❷ \$50.80 (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you attain age 62, whichever is earlier*.
- ❸ \$53.55 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,338.75 (\$53.55 x 25) without the Survivorship Coverage.
- ❹ \$53.80 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,345.00 (\$53.80 x 25) without the Survivorship Coverage.
- ❺ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or \$76.20. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)
- ❻ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

* or until you are eligible for 80% of your full Social Security retirement benefit if you were born between 1/1/44 and 9/14/49.

An example of monthly disability retirement benefits payable before age 55 with less than 30 years of credited service

Your monthly retirement benefit would be calculated as follows if:

- You retired at age 50 on April 1, 2008 with 25 years of credited service
- Your Benefit Class Code is B
- Your spouse is the same age as you

	At Retirement	At Age 55	At Age 62 *	At Age 65
Life Income Benefit	\$1,163.98 ^❶	\$1,277.75 ^❷	\$1,277.75 ^❸	\$1,277.75 ^❹
Temporary Benefit	\$1,270.00 ^❺	\$1,270.00 ^❻	—	—
Special Age 65 Benefit	—	—	—	\$ 76.20 ^❼
Your Benefit	\$2,433.98	\$2,547.75	\$1,277.75	\$1,353.95
Survivor Benefit	\$ 581.99 ^❽	\$ 830.54 ^❾	\$830.54 ^❿	\$ 830.54 ^⓫

- ❶ \$53.15 (Life Income Benefit rate) x 25 (years of credited service) x 87.6% (Special Disability Survivorship Coverage adjustment). The benefit amount would be \$1,328.75 (\$53.15 x 25) without the Special Disability Survivorship Coverage.
- ❷ \$50.80 (Temporary Benefit rate) x 25 (years of credited service). The Temporary Benefit is payable until you become eligible for a Social Security disability benefit (or other Social Security benefit not reduced because of your age) or until one month after you attain age 62, whichever is earlier*.
- ❸ \$53.80 (Life Income Benefit rate) x 25 (years of credited service) x 95% (Survivorship Coverage adjustment). The benefit amount would be \$1,345.00 (\$53.80 x 25) without the Survivorship Coverage.
- ❹ Special Age 65 Benefit is the lesser of the applicable Medicare Part B Premium or \$76.20. (See conditions regarding your participation in Medicare Part B applicable to this benefit.)
- ❺ Equals 50% of the Life Income Benefit amount after the Special Disability Survivorship Coverage adjustment; payable to the surviving spouse after the retired employee would have reached age 55 (assuming the retiree died before reaching age 55). The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when the spouse reaches age 65.
- ❻ Equals 65% of the Life Income Benefit amount after the Survivorship Coverage adjustment. The monthly Special Age 65 Benefit will be added to the surviving spouse benefit when such spouse reaches age 65.

What is the Special Age 65 Benefit?

Special Age 65 is a benefit payable to retirees and surviving spouses who are at least age 65, receiving retirement benefit and enrolled in Medicare Part B.

A Special Age 65 Benefit is included in your retirement check when you are receiving a retirement benefit (other than a deferred vested benefit), you are at least age 65 and enrolled in Medicare Part B. Although included in your retirement check, the Special Age 65 Benefit is a health benefit and is funded through the health plans.

In some circumstances, you may be eligible to receive a Special Age 65 Benefit before you are age 65. *You must apply* for this benefit. To be eligible you must be enrolled for voluntary medical insurance under Medicare, commonly known as Medicare Part B.

Commencing on or after January 1, 2004, the monthly age 65 benefit is the lesser of \$76.20 or the applicable Medicare Part B premium.

Your surviving spouse who is at least age 65 may receive a Special Age 65 Benefit when he or she is receiving a retirement benefit and is enrolled in Medicare Part B (other than a surviving spouse benefit payable as a result of a deferred vested benefit or a pre-retirement survivor benefit). Surviving spouses must be enrolled or enroll for Medicare Part B when first eligible to continue company paid health care.

Retirees eligible for Medicare Part B must enroll and maintain continued enrollment in Medicare Part B to be eligible to receive the Special Age 65 Benefit. Proof of Part B participation may be required.

What are your survivorship coverage options?

There are three automatic and two optional survivorship coverage options under the Plan.

If you are not legally married, the automatic or optional survivorship coverage does not apply to you. Otherwise, the Plan offers three automatic payment options—the Survivorship Coverage, the Special Disability Survivorship Coverage and the Pre-Retirement Survivorship Coverage.

The Payment Option in effect for you is the:	If you are married for at least one year and are:
Survivorship Coverage	<ul style="list-style-type: none"> • Receiving retirement benefits (including deferred vested benefits) or eligible for Regular Early or Normal Retirement or between age 50 and age 55 and eligible for immediate Special Early Retirement • At least age 55 on Disability Retirement or have 30 or more years credited service at Disability Retirement
Special Disability Survivorship Coverage	<ul style="list-style-type: none"> • On Disability Retirement and • Under age 55 and have less than 30 years credited service
Pre-Retirement Survivorship Coverage	<ul style="list-style-type: none"> • An employee with 5 years credited service or ERISA Service (10 such years if you don't accrue service after 1988) • A former employee with 5 Years credited service or ERISA Service (10 such years if you don't accrue service after 1988) • Not eligible for the Survivorship Coverage or the Special Disability Survivorship Coverage

If you are married and want your benefit paid for your lifetime only, you can reject the applicable option shown above. Your spouse must agree to this decision by giving written consent witnessed by a Plan representative or notary public.

Keep in mind that if you are married for less than one year at the time of your retirement, you will have no survivorship coverage in effect until your first wedding anniversary. At that time, you will be appropriately covered under the Survivorship Coverage or the Special Disability Survivorship Coverage, unless you and your spouse elect otherwise.

Notwithstanding the foregoing, effective January 1, 2008, if you die during the month the survivorship coverage was to become effective, you will be deemed to have met the one year eligibility requirement and your surviving spouse will receive the survivorship coverage elected.

The Survivorship Coverage

With this coverage, you receive an income for life and your surviving spouse receives continuing income in the event of your death.

If you are otherwise eligible for Normal or Regular Early Retirement, your spouse will be eligible for this survivor benefit as though you retired under Regular Early or Normal Retirement at death. You must have been married to your spouse for one year at the time of your death.

Your spouse's benefit is based on your Life Income Benefit if you are at least age 62 at the time of your death. Otherwise, it is based on the Life Income Benefit that would have been payable to you at age 62 had you retired under Regular Early or Normal Retirement on the date of your death.

Your Life Income Benefit paid during your lifetime is reduced to provide this survivor protection. If you and your spouse are within five years of each other's age, the reduction is 5%. This percentage reduction will vary by one-half percent for each year more than five that your spouse is younger or older than you.

To illustrate:

If your spouse is:	You are paid this percentage of your life Income benefit to account for the survivorship coverage
10 years younger than you	92 ½%
9 years younger than you	93%
8 years younger than you	93 ½%
7 years younger than you	94%
6 years younger than you	94 ½%
The same age as you and up to 6 years younger or older	95%
6 years older than you	95 ½%
7 years older than you	96%
8 years older than you	96 ½%
9 years older than you	97%
10 years older than you	97 ½%

Note: The percentage may never exceed 100%.

These reductions in your benefit are effective on the latest of:

- Your retirement date
- The first day of the month following your first wedding anniversary, if married less than one year at retirement
- Your 55th birthday, if you are on Disability Retirement before age 55 with less than 30 years of credited service

After your death, 65% of your reduced Life Income Benefit will be paid each month to your spouse. This amount does not include any Temporary Benefit or Supplemental Allowance that was payable to you.

Survivor benefits begin on the first day of the month following your death and receipt of an application from your surviving spouse. However, if you are between age 50 and age 55 when eligible for immediate Special Early Retirement, but die before you retire or before benefit payments begin, your spouse will be eligible for a survivor benefit beginning when you would have reached age 55 as though you retired under Regular Early Retirement.

Your spouse will not receive a benefit in any month he or she is receiving a Transition or Bridge Survivor Income Benefit under the Life and Disability Insurance Program.

Your Life Income Benefit will be restored to the amount payable, without the survivorship election, if:

- Your spouse dies before you do and you submit a certified copy of the death certificate to the Retirement Board
 - ◇ The increase will be effective the first day of the month following the date of your spouse's death, provided that proper notice and proof of death is submitted to the Board within six months of the date of your spouse's death. If proper notice and proof of death is provided more than six months after your spouse's death, the increase will be effective six months prior to the receipt of the notice by the Board.
- You are divorced and the divorce decree specifically provides for the cancellation of the Survivorship Coverage, and you cancel your election, or you obtain written, notarized consent from your former spouse on a Company approved waiver form, or you obtain a Qualified Domestic Relations Order (QDRO) that specifically cancels the option.
 - ◇ The increase will be effective the first of the month following receipt of documentation that is approved by the Plan Administrator.

You may elect a Survivorship Coverage if you marry or remarry after retirement and you:

- Are receiving retirement benefits other than deferred vested benefits
- Have not previously rejected the Survivorship Coverage
- Do not have any survivorship coverage in effect
- Apply before you have been married eighteen months

The amount of your benefit reduction and the percentage that will be payable to your spouse will be determined by Plan provisions in effect at the time of your retirement.

The Special Disability Survivorship Coverage

With this coverage, you receive an income for life and your surviving spouse receives an income in the event of your death, if married twelve months. This option remains in effect until you have reached age 55.

There is a reduction made in your Life Income Benefit to provide the Special Disability Survivorship Coverage. The reduction is based on your age and your spouse's age, as shown for selected ages in the table below:

	You are paid this percentage of your Life Income Benefit to account for the Special Disability Survivorship Coverage if your spouse is:		
Your age when Disability Benefits begin	5 years younger	Same Age	5 years older
50	86.8%	87.6%	88.6%
40	88.2%	89.0%	90.0%
30	91.9%	92.5%	93.3%

If you die while this option is in effect, and you have been married for twelve months, 50% of your reduced Life Income Benefit will be paid for the lifetime of your spouse. Payments will begin on the first of the month following the month you would have been age 55.

For your spouse to receive benefits, you must be married at retirement and for at least one year as of the date of your death.

Your spouse will not receive a benefit in any month he or she is receiving a Transition or Bridge Survivor Income Benefit under the Life and Disability Insurance Program.

Remember, this option remains in effect only until you have reached age 55. When you have reached age 55, the reduction in your Life Income Benefit for the Special Disability Survivorship Coverage will cease. At that time, if you are married, you will be covered by the Survivorship Coverage, unless you and your spouse reject the coverage.

If, prior to your becoming age 55, your spouse dies or you become divorced, the provisions regarding cancellation described earlier would apply.

Under the following circumstances, your surviving spouse will be eligible for the survivor's benefit of a disability retiree if you have applied for disability retirement but do not live for the five months normally required for disability retirement.

- You must be on a medical leave of absence (except in the case of an occupational illness or injury) for at least one month and have applied for 'Disability Retirement. If an occupational illness or injury, or terminal illness results in death, then the one month waiting period does not apply.
- Satisfactory medical evidence must be provided to the Retirement Board to support that your death was directly or indirectly the result of the medical condition which gave rise to the medical leave of absence (excluding death as a result of homicide, suicide, or accidental death), or be the result of an occupational accident or injury.

Pre-Retirement Survivorship Coverage

If you should die as an employee or former employee and you are *not* eligible for Regular Early or Normal Retirement, the Pre-Retirement Survivorship Coverage may apply.

This option is automatic for employees and becomes effective when you have 5 years of credited service or ERISA Service (10 such years if you don't accrue service after 1988). If you leave the Company and were eligible for the option at the time you left, the Pre-Retirement Survivorship Coverage continues in effect until your retirement benefit begins.

Benefit amount

If you die while the Pre-Retirement Survivorship Coverage is in effect, a monthly benefit will be paid to your surviving spouse.

The amount paid to your surviving spouse will be 50% of your Life Income Benefit. Your Life Income Benefit is based on the rate in effect at the time of your death. If you have a break in seniority prior to your death, the Life Income Benefit will be paid at the rate in effect at the time of the break in seniority.

When payments begin

Whether you are an employee or former employee, if you die before age 55, benefits begin on the first day of the month following application by your surviving spouse, but in no event before the month following the day you would have reached age 55.

If you broke seniority before age 55 but die after age 55, benefits start on the first day of the month following your death and receipt of an application from your surviving spouse.

Your surviving spouse will receive monthly benefits for life. If the present cash value of your surviving spouse's retirement benefit is less than \$3,500, however, he or she will receive the benefit in a single lump sum.

If the lump sum payment is at least \$200, your surviving spouse may elect to have any portion of the distribution paid directly to an IRA or his or her tax-qualified Plan. Effective January 1, 2008 if the lump sum payment is greater than \$1,000 and your surviving spouse does not elect to receive the benefit as a direct rollover or as a cash distribution, the benefit will be rolled over to an individual retirement plan designated by the Board. If a direct rollover is not elected, the taxable portion of the distribution will be subject to mandatory 20% federal income tax withholding.

Your spouse will not receive a benefit in any month he or she is receiving a Transition or Bridge Survivor Income Benefit under the Life and Disability Insurance Program.

Optional forms of survivorship coverage

Beginning January 1, 2004, you can elect someone other than a spouse for a survivor's benefit. If you are married, your spouse must consent to this election in writing and have their consent witnessed by a notary. You can also elect your spouse for one of these optional survivor benefits, but generally the automatic options provide more value for you and your spouse over your lifetimes.

Optional 50% Surviving Beneficiary benefit

This option provides you a reduced monthly benefit for life and 50% of your benefit to a beneficiary of choice upon your death. The reduction in your benefit is based on your age and your beneficiary's age. The reduction factors are greater than those used in the Automatic Survivorship Coverage Options described earlier.

This option is available to members who apply for Normal, Regular Early, Special Early or Deferred Vested retirement. This option cannot be elected after retirement benefits commence and is not available to employees who apply for Disability Retirement. **Further, this option cannot be canceled due to death of the beneficiary or divorce if elected for a spouse.**

Qualified Optional 75% Surviving Beneficiary benefit

Effective January 1, 2008, this option provides you a reduced monthly benefit for life and up to 75% of your benefit to a beneficiary of choice upon your death. The reduction in your benefit is based on your age and your beneficiary's age. The reduction factors are greater than those used in the Automatic Survivorship Coverage Options described earlier.

This option is available to members who apply for Normal, Regular Early, Special Early or Deferred Vested retirement. This option cannot be elected after retirement benefits commence and is not available to employees who apply for Disability Retirement until they reach Early Retirement eligibility. **Further, this option cannot be canceled due to death of the beneficiary or divorce if elected for a spouse.**

If the beneficiary you elect is up to 10 years younger than you, or is your spouse, 75% of your reduced benefit will be payable to your beneficiary upon your death for their lifetime. If your beneficiary is not your spouse and is 11 or more years younger than you, the percentage your beneficiary will receive is regulated by the Internal Revenue Code (Section 1.40(a)(9) - 6T A-2(c)(2)). An example of the percentage payable to a beneficiary under this survivorship option is illustrated below.

Optional 100% Surviving Beneficiary benefit

This option provides you with a reduced monthly benefit for life and up to 100% of your benefit to a beneficiary of choice upon your death. The reduction in your benefit is greatest under this method because a greater percentage of your benefit will continue to be provided to a survivor after your death.

This option is available to members who apply for Normal, Regular Early, Special Early or Deferred Vested retirement. This option cannot be elected after retirement benefits commence and is not available to employees who apply for Disability Retirement. **Further, this option cannot be canceled due to death of the beneficiary or divorce if elected for a spouse.**

If the beneficiary you elect is up to 10 years younger than you, or is your spouse, 100% of your reduced benefit will be payable to your beneficiary upon your death for their lifetime. If your beneficiary is not your spouse and is 11 or more years younger than you, the percentage your beneficiary will receive is regulated by the Internal Revenue Code (Section 1.40(a)(9) - 6T A-2(c)(2)). An example of the percentage payable to a beneficiary under this survivorship option is illustrated below.

NON SPOUSE 100% CONTINGENT ANNUITANT
PERCENTAGE FOR BENEFICIARY MORE
THAN 10 YEARS YOUNGER

Beneficiary Years Younger Than Participant	Permitted Percentage for Beneficiary
10 or less years younger	100%
11 years younger	96%
12	93%
13	90%
14	87%
15	84%
16	82%
17	79%
18	77%
19	75%
20	73%
21	72%
22	70%
23	68%
24	67%
25	66%
26	64%
27	63%
28	62%
29	61%
30	60%
31	59%
32	59%
33	58%
34	57%
35	56%
36	56%
37	55%
38	55%
39	54%
40	54%
41	53%
42	53%
43	53%
44 and greater	52%

What is a deferred vested benefit?

If you leave the Company for reasons other than retirement, you may be eligible for a deferred vested benefit.

Eligibility

You are eligible to receive a deferred vested benefit if you have a break in seniority and you:

- Have at least 5 years of credited service under the Plan, 5 years of ERISA Service (described later in this section) or 10 such years if you don't accrue service after 1988
- Are not eligible for any other retirement benefit under the Plan

Benefit amount

Your deferred vested benefit is calculated as follows:

The Life Income Benefit rate
for a deferred vested benefit
based on the date of your break in seniority
multiplied by
your years of credited service

Keep in mind that years of ERISA Service may be used to determine your eligibility for a benefit, but to determine the amount of your Life Income Benefit, years of credited service as defined under the Plan are used.

The Life Income Benefit rates for deferred vested benefits are:

If the date you have a break in seniority is:	And your Benefit Class Code is:	The Life Income Benefit Rate for your Deferred Vested Benefit is:
10/1/07 through 9/30/08	A	\$52.90
	B	\$53.15
	C	\$53.40
	D	\$53.65
10/1/08 through 9/30/09	A	\$53.10
	B	\$53.35
	C	\$53.60
	D	\$53.85
10/1/09 through 9/30/10	A	\$53.30
	B	\$53.55
	C	\$53.80
	D	\$54.05
10/1/10 and later	A	\$53.55
	B	\$53.80
	C	\$54.05
	D	\$54.30

A reduced benefit can begin as early as age 55—as long as you make application at least 180 days before you want payments to start.

Early receipt of deferred vested benefits

If you choose to begin payments before age 65, your Life Income Benefit will be reduced. The amount of the reduction depends on the number of years and months you receive payments before age 65 as shown in the table:

Age when Deferred Vested Benefit begins:	Percentage of Life Income Benefit payable:
64	93.3%
63	86.7%
62	80.0%
61	73.3%
60	66.7%
59	60.7%
58	55.4%
57	50.6%
56	46.4%
55	42.5%

If you retire between the exact ages shown in the table, the percentage of the Life Income Benefit payable will be pro-rated based on whole months.

If you had a break in seniority after June 1, 1955 but before October 1, 2007, your eligibility for deferred vested benefits and the benefit amount will be based on the Plan provisions in effect at the time of your break.

Survivorship coverage

If you are legally unmarried, the automatic survivorship coverage does not apply to you but you may elect one of the optional forms for someone other than a spouse. If you are married for at least one year when you begin receiving deferred vested benefits, the Plan automatically provides the Survivorship Coverage.

You can reject the automatic Survivorship Coverage and choose to have a monthly benefit during your lifetime with payments stopping at your death, or you may elect one of the optional survivorship options. Your spouse must agree to this decision, however, by giving written consent witnessed by a Plan representative or notary public.

A special Pre-Retirement Survivorship Coverage protects your spouse before you begin receiving deferred vested benefits.

The Pre-Retirement Survivorship Coverage is in effect automatically for vested employees. If you left the Company and the Pre-Retirement Survivorship Coverage was in effect at the time you left, it continues in effect (regardless of age) until your Plan benefit begins.

More information about both survivorship coverages is in the "What are your survivorship coverage options?" section.

ERISA Service

If you leave the Company before you have earned 5 years of credited service under the Plan (10 years of such service if you don't accrue service after 1988), you will be eligible to receive a deferred vested benefit if you have 5 years of ERISA Service (10 years of such service if you don't accrue service after 1988). Your benefit amount, however, will be based on your years of credited service under the Plan.

You are eligible to be credited with ERISA Service when you have completed one year of service and are then at least age 21 (age 25 prior to January 1985).

You earn a year of ERISA Service for all years you've worked at least 750 regular time hours for the Company except:

- Years of ERISA Service before age 18 (age 22 if you have no credited service under the Plan after December 31, 1984)
- Years of ERISA Service before January 1, 1971 unless you have at least three years of credited service under the Plan after December 31, 1970
- Years before January 1, 1976 which would be lost under the Plan's break in seniority rules in effect on December 31, 1975
- Years of ERISA Service before a one-year break in ERISA Service until you complete one year of service after the break; a one-year break in ERISA Service is a calendar year in which you do not complete 376 ERISA Hours of Service; an ERISA Hour of Service means each regular time hour for which you are paid for the performance of duties
- Years of ERISA Service before consecutive one-year breaks in ERISA Service which equal the greater of five or your aggregate years of ERISA Service before the break; (this provision applies to employees at work on or after January 1, 1985; prior to January 1, 1985, ERISA Service before a break that was equal to or greater than your ERISA Service was not counted)

In determining whether you have an ERISA break, the following will be counted as ERISA Hours of Service even though you're away from work (on or after January 1, 1985) due to:

- Your pregnancy
- The birth of your child
- Placement of a child with you for adoption
- Caring for your child immediately following birth or placement
- Any reason that qualifies you for a leave under the Family and Medical Leave Act of 1993, for absences commencing on or after September 17, 1993

Up to 376 hours for such absences will be counted to prevent a break in ERISA Service in the year in which your absence begins. If you don't need any hours that year to reach 376, the hours will be credited to you the following year to prevent a break if your absence continues into that year.

How do you apply for a Retirement Plan benefit?

When you are ready to retire, the National Employee Services Center (NESC) can help you file an application.

Processing your application requires many steps. This means you should apply for benefits at least 180 days before you'd like payments to begin.

You must apply for benefits before any payments from the Plan can begin. To apply, you must contact the NESC at 1-800-248-4444 to obtain an application form 30 to 180 days before you wish benefits to commence. Forms must be signed and dated prior to the retirement effective date and returned to the Fidelity Service Center for Ford Motor Company on a timely basis.

Applications signed after the effective date may be made effective the month following signature and may result in a loss of benefits. If you need any information about the Plan, you can call the NESC.

If you die before retirement, a Personnel Benefits Representative at the NESC can help your surviving spouse apply for any benefits that may be due. The application must be completed by your surviving spouse and returned according to the instructions on the application before survivor benefits can commence.

Payment of benefits must be approved by the Retirement Board:

- For Disability Retirements the Board must determine that you meet the Plan's eligibility requirements
- For return to work applications by disability retirees, the Board must determine that your disability has ended and must approve your return to work
- Your benefits are effective the first day of the first month after you file your application, or later if you sign your application after the effective date or voluntarily choose a later date for your benefit to commence

Your first payment normally will be made about six weeks after your retirement date. Subsequent payments will be mailed by the first of each month and each is an advance payment for that month.

You can make arrangements to have direct deposit or electronic funds transfer of your pension check to a bank or other financial institution of your choice. You may change these arrangements by advising the Retirement Board.

Once your retirement benefit commences, and you have questions, write or call:

Ford-UAW Retirement Board of Administration
P.O. Box 6050
Dearborn, Michigan 48121
1-800-829-8833

Be sure to include your Social Security number (or your spouse's Social Security number, if he or she is the employee) on any correspondence.

Payments may be delayed if you do not keep the Retirement Board informed of your current mailing address.

If you disagree with the Board's findings, you may make a written request to the Plan Administrator for a review of your claim. A detailed discussion of what to do in this event is covered in the "What if a claim of benefits or participation is denied" section of the handbook.

How are taxes paid on your Retirement benefits?

Your retirement benefits are taxed as you receive them.

When you receive benefits from the Plan, those benefits are taxed as ordinary income.

Federal tax law requires the Company to withhold income taxes from your benefits unless you tell the Company not to withhold tax. Whether or not you want tax withheld, you should complete Forms W-4P and submit it to the Retirement Board. Forms W-4P are available from the NESC, the Retirement Board, a local office of the Internal Revenue Service or Comerica Bank.

If you do not submit any Forms W-4P, the Company automatically will withhold taxes from your benefits and will assume you are married and claim three withholding allowances.

If no taxes are withheld from your benefit, or if the amount withheld is not enough to cover the actual taxes due, you may be required to make estimated tax payments.

State tax withholding will apply in those states that require withholding. As with federal withholding, the Company will withhold unless you tell the Company not to withhold state income tax. You may elect voluntary state tax withholding in those states that permit voluntary withholding.

Who pays for Retirement benefits?

The Plan is non-contributory. This means the Company pays for it and you don't contribute.

The Company makes contributions to a special Pension Fund. The amount of the Company's contributions is determined by an independent actuary in accordance with the funding policy adopted by the Company. No portion of contributions to the Pension Fund or its assets is paid or set aside for the account or benefit of any individual employee.

The assets of the Pension Fund are held in a trust. The money in the trust can be used only to pay benefits and administrative costs of the Plan and cannot be returned to the Company until all benefits have been paid.

The trustee makes all payments from the Plan. Investments of the trust money are made by investment managers appointed under the Ford Motor Company Master Trust Fund. These investment managers are banks, trust companies and investment advisors. A portion of the Fund not exceeding 10% may be invested by the Company.

What circumstances might affect Retirement benefits?

Some circumstances could cause your benefits to be denied, delayed or reduced.

The Plan is designed to provide you with a continuing income after active employment ends, but some situations could affect Plan benefits. Those situations are summarized here.

If you leave the Company

If you leave the Company permanently for any reason before age 65 and you have less than 5 years of credited service or ERISA Service (10 years of such service if you don't accrue service after 1988), no benefits are payable to you or your surviving spouse.

If you die

- If the survivorship coverage is rejected, no benefits are payable
- If the survivorship coverage was elected, benefits may be payable per Plan provisions

Applying for benefits

Payments will begin only after application is made and approved. Until you apply for benefits and provide information requested by the Company or the Retirement Board, no payments will be made.

You may contact the National Employee Services Center (NESC) by writing or calling:

Ford National Employee Services Center
P.O. Box 6214
Dearborn, Michigan 48121-6214
1-800-248-4444

Be sure to include your Social Security number (or your spouse's Social Security number, if he or she is the employee) on any correspondence.

Payment of small amounts

If the present cash value of your surviving spouse's retirement benefit is less than \$3,500, your spouse will receive his or her benefit in a single lump sum.

If the lump sum payment is at least \$200, your surviving spouse may elect to have any portion of the distribution paid directly to an IRA or his or her tax-qualified Plan. Effective January 1, 2008, if the lump sum payment is greater than \$1,000 and your surviving spouse does not elect to receive the benefit as a direct rollover or as a cash distribution, the benefit will be rolled over to an individual retirement plan designated by the Board. If a direct rollover is not elected, the taxable portion of the distribution will be subject to mandatory 20% federal income tax withholding.

Assignment of benefits and deductions

Generally your retirement benefits cannot be assigned, transferred, pledged, sold or attached. However, certain court orders could require that part of your benefit be paid to someone else -- your spouse, former spouse, child, or other dependents, for example. You will be notified if the Plan receives any such order. Also, the trustee may be authorized by the Retirement Board and as approved by you to deduct Blue Cross/Blue Shield payments, union dues, TESPHE loan repayments, benefit plan overpayments or as required by law to deduct required taxes from your retirement benefits. Certain Workers' Compensation payments are deducted, if you file the claim later than two years after retiring or after breaking seniority.

In Case of Divorce or Legal Separation

Benefits under qualified retirement plans generally may not be assigned or alienated, except in accordance with a judgment, decree, or order that is issued under state domestic relations law that relates to the provision of child support, alimony, or marital property rights to a spouse, former spouse, child, or other dependent of a Plan participant. Such an order must meet the requirements of a Qualified Domestic Relations Order (QDRO) as defined in Section 206(d) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, as determined by the Company.

You can obtain a copy of Ford Motor Company's QDRO Approval Guidelines and Procedures in one of two ways.

The Fidelity QDRO Center at <http://qdro.fidelity.com> is an internet website available to attorneys, plan participants, and alternate payees to generate a web Order or to obtain a copy of the QDRO Approval Guidelines and Procedures. This free online application does not interface with any participant account or benefits information. Or you can obtain a copy of the QDRO Approval Guidelines and Procedures through NetBenefits. From the Fidelity NetBenefits home page, select your Pension Plan, "Request a Pension Form" and then "QDRO Guidelines".

If you would like to submit your QDRO for review send it to:

Fidelity Services Center for Ford Motor Company
P.O. Box 770003
Cincinnati, OH 45277-0066
Attention: QDRO Administrative Group

If the QDRO is acceptable, you will be notified and the QDRO will be implemented according to its terms. Other forms of QDROs may be acceptable if they comply with the legal requirements set forth in Section 206(d) of ERISA as determined by the Plan Administrator.

Other forms of marital dissolution documents may be acceptable as QDROs if they comply with the legal requirements set forth in Section 206(d) of ERISA as determined by the Plan Administrator.

Please submit any of the following documents to Fidelity Services Center for Ford Motor Company, P.O. Box 770003, Cincinnati, OH 45277-0066
Attention: QDRO Administrative Group:

- Domestic Relations Orders (DROs) (original, true or court certified copies of original Orders filed in a court of competent jurisdiction)
- Proposed DROs
- Decrees of Divorce
- Judgments
- Property Settlement Agreements

In Case of a Federal Garnishment

A Federal Writ of Garnishment against your pension benefit may be obtained by the U.S. Government pursuant to the procedures authorized by the Federal Debt Collection Procedures Act of 1990 ("FDCPA"), 28 U.S.C. § 3001-3308, and the Mandatory Victims Restitution Act, 18 U.S.C. §3614 (c). The Federal Garnishment will attach a lien to your pension benefit. Recovery of the Federal Garnishment will begin once you begin to receive your pension benefit.

If you or your spouse is incapacitated

If the Retirement Board finds that any person to whom a benefit is payable is unable to handle his or her affairs, payments may be made to a duly appointed representative as determined by the Retirement Board.

In Case of Guardianship

If you are physically or mentally unable to handle your affairs, or if your beneficiary is a minor, payments may be made to a legal guardian or representative on your behalf or on behalf of your beneficiary.

Durable Power of Attorney

In limited circumstances, the Plan will recognize a Durable Power of Attorney (DPOA) to conduct certain transactions on behalf of an employee who is incapacitated or otherwise unable to handle their personal affairs. For example, a DPOA can direct the monthly retirement check to a new address or affect a direct deposit transfer to the employee's financial institution.

A DPOA is also authorized to assist an employee with the retirement application process. In this situation for example, an employee's spouse who holds DPOA may sign the employee's retirement application.

A general Power of Attorney will not be accepted for any transaction.

Can Plan provisions change?

Under certain circumstances, Plan provisions may change. Those circumstances are explained here.

Neither the Company nor the UAW may amend or terminate the Plan while the 2007 Agreement is in effect without the consent of the other party. The Agreement expires on November 19, 2011.

At that time, the Plan may be renewed automatically for successive one-year periods, unless Ford or the UAW gives written notice at least 60 days before the applicable expiration date. When such notice is given, the Agreement and Plan may be modified, amended or terminated.

The Pension Benefit Guaranty Corporation (PBGC)

Your pension benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people will receive all of the pension benefits they would have received under their Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits if you become disabled before the Plan terminates
- Certain benefits for your survivors

The PBGC guarantee generally does **not** cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than 5 years at the time the Plan terminates
- Benefits that are not vested because you have not worked long enough for the Company
- Benefits for which you have not met all of the requirements at the time the Plan terminates
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's Normal Retirement age
- Non-pension benefits such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact:

PBGC's Technical Assistance Division
1200 K Street N.W., Suite 930
Washington, D.C. 20005-4026

or call (202)326-4000
(not a toll-free number)

TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to (202)326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website at <http://www.pbgc.gov>.

How do you file a claim?

You have the right to file a claim if you do not agree with the administration of your retirement benefit.

You may make a claim for benefits or participation by making a request in accordance with the Plan.

What if a claim of benefits or participation is denied?

Denial of a claim

If a claim for benefits or participation is denied in whole or in part, the member will receive written notification from the Plan Administrator or an employee of the Board of Administration within ninety (90) days (within forty-five (45) days if the claim is related to a disability pension claim) from the date your claim for benefits or participation is received. The notice will be deemed given upon mailing, full postage prepaid in the United States mail or on the date sent electronically to you.

The decision will be in writing and it will include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based along with a copy of the Plan provisions or a statement that one will be furnished at no charge per your request;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, following a denial for benefits on review.

If the denial for benefits is because of a disability claim, the denial of the claim will also include:

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion that was relied upon in making the claim denial will be provided free of charge to you at your request; and
- If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, (applying the terms of the Plan to your medical circumstances), or a statement that the explanation will be provided free of charge upon your request.

If the Plan Administrator or an employee of the Board of Administration determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period (forty-five (45) day period if the claim is related to a disability pension claim). In no event will the extension exceed a period of ninety (90) days (or a period of thirty (30) days for disability pension claims) from the end of such initial period. For general claims, the extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator or the employee of the Board expects to render the determination.

In regard to a disability pension claim, if prior to the end of the first thirty (30) day period the Plan Administrator or an employee of the Board of Administration determines that, due to matters beyond control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination.

If an extension is required because the information in the disability claim is incomplete, the extension notice will specifically explain:

- The standards on which entitlement is based;
- The unresolved issues that prevent a decision;
- The additional information required for a decision; and
- That you have at least forty-five (45) days to provide the information being requested.

If such additional information is required, the period between the date of the request and the date of your response is not included when calculating the decision deadline.

Review of denial of the claim (other than disability) to the Board of Administration

In the event that the Plan Administrator or an employee of the Board of Administration denies a claim, you may:

- Request a review upon appeal by written application to the full Board of Administration;
- Review pertinent documents; and
- Submit issues and comments in writing.

The Board of Administration must take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

You must request a review upon an appeal of the denial of the claim within sixty (60) days after you receive the written notification of denial of the claim. It will be considered at the Board of Administration's next regularly scheduled meeting. If it is filed within thirty (30) days of the next meeting, a decision by the Board of Administration will be made by the date of the second meeting after receipt of your request for review. Under special circumstances an extension of time for processing may be required, in which case a decision will be rendered by the date of the third meeting. If an extension is required because information is incomplete, the review period will be adjusted from the date the notice was sent to the date the complete information is received. In the event an extension is needed, written notice of the extension will be provided to you prior to the commencement of the extension.

Written notice of a decision will be made not any later than five (5) days after the Board of Administration has made a decision. The decision will be in writing and if adverse it will include:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based along with a copy of the Plan provisions or a statement that one will be furnished at no charge upon your request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits; and
- A statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

Review of denial of disability pension claim to the Board of Administration

In the event that the Plan Administrator or the Board of Administration denies a disability pension claim, you may:

- Request a review upon appeal by written application to the full Board of Administration;
- Review pertinent documents; and
- Submit issues and comments in writing.

The Board of Administration must take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

You must request a review upon an appeal of the denial of the claim within one hundred eighty (180) days after you receive the written notification of denial of the claim.

The Board of Administration:

- Will give no deference to the earlier decision;
- Will provide for review by a person who did not make the initial decisions and who is not a subordinate of the initial decision maker;
- If the decision involves a medical judgment, provide that named fiduciary must consult with a health care professional who is independent of any health care professional involved in the initial denial; and
- Provide for identification of all medical or other experts consulted who have appropriate training and experience in the field of medicine involved in the medical judgment.

A decision, as appropriate, shall be made within forty-five (45) days after receipt of your request for review, unless special circumstances require an extension of time for processing. One forty-five (45) day extension will be available to the Board of Administration if necessary due to matters beyond the control of the Plan and with written notice to you. The extension notice will specify the circumstances requiring the extension and the expected date of the determination. If an extension is required because the information is incomplete, the extension notice will specifically explain the standards on which entitlement is based, the unresolved issues that prevent a decision and the additional information required for a decision. You will have forty-five (45) days to provide the information being requested. If additional information is required, the period between the date of the request and the date of your response will not be included in calculating the decision deadline.

The decision will be in writing and it will include:

- The specific reason or reasons for the claim denial;
- Reference to the specific Plan provisions on which the determination is based along with a copy of the Plan provisions or a statement that one will be furnished at no charge upon your request;
- A statement that you are entitled to receive, upon request and free of charge reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits;
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion that was relied upon in making the claim denial will be provided free of charge to you at your request;
- If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that the explanation will be provided free of charge upon your request; and

- The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Such notice shall be deemed given upon mailing, full postage prepaid in the United States mail or if provided electronically to you.

Decision of the Retirement Board

Decisions of the Board of Administration are final and conclusive and are only subject to the arbitrary and capricious standard of judicial review.

Limitations Period

No legal actions for benefits under the Plan may be brought against the Plan until after the claims and appeal procedures have been exhausted. Unless the Employee Retirement Income Security Act (ERISA) of 1974, as amended, specifically provides a different period of limitations, legal actions under the Plan for benefits must be brought not later than two (2) years after the claim arises. No other action may be brought against the Plan more than six (6) months after the claim arises.

NOTES

Supplemental Unemployment Benefit (SUB) Plan

After an overview of your benefits from the SUB plan, this section of your handbook answers these questions:

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Supplemental Unemployment Benefit (SUB) Plan

An overview: the Supplemental Unemployment Benefit (SUB) Plan

The Ford-UAW Supplemental Unemployment Benefit (SUB) Plan provides financial security during layoffs for eligible hourly employees represented by the UAW.

An overview

If you are laid off from the Company and meet the eligibility requirements, you may be eligible for:

- **Regular Benefits** — providing a weekly income for full weeks of layoff; Regular Benefits are a supplement to benefits provided under State Unemployment Systems
- **Automatic Short Week Benefits** — providing additional income in a short workweek
- **Lump-Sum Separation Payments** — providing a lump-sum benefit if you are separated from the Company under certain circumstances

A Moving Allowance also is available under the Collective Bargaining Agreement. This Allowance pays a benefit if you begin work at another plant and the new plant is more than 50 miles in distance from the original plant.

More details follow.

Who is eligible for Regular Benefits?

If you are on layoff from a Ford-UAW Contract Unit, you may be eligible for Regular Benefits under the SUB Plan.

Eligibility requirements

You may be eligible for Regular Benefits under the SUB Plan if you are an Employee and:

- Have at least one year of Seniority
- Are on a qualifying layoff from a Contract Unit because of:
 - ◇ A reduction in force (including closing of a plant or operation)
 - ◇ A temporary layoffor
 - ◇ Your inability to do work offered by the Company, even though you are able to perform other work in the plant that you would be entitled to if you had sufficient Seniority
- Have reported at a State employment office, if required by your State
- Have applied for Regular Benefits either in person or by mail and
- Qualify for a Regular Benefit of at least \$2

State Unemployment Compensation (UC) Benefits

In addition to the eligibility requirements described in the prior section, you must have received a State UC benefit, or be ineligible for one because you:

- Did not have a sufficient period of employment or earnings to qualify for State UC benefits
- Have exhausted your State UC benefits
- Worked or had earnings in the week that disqualified you for State UC benefits or Waiting Week Credit
- Were employed full time by an employer other than the Company and are not eligible for an Automatic Short Week Benefit
- Are serving a waiting week under the State UC System while you are laid off out of line of Seniority (with certain exceptions)

- Are serving:
 - ◊ A second waiting week within your State UC System benefit year
 - ◊ A waiting week which occurred within less than 52 weeks since your last waiting week
- or
- ◊ A waiting week immediately following a week for which you received a State UC benefit
- Refuse a Company offer of work that you have an option to refuse under the Collective Bargaining Agreement
- Are on layoff because you are unable to do your regular job, or other work offered by the Company, provided you are able to do other work in the plant that you would be entitled to if you had sufficient Seniority
- Have failed to claim a State UC benefit because pay from the Company would result in a State UC benefit of less than \$2
- Are receiving pay for military service for a period following your release from active duty or were on short-term active duty of 30 days or less
- Are entitled to benefits for retirement or disability that would be payable while you are working full time
- Are on layoff for part of a week and have been denied a State UC benefit because for another part of the same week you were on a disciplinary layoff or layoff because of strike or other concerted action or received any statutory or Company Accident and Sickness benefit or Company retirement benefit
- Have been denied a State UC benefit and it would be contrary to the intent of the Plan to deny you a benefit
- Are otherwise qualified for Unemployment Compensation and SUB Regular Benefits, except for having failed to satisfy your state system reporting or certification requirements

The term "State Unemployment Compensation (UC) benefit" or "State System benefit" throughout this section includes certain allowances for training, Trade Readjustment Allowances and certain Workers' Compensation benefits.

If you exhaust your State Unemployment Compensation

Some special rules apply if you exhaust your State Unemployment Compensation and apply for Regular Benefits. In that instance, you must:

- Be able to work, be available for work and maintain an active registration for work with the State employment service
- Do what a reasonable person would do to obtain work and
- Apply for or accept suitable work that the State employment service or the Company informs you is available

Who is not eligible for Regular Benefits?

Certain circumstances affect your benefit eligibility under the Plan.

You are not eligible for Regular Benefits if you:

- Are laid off:
 - ◇ For disciplinary reasons
 - ◇ Because of a strike, slowdown, work stoppage, picketing (whether or not by Ford-UAW employees) or concerted action—at a Company plant or plants—or any dispute of any kind involving Ford-UAW employees at a Company plant or elsewhere
 - ◇ Through your own fault
 - ◇ Because of any war or hostile action of a foreign power
 - ◇ Because of sabotage (including arson) or insurrection
 - ◇ Beyond the first two consecutive full weeks of layoff for which a Regular Benefit is payable in any period of layoff because of any act of God or
 - ◇ Act of terrorism
- Refuse a Company offer of work that you cannot refuse under the Collective Bargaining Agreement
- Are in military service or on a military leave (other than short-term duty of 30 days or less)
- Are eligible for or claiming any statutory accident or sickness benefit, or other disability benefit (other than a disability benefit you would get even if working full time or a lost-time Workers' Compensation benefit while not disabled) or a Company retirement benefit (your eligibility for a regular early or normal retirement benefit if you are not yet receiving the benefit, however, will not disqualify you)
- Are receiving SUB payments from another employer or are eligible to receive them from another employer with whom you have more Seniority than you have with the Company
- Are receiving or are eligible to receive SUB payments under any other Ford SUB Plan or
- Are eligible for an Automatic Short Week Benefit

How are Regular Benefits determined?

Your SUB amount is determined by your weekly after-tax pay, certain other pay and State System benefits.

The weekly Regular Benefits calculation

Your weekly Regular Benefits are figured according to a formula:

95% of your Weekly After-Tax Pay
- less \$30.00
- less any State System Benefit,
pay from the Company*
excluding call-in pay, and earnings in excess
of the greater of \$10 or 20% of such
wages from another employer or
military pay in excess of \$10.00

Your weekly After-Tax Pay is:

Your Weekly Straight-Time Pay
(including any cost-of-living allowance
in effect at time of calculation)
- reduced by:

- all federal, state and municipal taxes and
- contributions required to be withheld by the Company based on the number of exemptions you may claim on your tax return, excluding exemptions taken for old age and blindness

The \$30.00 reduction takes into account the work-related expenses you do not have when you are on layoff.

**80% of vacation pay received from the Company during Vacation Shutdown, under certain circumstances.*

An example

Suppose you are married and have two children, live in Detroit and receive a State UC benefit of \$362. Let's also assume your weekly straight-time pay for 40 hours of work is \$1025.40. All federal, state and municipal taxes and contributions on your pay come to \$216.91. As a result, your after-tax pay is \$808.49.

Your Regular Benefit from the Plan for a full week of layoff would be:

\$808.49	your after-tax pay
x 95%	times the rate
<hr/>	
\$768.06	subtotal
- 30.00	less work-related expenses
<hr/>	
\$738.06	subtotal
-362.00	less State UC benefit
<hr/>	
\$376.06	your before-tax benefit

How long are Regular Benefits paid?

You would receive \$376.06 from the Plan, less withholding taxes such as federal, state and local income taxes on that amount.

Your Regular Benefit would be \$738.06 less withholding taxes such as federal, state and local income taxes—if you were otherwise eligible for SUB and either:

- Did not receive a State UC Benefit for one of the reasons listed in the “Who is eligible for Regular Benefits?” section or
- Exhaust your State UC Benefit

Note: *If you fail to apply for SUB benefits when you are first eligible, the SUB benefit will be reduced by the State UC Benefit for which you otherwise were eligible.*

Maximum benefits

In most instances, Regular Benefits are paid with no maximum. There is an exception, though. The maximum benefit is \$200 if you refuse an offer of work by the Company (even though you had an option under the Collective Bargaining Agreement to refuse such work) if such a refusal:

- Results in your disqualification for State UC Benefits or
- Occurs or such layoff continues after you have exhausted your State UC Benefits

The maximum will not apply, however, if you are a skilled Tool & Die, Maintenance and Construction or Power House employee and refuse an offer of work other than work in Tool Room Departments, Maintenance Departments and Power House Departments.

Reduced benefit

The following provision will apply only in the event the terms of the 1987 SUB Plan are reactivated.

If you have less than 20 years of Seniority and the Credit Unit Cancellation Base (CUCB) is below \$144.50, the Regular Benefit will be reduced by 20% but not to an amount less than five dollars. If you have less than 10 years of Seniority and the CUCB is below \$44.50, a Regular Benefit will not be paid to you.

Benefit overpayments

If for any reason you receive a benefit payment that should not have been paid or should have been paid in a lesser amount, the Plan provides for recovery of the overpayment amount. The overpayment will be recovered from future benefit payments or from regular paychecks.

How do you apply for Regular Benefits?

An electronic application will be automatically submitted for you if you receive a UC Benefit payment and work in a state where the automated SUB application process has been implemented (Michigan, Minnesota, Missouri, Kentucky and Ohio as of December 2003). Otherwise, you may apply for Regular Benefits in person or by mail. For instructions on how to apply by mail, contact the Company SUB office at the location where you work.

When to apply

You must apply for Regular Benefits within 60 calendar days after the end of the week for which you claim the benefit. You may apply after this time limit, however, if you retroactively become eligible for State UC Benefits or your State UC Benefit amount is adjusted retroactively, which in turn affects your eligibility or benefit amount under this Plan. You must submit a new application form each week you claim a Regular Benefit. Regular Benefit payments are mailed to your home.

Information to be provided

The application form asks:

- The amount of any State UC and other benefits you have received. These include Workers Compensation Benefits, Retirement Plan Benefits, Trade Readjustment Allowances, benefits under any other SUB-type plans and state or federal disability payments and
- The amount of your earnings for each day in the week from any source other than the Company

You also must submit evidence that shows you:

- Have received a State UC Benefit
- Are entitled to receive a State UC Benefit or
- Are ineligible for a State UC Benefit for a reason under the Plan, described in the “Who is eligible for Regular Benefits?” section

Your Company SUB office can tell you what is considered qualifying evidence in your state.

Who is eligible for Automatic Short Week Benefits?

In certain circumstances, you may be eligible for Automatic Short Week Benefits.

Eligibility requirements

You may be eligible for an Automatic Short Week Benefit if:

- You have at least one year of Seniority
- You work for the Company during the week or:
 - ◊ you receive some jury duty pay, bereavement pay or military pay from the Company or
 - ◊ you receive only holiday pay during the week from the Company and you received an Automatic Short Week Benefit or had 40 hours paid for or made available in the previous week
- Because of layoff, the hours paid for or made available to you by the Company are less than 40 and
- Generally, you meet all of the eligibility requirements necessary to receive a Regular Benefit except you:
 - ◊ need not have any Credit Units and
 - ◊ need not have registered and reported to a State Employment Office

How are Automatic Short Week Benefits determined?

Automatic Short Week Benefits are based on your straight-time pay and your hours worked.

Your Automatic Short Week Benefits are equal to:

80% of your straight-time pay
(including any cost-of-living allowance)
for each hour less than 40 not paid for
or made available to you during the week.

In determining your hours made available for purposes of the Plan, there are two important points to keep in mind:

- If, before a layoff during a week, notice of intent to work overtime has not been given to employees by the Company, overtime that is worked or available during that week but after the layoff and is not included in determining hours paid or made available during the week
- Overtime hours that otherwise would be counted are not counted as hours made available if you are prohibited from working due to written restrictions imposed by your personal physician and agreed to by the plant physician

An example

Suppose your straight-time hourly rate (including any cost-of-living allowance) is \$25.635, you work 24 hours and you are on a qualifying layoff for the remaining 16 hours of the workweek.

Your Automatic Short Week Benefit is computed as follows:

\$ 25.635	hourly rate plus COLA
x 80%	times short week percentage
\$20.005	subtotal
- 16	times hours laid off
\$ 328.00	short week benefit amount

The \$328.00 short week benefit amount when added to your regular pay of \$615.24 will total \$943.24 for the week.

This total is paid in one check. It is subject to all federal, state and local income taxes and all other deductions normally taken from your pay.

Applying for benefits

Generally, you do not need to apply for Automatic Short Week Benefits. If you believe you are entitled to an Automatic Short Week Benefit and do not receive it on the day it normally would be paid, however, submit a written application to the Company within 60 days of the day such benefit was payable. Also, submit a written application if the Automatic Short Week Benefit you receive is smaller than the amount you believe you are entitled to.

Are Separation Payments payable under the Plan?

Under certain circumstances, you may be eligible for a lump-sum Separation Payment.

The Separation Payment amount depends on:

- Your Seniority as of your last day on the Active Employment Roll and
- Your hourly rate

Eligibility requirements

You are eligible to receive a Separation Payment if you:

- Have at least one year of Seniority on the last day you are on the Active Employment Rolls of the Company
- Have been laid off for at least 12 continuous months (unless you are on a permanent layoff and appear to have no further employment opportunity with the Company) or have become totally and permanently disabled and are ineligible for a Company retirement benefit solely because you have less than 10 years of credited service
- Do not have a break in Seniority between the date of your layoff and the earliest date you can apply for a Separation Payment and
- Do not refuse an offer of work by the Company (unless permitted by the Collective Bargaining Agreement) between layoff and the earliest date that you can apply

The payment amount

Your Separation Payment is based on your Base Hourly Rate plus the cost-of-living allowance in effect on your last day worked and your years of Seniority. Your Seniority is translated into a specific number of hours of separation pay you will receive using the following table:

SEPARATION PAYMENT TABLE

Years of seniority:	Hours of pay you receive:	Years of seniority:	Hours of pay you receive:
1 but less than 02	150	16 but less than 17	1,770
2 but less than 03	170	17 but less than 18	1,840
3 but less than 04	100	18 but less than 19	1,920
4 but less than 05	135	19 but less than 20	1,000
5 but less than 06	170	20 but less than 21	1,085
6 but less than 07	210	21 but less than 22	1,170
7 but less than 08	255	22 but less than 23	1,260
8 but less than 09	300	23 but less than 24	1,355
9 but less than 10	350	24 but less than 25	1,455
10 but less than 11	400	25 but less than 26	1,560
11 but less than 12	455	26 but less than 27	1,665
12 but less than 13	510	27 but less than 28	1,770
13 but less than 14	570	28 but less than 29	1,875
14 but less than 15	630	29 but less than 30	1,980
15 but less than 16	700	30 and over	2,080

In the event the provisions of the 1987 SUB Plan are reactivated, the following method of calculating the amount of a Separation Payment also will be available to employees who were at work on or after March 1, 1982:

The cash equivalent of your remaining Regular Benefits otherwise payable from the SUB Plan
+ plus

the cash equivalent of any insurance continuation coverage you are eligible to receive (unless eligible for insurance continuation due to retirement)

- minus

the amount of any Regular Benefits received after your application for a Separation Payment was made

Under both methods, the amount you receive is reduced by:

- Any Moving Allowance you have received
- Any amounts which must be withheld by law or regulation, such as taxes
- SUB overpayments and
- Any SUB payments you received for weeks after your last day worked

To receive a Separation Payment

To receive a Separation Payment, you must apply within 24 months (36 months if you have at least 10 years of Seniority and you were at work on or after March 1, 1982) after your layoff or disability period begins. An exception is made, however, if you become totally and permanently disabled and are not eligible for a disability retirement benefit because you do not have 10 years of credited service and you are receiving an Extended Disability Benefit under Section 13 of the Life and Disability Insurance Program. If this is the case, you may apply for a Separation Payment on or before the 30th day following the last month you were eligible to receive an Extended Disability Benefit.

Effect of Separation Payment on Seniority

If you accept a Separation Payment, you:

- Agree that such payment is a lump-sum payment allocable to an inactive period (“Allocation Period”) during which no other pay or benefits or rights of employment shall apply
- Shall cease to be an Employee and your Seniority shall be deemed to have been broken as of the date your application for such Separation Payment was received by the Company (“Termination Date”) for all purposes
- Shall not be able to receive a special early retirement under any Company retirement plan
- Shall not be permitted to retire under any Company retirement plan during the Allocation Period following the Termination Date and
- Cannot grow into retirement if ineligible as of the break in Seniority (but without prejudice to any right to a deferred vested benefit)

The Allocation Period in weeks shall equal your Separation Payment divided by one-half the unreduced SUB Regular Benefit you received, or would have received, for the current period of layoff.

If you return the Separation Payment draft within 30 days of the date of the draft, your Seniority will be reinstated. If you are later rehired by the Company, you cannot refund the payment and your Seniority cannot be reinstated.

If you are eligible for an immediate pension benefit under the Ford-UAW Retirement Plan, at the time of your break in service (due to receipt of a SUB Separation Payment), you shall upon completion of the Allocation Period and application for a pension benefit become eligible for post-retirement health care and life insurance on the same basis as other retirees. For purposes of applying the terms of the Ford-UAW Retirement Plan, you shall not be treated as a deferred vested retiree by reason of your receipt of a SUB Separation Payment.

If you are rehired

In the event that you are rehired by the Company within three years from the date of a prior separation from the Company, you may later become entitled to receive a second Separation Payment that would take into account the earlier Separation Payment.

How is the SUB Plan financed?

During the term of the 2007 Agreement, payment of benefits will continue to be made from the trust or Company funds.

Who is eligible to receive a Basic Moving Allowance?

A Basic Moving Allowance is provided if certain conditions are met.

You may receive a Moving Allowance from the Company if:

- There are 50 miles or more between plant locations and you apply within six months after the date you start work at your new location. The amount of your Basic Moving Allowance is \$4800.

If you accept the Basic Moving Allowance you will be eligible to apply for Return to Basic Unit after working at the plant of relocation for a period of six (6) months or upon indefinite layoff from the plant of relocation.

Enhanced Moving Allowance

An Enhanced Moving Allowance is available for eligible employees who have terminated their seniority at all other locations.

If you qualify and elect the Enhanced Moving Allowance, you will receive up to a maximum of \$30,000, of which \$6,000 will be provided as a signing bonus to cover miscellaneous up-front cash expenditures. \$16,000 will be paid at the new location.

After one year of employment, you may receive the remaining balance of the \$8,000.

To assist the spouse in finding employment in the new location, Spousal relocation assistance will also be provided through Associates Relocation Management Company, Inc. to assist the spouse in finding employment in the new location.

If you receive the Enhanced Moving Allowance, you will terminate your seniority at all other locations and, therefore, not be eligible for recall/rehire or Return to Basic Unit.

Application for an Enhanced Moving Allowance

To obtain the Enhanced Moving Allowance you must submit an application to the Human Resources office where you presently work prior to entering into agreements for the sale of your present residence, purchase a new residence and move household goods. The application form is available at your Human Resources office.

Moving Allowance Limitations

Any Moving Allowance you receive will be deducted from any subsequent Separation Payment and reduced by the amount of any moving allowance available under any state or federal law.

Only one Moving Allowance is payable when two or more Company employees of the same family living in the same home are relocated.

If you relocate pursuant to preferential placement provisions or other special placement programs, you may receive a maximum of two Moving Allowances, during the term of the 2007 Agreement.

The services of the UAW-Ford Relocation Services Center are available to provide information to help you with selling your existing home, buying a home at the new location, moving household goods and gaining knowledge of the new community.

What other circumstances might affect SUB Plan Benefits?

This section of your handbook has described how the SUB Plan works. Some other circumstances might affect your benefits, however.

Appeal procedures

If you believe you have been improperly denied a Benefit or Separation Payment, or receive a Benefit or Separation Payment that is smaller in amount than that to which you believe you are entitled, you may file an appeal. Such an appeal must be in writing and must be filed with your local SUB office within 30 days following date of mailing of the payment, notice of denial or suspension of SUB or a Separation Payment or within 30 days of payment of an Automatic Short Week Benefit that is smaller in amount than that to which you believe you are entitled.

A local SUB Plan Committee has been established for each Company location. There are two members representing the UAW and two members representing the Company who will consider your appeal. If the local Committee denies the appeal, there is no further appeal.

If the local Committee does not resolve the issue, a further appeal may be made at the request of the employee to the Ford-UAW Board of Administration for SUB. This Board includes three Company members and three UAW members. The Plan provides for an impartial chairman. There is no appeal from the Board's decision.

If the Plan terminates

If the Plan terminates, all assets remaining in the SUB Fund will be used to pay Plan Benefits to eligible employees for one year, unless the assets are exhausted sooner.

Plan provisions that provide for additional Company contributions to the SUB Fund when the CUCB falls below certain levels will not apply if the Plan terminates.

After the end of the first year after Plan termination, the Company and the UAW will negotiate a program that will specify how any assets remaining in the Fund will be allocated.

Guaranteed Income Stream (GIS) Benefit Program

The Guaranteed Income Stream (GIS) Benefit Program has been eliminated with the 2007 UAW Ford Collective Bargaining Agreement.

Reference the Letter of Understanding:

Subject: Elimination of the Guaranteed Income Stream Benefit (GIS) Program

NOTES

UAW-Ford Legal Services Plan

After an overview of your benefits from the Legal Services Plan, this section of your handbook answers these questions:

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Legal Services Plan

An overview: the UAW-Ford Legal Services Plan

At one time or another, most of us need the help of a competent attorney. The UAW-Ford Legal Services Plan can provide important assistance when these situations arise.

When you encounter a legal problem, the UAW-Ford Legal Services Plan can go to work for you. Depending on the circumstances, the Plan may provide three types of services:

1. **Full legal services** for such things as wills, adoptions, consumer complaints and real estate closings. These services are provided at no cost to you. In some situations, you also may receive full services for an appeal of a decision
2. **Office work** for matters such as divorce and traffic and criminal offenses. These services are provided at no cost to you.
3. **Referrals** to a Cooperating Attorney for certain other matters. In this case, you pay the fees for services provided — but at specified rates for the type of work being done

Services are provided directly by the Plan's legal staff if you live near an office where the Plan's legal staff is located. If you live outside of an area where the Plan's legal staff is available, services are provided by a Cooperating Attorney. (A Cooperating Attorney is an independent attorney who has contracted to provide services to Plan members through the Plan.)

Who is eligible and what are some basic coverage details?

You, your spouse and your dependent children may be covered by the Plan. Coverage generally begins after you have been employed 90 days.

Eligibility

You are eligible for the UAW-Ford Legal Services Plan if you:

- Are a full-time hourly employee represented by the UAW and
- Have been employed for 90 days

You also are eligible for the UAW-Ford Legal Services Plan if you retire and are eligible for benefits (other than deferred vested benefits) under the Ford-UAW Retirement Plan.

Your dependents also may be eligible for coverage. Your dependents include:

- Your spouse, to whom you are currently married. (A spouse by common law marriage is covered only if common law marriage is recognized by the laws in your jurisdiction)
- Your or your spouse's unmarried dependent children, until the end of the calendar year in which they reach age 25. Children include natural or legally adopted children and children for whom you are the legal guardian. The child must live with you or be your legal responsibility
- All individuals who may be legally claimed as your dependents under Section 152 of the Internal Revenue Code for Federal income tax purposes
- Your same sex domestic partner, consistent with the Company's healthcare benefit eligibility criteria

When coverage begins

Coverage begins when you attain seniority.

When coverage ends

Generally, your coverage ends when you leave the Company.

Coverage for your dependents generally ends on the day your coverage ends or when the dependent relationship ends. This occurs for your spouse if you become divorced or your marriage is annulled. It occurs for your dependents when they no longer may be legally claimed as dependents under Section 152 of the Internal Revenue Code for federal income tax purposes.

Coverage for you and your dependents also will end if you lose your seniority rights. (However, Coverage will continue while a Union grievance related to your seniority rights is pending.)

If you lose your seniority rights, but are later reinstated or reacquire them, you will become eligible on the date they are reacquired.

When coverage is continued

Under the following circumstances, coverage may continue after the time it normally would end:

- **If you are laid off**, coverage for you and your dependents will continue for 24 months after the last day of the month in which your layoff begins
 - If you are on an approved leave of absence, coverage for you and your dependents continues during the leave
 - If you retire and are eligible for retirement benefits (other than deferred vested benefits) under the Ford-UAW Retirement Plan, coverage for you and your eligible dependents will continue after you retire
 - **If you die**, coverage for your spouse may continue if he or she is eligible for:
 - ◇ Surviving spouse benefits under the Retirement Plan
 - ◇ Transition or Bridge Survivor Income Benefits under the Life and Disability Insurance Program
- or**
- ◇ Health care Benefits

Under these conditions, coverage would continue until those benefits end.

If your spouse is not eligible for any of these benefits, coverage ends twelve months following the month in which your death occurs.

Coverage for your eligible dependents and same-sex domestic partners ends twelve months following the month in which your death or your surviving spouse's death occurs.

- **If your unmarried child has a physical or mental disability** which prevents the child from doing any substantial gainful activity, coverage can continue after the calendar year in which he or she reaches age 25. To qualify:
 - ◇ The child must live in your household or your surviving spouse's household
 - ◇ The disability must be medically determinable
- and**
- ◇ The disability must be expected either to continue for a long or indefinite period or result in death

Plan cost

The Company pays all the costs of the Plan. For years, coverage under the Plan was provided tax free to Plan members in accordance with Section 120 of the Internal Revenue Code. That Section and the tax exclusion provided by it for Plan members expired on June 30, 1992. Without Section 120, the Company must "impute" income to all Plan members. Imputed income is income that is not actually received as pay, but it is subject to federal, state and local income and Social Security (FICA) taxes.

Plan administration

Money the Company contributes goes into a trust fund. The trustee of the fund is Comerica Bank. Money in the fund is used for the sole purpose of paying Plan benefits. It cannot be returned to the Company, Union or Administrative Committee. An Administrative Committee is made up of three members appointed by the Union, three members appointed by the Company and one member appointed jointly by the Union and the Company. A Plan Director is chosen by this Administrative Committee.

For what matters can full legal services be provided?

The Plan provides full legal service benefits for matters such as wills, adoptions, consumer complaints, real estate closings and termination of Social Security benefits.

If you or your dependents require legal services for any of the items listed below, the Plan will provide all necessary and appropriate legal services. This includes an attorney's services, court work, court costs, filing fees and deposition and discovery charges for:

- Suspension or termination of Social Security disability benefits
- Probate proceedings
- Wills, codicils and trusts
- Guardianships
- The adoption or legitimization of a child
- Name changes
- Consumer complaints and warranties (including litigation on plaintiff claims exceeding \$700)
- Contracts for goods and services (including litigation on plaintiff claims exceeding \$700)
- Defending a collection action on personal or family debts
- Defending a garnishment
- Repossession and replevin (recovery) of goods
- Personal bankruptcy
- Denial of insurance claims or loss of insurance coverage (except against the Company or Company-sponsored insurance plans)
- IRS audits and administrative proceedings (administrative appearances only)
- Tenant representation
- Leases on personal or family residences
- Property damage (real and personal)
- Real estate matters for a personal or family residence, including closings, purchases, mortgages, sales, foreclosures, boundary disputes, title disputes, zoning matters and eminent domain
- Property tax assessment disputes

- Uncontested divorces, uncontested custody, uncontested non-support, and uncontested alimony in jurisdictions in which an attorney is required to appear in court to finalize the proceedings
- Post-divorce modification of child support order and alimony order, provided that the cause is a material change in the participant's earnings from the Company (only)
- Termination of parental rights (excluding cases where criminal charges are involved)

Can services be provided for an appeal?

For certain matters, you can receive full legal services to appeal a decision. In some cases, however, approval by the Administrative Committee is required.

The Plan will provide full legal services for appeals on these matters:

- Defending a collection action on personal or family debts
- Defending a garnishment
- Repossession or replevin (recovery) of goods
- Personal bankruptcy
- Consumer complaints and warranties
- Contracts for goods and services
- Denial of insurance claims or loss of coverage
- Medicare claims, but only if, in the opinion of the Director or his/her designee, there is a substantial likelihood of prevailing on such appeal

Appeals for the following matters also will be covered when approved by the Plan's Administrative Committee:

- Suspension or termination of Social Security disability benefits
- Probate proceedings
- Wills, codicils and trusts
- Guardianships
- Adoption or legitimization of children
- Name changes
- Tenant representation
- Leases on personal or family residences
- Property damage (real and personal)
- Real estate matters for a personal or family residence, including closings, purchases, mortgages, sales, foreclosures, boundary disputes, title disputes, zoning matters and eminent domain
- Property tax assessment disputes

For what legal matters is office work provided?

Office work is provided for such things as traffic offenses, divorce, public assistance claims and veteran's benefit claims.

The Plan covers office work by an attorney, in his or her office, for the matters listed below. Office work includes such things as document preparation, advice, correspondence and telephone calls for:

- Social Security claims other than disability suspensions or terminations
- Veterans' benefits claims
- Food stamp or other public assistance claims
- Moving violations and other traffic offenses (but not parking violations)
- Misdemeanors
- Juvenile offenses
- Divorce, separation, annulment, dissolution, maintenance and child custody
- Nonsupport and alimony
- Naturalization, immigration and deportation
- Federal, state and local claim to taxes (excluding tax return preparation)

If you need legal services beyond office work for these matters, you may be referred to a Cooperating Attorney. At that time, benefits for office work will end. You will be responsible for paying the Cooperating Attorney's charges, as explained in the next section.

Family Planning Matters

The Plan provides office work services to prepare for or respond to the death or incapacity of an Employee's, Retiree's or Spouse's parent. Office work services may be provided in the areas of guardian-ship, probate, wills, trusts, and real estate matters. The Plan can only provide these services if all necessary family members consent to the Plan's representation and waive conflicts of interest.

For what legal matters is a referral provided?

For legal services beyond those covered by other parts of the Plan, you may be referred to a Cooperating Attorney. It is your responsibility to pay the attorney's fees at specified rates.

You can receive a referral to a Cooperating Attorney:

- When you require full legal services for a matter not covered by the Plan's full legal service benefits
- When you need legal services beyond office work for matters covered by office work only

In these cases, you may be referred to a Cooperating Attorney. Cooperating Attorneys have an agreement through the Plan to provide legal services to Plan members. It is your responsibility to pay the cost of the services according to a scheduled fee determined by the Plan.

If you have questions or concerns about the services you receive from a Cooperating Attorney, you may call the Plan's legal staff for advice on how to handle the situation.

What expenses are not covered?

While many legal services are provided, some expenses are not covered.

The Plan does not cover legal expenses for the following matters:

- Any action pending before April 1, 1985 (the effective date of the Plan)
- Legal services which are not considered personal legal services by law (for example, for matters involving a family business)
- Workers' Compensation or Unemployment Compensation matters involving the Company
- Any bankruptcy proceeding that would result in discharge of a debt owed to the Company, the Union or any benefit Plan or trust established or maintained by the Company
- Proceedings against any benefit Plan or arising out of any benefit Plan established or maintained by the Company, including proceedings against any trust or insurance carrier through which such benefits are provided to the Company, employees or retirees
- Any dispute between you and the Company, its subsidiaries, its dealers or any of its officers or agents
- Fines and penalties, whether civil or criminal
- Any judgment for civil damages
- Proceedings involving disputes between you and another Plan member, unless you and the other Plan member are represented separately
- Any non-legal costs associated with the purchase or sale of real estate
- Matters involving election laws, or warrant to any civil office
- Any dispute involving this Plan
- Any proceeding against the Union, any of its subordinate or affiliated bodies, or the officers or agents of such or against any labor organization representing employees of the Company
- Any proceeding in which the Union would be prohibited from defraying the cost of legal services under law or any proceeding arising under the National Labor Relations Act or Labor Management Relations Act
- Tax return preparation

How do I receive Plan services?

Services are provided by the Plan's legal staff or by a Cooperating Attorney.

If you live near a Plan office

If you live near a Plan office, legal services are provided directly by the Plan's legal staff. Plan offices are listed in the next section. You may call the Plan office in your area, collect, for an appointment. If you wish, you may talk to an attorney over the phone before making an appointment.

If you do not live near a Plan office

If you do not live near a Plan office, you may call the national office for a referral to a Cooperating Attorney in your area. In this case, the Plan pays the Cooperating Attorney for all services provided they are covered by the Plan. To reach the national office, call toll-free:

- In Michigan: 1-800-482-5007 or
- Outside Michigan: 1-800-645-5203

Some things to keep in mind

In many cases, sound advice or steps taken early can keep a minor legal problem from turning into a major one. You will receive the most benefit from the Plan if you contact an attorney as soon as you are aware of a situation in which legal counsel is needed.

The attorney providing Plan services represents you on an individual basis. You are entitled to the attorney's sole protection of your interests.

Information exchanged between you and an attorney is treated confidentially. That information is not released to the Company, Union or other persons.

If you are dissatisfied with work performed

If you or a dependent are dissatisfied with the work performed under the Plan or by a Cooperating Attorney, you may turn in a written complaint to the Plan's Assistant Director. Within 50 days following the date you submit your complaint, the Plan's Director will send you a written decision on your complaint.

If you are dissatisfied with the decision, you may make a written appeal to the Administrative Committee within 30 days. The appeal should state your reasons for a change in the Director's decision.

As soon as possible, you will receive a written notice from the Director stating the final decision on your complaint.

Coordination of benefits

The Plan does not provide legal services in matters for which you or a dependent are entitled to services or benefits through another plan or insurance. In the event of duplicate coverage, the other plan or insurance contract would provide benefits before this Plan.

Services may be limited or denied if you and another Plan member — or two or more covered family members — have a legal dispute, since representing two covered persons could result in a conflict of interest. If the dispute is between you and another family member, you would be entitled to services covered by the Plan. Your dependent would need to obtain an outside attorney and pay resulting costs and fees. If the conflict is between you and another Plan member, services provided by the Plan generally are provided through separate Cooperating Attorneys.

What are other Plan details?

Following is additional information about the UAW-Ford Legal Services Plan.

Legal matters arising from U.S. and Canadian laws are covered

The Plan covers legal problems arising under the laws of the United States and Canada — or any state, commonwealth, district, territory, province, or political subdivision of the United States or Canada. Legal matters arising from other laws are not covered.

No assignment of benefits

Benefits under this Plan cannot be assigned, pledged, attached, or made subject to debts.

If the Plan is terminated

Although termination of the Plan is unlikely, the Company and Union reserve the right to terminate or amend the Plan. If funds are available at Plan termination, legal representation of matters pending would continue until the matter is concluded, or for one year, whichever is earlier. If funds are not available to continue representation, benefits would be prorated based on available assets.

Where are Plan offices located?

Plan offices are located in many states throughout the country.

ALABAMA

Decatur

401 Lee Street N.E.
Amsouth Bank Bldg., Suite 600
Decatur, Alabama 35601
(256) 353-1555

Madison

Meadow Green Centre
9238 Highway Blvd., Suite 750
Madison, Alabama 35758
(256) 461-7526

DELAWARE

Newark

200 Continental Drive, Suite 212
Newark, Delaware 19713
(302) 366-0513

FLORIDA

Clearwater

2454 McMullen Booth Road
Building B, Suites 424 & 425
Clearwater, Florida 33759
(877) 309-1787
(727) 669-5319

GEORGIA

Atlanta

2200 Century Drive Parkway, Suite 950
Atlanta, Georgia 30345
(404) 248-0808

777 Cleveland Avenue SW, Suite 607
Atlanta, Georgia 30315
(404) 761-3116

ILLINOIS

Belvidere

Landmark Financial Center
600 South State Street, Suite 200
Belvidere, Illinois 61008
(815) 544-2525

Burr Ridge

Harris Bank Hinsdale Building
101 Burr Ridge Parkway, Suite 200
Burr Ridge, Illinois 60527
(630) 850-9700

Calumet City

1579 Huntington Drive
Calumet City, Illinois 60409
(708) 868-7520

INDIANA

Anderson

1106 Meridian Plaza, Suite 300
Anderson, Indiana 46016
(765) 646-6076

Fort Wayne

3110 Mallard Cove Lane
Covington Creek Professional Village
Fort Wayne, Indiana 46804
(260) 432-7403

Indianapolis

5155 N. Shadeland Avenue, Suite 300
Indianapolis, Indiana 46226
(317) 543-5001

3750 Guion Road, Suite 185
Indianapolis, Indiana 46222
(317) 926-7036

Kokomo

217 Southway Boulevard East, Suite 201
Kokomo, Indiana 46902
(765) 864-6400

Marion

220 South Norton Avenue
Marion, Indiana 46952
(765) 662-8411

Muncie

1200 S. Tillotson Overpass, Suite 1
Muncie, Indiana 47304
(765) 288-8980

KANSAS

Kansas City

Gateway No. II Building
4th and State Avenues, Suite 1002
Kansas City, Kansas 66101
(913) 321-1619

KENTUCKY

Louisville

Austin Building
1939 Goldsmith Lane, Suite 117
Louisville, Kentucky 40218
(502) 456-4222

LOUISIANA

Shreveport

6007 Financial Plaza, Suite 704
Shreveport, Louisiana 71129
(318) 688-3960

MARYLAND

Baltimore

Maritime Center
6610 Tributary St., Suite 210
Baltimore, Maryland 21224
(410) 633-5600

MICHIGAN

Bay City

4139 East Wilder Road
Bay City, Michigan 48706
(989) 684-3300

Dearborn

5220 Oakman
Dearborn, Michigan 48126
(313) 943-5300

Detroit

7430 Second Avenue, Suite 1000
Detroit, Michigan 48202
(313) 875-6033
(313) 872-4600

Flint

5125 Exchange Drive
Flint, Michigan 48507
(810) 257-0430

G-2370 South Linden Road
Flint, Michigan 48532
(810) 720-0044

Flint (continued)
432 N. Saginaw, Suite 504
Flint, Michigan 48502
(810) 257- 0400

Lansing
6500 Mercantile Way, Suite 3
Lansing, Michigan 48911
(517) 887-2838

Livonia
33067 Schoolcraft
Livonia, Michigan 48150
(734) 427-4505

Monroe
898 S. Telegraph
Monroe, Michigan 48161
(734) 242-9700

Pontiac
91 N. Saginaw, Suite 204
Pontiac, Michigan 48342
(248) 858-5850

Portage
590 West Centre Avenue
Portage, Michigan 49024
(269) 324-3106

Saginaw
Morley Building
One Tuscola Street
Saginaw, Michigan 48607
(989) 776-6650

Saline
601 Woodland
Saline, Michigan 48176
(734) 429-4272

Sterling Heights
42140 Van Dyke Avenue, Suite 110
Sterling Heights, Michigan 48314
(586) 254-0320

36177 Mound Road,
Sterling Heights, Michigan 48310,
(586) 446-4605

Taylor
20600 Eureka Road, Suite 620
Taylor, Michigan 48180
(734) 282-8118

Wayne
36129 East Michigan
Wayne, Michigan 48184
(734) 721-5483

Wixom
29600 Wixom Road
Wixom, Michigan 48393
(248) 669-3860

Wyoming
4433 Byron Center Rd. S.W.
Wyoming, Michigan 49519
(616) 531-7722

Ypsilanti
1011 Emerick
Ypsilanti, Michigan 48197
(734) 482-4500

MINNESOTA

St. Paul
2233 University Avenue
Wright Building, Suite 235
St. Paul, Minnesota 55114
(651) 641-0647

MISSOURI

Lake St. Louis
1000 Lake St. Louis Blvd., Suite 120
Lake St. Louis, Missouri 63367
(636) 561-2057

Liberty
One Victory Drive, Suite 201
Liberty, Missouri 64068
(816) 781-7791

St. Ann
500 Northwest Plaza, Suite 710
St. Ann, Missouri 63074
(314) 291-6868

Sunset Hills
10820 Sunset Office Drive, Suite 141
Sunset Hills, Missouri 63127
(314) 822-9330

NEW JERSEY

Woodbridge
Woodbridge Center
10 Woodbridge Center Dr., Suite 730
Woodbridge, New Jersey 07095
(732) 602-1166

NEW YORK

Cheektowaga

Airport Commerce Park
307 Cayuga Road, Suite 150
Cheektowaga, New York 14225
(716) 632-1644

Hamburg

4819 South Park Avenue
Hamburg, New York 14075
(716) 646-5530

Lockport

90 Professional Parkway
P.O. Box 877
Lockport, New York 14095-0877
(716) 433-1991

Rochester

1200-C Scottsville Road, Suite 361
Rochester, New York 14624
(585) 436-7720

Syracuse

6712 Brooklawn Parkway, Suite 200
Syracuse, New York 13211
(315) 437-6655

OHIO

Austintown

Cider Mill Crossing Complex
1570 S. Canfield-Niles Road
Building B, Suite 101
Austintown, Ohio 44515
(330) 799-7711

Brooklyn Heights

707 Brookpark Road
Brooklyn Heights, Ohio 44109
(216) 741-2365

Canton

4801 Dressler Road, N.W., Suite 176
Canton, Ohio 44718
(330) 493-8955

Cincinnati

4010 Executive Park Drive, Suite 225
Cincinnati, Ohio 45241
(513) 984-2640

Columbus

5212 W. Broad Street
Columbus, Ohio 43228
(614) 878-9262

Dayton

111 W. First St., Suite 1045
Dayton, Ohio 45402
(937) 222-6090

Defiance

1450 South Clinton Street
Defiance, Ohio 43512
(419) 782-2253

Euclid

Omni Park
27801 Euclid Avenue, Suite 210
Euclid, Ohio 44132
(216) 261-8904

Lima

209 N. Main Street, Suite 2A
Lima, Ohio 45801
(419) 227-1405

Lorain

5300 Baumhart Road, Suite 3
Lorain, Ohio 44053
(440) 282-1392

Macedonia

8536 Crow Drive, Suite 110
Macedonia, Ohio 44056
(330) 467-5030

Mansfield

1075 National Parkway
P.O. Box 2668
Mansfield, Ohio 44906
(419) 529-4560

Sandusky

3116 Bardshar Rd.
Sandusky, Ohio 44870
(419) 625-0536

Toledo

3360 W. Laskey
Toledo, Ohio 43623
(419) 471-1489

OKLAHOMA

Oklahoma City

3901 Southeast 29th Street
Del City, Oklahoma 73115
(405) 677-2670

TENNESSEE

Nashville

95 White Bridge Pike, Suite 411
Nashville, Tennessee 37205
(877) 501-4579
(615) 356-6280

Spring Hill

100 Stephen P. Yokich
P.O. Box 1797
Spring Hill, Tennessee 37174
(877) 501-4579
(931) 487-9818

TEXAS

Arlington

2225 E. Randol Mill Road, Suite 427
Arlington, Texas 76011
(817) 633-2283

WISCONSIN

Janesville

20 East Milwaukee Street, Suite 400
Janesville, Wisconsin 53545
(608) 755-1566

Milwaukee

4915 South Howell Avenue, Suite 100
Milwaukee, Wisconsin 53207
(414) 482-7160

UAW-FORD Legal Services Plan

200 Albert Kahn Building
7430 Second Avenue
Detroit, Michigan 48202
Administrative Committee

Rebecca Eisenberg, Chair
625 State Street
University of Michigan Law School
Ann Arbor, Michigan 48109

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Dearborn, Michigan 48121-6214

Robert W. Esler, Director
Jeff Hartzel, UAW Coordinator

The information contained in the section of Your Employee Benefits handbook entitled “Tax-Efficient Savings Plan For Hourly Employees” constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933, as amended.

Tax-Efficient Savings Plan for Hourly Employees

(A supplemental savings plan)

After an overview of the Tax-Efficient Savings Plan for Hourly Employees (TESPHE), this section of your handbook answers these questions:

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Tax-Efficient Savings Plan for Hourly Employees

An overview: the Tax-Efficient Savings Plan for Hourly Employees ("TESPHE" or the "Plan")

TESPHE makes saving for the future convenient and tax efficient.

TESPHE gives you a convenient way to save and invest money to help you achieve your long-term financial goals. Listed below are some significant advantages:

Under TESPHE, you have:

- **A systematic savings and investment program.** You can save up to 50% of eligible pay from each paycheck. You also can save all or part of any Profit Sharing payment.
- **A choice of pre-tax, or after-tax contributions, or both.**
- **For employees age 50+, an opportunity to make additional pre-tax contributions in the form of catch-up contributions.**
- **Unique tax advantages.** Your pre-tax contributions are deducted from your eligible pay before you have federal income tax and most state and local income taxes withheld. Also, earnings on your contributions are sheltered from taxes while they're in the TESPHE. Other tax advantages also may be available at distribution.

Assets attributable to pre-tax contributions cannot be withdrawn prior to age 59 $\frac{1}{2}$ or termination of employment, except for financial hardship. Further, a taxable withdrawal of savings from the TESPHE prior to age 59 $\frac{1}{2}$ may be subject to certain tax penalties. For more information, refer to the section entitled "What are the Tax Consequences of my withdrawal or distribution?"

- **Investment opportunities.** You may choose among investment options that offer a wide range of risk/return preferences and that will allow you to accommodate different investment goals.
- **Daily transactions.** You may make exchanges between most investment options, make withdrawals or initiate loans on any business day. Generally, transaction requests confirmed before 4:00 p.m. Eastern Time will be effective at the close of the business day.

- **Daily account valuation.** Your account will be valued each business day to provide up-to-date account information when you need it.
- **Deferred Distribution.** In most cases, you may elect to leave your assets in the TESPHE after you leave Ford Motor Company (the "Company" or "Ford").

The Tax-Efficient Savings Plan for Hourly Employees is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974, as amended, and Title 29 of the Code of Federal Regulations Section 2550.404c-1. The fiduciaries of the TESPHE may be relieved of the liability for any losses which are the direct and necessary result of investment instructions given by a member or beneficiary.

Account statements

As soon as practicable after the end of each quarter, a statement of your account will be provided, unless you elect to receive your statements online. If you elect to receive your statement online, an annual statement covering the entire year will be mailed to you. You will also be able to request a statement whenever you want one. The statement shows your savings and investments, the value of your account, and other information regarding your account.

If you think that there is an error in your quarterly statement, you should notify the Fidelity Service Center for Ford Motor Company in writing within 30 days after you receive it. If you do not notify the Fidelity Service Center for Ford Motor Company of errors, we will assume that your statement is correct.

Performance History Sheet

If you are a participant in the TESPHE, you will be provided with the Performance History Sheet with your Quarterly Account Statement. Members who receive mailed statements will receive this document with the quarterly statements. Members who elect to receive their statements online can access this document at any time through Fidelity NetBenefits® at netbenefits.fidelity.com. Otherwise, the Performance History Sheet may be requested by calling the Fidelity Service Center for Ford Motor Company.

You can always obtain performance data on all of the available investment options through Fidelity NetBenefits at netbenefits.fidelity.com. From the NetBenefits home page, select Investment Choices and Research from the "quick links" menu. Select any investment option to obtain additional information (e.g., fund overview, quick stats, rankings/ratings, performance, volatility measures, top holdings, fees & expenses, fund facts and prices and distributions). If you do not have web access, call the Fidelity Service Center for Ford Motor Company and request a mutual fund prospectus.

Note to Members Who Are Not Active Employees

As you review this document, keep in mind that some of the TESPHE features, such as making contributions and requesting loans, do not apply to retirees, terminated employees, alternate payees and beneficiaries, and certain other members who are not active employees.

Who can participate in TESPHE?

TESPHE participation is voluntary. You can enroll upon becoming eligible.

Eligibility

You're eligible to participate in TESPHE three months after your initial date of hire if:

- You're an hourly employee of Ford Motor Company ("Ford" or the "Company") or a participating subsidiary, and
- You're on the active employment roll as a full-time or part-time employee.

If you leave Ford and later return, your eligibility continues to be based on your original date of hire.

How to enroll or re-enroll

Participation in TESPHE is voluntary. If you want to participate, you must elect to make contributions.

- To have a portion of your weekly eligible pay contributed to TESPHE, you must enroll by calling the Fidelity Service Center for Ford Motor Company or by accessing Fidelity NetBenefits. (See "Managing Your Account" in the Appendix at the end of this section.) You may enroll as early as two weeks prior to your eligibility date. It could take up to two pay periods before your elections become effective after you enroll following your eligibility date. **Be sure to look at your paycheck to confirm deductions have started. Notify the National Employee Services Center (NESC) at 1-800-248-4444 if deductions do not commence within two pay periods (after your eligibility date) if you have enrolled.**
- When you elect to participate, you must indicate the percentage of your eligible pay to be contributed to the TESPHE. You also must choose how your savings will be invested among the available investment options.
- You may stop your contributions at any time. To re-enroll for weekly contributions, call the Fidelity Service Center for Ford Motor Company, or access Fidelity NetBenefits at netbenefits.fidelity.com. (See the "Managing Your Account" section in the Appendix at the end of this section.)

- You may also enroll by electing to have all or a portion of any Profit Sharing payment contributed to the TESPHE during the special open enrollment period as announced by the NESC. If you have not otherwise enrolled, your participation would then begin on Profit Sharing Day which occurs by March 15 of any year a Profit Sharing payment is made. Remember that a Profit Sharing contribution to the TESPHE is a one-time annual election. To continue payroll deductions, you must enroll in the TESPHE and indicate the percentage of your eligible pay to be contributed. (Please note that if you are already enrolled in the TESPHE, you must make a separate election to contribute any Profit Sharing payments.) All Profit Sharing payments are considered pre-tax contributions.

Electing or changing your savings contributions

You may elect or change the percentage of eligible pay you contribute to the TESPHE by calling the Fidelity Service Center for Ford Motor Company or by accessing NetBenefits. It could take up to two pay periods before your contribution election or change becomes effective.

The chart in "Managing Your Account" located in the Appendix at the end of this section provides specific details on navigating NetBenefits to perform transactions (e.g., enrolling, changing your savings contributions, exchanges (transfers) between investment options, etc.).

How are contributions made to your account?

You can choose to save a portion of your eligible pay and certain other compensation in the TESPHE.

When you enroll in the TESPHE, you elect how much to save and whether you will save through pre-tax contributions, after-tax contributions (or both), or, for members age 50+, catch-up contributions. You can save up to 50% of your eligible pay in any combination of pre-tax contributions and after-tax contributions, in whole percentages. Eligible members also may contribute up to 50% of eligible pay as catch-up contributions. However, there are limitations on how much you can contribute to the TESPHE as described later in this section.

Pre-Tax contributions from eligible pay

You can designate from 1% to 50% of your eligible pay as pre-tax contributions under the TESPHE. Pre-tax contributions are subject to an annual limit imposed under the Internal Revenue Code of 1986, as amended ("Internal Revenue Code" or the "Code"). The annual limit may be adjusted for inflation and will be communicated each year. Pre-tax contributions are made with **before-tax** dollars.

Additional Pre-Tax Catch-Up contributions from eligible pay

If you are at least age 50 (or will attain age 50 by the end of the calendar year), you can designate up to 50% of eligible wages as catch-up contributions. This feature gives eligible employees the opportunity to make additional pre-tax contributions over certain applicable annual regulatory limits. However, catch-up contributions are subject to an annual limit. This limit may be adjusted annually for inflation and will be communicated each year. (See the Appendix at the end of this section for more information on catch-up contributions.)

Here's how it works:

Your pre-tax contributions are deducted from your eligible pay and contributed to your TESPHE account **before** current federal income taxes are withheld. In effect, your taxable pay for current federal income tax purposes is lowered by the amount of your pre-tax contributions. However, your pre-tax contributions are subject to social security taxes, as well as applicable state and local income taxes.

You eventually will pay income taxes on the value of your pre-tax contributions assets, including any related earnings, when they are withdrawn or distributed from your TESPHE account. For more information on tax treatment at the time of withdrawal or distribution, read the "Special Tax Notice" section.

After-Tax Contributions from eligible Pay

You may designate from 1% to 50% of your eligible pay as after-tax contributions, subject to certain Internal Revenue Code limits that will be communicated each year. After-tax contributions are subject to federal income taxes, social security taxes, and any state or local income taxes.

Any taxes on investment earnings are deferred until the earnings are paid to you. However, you won't pay taxes again on the amount of your after-tax contributions when you receive them from the TESPHE. For more information on tax treatment at the time of withdrawal or distribution, read the "Special Tax Notice" section.

A combination of Pre-Tax Contributions and After-Tax Contributions

You can authorize pre-tax contributions, after-tax contributions, or a combination of both, up to 50% of your eligible pay, subject to the Internal Revenue Code limitations described in "Limits on the TESPHE Contributions" section.

Contribution Spillover election

The contribution spillover election is provided so that you may preserve your rate of savings should you reach the annual limit on pre-tax contributions before the end of the year. When activated, this election authorizes the Company to deduct up to 10% of your base pay as after-tax contributions instead of pre-tax contributions, in the event you reach the annual pre-tax dollar limit. Generally, you do not need to activate the spillover election if you have made a separate after-tax election. If the spillover election is activated *and* you have made a separate after-tax election, an amount equal to your pre-tax deduction (up to 10%) will be added to your separate after-tax deduction percentage after you reach the annual pre-tax limit. For example, if you elect a 15% pre-tax deduction, a 15% after-tax deduction and activate the spillover election, a total of 25% will be deducted from your pay check in after-tax contributions after you reach the annual pre-tax limit.

How is money contributed to the TESPHE?

Subject to legal limits, you can elect to have up to 50% of your eligible pay and all or part of any Profit Sharing payment contributed to the TESPHE.

There are three ways money can be contributed to your TESPHE account:

- Automatic payroll contributions (deducted directly from your eligible pay)
- Contribution of all or a portion of any Profit Sharing payment, and
- Rollover from a prior employer's plan

Effective March 1, 2008, rollover of a lump-sum distribution from the UAW-Ford Retirement Plan or the General Retirement Plan

Payroll contribution deductions

You can designate from 1% to 50% of your eligible pay to be contributed to your TESPHE account. The percentage you choose will be deducted from your eligible pay and added to your account weekly as soon as possible, usually within two business days of payday.

The Fidelity Service Center for Ford Motor Company will refer to your TESPHE contributions as pre-tax contributions, after-tax contributions or catch-up contributions.

Under TESPHE, your "eligible pay" is generally your regular base pay for straight-time hours. "Eligible pay" cannot exceed 40 hours per week and includes:

- Straight-time hours
- Straight-time portion of overtime hours
- Holiday and vacation pay (including the related excused absence allowance)
- Incentive pay
- Bereavement pay
- Jury duty pay
- Short-term military duty pay
- Cost-of-living allowance applicable to eligible pay listed above
- Military Differential Pay

The Performance Bonus payments are issued to you in a separate check. TESPHE contributions are automatically deducted at the same payroll deduction percentage as your weekly payroll contributions, and will be invested in the same investment options.

Your eligible pay under the TESPHE does *not* include overtime premium pay, Christmas bonus, shift differential, or weekend premiums, or other special payments.

Profit Sharing Payments

If you're eligible to contribute to TESPHE, you also may elect to have all or a portion of any Profit Sharing payments contributed as pre-tax contributions to your TESPHE account, whether or not you make weekly payroll contributions.

Any contributions directed to your TESPHE account from Profit Sharing payments will be invested in accordance with your most recent investment elections.

Rollover from subsidiary plan

Under certain circumstances, you may elect to have the TESPHE accept a transfer from a savings plan of a subsidiary where you were previously employed of fully vested amounts, either in the form of cash or Company stock, provided such acceptance would not require the TESPHE to provide benefits in an amount or form not otherwise provided under the TESPHE. Amounts transferred will be invested in accordance with your elections among the investment options available under the TESPHE. Transferred assets will be subject to all the provisions of the TESPHE applicable to any other assets credited to your account.

Rollover from prior employer's plan

You may arrange for a rollover of the taxable portion of a cash distribution from an eligible tax qualified plan of your last employer. Eligible tax-qualified plans include: 401(k) plans like the TESPHE, defined benefit plans like the Ford UAW Retirement Plan, or a conduit IRA. (A conduit IRA is one that holds nothing more than the distribution from your prior employer's plan, plus earnings, and is not mixed with other IRA assets.) Beginning January 1, 2002, you may also roll over distributions from 403(b) arrangements (tax-free annuities), 457 plans (governmental plans), traditional IRAs, and after-tax amounts from eligible tax qualified plans. The after-tax contributions from another tax qualified plan must be made directly between your prior employer plan and TESPHE in a direct rollover. TESPHE may not accept after-tax monies from an IRA.

Beginning March 1, 2008, employees who retire from the Company may roll over lump-sum distributions from the Ford UAW Retirement Plan and the General Retirement Plan to the TESPHE.

You may also roll over an eligible distribution from your deceased spouse or former spouse (as a result of a Qualified Domestic Order) from the eligible plans listed above.

You may:

- Have the cash assets transferred from the plan of your prior employer directly to TESPHE (direct rollover); or
- Contribute to TESPHE all or a portion of the cash assets distributed to you from your prior employer's plan, provided you make the contribution within 60 days after you receive the distribution (60-day rollover)

You should be aware that once your assets are transferred into the TESPHE, they are subject to TESPHE withdrawal and distribution rules.

You may make a rollover to TESPHE without waiting the normal three months for eligibility. You may contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 for more information if you would like to arrange a rollover and to obtain the necessary forms.

Contributions following qualified military service

A member of the TESPHE, who is reinstated following qualified military service, as defined in the Uniformed Services Employment and Reemployment Rights Act, may elect to have contributions made to the TESPHE from such member's wages paid following such qualified military service that will be attributable to the period contributions were not otherwise possible due to military service. Such additional contributions will be based on the amount of wages and Profit Sharing payments that the member would have received, but for military service, and will be subject to the provisions of the TESPHE in effect during the applicable period of military service. After you are reemployed, you will have until the lesser of (i) five years or (ii) the period of your military service multiplied by three to make up contributions. The additional contributions will not be taken into account in the year in which they are made for purposes of any limitation or requirement generally imposed on contributions by the Internal Revenue Code. However, when added to contributions previously made, they will not exceed the applicable limits in effect during the period of military service if the member had continued to be employed by the Company during such period. Further, payments on any loan or loans outstanding during the period of military service will be extended for a period of time equal to the period of qualified military service.

Limits on TESPHE contributions

Complex tax rules govern contribution levels to plans like TESPHE, including:

- Your pre-tax TESPHE contributions are subject to an annual limit. The annual limit will be communicated to TESPHE members each year. You may also access this information from Fidelity NetBenefits or the Fidelity Service Center for Ford Motor Company.
- The tax law tries to encourage fair rates of savings among employees at all pay levels. If the savings rates among all TESPHE members do not meet certain Internal Revenue Code requirements, the Company may need to adjust individual savings rates of highly compensated employees to comply with these requirements. The Internal Revenue Code defines highly compensated employees as those who received compensation from the Company in excess of a certain limit earned in the prior year. This figure may be adjusted annually to reflect changes in cost of living and will be communicated each year.
- In addition, contributions to the TESPHE (e.g., pre-tax contributions (excluding any catch-up contributions), after-tax contributions and any Company contributions) cannot exceed the lesser of the Internal Revenue Code annual additions limit or 100% of your compensation. (NOTE: The annual additions limit may be adjusted for inflation and will be communicated to TESPHE members each year.) For this purpose, compensation is your gross earnings from April 1 through March 31. Generally, the annual additions limit is prorated by the number of annual weekly pay periods. Your weekly contributions may not exceed this prorated amount on a cumulative basis. You may be affected by this weekly limit if you are contributing on a weekly basis at or near the maximum TESPHE contribution rate of 50%. As a result, your requested pre-tax deferrals from Profit Sharing would be reduced, and any reduction will be paid by check.

Contributions will be adjusted to comply with these limits.

Investing your contributions

You must invest your contributions in increments of 1% with a minimum of 5% for each investment option you select. Your contributions will be deducted from your weekly paychecks and will be invested in the options you have elected as soon as possible, usually within two business days after payday.

You may change your investment elections for your contributions by calling the Fidelity Service Center for Ford Motor Company or through Fidelity NetBenefits. Your new investment elections will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the New York Stock Exchange (usually 4:00 p.m. Eastern Time) on that day. If your request is made or confirmed after this time or on non-business days such as weekends or holidays, your new investment elections will be effective as of the close of business on the next business day.

What are the investment options?

You can invest in any of the available investment options.

The TESPHE offers a diversified line-up of passively managed, actively managed and life stage (or target-date retirement) investment options from which you may choose. These options provide a range of risk/return preferences.

A booklet entitled '*Your Investment Guide*' contains a brief description of the available investment options as well as some educational material. Please call Fidelity at 1-800-544-3333 to obtain a copy of this booklet. You may also print a copy from NetBenefits at netbenefits.fidelity.com.

The current investment options and the accompanying Voice Response System (VRS) codes are listed below.

Available Investment Options (VRS Code)

Life Stage (or Target-Date Retirement) Funds:*

- BGI LifePath Index[®] Retirement Fund NL (13020)
- BGI LifePath Index[®] 2015 NL Fund (13022)
- BGI LifePath Index[®] 2020 NL Fund (13023)
- BGI LifePath Index[®] 2025 NL Fund (13024)
- BGI LifePath Index[®] 2030 NL Fund (13025)
- BGI LifePath Index[®] 2035 NL Fund (13026)
- BGI LifePath Index[®] 2040 NL Fund (13027)
- BGI LifePath Index[®] 2045 NL Fund (13028)
- BGI LifePath Index[®] 2050 NL Fund (13029)

* - Plan Default Investment Option

Equity Funds - Passively Managed:

- BGI EAFE Equity Index Fund - Class T (44715)
- Common Stock Index Fund (99527)
- Ford Stock Fund (20207)
- U.S. Extended Market Index Fund (10152)
- Vanguard Institutional Index Trust - Institutional Plus Shares (20745)
- Vanguard FTSE Social Index Fund - Institutional Shares (43131)

Equity Funds - Actively Managed - Domestic:

- Fidelity Capital Appreciation Fund (00307)
- Fidelity Contrafund[®] (00022)
- Fidelity Equity-Income Fund (00023)
- Fidelity Growth Company Fund (00025)
- Fidelity Real Estate Investment Portfolio (00303)
- Janus Aspen Large Cap Growth Portfolio - Institutional (20569)
- Neuberger Berman Genesis Fund – Institutional Class (45418)
- Royce Low-Priced Stock Fund – Institutional Class (40390)

Equity Funds - Actively Managed - International:

- Fidelity Overseas Fund (00094)
- T. Rowe Price International Discovery Fund (99542)

Fixed Income:

- Bond Index Fund (99529)
- Interest Income Fund (18988)
- PIMCO Real Return Fund - Institutional Class (96095)
- PIMCO Total Return Fund - Institutional Class (99622)
- PIMCO Total Return Fund III - Institutional Class (91391)
- T. Rowe Price Institutional High Yield Fund (99544)

What are the Fees and Expenses?

This explanation is intended to provide you with important information regarding how plan administrative expenses and investment fees affect your savings plan account. You should not base your investment decisions on expense and fee information alone. There are many other features that may make a particular investment option an appropriate choice for you; expenses and fees are only one component.

Plan Administrative Expenses

Plan administrative expenses are the separately stated costs of maintaining the TESPHE's day-to-day operations. These expenses include the cost of all basic services that are necessary for administering the TESPHE as a whole, as well as for additional services such as recordkeeping fees, annual maintenance fees, electronic services, statements, education, transactional services, etc.

Generally, administrative costs incurred by the TESPHE are paid by the Company or from non-participant TESPHE assets. These costs may be offset as described below under the Expense ratio section. Your TESPHE account is not assessed fees for transactional services (e.g., loans, withdrawals, Domestic Relation Order processing, etc.). However, your account is charged if you request expedited mail delivery. Before requesting this service, be sure you understand the specific cost.

Investment Fees

- **Sales charges.** Also known as loads or commissions, sales charges are waived for any fund offered under the TESPHE.
- **Redemption fees.** A fee (expressed as a percentage) imposed on fund shares sold if the transaction is processed within a specified period of time after the purchase of such assets. Any redemption fees are deducted from your account when you sell your shares.
- **Expense ratio.** The percentage of the fund's assets used to pay for the fund's total operating expenses (management fees, 12b-1 fees and other expenses).
 - ◇ **Management fees** (the largest component of the expense ratio) are paid to the fund's investment manager or advisor for overseeing the portfolio.

- ◇ **12b-1 fees** (sometimes called a distribution fee) are used to cover marketing and advertising costs for the fund.
- ◇ **Other expenses** include the costs for operating the fund (administrative services, transfer agent fees, shareholder reports, auditing and financial statement preparation fees, participant recordkeeping, preparing and distributing prospectuses, custodial fees, etc.).

Mutual fund expense ratios are reported in "basis points". A basis point is 1/100th of one percent.

Hypothetical Example: If a fund charges an expense ratio fee of 55 basis points, the fund's return is reduced by 55/100ths of one percent (.0055) annually to cover total operating expenses. For each \$10,000 invested in that hypothetical fund, \$55 annually (\$10,000 X .0055) is deducted from that fund.

Expense ratio fees accrue daily on the average daily fund balance and are paid monthly. The total is deducted from the fund's assets and they are realized through reduced returns. These fees are factored into the daily share price, or net asset value ("NAV"), and are not charged directly to your account.

In some instances, mutual fund companies will make payments to the record keeper or to the TESPHE to offset administrative services.

Ford Motor Company - Specific Funds

Ford Motor Company pays:

- All fees and expenses (including brokerage commissions) for the Ford Stock Fund.
- The management fees of the Common Stock Index Fund and the Bond Index Fund. (Any brokerage fees and other expenses of these funds are paid from the fund assets and reduce the value of your investment in the funds.)

Summary

Higher investment management fees do not necessarily mean better performance, nor is cheaper necessarily better. Fees are only one factor to consider when selecting an investment. The bigger picture includes investment risk, investment returns, diversity of portfolio, cost averaging by making regular contributions, and the extent and quality of the services the TESPHE provides.

For each mutual fund, fees are included in the fund's prospectus. Please refer to the prospectus for more detailed information. Call the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 for a free prospectus for each mutual fund offered under the Plan.

Where to get Information on investment fees

The Fees and Expenses Information brochure and the Performance History sheet provide fee information. Currently, the Fees and Expense Information brochure is updated and distributed annually. The Performance History sheet is distributed each quarter with your TESPHE account statement if you elect to receive your statement via mail. Otherwise, both documents are available through Fidelity NetBenefits.

You may also request a mutual fund prospectus free of charge from the Fidelity Service Center for Ford Motor Company or through Fidelity NetBenefits. Additional mutual fund financial information may be obtained from a mutual fund's Summary of Additional Information ("SAI"). This is a separate document and must be specifically requested from the mutual fund company. Generally, the SAI is available online through the mutual fund's website.

Responsibility of members

Under the TESPHE, you are solely responsible for the selection of your investment options. Ford Motor Company, the Trustee, any appointed Fiduciary, the Plan Administrator, the Fidelity Service Center for Ford Motor Company, the Union, and employees and agents of the Company are not empowered to provide investment advice. The fact that an investment option is available for investment under the TESPHE should not be construed as a recommendation for investment in that option. It should be noted that the market price and the rate of return on each investment option may fluctuate over time and in varying degrees. Accordingly, the proceeds realized from such investments, if any, will depend on the prevailing market price of the investments at a particular time, which may be more or less than the amount expended initially. There is no guarantee that the investment options will achieve their objectives.

The TESPHE is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act of 1974, as amended, and Title 29 of the *Code of Federal Regulations* Section 2550.404c-1. The fiduciaries of the TESPHE may be relieved of liability for any losses which are the direct and necessary result of investment instructions given by a member or beneficiary.

Appointment of Independent Fiduciary and Investment Manager for the Ford Stock Fund

Effective April 19, 2006, Ford Motor Company ("Ford") appointed Bank of America, National Association ("U.S. Trust") to be the independent fiduciary and investment manager for the Ford Stock Fund available under the TESPHE.

The decision of how to invest your TESPHE account is yours to make, but we would like to remind you that the best way to reduce market risk is to diversify your investments. The TESPHE offers numerous investment choices with a wide range of risk and return that allow you to construct a diversified portfolio tailored to your own investment goals. You may transfer the portion of your TESPHE account that is invested in the Ford Stock Fund into other investment funds under the TESPHE at any time. You should periodically review your asset allocation strategy and consider whether the level of your investment in the Ford Stock Fund is appropriate in light of your own situation and your personal retirement goals.

The Ford Stock Fund holds shares of Ford common stock. U.S. Trust has the authority to restrict investments in the Ford Stock Fund, or to sell or otherwise dispose of all or any portion of the Ford common stock held in the Ford Stock Fund. In such event, U.S. Trust would designate an alternate investment fund under the TESPHE for the temporary investment of any proceeds from such sale. U.S. Trust is required to consider the sale of the Ford common stock held in the Ford Stock Fund only if it determines, on the basis of reliable public information, that there is a serious question as to the short-term viability of Ford as a going concern.

U.S. Trust will not be in possession of any inside information concerning Ford or its financial condition. Also, U.S. Trust will not take any action with respect to the Ford Stock Fund simply because of fluctuations in the market price of Ford common stock, even if a substantial or prolonged decline in the market price of Ford common stock occurs as a result of adverse disclosures concerning Ford or its businesses or for any other reason, unless the situation calls into serious question the short-term viability of Ford as a going concern. While U.S. Trust intends to communicate to members any significant action it takes with respect to the Ford Stock Fund, circumstances may require U.S. Trust to act prior to doing so.

If you have any questions regarding matters such as fund transfers, distributions, loans and account balance information should contact the Fidelity Services Center for Ford Motor Company at 1-800-544-3333. Please check the U.S. Trust Web site established for TESPHE members at <http://www.ustrust-fordplans.com> periodically for communications from U.S. Trust concerning the Ford Stock Fund. If you have questions or comments regarding this letter or the Ford Stock Fund, please contact U.S. Trust at fordmotorco@ustrust.com or at 1-800-573-4395. You may also contact U.S. Trust by mail at:

Ford Participant Inquiry
c/o Special Fiduciary Services Division
Bank of America, N.A.
515 South Flower Street; Suite 2700
Los Angeles, CA 90071

BANK OF AMERICA, NATIONAL ASSOCIATION

Note: The contact information and website address may change. If you have a balance in the TESPHE, you will be provided with any updated information.

Making an investment option selection

Before you select any of the investment options, be sure to request a prospectus for the mutual funds offered through the TESPHE from Fidelity. You can also view fund information online at Fidelity NetBenefits. From the home page, select Investment Performance and Research from the quick links menu, and then click on the investment option you wish to research. You can obtain complete descriptions of certain funds that are only available through Ford savings plans and are not publicly traded from the *'Your Investment Guide'* brochure. You may also obtain brief descriptions of the remaining investment options and general investment information from the brochure. Contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 to obtain a copy. You may also view or print a copy of the brochure from NetBenefits. Once logged on to your account, select the *Your Investment Guide and Plan Information* link under the News section.

Designated Default Investment Option

Effective March 19, 2008, the TESPHE designated default investment option is a target date retirement fund, presently, the BGI LifePath[®] Index NL Funds. (See the Appendix for the default schedule.)

Under the TESPHE, any contributions (e.g., pre-tax (including catch-up), and after-tax contributions) for which you do not provide investment direction are automatically invested in TESPHE's designated default investment option. If your contributions default to a target date retirement fund, you have the right to direct the investment of your existing balances and future contributions to any investment options available under the TESPHE, subject to any restrictions imposed by the funds.

How can you exchange assets?

You can exchange assets between investment options daily.

Assets may be exchanged from any one investment option directly to any other investment option, subject to certain fund exchange restrictions. You may initiate one or more exchanges daily. For example, on any day, you could exchange the value of a portion of your Interest Income Fund assets and reinvest the value of those assets in the Bond Index Fund and then request a second exchange from the Interest Income Fund and reinvest the value of those assets in the Neuberger Berman Genesis Fund – Institutional Class .

Assets may be exchanged in dollar amounts, percentage of current balance (in increments of 1%) or number of shares or units. The **minimum exchange** amount is **\$250**, or the entire value of the assets invested in the option if \$250 or less.

Making an exchange

You may request an exchange by calling the Fidelity Service Center for Ford Motor Company or through Fidelity NetBenefits at netbenefits.fidelity.com. Your exchange will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the New York Stock Exchange (usually 4:00 p.m. Eastern Time) on that day. If your request is made or confirmed after this time or on non-business days, such as weekends or holidays, your exchange will be effective as of the close of business on the next business day. Because of high call volume near the close of the market at times, you may wish to call early to be sure your request is made and confirmed before the deadline. A business day is any day that the New York Stock Exchange is open. Note: Interest Income Fund transactions cannot be completed on bank holidays even though the New York Stock Exchange may be open.

Short-term Redemption Fees

Several mutual funds in the TESPHE impose a short-term redemption fee which is charged to discourage short-term buying and selling of fund shares. These fees are paid to the fund and are disclosed in each mutual fund's prospectus. You can also find this information on the Performance History sheet (accessed by clicking on the *Investment Performance* link under the News section on NetBenefits), or by clicking on the investment option from the Investment Option and

Research category which you can access from the quick links menu. Since these fees are subject to change at any time by the fund, you should always consult the fund's most recent prospectus or contact the Fidelity Service Center for Ford Motor Company for current short-term redemption fee information.

Trading Restrictions

The investment options in the TESPHE may impose limits on how frequently you may trade into and/or out of the investment option. For example, a fund may not allow you to exchange back into the fund if you exchange out of the fund within the previous 90 days. You may contact the Fidelity Service Center for Ford Motor Company for up-to-date information on a fund's trading restrictions.

Exchange Privileges

The investment options available through the TESPHE reserve the right to modify or withdraw the exchange privileges at any time, including rejecting any transactions deemed to be disruptive to the fund manager's ability to manage the fund's portfolio. This may include, but is not limited to substantive dollar amounts and/or frequent "round-trip" transactions. (Generally, a "round-trip" is defined as an exchange into and out of, or out of and into, the same fund.) You are able to make exchanges out of a fund at any time.

If your transaction is rejected by the fund, Fidelity, as the provider of recordkeeping services for the TESPHE, is not notified until the following business day. At that time, affected members are notified and the transaction is reversed (monies are reinvested into the fund(s) from which the exchange was originally processed). Please note that neither Ford nor Fidelity has the ability to influence the fund's decision with respect to modifying or withdrawing exchange privileges.

Exchange Privileges regarding the Ford Stock Fund

Effective April 18, 2007, there are no restrictions on the number of times members may exchange into the Ford Stock Fund. You may continue to exchange out of the Ford Stock Fund at any time. As with other investment options, be sure to confirm trading restrictions on the Ford Stock Fund with the Fidelity Service Center for Ford Motor Company prior to investing in this Fund.

How can you borrow from TESPHE?

Loans may give you access to your account while you're still working at Ford.

You may borrow from the value of your TESPHE assets, if you're an active employee, either full-time or part-time. Employees on leave of absence from the Company may initiate loans while on leave, unless they have a history of loan default. Assets will be sold to provide cash for your loan. You then pay back your account (at a competitive rate of interest) over time.

Know the facts before you act

- **The more you borrow, the less money you have to potentially grow for your retirement or other long-term savings goals.**

Leave your money untouched and you could be looking at a better retirement lifestyle or an earlier retirement.

- **Your loan money misses out on growth opportunities in a rising market.**

You want your money invested when the market is rising. After all, that's how money invested in your TESPHE account can grow. But if you take out any of your TESPHE assets for a loan that money is not invested and, therefore, is missing an opportunity for growth.

- **If your loan defaults, the IRS considers the outstanding balance (plus accrued interest since the last loan payment) a distribution.**

The distribution will be subject to ordinary income taxes, and possibly a 10% early withdrawal penalty if you're younger than age 59½.

- **The interest and principal you repay to your account may be subject to double taxation.**

One of the benefits of participating in the TESPHE is that you are able to make pre-tax contributions. Your pre-tax contributions are not subject to taxes until you withdraw them at retirement, or for some other reason. The repayments and interest you pay back on a loan are made on an after-tax basis and added to either your pre-tax, after-tax source, and/or roll over sources based on how the monies were deducted from your account to provide loan proceeds. The interest and principal, that goes back into your pre-tax account (and in some cases, your rollover account) may be subject to taxes a second time when you eventually withdraw them, depending on your individual circumstance.

You are encouraged to speak with your financial advisor regarding your personal tax situation.

Eligible assets

The maximum amount you may borrow is the lesser of:

- 50% of the aggregate value of your account, but not more than \$50,000, or
- \$50,000 reduced by the difference between your highest loan balance under all Ford plans during the previous 12 months (ending on the day before the effective date of your loan from the TESPHE) and your loan balance on the effective date of your loan.

You can apply for one loan each calendar year, and you may have up to four loans outstanding at any time. Usually, you may choose a loan repayment period of up to five years in one-year increments. If the loan is being used to buy or construct your principal residence, you may select a repayment period of ten years. The minimum loan amount is \$1,000. Loan amounts over this minimum may be requested in \$100 increments.

Interest charges

Loan interest rates are set monthly but will not change during the term of the loan. The interest rate will be the prime rate as quoted in *The Wall Street Journal* under "Money Rates" located in the *Money & Investing* section of the paper as of the last business day of the month preceding the month in which the loan is taken. If more than one rate is quoted in *The Wall Street Journal* on the day the loan rate is set, the lowest rate will be used.

Interest you pay on your loan will be credited to your account. Under current tax laws, you may not deduct your interest payments for loans obtained after 1986 on your tax return.

Applying for a loan

When you apply for a loan, you can specify the order in which your eligible assets are to be sold to provide cash for the loan. The market value of assets sold to provide cash for your loan will be transferred to a loan investment account from which your loan will be made.

You may request a loan for one to five years by calling the Fidelity Service Center for Ford Motor Company or through NetBenefits at netbenefits.fidelity.com. You must speak with a Fidelity Service Center for Ford Motor Company representative if you wish to specify the order in which your eligible assets are to be sold. If you use the automated telephone system or request a loan online through NetBenefits, your assets will be sold proportionately from each investment option.

Your loan will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the New York Stock Exchange (usually 4:00 p.m. Eastern Time) on that day. If your request is made and confirmed after this time or on non-business days such as weekends or holidays, your loan will be effective as of the close of business on the next business day. Because of high call volume near the close of the market at times, you may wish to call early to be sure your request is made before the deadline. A business day is any day that the New York Stock Exchange is open. Note: Interest Income Fund assets cannot be sold on bank holidays even though the New York Stock Exchange is open.

A ten-year loan can be used only to buy or construct your principal residence. It may not be taken to refinance an existing residence, make a balloon payment on an existing mortgage, or purchase a second home or land. If you would like a ten-year loan, you must first request an application for a ten-year loan from the Fidelity Service Center. The completed application and a copy of your purchase agreement from a realtor or homeowner, your builder's contract, or your bridge loan due to relocation, should be mailed to the Fidelity Service Center for Ford Motor Company. Your ten-year loan must be issued before the closing on the purchase of your primary residence.

Your loan check will be mailed to you within three to five business days after your request is effective. Interest begins accruing on the first day following the day the loan is effective. When you receive the check, you will be provided Truth-in-Lending information. Your endorsement on the back of the check indicates your agreement to the promissory note's repayment conditions.

If you prefer to have your loan proceeds sent to your bank via an electronic funds transfer (EFT), you must request the loan online via Fidelity NetBenefits. You may set up your SSIP account for electronic payments through Fidelity NetBenefits or through the Fidelity Service Center for Ford Motor Company. **Note:** It takes fifteen days to verify your banking information when your electronic payment is initially established.

Loan repayments

Effective January 1, 2004, you can accelerate the payoff of your loan by making additional payments above your scheduled payments. These payments must be made in the form of a cashiers or certified check or a money order. Call the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 for details. Descriptions listed below:

- **Active full-time hourly employees.** Your loan repayments will be payroll-deducted from your weekly paychecks. Normally, loan repayment information is transmitted to Ford from Fidelity each Friday. If your loan is effective on or before Thursday, payroll deductions will begin the next payday following the Friday transmission; otherwise, the following payday. Be sure to contact Fidelity if loan payments are not deducted from your check.
- **Transfers to a non-participating subsidiary.** You will be sent a coupon book for your use in making loan repayments directly to Fidelity.
- **Layoffs (except temporary layoffs), leaves, transfers to salaried.** You will be sent a coupon book for your use in making loan repayments directly to Fidelity. Generally, when you return to work from leave or layoff, or if you return to work as a full-time hourly employee, loan repayments through payroll deductions will begin automatically. To avoid missed payments in the event loan deductions do not begin upon return to the active hourly rolls, be sure to contact Fidelity if the loan deduction is not reflected on your first paycheck. Note: Until you have been on medical leave for 90 days and are removed from the active roll under a medical leave expired status, you will not receive a coupon book. However, you are still required to make loan repayments. Acceptable forms of payment include: cashiers or certified check or money order. **Contact the Fidelity Service Center for instructions to ensure your payments are applied appropriately.**

For loans initiated **while on leave**, you must contact Fidelity upon your return to work and request that they make the necessary arrangements for loan payments through payroll deduction.

Note: Loan payments may be suspended while you are on military leave for more than thirty-one days. However, if you choose, you may continue to repay your loans using the coupon book that will be sent to you once Fidelity is notified of your military leave status.

- **Temporary layoffs** You will not receive a coupon book while you are on a temporary layoff. Unless you send in payments, your loan may default. (The payment must be in the form of a cashiers check, certified check, or a money order), **Contact the Fidelity Service Center for instructions to ensure your payments are applied appropriately.** Generally, when you return to work from a temporary layoff and your pay checks resume, loan repayments through payroll deduction will begin automatically.
- **Retirement/termination.** Generally, if you do not pay off your loans in full at the time of retirement or termination, you will be sent a coupon book for your use in making monthly loan repayments directly to Fidelity.

Note: If you are on a coupon eligible status, you can also request that payments be deducted directly from your bank account (ACH payments).

- **Loans taken out beginning January 1, 2004.** Internal Revenue Code regulations stipulate that TESPHE members who:
 - ◇ have a history of a loan default (now or in the future); and
 - ◇ initiate a TESPHE loan beginning January 1, 2004, or later; and
 - ◇ cannot continue loan repayment via payroll deduction due to layoff, retirement, separation from active employment (all leaves), or otherwise become payroll ineligiblewill not be allowed to continue repayment of loan via coupons or ACH. The member must pay off any loans taken out beginning January 1, 2004 in full or they will default, and the principal and any accrued interest will be subject to income taxes and if applicable, the penalty for early withdrawal.

Loans taken out prior to January 1, 2004 are not subject to this Internal Revenue Code regulation and members may continue to make repayments on these loans via a coupon book or ACH if they become ineligible for repayment via payroll deduction.

Examples:

Susan Jones defaulted on a TESPHE loan in 2003. In February 2004, Susan takes out a new loan and she is subsequently laid off in May 2004. Under IRS regulations governing TESPHE loans, Susan will not be permitted to continue repayment of the February 2004 loan via a coupon book while on layoff. She must either pay the loan off in full or the loan will default.

John Smith has no history of a loan default. He takes out a loan in 2004. John, like Susan above, is laid off in May 2004. Because he does not have a history of any prior loan default, he may continue loan repayments via coupon book or ACH while on layoff.

Remember to always verify that your loan payment is being deducted from your paycheck (if you are an active employee receiving a check from the Company). If it is not, contact the Fidelity Service Center for Ford Motor Company immediately so that they can take corrective action.

If you are required to make loan payments via coupons, Fidelity will mail the coupon book within 15 days of notification of your change in status (e.g., leave, layoff, termination, etc). If you do not receive the coupon book within this timeframe, contact Fidelity immediately so that they can take corrective action.

Ultimately, YOU are responsible for loan repayments. If loan payments are not being deducted from your paycheck (active employees), or if you have not received coupons to make loan payments (inactive employees on leave, employees transferred to salaried status, employees on layoff or terminated/retired employees), you must contact the Fidelity Service Center for Ford Motor Company immediately. If you are on a temporary layoff, you must send in payments as described above, or your loan(s) will default.

Loan default service

If you do not comply with the TESPHE loan repayment provisions (e.g., failure to make payments on time), the delinquent loan payments will subject your loan to the default service. This service will generate a warning letter reflecting the delinquent payments and the due date. The letter will be sent to your address of record at Fidelity. If you fail to remit the total delinquent payments by the due date and in the form of payment requested, your loan will default. The outstanding loan balance (principal and accrued interest) will be treated as a deemed distribution of assets in the year of default and will be subject to federal, state, and local income taxes, and early withdrawal penalties. Fidelity will report the taxable amount of this distribution to the IRS and you will be sent a Form 1099-R.

Investment of loan repayments

Loan repayments, including interest, will be invested in accordance with your most recent investment elections except as noted in the following paragraph. Loan repayments, including interest, will be allocated to Pre-Tax Contributions, After-Tax Contributions, and/or rollover contributions from which they were borrowed and in the same proportion. For example, if you take a loan of \$5,000, and 60% of the amount is from Pre-Tax Contributions and 40% is from After-Tax Contributions, 60% of each repayment will be invested in your Pre-Tax Contributions investment options and 40% will be invested in your After-Tax Contributions investment options.

If you take a loan from Pre-Tax Contributions, After-Tax Contributions, and/or rollover contributions, and you have not made an investment election for your contributions, your repayments, including interest, will be invested in the TESHPE designated default investment option and can be exchanged to other investment options, subject to the Plan's exchange rules as described in "Exchanges."

How are assets paid from the TESPHE?

Generally, assets must stay in your TESPHE account until you retire or terminate employment from the Company or attain age 59½. Withdrawals from your account may be available under certain conditions.

TESPHE is intended to help you save for the long term. You have access to your TESPHE account with some restrictions. However, your pre-tax contributions (including pre-tax rollover assets) cannot be withdrawn while you're still working (including leaves of absence) for the Company unless you are at least age 59½ or have a financial hardship. For information on the tax implications of withdrawals including penalty for certain withdrawals before age 59½, see the "Tax Consequences" section.

After-Tax Contributions

You may withdraw all or a portion of your after-tax assets (and effective January 1, 2008, any after-tax rollover assets) at any time.

Pre-Tax Contributions

Under current tax law, you may withdraw all or a portion of your assets after you reach age 59½, terminate employment, or have an approved financial hardship. You may also withdraw your pre-tax monies if you have a "severance from employment", an event that occurs if you transfer to an unrelated employer as a result of a corporate action (e.g., sale, disposition or reorganization of one of the Company's businesses).

Withdrawals after you reach age 59½

You may make a withdrawal of all or a portion of your account balance at any time after you reach age 59½. If you make a withdrawal at age 59½, or later, your contributions will continue unless you request a cancellation through the Fidelity Service Center for Ford Motor Company or through Fidelity NetBenefits. You may continue to have contributions made to your TESPHE account as long as you work for the Company.

Hardship withdrawals before you reach age 59½

Under Internal Revenue Code regulations, before you can take a hardship withdrawal, you must use all other withdrawal options under the TESPHE (e.g., loan, withdrawal of after-tax monies, and age 59½ withdrawal).

The requirements for a financial hardship are:

- You must have an immediate and heavy financial need, and
- The withdrawal must be necessary to satisfy such financial need, and
- The amount of the hardship withdrawal cannot be in excess of the heavy financial need

Generally, a hardship withdrawal will provide you with monies rolled over from another plan described in the "Rollovers from prior employer's plan" section, and monies attributable to your pre-tax contributions. Fidelity can advise you of that portion of your account available for a hardship withdrawal. A hardship withdrawal cannot be rolled over to another eligible plan or IRA.

If your hardship withdrawal is approved, you will be **suspended** from making pre-tax, after-tax, or catch-up contributions to the savings plans of the Company, or its subsidiaries, for 12 months, from eligible pay or any other type of compensation, such as profit sharing contributions. Contributions will resume after the 12 month period, unless you request a cancellation through the Fidelity Service Center for Ford Motor Company or through NetBenefits.

You may contact the Fidelity Service Center for Ford Motor Company to initiate a hardship withdrawal and to obtain more information.

Systematic withdrawal with a series of payments from your account

After termination of employment (including a "severance from employment" as a result of a corporate action involving a sale, disposition or reorganization of one of the Company's businesses) **or attainment of age 59 ½**. At any time after you terminate employment or reach age 59 ½, you may elect to receive payment of your TESPHE account in monthly, quarterly, semi-annual or annual installments over a period of time you specify. You may choose any period of time in whole years over which you would like payments to be made as long as the period is at least one year, and no greater than a number of years approximately equal to your life expectancy at the age at which you make the election, or a number of years approximately equal to your joint life expectancy with your spouse or other beneficiary. The Fidelity Service Center for Ford Motor Company will be able to tell you from IRS tables what the average life expectancy is, based on your age and information on the age of your beneficiary that you provide.

Regardless of how you choose the number of years over which you want systematic payments to be made, the manner of determining the amount of each payment will be the same and will be based on the value of your account at the effective date of payment of each installment and the number of installments remaining to be paid. For example, if you specify a period of ten years and monthly payments, the number of installments would be 120. The amount of the first payment will be equal to the value of your account on the effective date of payment divided by the total number of installments; that is, 120. The amount of the next installment would be based on the value of your account at the time of payment of the next installment divided by the number of installments remaining; that is, 119. For the last installment, the entire value of your account would be paid to you.

The amount for each installment will be withdrawn proportionally from each investment election in which you have assets on the effective date of each installment.

Members who are not active employees

If you make an election for systematic withdrawal with payments before you reach age 59½, you may be subject to an early withdrawal tax penalty of 10% of the amount of each installment paid to you before you reach age 59½, unless you elect payment over a period at least equal to your life expectancy (based on your age) or to your life expectancy jointly with that of your beneficiary under TESPHE (based on your age and the age of your beneficiary). If you make this election so that you avoid the penalty and later change your election before you reach age 59½, payments under your changed election must be made over the longer of: a period of at least five years or a period extending beyond your attainment of age 59½, if you wish to avoid the tax penalty of 10% that would be imposed on payments made before you attain age 59½, including payments already made before you changed your election. You should consult with your tax advisor.

In the event the payments made under the systematic withdrawal you have elected are less than the amounts required to be distributed after you reach age 70½, an additional amount will be distributed to you in December of each year in an amount necessary to satisfy the minimum required distribution amounts as described in the "When would assets be paid automatically from the TESPHE?" section.

If you retire or terminate employment, you may withdraw all or a portion of your TESPHE assets effective on any business day.

If you are on a leave of absence or layoff, or transfer to salaried roll or to a non-participating subsidiary, you are subject to the same withdrawal provisions as an active employee.

If you are an alternate payee because you were awarded assets under a Qualified Domestic Relations Orders (QDRO), you will be treated in accordance with the terms stated in the court order. For more information, see the "What circumstances might affect TESPHE benefits?" section.

Making a withdrawal

You may request a withdrawal of all or a portion of your eligible assets by calling the Fidelity Service Center for Ford Motor Company or through Fidelity NetBenefits at netbenefits.fidelity.com.

Your withdrawal will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the New York Stock Exchange (usually 4:00 p.m. Eastern Time) on that day. If your request is made and confirmed after this time or on non-business days such as weekends or holidays, your withdrawal will be effective as of the close of business on the next business day.

Because of high call volume near the close of the market at times, you may wish to call early to be sure your request is made before the deadline. A business day is any day that the New York Stock Exchange is open.

Withdrawal checks will be mailed to you within three to five business days after your request has been processed. You may also request that proceeds be paid to you electronically (wired to your bank account).

How withdrawals are paid

If you request a withdrawal, the value of your Ford Stock Fund assets, if any, will be paid in cash, unless you request an "in-kind" distribution (a distribution in Ford common stock). You may request that any whole shares of Ford common stock represented by your units in the Ford Stock Fund be issued in-kind by talking to a representative at the Fidelity Service Center. If you request a withdrawal from the Ford Stock Fund and you request an "in-kind" distribution, you will receive a stock certificate for your Ford common stock assets in the Fund. A certificate representing whole shares will be issued in your name or, if you request it, in your name and the name of another person you designate. Any fractional shares will be paid in cash.

Any assets withdrawn from other investment options will be paid to you in cash.

Direct rollover

If you elect to withdraw assets or expect to receive a distribution of assets from TESPHE, you may instruct the Trustee to make a direct rollover of eligible assets to another employer's qualified plan (similar to TESPHE), governmental plans, plans of tax-exempt organizations or to a traditional or Roth IRAs (if the receiving plan permits and agrees to separately account for the transferred amounts).

In a direct rollover, assets can be transferred without penalty or payment of income tax. Generally, your assets attributable to pre-tax contributions (including catch-up contributions) and all associated earnings are eligible for direct rollover. After-tax contributions may be rolled over to an IRA or annuity described in Sections 408(a) or (b) of the Internal Revenue Code, or to a qualified plan described in Sections 401(a) or 403(b) of the Internal Revenue Code that agree to account for the transferred after-tax amounts separately. To qualify as a direct rollover, the assets must be transferred by Fidelity to the receiving eligible plan or IRA. You should contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 for the forms necessary to arrange a direct rollover.

If you receive a withdrawal or distribution from TESPHE and you do not elect a direct rollover, the taxable portion of the withdrawal or distribution is subject to a mandatory 20% federal income tax withholding from any cash distributed. You may make a rollover of eligible assets after you receive a withdrawal or distribution, but the 20% withholding on the taxable portion of the withdrawal or distribution from TESPHE still applies. Special tax rules apply to direct rollover of an eligible rollover distribution to a Roth IRA.

See the special tax notice which was prepared by the Internal Revenue Service and modified for TESPHE. You should consult your a tax professional to ensure that any actions you take are to your best advantage.

When would assets be paid automatically from the TESPHE?

In some circumstances, distributions will be made by TESPHE even if you do not request them.

All or a portion of your TESPHE assets will be distributed to you under certain circumstances even if you do not request them. You will be notified before a distribution is made. In this situation, you may wish to consult your tax advisor regarding alternatives available to you.

After termination of employment

Accounts valued at less than \$3,500

Your assets in the TESPHE will be distributed to you after termination of employment if the value of your assets is less than \$3,500. This value is determined within 90 days after termination and effective January 1, 2009, includes any rollover amounts. Effective January 1, 2008, the only members excluded from this provision are members receiving installment payments or who are subject to minimum required distributions described below.

Effective for small account distributions paid after March 28, 2005, unless you provide specific instructions to Fidelity upon receipt of the prior notification of the distribution, vested account balances equal to or less than \$1,000 will be distributed in cash. The TESPHE will automatically withhold 20% of the taxable portion of amounts eligible for a rollover. If your vested account balance is greater than \$1,000 but less than \$3,500, it will be automatically liquidated and transferred to a Fidelity Rollover IRA and invested in the Fidelity Cash Reserves Fund. Appropriate fees will be applied to your Fidelity Rollover IRA. Presently, these fees do not include the mutual fund small balance fee or annual account maintenance fee.

If you do **not** want your monies automatically transferred to a Fidelity Rollover IRA, be sure to provide Fidelity with specific instructions as to how you would like your account balance distributed within the timeframe prescribed in the notification of distribution.

Required Minimum Distributions

If you elect to have the TESPHE retain your assets after you attain age 70½, they will be distributed to you by the required beginning date. These distributions are referred to as minimum required distributions, or MRDs. The required beginning date is April 1 of the calendar year following the later of the calendar year in which you: (i) attain age 70½, or (ii) retire from the Company. Thereafter, the MRDs must be distributed by December of each year.

In general, the applicable distribution period is obtained from the Internal Revenue Code Uniform Lifetime Table and is based solely on your age as of your birthday in the relevant distribution calendar year. If the sole beneficiary is your spouse, however, the distribution period is the longer of the distribution period from the Uniform Lifetime Table, or in the case of a spouse beneficiary who is more than 10 years younger than you, the joint life expectancy of you and your spouse.

Generally, payout under the distribution schedule for mandatory age 70½ payments would permit you to leave your assets in TESPHE for the longest possible period (if you have terminated employment). The amount of any mandatory age 70½ distribution would be reduced by the amount of payments made earlier in the year under any other withdrawal election. For example, assume during any given year you requested a \$1,000 withdrawal from your account. The mandatory 70½ distribution is processed in December and amounts to \$4,000. Only \$3,000 would be distributed to you in that year to satisfy the remaining minimum required distribution payment. While MRD rules require that a minimum amount be distributed to you, you may elect to receive a greater amount under the withdrawal options described in the section titled "How are assets paid from the Plan?"

Timing of Your MRD

When you first become eligible to receive your MRD, you have the option of receiving your MRD either in the year you turn 70½, or no later than April 1 of the year following the year in which you attain 70½. You should be aware that if your MRD is not taken until the following year, then you will be required to take an additional MRD distribution to cover the current year MRD. Since multiple MRD payments in one calendar year could increase your tax liability, you should carefully consider the timing of your MRD.

Example: You turn 70½ in 2009. You can elect to receive your distribution by December 31, 2009 or by April 1, 2010. If you elect to receive your first MRD payment by April 1, 2010, you are still required to take an additional MRD by December 31, 2010 to cover the 2010 MRD. As a result, you will receive two MRD payments in 2010 and will be taxed upon distribution of each payment.

Fidelity will notify affected members in advance to allow you to select your payment date. The default payment date is no later than April 1 in the year following the year in which you attain 70½. Failure to notify Fidelity that you would like to receive your first MRD in December in the year you turn 70½ (to avoid the double MRD payment described above), will result in a MRD payment made on or near the default payment date in the year following the year you turn 70½.

Generally, terminated members who will turn 70½ are identified in January of each year. If you terminate employment after January in the same year you turn 70½, notify Fidelity if you would like to receive your first MRD in December of the year you turn 70½.

Dividends on stock in the Ford Stock Fund

You may choose to receive a distribution in cash of dividends attributable to your equivalent shares of Ford common stock based on the units held in the Ford Stock Fund, or to reinvest such dividends in your account.

If you enrolled in the TESPHE before January 1, 2002, your proportionate share of any cash dividends will be handled in the same manner as they had been immediately prior to this date (either distributed to you in cash or reinvested in the Ford Stock Fund, depending on your arrangement).

If you enrolled January 1, 2002 or after, your proportionate share of any quarterly cash dividends paid on the Ford Stock Fund will be reinvested in your account in the Ford Stock Fund, unless you elect to have them distributed to you in cash.

The amount of such cash dividend not distributed generally will be used by the Trustee to acquire additional shares of Ford Common Stock. To the extent such dividends remain in the TESPHE, the number of units in your account will be increased to reflect the acquisition by the Trustee of those additional shares.

You may change your dividend election at any time by contacting the Fidelity Service Center for Ford Motor Company or by accessing Fidelity NetBenefits at www.netbenefits.fidelity.com. From the home page, using the quick links menu selection window, select the *transaction history* link to get to the next panel. Scroll down the left-hand menu and select *Dividend Elections*.

With respect to the Ford Stock Fund, the amount of any such cash payment made directly to you maybe reduced to comply with legal restrictions on the amount that may be paid out to all members in total. The amount in total that may be paid out of the Ford Stock Fund is limited to cash dividends received by TESPHE on Ford Common Stock shares that have not been in TESPHE continuously since January 1, 1989, without regard to Ford Common Stock shares associated with individual accounts.

Payments of dividends are not subject to the 10% early withdrawal penalty and are generally not subject to income tax withholding. They are considered taxable income subject to ordinary income tax rates and are not eligible for rollover to an IRA or another employer's qualified plan.

Only shares of Ford stock in the Plan by 4:00 p.m. Eastern Time one day prior to the ex-dividend date are eligible for the dividend payment. Payment will be made as soon as practicable after receipt by Fidelity of the dividend.

If you die

If you die, the assets in your account will be payable to your beneficiary. If your beneficiary is not your surviving spouse, the assets will be distributed as soon as practicable after notification of your death.

If your beneficiary is your surviving spouse, special rules apply:

- If you elected a distribution schedule which commences before your death, your account will continue to be paid to your surviving spouse according to your schedule.
- At any time, your surviving spouse can elect a lump sum distribution.
- If distribution has not commenced at the time of your death, your surviving spouse will be considered a participant for purposes of distribution under the TESPHE. Your surviving spouse will be deemed to attain age 70½ on the date you would have attained 70½ and may elect the 'life expectancy' method for distribution.
- While your surviving spouse retains your account in the TESPHE, he or she will be able to exchange among the investment options as any other participant.
- **Beneficiaries may not designate another beneficiary (ies).** In the event of the death of your surviving spouse, the account will be paid to your surviving spouse's estate.

It is important that you keep your beneficiary designation up to date and your current address on file at your hourly personnel department. For information on beneficiaries, see the "Surviving spouses, alternate payees, and other beneficiaries" section.

Loans unpaid at termination of employment

You are required to repay your outstanding loans in full at the time you retire, or to use a coupon book or ACH (e.g., payments directly from your banking account). If you do not repay your loans according to TESPHE's provisions, Fidelity will report to you and the IRS that a distribution of assets equal to the outstanding loan balance was made, some or all of which may be taxable.

NOTE: Final regulations governing loans from the TESPHE require that repayments of loans initiated beginning January 1, 2004 (by members who have a history of loan default) must be payroll deducted. As a result, such loans must be paid off once members are separated from the Company. Using a coupon book to continue loan repayments will not be an option. See the "Loan Repayments" section for details.)

How distributions are paid

Distributions are paid in a similar manner as withdrawals, as described in the "How are assets paid from the TESPHE?" section.

What are the tax consequences of my withdrawal or distribution?

You may owe taxes after all or a portion of your account is paid to you.

SPECIAL TAX NOTICE

The tax law contains several complex rules regarding the taxation of withdrawals and distributions. The Internal Revenue Service has prepared a summary of many of these rules in the following "Special Tax Notice". The Company has inserted references to the TESPHE to assist you. This notice contains important information you will need before you decide how to receive withdrawals or distribution payments from the TESPHE. Regulatory changes affecting this notice may not be updated in the TESPHE immediately. As a result, the notice may not always be current. However, Fidelity is required to send you the most recent notice prior to processing a distribution or withdrawal.

A rollover is a payment by you or Fidelity of all or part of your benefit to another plan or to a traditional IRA that allows you to continue to postpone taxation of that benefit until it is paid to you. (Beginning January 1, 2008, you may roll over your distribution to a Roth IRA; however, there may be tax consequences and minimum income requirements. You should consult with your tax adviser prior to initiating such a rollover.) This notice describes the federal tax rules applicable to "eligible rollover distributions". Your distribution payment cannot be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account (formerly known as an education IRA). An "eligible employer plan" includes a plan qualified under section 401(a) of the Internal Revenue Code (including a 401(k) plan), profit-sharing plan, defined benefit plan, stock bonus plan, and money purchase plan; a section 403(a) annuity plan; a section 403(b) tax-sheltered annuity; and an eligible section 457(b) plan maintained by a governmental employer (governmental 457 plan).

An eligible employer plan is not legally required to accept a rollover. Before you decide to roll over your payment to another employer plan, you should find out whether the plan accepts rollovers and, if so, the types of distributions it accepts as a rollover. You should also find out about any documents that are required to be completed before the receiving plan will accept a rollover. Even if a plan accepts rollovers, it might not accept rollovers of certain types of distributions, such as after-tax amounts. If this is the case, and your distribution includes after-

tax amounts, you may wish instead to roll your distribution over to a traditional IRA or split your rollover amount between the employer plan in which you will participate and a traditional IRA. If an employer plan accepts your rollover, the plan may restrict subsequent distributions of the rollover amount or may require your spouse's consent for any subsequent distribution. A subsequent distribution from another employer plan or an IRA that accepts your rollover may also be subject to different tax treatment than distributions from the TESPHE. Check with the administrator of the other employer plan or the trustee of the IRA that is to receive your rollover prior to making the rollover.

If you have additional questions after reading this Notice, you may contact Fidelity.

SUMMARY

A payment from TESPHE that is eligible for "rollover" can be taken in two ways. You can have all or any portion of your payment either **1) paid in a "direct rollover"** or **2) paid to you**. A rollover is a payment of your TESPHE distribution that you make to your traditional individual retirement arrangement (IRA), a Roth IRA, or to another eligible employer plan that will accept it. A "direct rollover" is a payment made directly to a traditional and/or Roth IRA, or another qualified plan that accepts your rollover. This choice could affect the tax you owe.

If you choose a Direct Rollover:

- Your payment will not be taxed in the current year and no income tax will be withheld, unless you roll it over to a Roth IRA as a direct rollover conversion. The taxable portion of an eligible rollover distribution rolled over to a Roth IRA does not trigger 20% mandatory withholding; however such amounts are included in gross income and subject to tax as a result of the conversion.
- Your payment will be made directly to your traditional or Roth IRA or, if you choose, to another eligible employer plan that accepts your rollover. Your TESPHE payment cannot be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account.
- The taxable portion of your payment will be taxed later when you take it out of the traditional IRA or the eligible employer plan. Depending on the type of plan, the later distribution may be subject to different tax treatment than it would be if you received a taxable distribution from the TESPHE.

If you choose to have a TESPHE payment that is eligible for rollover paid to you

- You will receive only 80% of the taxable amount of the payment because the TESPHE is required to withhold 20% of the taxable amount of the payment and send it to the IRS as income tax withholding to be credited against your taxes.
- The taxable amount of your payment will be taxed in the current year unless you roll it over. Under limited circumstances, you may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before age 59½, you also may have to pay an additional 10% tax.
- You can roll over all or part of the payment by paying it to your traditional or Roth IRA, or to an eligible employer plan (that accepts your rollover) within 60 days of receiving the payment. The amount rolled over will not be taxed until you take it out of the traditional IRA or eligible employer plan.
- If you want to roll over 100% of the payment to a traditional IRA or an eligible employer plan, **you must find other money to replace the 20% that was withheld.** If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld and that is not rolled over. Taxable amounts converted to a Roth IRA using the 60-day rollover rules are included in gross income and subject to tax at the time of the distribution, but the 10% early withdrawal tax under Internal Revenue Code Section 72(t) may not apply. The 10% early withdrawal tax may later apply to those amounts when they are distributed from the Roth IRA if they are not held by the Roth IRA for at least five years. This does not constitute tax advice. You should consult a tax professional for specifics prior to initiating such a rollover to assure you understand all of the tax consequences.

Your right to waive the 30-day notice period

Generally, neither a direct rollover nor a payment can be made from the TESPHE until at least 30 days after your receipt of this notice. Thus, after receiving this notice, you have at least 30 days to consider whether or not to have your withdrawal directly rolled over. If you do not wish to wait until this 30-day notice period ends before your election is processed, you may waive the notice period by making an affirmative election indicating whether or not you wish to make a direct rollover. Your withdrawal will then be processed in accordance with your election as soon as practical after it is received by Fidelity.

Payments that can and cannot be rolled over

Payments from the TESPHE may be “eligible rollover distributions.” This means that they can be rolled over to a traditional or Roth IRA, or to an eligible employer plan that accepts rollovers. Payments from the TESPHE cannot be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account. Before January 1, 2008, only amounts attributable to a designated Roth account were eligible for rollover to the Roth IRA. Beginning January 1, 2008, you may roll over the portion of your payment that is an eligible rollover distribution to a Roth IRA; however, you should check with a tax professional prior to initiating such a rollover regarding the tax consequences and to determine income requirements.

Fidelity will be able to tell you what portion of your payment is an “eligible rollover distribution”.

After-tax contributions. If you made after-tax contributions to the TESPHE, these contributions may be rolled into either a traditional or Roth IRA or to certain employer plans that accept rollovers of the after-tax contributions. The following rules apply:

- Rollover into a traditional IRA
You can roll over your after-tax contributions to a traditional IRA either directly or indirectly. Fidelity will be able to tell you how much of your payment is the taxable portion and how much is the after-tax portion.
If you roll over after-tax contributions to a traditional IRA, it is your responsibility to keep track of, and report to the IRS on the applicable forms, the amount of these after-tax contributions. This will enable the nontaxable amount of any future distributions from the traditional IRA to be determined.
You should consult a tax professional regarding the roll over of after-tax contributions to a Roth IRA.

Once you roll over your after-tax contributions to a traditional or Roth IRA, those amounts CANNOT later be rolled over to an employer plan.

- Rollover into an employer plan
You can roll over after-tax contributions from an employer plan that is qualified under Internal Revenue Code section 401(a), a section 403(a) annuity plan or section 403(b) plan to another such plan using a direct rollover if the other plan provides separate accounting for amounts rolled over, including separate accounting for the after-tax employee contributions and earnings on those contributions.

You can also roll over after-tax contributions from a section 403(b) tax-sheltered annuity to another section 403(b) tax-sheltered annuity using a direct rollover if the other tax-sheltered annuity provides separate accounting for amounts rolled over, including separate accounting for the after-tax employee contributions and earnings on those contributions.

You **CANNOT** roll over after-tax contributions to a governmental 457 plan.

If you want to roll over your after-tax contributions to an employer plan that accepts these rollovers, you cannot have the after-tax contributions paid to you first. You must instruct Fidelity to make a direct rollover on your behalf. Also, you cannot first roll over after-tax contributions to a traditional IRA and then roll over that amount into an employer plan.

The following types of payments **cannot** be rolled over:

- Payments spread over long periods. You cannot roll over a payment if it is part of a series of equal (or almost equal) payments that are made at least once a year and that will last for:
 - ◊ Your lifetime (or a period measured by your life expectancy), or
 - ◊ Your lifetime and your beneficiary's lifetime (or a period measured by your joint life expectancies), or
 - ◊ A period of ten years or more
- **Required minimum payments.** Beginning in the year you reach age 70½ or retire, whichever is later, a certain portion of your payment cannot be rolled over because it is a "required minimum payment" that must be paid to you.
- **Hardship Distributions.** A hardship distribution cannot be rolled over.
- **ESOP Dividends.** Cash dividends paid directly to you on company stock held in an employee stock ownership plan cannot be rolled over.
- **Corrective Distributions.** A distribution that is made to correct a failed nondiscrimination test or because legal limits on certain contributions were exceeded cannot be rolled over.
- **Loans treated as Distributions.** The amount of a TESPHE loan that becomes a taxable deemed distribution because of a default cannot be rolled over. However, a loan offset amount is eligible for rollover. Fidelity will be able to tell you if distribution of your loan qualifies for rollover treatment.

Fidelity will be able to tell you if your payment includes amounts that cannot be rolled over.

Direct rollover

You can choose a direct rollover of all or any portion of your payment that is an "eligible rollover distribution", as described above. In a direct rollover, the eligible rollover distribution is paid directly from TESPHE to an IRA, or to an eligible employer plan that accepts rollovers. If you choose a direct rollover to a traditional IRA or eligible employer plan, there is no income tax withholding on the taxable portion of your payment for which you choose a direct rollover until you later take it out of the traditional IRA or eligible employer plan. Special tax rules apply to direct rollover to a Roth IRA.

Direct rollover to a Traditional or Roth IRA. You can open a traditional IRA to receive the direct rollover. If you choose to have your payment made directly to a traditional IRA, contact an IRA sponsor (usually a financial institution) to find out how to have your payment made in a direct rollover to a traditional IRA at that institution. If you are unsure of how to invest your money, you can temporarily establish a traditional IRA to receive the payment. However, in choosing a traditional IRA, you may wish to consider whether the traditional IRA you choose will allow you to move all or a part of your payment to another traditional IRA at a later date without penalties or other limitations. See IRS Publication 590, Individual Retirement Arrangements, for more information on traditional IRAs (including limits on how often you can roll over between IRAs). Also, beginning January 1, 2008, you may directly roll over amounts to a Roth IRA with similar tax consequences as converting a traditional IRA to a Roth IRA. (Please consult with a tax professional before initiating such a rollover.)

Direct rollover to a plan. If you are employed by a new employer that has an eligible employer plan, and you want a direct rollover to that plan, ask the administrator of that plan, ask the administrator of that plan whether it will accept your rollover. An eligible employer plan is not legally required to accept a rollover. Even if your new employer's plan does not accept a rollover, you can choose a direct rollover to a traditional IRA. If the employer plan accepts your rollover, the plan may provide restrictions on the circumstances under which you may later receive a distribution of the rollover amount or may require spousal consent to any consequent distribution. Check with the plan administrator of that plan before making your decision.

Direct rollover of a series of payments. If you receive a payment that can be rolled over to a traditional or Roth IRA, or to an eligible employer plan that will accept it, and it is paid in a series of installments for less than ten years, your choice to make or not make a direct rollover for a payment will apply to all later payments in the series until you change your election. You are free to change your election for any later payment in the series.

Change in tax treatment resulting from a direct rollover. The tax treatment of any payment from the eligible employer plan or IRA receiving your direct rollover might be different than if you received your benefit in a taxable distribution directly from the TESPHE. For example, if you were born before January 1, 1936, you might be entitled to ten-year averaging or capital gain treatment, as explained below. However, if you have your benefit rolled over to a section 403(b) tax-sheltered annuity, a governmental 457 plan, or an IRA in a direct rollover, your benefit will no longer be eligible for that special treatment. See the sections below entitled “Additional 10% tax if you are under age 59½” and “Special Tax Treatment if you were born before January 1, 1936.”

Payment paid to you

If your payment can be rolled over and the payment is made to you, it is subject to 20% income tax withholding on the taxable portion (state tax withholding may also apply). The payment is taxed in the year you receive it unless, within 60 days, you roll it over to an IRA or an eligible employer plan that accepts rollovers. If you do not roll it over, special tax rules may apply.

Income tax withholding:

Mandatory withholding. If any portion of the payment can be rolled over and you do not elect to make a direct rollover, TESPHE is required by law to withhold 20% of the taxable amount. This amount is sent to the IRS as income tax withholding. For example, if your eligible rollover distribution is \$10,000, only \$8,000 will be paid to you because TESPHE must withhold \$2,000 as income tax. However, when you prepare your income tax return for the year, unless you make a rollover within 60 days (see “Sixty-day rollover option” below), you must report the full \$10,000 as a taxable payment from TESPHE. You must report the \$2,000 as tax withheld, and it will be credited against any income tax you may owe for the year.

If any portion of your payment is taxable but cannot be rolled over, the mandatory withholding rules described above do not apply. In this case, you may elect not to have withholding apply to that portion. If you do nothing, an amount will be taken out of this portion of your payment for federal income tax withholding. To elect out of withholding, please contact the Fidelity Service Center for Ford Motor Company for the election form and related information.

Sixty-day rollover option. If you have an “eligible rollover distribution” paid to you, you can still decide to roll over all or part of it to a traditional IRA or an eligible employer plan that accepts rollovers. If you decide to roll over, you must contribute the amount of the payment you received to a traditional IRA or, with the exception of a distribution of after-tax amounts, to an eligible employer plan within 60 days after you receive the payment. The portion of your payment that is rolled over will not be taxed until you take it out of the traditional IRA or the eligible employer plan. Special tax rules apply to rollovers to a Roth IRA.

You can roll over up to 100% of the eligible rollover distribution, including an amount equal to the 20% that was withheld. If you choose to roll over 100%, you must find other money within the 60-day period to contribute to the traditional IRA or the eligible employer plan to replace the 20% that was withheld. On the other hand, if you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

Example. Suppose your payment that can be rolled over is \$10,000, and you choose to have it paid to you. You will receive \$8,000, and \$2,000 will be sent to the IRS as income tax withholding. Within 60 days after receiving the \$8,000, you may roll over the entire \$10,000 to a traditional IRA or eligible employer plan. To do this, you roll over the \$8,000 you received from the TESPHE, and you will have to find \$2,000 from other sources (your savings, a loan, etc.). In this case, the entire \$10,000 is not taxed until you take it out of the traditional IRA or eligible employer plan. If you roll over the entire \$10,000, when you file your income tax return you may get a refund of the \$2,000 withheld.

If, on the other hand, you roll over only \$8,000, the \$2,000 you did not roll over is taxed in the year it was withheld. When you file your income tax return, you may get a refund of part of the \$2,000 withheld. (However, any refund is likely to be larger if you roll over the entire \$10,000.)

Additional 10% tax if you are under age 59½. If you receive a payment before you reach age 59½ and you do not roll it over, then, in addition to the regular income tax, you may have to pay an extra tax equal to 10% of the taxable portion of the payment. The additional 10% tax does not apply to:

- (1) payments that are paid to you because you separate from service with your employer during or after the year you reach age 55;
- (2) payments that are paid because you retire due to disability;
- (3) payments that are paid to you as equal (or almost equal) payments over your life or life expectancy (or your and your beneficiary's lives or life expectancies);
- (4) dividends paid with respect to stock by an employee stock ownership plan (ESOP) as described in Internal Revenue Code section 404(k);
- (5) payments that are paid directly to the government to satisfy a federal tax levy;
- (6) payments that are paid to an alternate payee under a qualified domestic relations order;
- (7) payments that do not exceed the amount of your deductible medical expenses; or
- (8) qualified reservist distributions.

See IRS Form 5329 for more information on the additional 10% tax.

The additional 10% tax will not apply to distributions from a governmental 457 plan, except to the extent the distribution is attributable to an amount you rolled over to that plan (adjusted for investment returns) from another type of eligible employer plan or IRA. Any amount rolled over from a governmental 457 plan to another type of eligible employer plan or to a traditional IRA will become subject to the additional 10% tax if it is distributed to you before you reach age 59½, unless one of the exceptions applies.

Special tax treatment if you were born before January 1, 1936. If you receive a payment from TESPHE and you do not roll it over to a traditional IRA or an eligible employer plan, the payment will be taxed in the year you receive it. However, if the payment qualifies as a "lump-sum distribution", it may be eligible for special tax treatment. (See also "Employer stock or securities" below.) A lump-sum distribution is a payment, within one year, of your entire balance under TESPHE that is payable to you because you have reached age 59½ or have separated from service with the Company. For a payment to be treated as a lump-sum distribution, you must have been a participant in TESPHE for at least five years before the year in which you received the distribution. The special tax treatment for lump-sum distributions is described below.

- **Ten-year averaging.** If you receive a lump-sum distribution and you were born before January 1, 1936, you can make a one-time election to figure the tax on the payment by using "10-year averaging" (using 1986 tax rates). "Ten-year averaging" often reduces the tax you owe.
- **Capital gain treatment.** If you receive a lump-sum distribution and you were born before January 1, 1936, you may elect to have the part of your payment that is attributable to your pre-1974 participation in TESPHE (if any) taxed as long-term capital gain at a rate of 20%.

There are other limits on the special tax treatment for lump-sum distributions. For example, you can generally elect this special tax treatment only once in your lifetime and the election applies to all lump-sum distributions that you receive in that same year. You may not elect this special treatment if you rolled amounts into the TESPHE from a 403(b) tax-sheltered annuity contract, a governmental 457 plan, or from an IRA not originally attributable to a qualified employer plan. If you have previously rolled over a payment from TESPHE, you cannot use this special averaging treatment for later payments from TESPHE. If you roll over your payment to a traditional IRA, a governmental 457 plan, or 403(b) tax-sheltered annuity, you will not be able to use this special tax treatment for later payments from that IRA, plan, or annuity. Also, if you roll over only a portion of your payment to a traditional IRA, governmental 457 plan, or 403(b) tax-sheltered annuity, this special tax treatment is not available for the rest of the payment. Additional restrictions are described in IRS Form 4972, which has more information on lump-sum distributions and how you elect the special tax treatment.

Employer stock or securities. There is a special rule for a payment from TESPHE that includes Ford Common Stock. To use this special rule, (1) the payment must qualify as a lump-sum distribution, as described above, except that you do not need five years of participation in the TESPHE) or (2) the Ford Common Stock included in the payment must be attributable to after-tax contributions, if any. Under this special rule, you may have the option of not paying tax on the “net unrealized appreciation” of the stock until you sell the stock.

Net unrealized appreciation generally is the increase in the value of the Ford Common Stock represented by units of the Ford Stock Fund during the time they were credited to your TESPHE account. For example, if Ford Stock Fund units were contributed to your TESPHE account when Ford Common Stock was worth \$1,000 but the stock was worth \$1,200 when you received it, you would not have to pay tax on the \$200 increase in value until you later sold the stock.

You may instead elect not to have the special rule apply to the net unrealized appreciation. In this case, your net unrealized appreciation will be taxed in the year you receive the stock, unless you roll over the stock. The stock (including any net unrealized appreciation) can be rolled over to a traditional IRA (if the IRA provider permits), or another eligible employer plan, either in a direct rollover or (with the exception of a rollover of after-tax contributions to another employer plan) a rollover that you make yourself. Generally, you will no longer be able to use the special rule for net unrealized appreciation if you roll the stock over to a traditional IRA or another eligible employer plan.

If you receive only Ford common stock in a payment that can be rolled over, no amount will be withheld from the payment. If you receive cash in addition to Ford common stock in a payment that can be rolled over, the 20% withholding amount will be based on the entire taxable amount paid to you (including the value of the Ford common stock determined by excluding net unrealized appreciation). However, the amount withheld will be limited to the cash (excluding Ford common stock) paid to you.

If you receive Ford common stock in a payment that qualifies as a lump-sum distribution, the special tax treatment for lump-sum distributions described above (such as 10-year averaging) also may apply. See IRS Form 4972 for additional information on these rules.

Repayment of TESPHE Loans. If you end your employment and have an outstanding loan (and withdraw your account balance), TESPHE may reduce (or “offset”) your balance by the amount of the loan you have not paid. The amount of your loan offset is treated as a distribution to you at the time of the offset and will be taxed unless you roll over an amount equal to the amount of your loan offset to another eligible employer plan or a traditional IRA within 60 days of the date of the offset. If the amount of your loan offset is the only amount you receive or are treated as having received, no amount will be withheld from it. If you receive other payments of cash or property from TESPHE, the 20% withholding amount will be based on the entire amount paid to you, including the amount of the loan payment. The amount withheld will be limited to the amount of other cash or property paid to you (other than Ford Common Stock). The amount of a defaulted plan loan that is a taxable deemed distribution cannot be rolled over.

Surviving spouses, alternate payees, and other beneficiaries

In general, the rules summarized above that apply to payment to employees also apply to payments to surviving spouses of employees and to spouses or former spouses who are “alternate payees.” You are an alternate payee if your interest in the TESPHE results from a “Qualified Domestic Relations Order”, which is an order issued by a court usually in connection with a divorce or legal separation.

If you are a surviving spouse or an alternate payee, you may choose to have a payment that can be rolled over paid in a direct rollover to a traditional IRA or to an eligible employer plan. If you have the payment paid to you, you can keep it or roll it over yourself to a traditional IRA or to an eligible employer plan. Thus, you have the same choices as the employee.

If you are a beneficiary other than a surviving spouse or you are a person who is a beneficiary of a trust designated as the deceased member’s beneficiary for the Plan, the Plan has a feature that allows a direct rollover to an IRA to be requested. When the direct rollover to the IRA occurs, the IRA custodian is required to administer the IRA as an “inherited IRA account”. You cannot roll over the payment yourself. You must instruct Fidelity to make a direct rollover to an “inherited IRA” established on your behalf or on behalf of the trust. You will be required to receive annual payments from the IRA in accordance with IRS regulations. See IRS Publication 590, Individual Retirement

Arrangements, for more information. If you are a designated beneficiary other than a surviving spouse and you do not choose a direct rollover to an IRA, the taxable portion of your payment will be taxed in the current year and federal income tax will be withheld to the extent required.

If you are a surviving spouse, an alternate payee, or another beneficiary, your payment is not subject to the additional 10% tax described above, even if you are younger than age 59½.

If you are a surviving spouse, an alternate payee, or another beneficiary, you may be able to use the special tax treatment for lump-sum distributions and the special rule for payments that include Ford common stock, as described above. If you receive a payment because of the employee's death, you may be able to treat the payment as a lump-sum distribution if the employee met the appropriate age requirements, whether or not the employee had five years of participation in the TESPHE.

How to obtain additional information from the IRS

This notice summarizes only the federal (not state or local) tax rules that might apply to your payment. The rules described above are complex and contain many conditions and exceptions that are not included in this notice. Therefore, you may want to consult with a professional tax advisor before you take a payment of your benefits from the TESPHE. Also, you can find more specific information on the tax treatment of payments from qualified retirement plans in IRS Publication 575, Pension and Annuity Income and IRS Publication 590, Individual Retirement Arrangements. These publications are available from your local IRS office or the IRS's Internet web site at www.irs.gov or by calling 1-800-TAX-FORMS.

When do you contact the Fidelity Service Center for Ford Motor Company?

Fidelity Service Center for Ford Motor Company lets you manage your TESPHE account over the phone.

Convenient account access

The Fidelity Service Center for Ford Motor Company generally provides 24-hour access to TESPHE account information and permits a variety of transactions to be initiated, toll free, from any touch-tone telephone. Fidelity representatives are available on business days from 8:30 a.m. to midnight (Eastern Time).

You can manage your TESPHE account almost entirely over the phone with the Fidelity Service Center for Ford Motor Company or through Fidelity's Internet access NetBenefits at netbenefits.fidelity.com. Most transactions, including exchanges (transfers), loans, and withdrawals may be initiated online and do not require paper forms.

Establishing your PIN

To use the Fidelity Service Center for Ford Motor Company, you will need to establish a PIN (personal identification number). The first time you call Fidelity or access your account via NetBenefits, you will be asked to establish your PIN. This is very important because your PIN allows access to confidential information about your TESPHE account. Without your PIN, you will not be able to access your account. Your PIN is a number you choose, six to twelve digits.

How to access your account

To access your TESPHE account, you'll need to enter your social security number or Alternate Customer ID and your PIN when you call or use NetBenefits. To avoid unauthorized access to your TESPHE account, it's very important to keep your PIN confidential at all times. Conversations initiated through a Fidelity Service Representative will be recorded.

To use the automated telephone system or speak to a representative, you should call the Fidelity Service Center for Ford Motor Company at 1-800-544-3333. The TDD phone line for the hearing impaired is 1-888-343-0860.

From Overseas, follow these instructions:

Dial your country's AT&T access number + 800-544-3333 (do not dial the leading "1"). From the U.S., access numbers are available by calling 1-800-331-1140. From anywhere in the world, access numbers are also available online at www.att.com/traveler, or from your local operator. If you are calling from an area not supported by AT&T Direct, please use the following international collect phone number: 508-787-9902. Follow the prompts and you will be connected to the Fidelity Service Center for Ford Motor Company.

To use NetBenefits, use the following URL: netbenefits.fidelity.com.

All conversations initiated through a Fidelity representative will be recorded.

Refer to the chart in the Appendix at the end of this section for information on managing your account.

Transaction deadlines

- **Changes in investment elections for your contributions, exchanges, loans for one to five years, and withdrawals.** Your transaction will be effective as of the close of business on any business day if your request is made and confirmed prior to the close of the New York Stock Exchange (usually 4:00 p.m. Eastern Time) on that day. If your request is made or confirmed after this time or on non-business days such as weekends or holidays, your transaction will be effective as of the close of business on the next business day.

- **Electing or changing your savings contributions.** Your contribution election change may take up to two pay periods before it becomes effective.

Because of high call volume near the close of the market at times, you may wish to call early to be sure your request is made by the deadline. A business day is any day that the New York Stock Exchange is open.

Ensuring accuracy

As you enter information in the Fidelity Service Center system to initiate a TESPHE transaction, its voice response system will:

- Tell you if your entry fails to meet plan guidelines
- Repeat your entry so you can verify its accuracy

Written confirmation of your transaction will be mailed to your address-of-record on Fidelity's recordkeeping system within three to five business days.

If you have questions

All questions and issues regarding the TESPHE should be directed to the Fidelity Service Center for Ford Motor Company representatives. You should call the NESG at 1-800-248-4444 only if the Fidelity Service Center for Ford Motor Company representatives is unable to help you.

What circumstances might affect TESPHE benefits?

You should be aware of circumstances that might affect your benefits and your account.

Naming a beneficiary

If you die before assets in your account are distributed to you, your beneficiary will be entitled to your benefit as follows:

- If you're married at the time of your death, your surviving spouse will be entitled to the assets in your account, unless you designate someone else as your beneficiary. Your spouse must consent to this alternative beneficiary designation in writing, as required by law, and your spouse's consent must be witnessed by a notary public.
- If you're not married and you're covered under the Company-paid life insurance plan at the time of your death, assets in your TESPHE account will be distributed to the person(s) entitled to receive your benefits under such plan, unless you designate someone else. You may name a different beneficiary for the TESPHE by requesting an alternative beneficiary designation form from the Fidelity Service Center for Ford Motor Company and filing the form with UNICARE.
- If you're not married and you're not covered under the Company-paid life insurance plan at the time of your death, assets in your account will be distributed to your estate, unless you designate a beneficiary. You may name a beneficiary for your TESPHE account by requesting an alternative beneficiary designation form from the Fidelity Service Center for Ford Motor Company and filing the form with UNICARE.

You may change or revoke your beneficiary designation at any time. If you terminate employment and decide to leave your TESPHE assets in the TESPHE, be sure that your beneficiary elections are in order.

Beneficiaries may not make beneficiary designations.

If you or your beneficiary is incapacitated

Payment of your account may be withheld until a legal representative is appointed if you or your beneficiary becomes legally incapacitated or incompetent.

Changes in laws and regulations

TESPHE is subject to approval by the Internal Revenue Service and other governmental bodies. As laws and regulations change, the TESPHE may require amendment as well. If changes affect your benefits, you will be notified.

Transfer of benefits

Payments from the TESPHE are intended to be made to you or your eligible spouse or beneficiary. Payments cannot be transferred, assigned, pledged or garnished. The TESPHE must honor qualified domestic relations court orders, however, in assigning benefits for a divorce settlement or child support payment.

Assignment of benefits; liens

Benefits under qualified retirement plans like the TESPHE generally may not be assigned or alienated except in accordance with a judgment, decree, or order that is issued under state domestic relations law that relates to the provision of child support, alimony, or marital property rights to a spouse, former spouse, child, or other dependent of a plan participant. Such an order must meet the requirements of a Qualified Domestic Relations Order (QDRO) as defined in Section 206(d) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, as determined by the Company. No benefits under the TESPHE are subject to legal process or attachment for the payment of any claim except as described above.

In Case of a Federal Garnishment

A Federal writ of garnishment against your TESPHE account may be obtained by the U.S. Government pursuant to the procedures authorized by the Federal Department Collections Procedures Act of 1990 (FDCPA), 28 U.S.C. 88 3001-3308, and the Mandatory Victims Restitution Act, 18 U.S.C. 83614(c). The Federal Garnishment will attach a lien to your TESPHE account. Recovery of the Federal Garnishment will begin once you are eligible to receive any distributions from your TESPHE account.

In case of divorce or legal separation

If you are involved in a divorce or legal separation and require information concerning your TESPHE benefits, you should review your quarterly statement or review your account through Fidelity NetBenefits at <https://netbenefits.fidelity.com>. If further information is required, contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333.

The Fidelity QDRO Center at <http://qdro.fidelity.com> is an internet website available to attorneys, TESPHE members, and alternate payees to generate a web Domestic Relations Order ("DRO" or "Order") or to obtain a copy of the QDRO Approval Guidelines and Procedures. This free online application does not interface with any member account or benefits information.

You may also obtain a copy of Ford Motor Company's QDRO Approval Guidelines and Procedures through Fidelity NetBenefits at <http://netbenefits.fidelity.com>. After accessing your TESPHE account, select "Plan Information and Documents" from the left-hand menu, then select "Plan Literature" and check "Ford QDRO Kit". A kit will be mailed to your address of record. You may also call the Fidelity Service Center for Ford Motor Company to request a QDRO kit.

If you would like to submit your QDRO for review send it to:

Fidelity Service Center for Ford Motor Company
P.O. Box 770003
Cincinnati, OH 45277-0066
Attention: QDRO Administrative Group

If the QDRO is acceptable, you will be notified and the QDRO will be implemented according to its terms. Other forms of QDROs may be acceptable if they comply with the legal requirements set forth in Section 206(d) of ERISA and Code Section 414(p), and can be administered in accordance with the guidelines of the TESPHE as determined by Fidelity.

Other forms of marital dissolution documents may be acceptable as QDROs if they comply with the legal requirements set forth in Section 206(d) of ERISA and Code Section 414(p) and can be administered in accordance with the guidelines of the TESPHE as determined by Fidelity. If you are in receipt of such a marital dissolution document, refer to the following description and mailing directions below.

- Send the following documents ***specifically intended to satisfy QDRO requirements*** to Fidelity Service Center for Ford Motor Company, P.O. Box 770003, Cincinnati, OH 45277-0066 Attention: QDRO Administrative Group:
 - ◇ Domestic Relations Orders (DROs) (original, true or court certified copies of original Orders filed in a court of competent jurisdiction)
 - ◇ Proposed DROs
 - ◇ Decrees of Divorce
 - ◇ Judgments
 - ◇ Property Settlement Agreements

- Send the following documents to Ford Motor Company, NESC, P.O. Box 6214, Dearborn, MI 48121-6214 ***if not intended to satisfy QDRO requirements***:
 - ◇ Decrees of Divorce
 - ◇ Judgments
 - ◇ Property Settlement Agreements

How do life events affect the TESPHE?

Certain life events will affect your TESPHE account.

Employment status changes

Transfer to salaried rolls or to a non-participating subsidiary

Your contributions cease upon transfer. You may be eligible for a different plan.

Family status changes

Marriage

Your spouse will be the beneficiary of your TESPHE assets.

New child (birth, adoption, etc.)

This has no effect on your TESPHE account.

Death of your spouse

Your life insurance beneficiary(ies) will be the beneficiary of your TESPHE assets unless you have designated or designate another beneficiary(ies).

Change in you spouse's employment

This has no effect on your TESPHE account.

Relocation

Be sure to change your address on Company records. Once completed, your new address information will be transmitted to Fidelity. It is also prudent to verify with Fidelity that your address change is updated in their system.

If your employment ends (e.g., retirements, quits, discharges)

Your contributions to the TESPHE cease when you separate from the Company and are no longer receiving a paycheck from the Company. Your assets may be exchanged effective any business day among investment elections in accordance with TESPHE provisions. You may initiate partial withdrawals or a total distribution at any time, effective any business day, in accordance with TESPHE provisions.

You cannot initiate new loans. Any outstanding loan balances must be repaid in full at or before separation of employment, or you may elect to make loan payments by utilizing a coupon book.

NOTE: Final regulations governing loans from the TESPHE require that repayment of loans initiated beginning January 1, 2004 (by members who have an outstanding defaulted loan) must be payroll deducted. As a result, such loans must be paid off once members are separated from the Company. Using a coupon book to continue loan repayments will not be an option. See the "Loan Repayments" section for more details.

If you leave your assets in the TESPHE

You may leave your assets in the TESPHE in the event your employment with Ford ends as described above.

If you choose to have the TESPHE retain your assets, unless you elect an earlier distribution, they will be distributed to you at age 70½. These distributions are referred to as minimum required distributions, or MRDs. The required beginning date for MRDs is April 1 of the calendar year following the later of (i) attainment of age 70½ or (ii) separation from the Company. Thereafter, the MRDs must be distributed by December 31 of each year. In general, the applicable distribution period is obtained from the Internal Revenue Code Uniform Lifetime Table and is based solely on your age as of your birthday in the relevant distribution calendar year. If the sole beneficiary is your spouse, however, the distribution period is the longer of the distribution period from the Uniform Lifetime Table, or, in the case of a spouse beneficiary who is more than 10 years younger than you, the joint life expectancy of you and your spouse.

Under the MRD schedule, generally, you will receive a smaller amount, allowing you to leave your assets in the Plan for a longer period of time. However, while MRD rules impose a minimum amount that you must receive, you may elect to receive a greater amount under other withdrawal options.

You will also receive a distribution if your account is below a certain amount.

See the "When would assets be paid automatically from the Plan?" section for more details.

You may, of course, elect to withdraw all or a portion of your assets at any time, effective on any business day.

If you die

Please refer to “When would assets be paid automatically from the TESPHE?” section

Leaves of absence and layoff

Medical leave of absence

Your contributions and payroll deductions for loan repayments cease. You may continue to make loan payments on existing loans once you are no longer receiving a paycheck from the Company. If you are on a medical leave for more than 90 days, you will be removed from the active employment rolls. After Ford transmits your updated status to Fidelity, you will receive a coupon book with which to make loan payments. Until you receive a coupon book, you may send payments to Fidelity directly. (Acceptable forms of payment: cashiers or certified check or money order.)

Unpaid leave of absence

Your contributions and payroll deductions for loan repayments cease. You may initiate new loans, unless you have a history of loan default. You must make loan repayments by utilizing a coupon book.

Layoffs

Your contributions and payroll deductions for loan repayments cease. You may not take out new loans. You must continue to make loan payments on existing loans once you are no longer receiving a paycheck from the Company. Coupon books are not sent to employees on a temporary layoff. However, you must continue to make your loan payments or your loans will default. Acceptable forms of payment: cashiers or certified check or money order.

Generally, you will receive a coupon book once your leave or layoff status is transmitted to Fidelity from the Company. You should contact Fidelity if you do not receive the coupon book within 15 days of your Leave of Absence (including medical leaves greater than 90 days) or indefinite layoff.

Failure to make payments will result in a warning letter advising of potential loan default. If, after receiving the warning letter you do not make the required payment, as stipulated in the warning letter and within the prescribed time frame, your loan will default. (See “How can you borrow from the TESPHE?” for consequences of loan defaults.)

General Information

Note: Final regulations governing loans from TESPHE require that repayment of loans initiated beginning January 1, 2004 by members who have a history of loan default must be payroll deducted.

Using a coupon book to continue loan repayments will not be an option. (See the “Loan Repayments” section for details.)

Members on leave or layoff are subject to the same withdrawal provisions as active employees. (See “How are assets paid from the TESPHE?” for more details.)

You may continue to manage your account (e.g., make exchanges between investment options) in accordance with TESPHE provisions.

Return from a leave of absence or layoff

Your contributions and payroll deductions for loan payments will resume automatically. Always check your pay stub to assure deductions resume. If for some reason they do not, contact Fidelity immediately to request that they make the necessary arrangements to resume loan deduction through payroll deduction. Note: Generally, there is a short time delay before your status updates at Fidelity since the update is dependent on when Ford transmits your reinstatement. If you elect to make loan repayments via ACH, this time delay could result in a loan payment from both your bank account and your pay check. Should this occur, all monies will remain in your TESPHE account.

Can the TESPHE provisions change?

It is possible the TESPHE could be changed or could end in the future.

The TESPHE is expected to continue in effect until the end of the 2007 Ford-UAW Collective Bargaining Agreement.

At that time, the TESPHE may be renewed automatically for successive one-year periods, unless Ford or the UAW makes a written request to modify the TESPHE at least 60 days before September 14, 2011, or any subsequent anniversary date. A request to terminate the TESPHE must be made within the same deadlines.

Subject to the 2007 Agreement, the Company Board of Directors may at any time change, suspend or terminate the TESPHE partially or completely. No change may reduce the value of your account, however, from what it was on the day before the change.

Your current account balance also is protected if the TESPHE is merged or consolidated with another plan, or if your account is transferred to another plan. Immediately after the change, your account balance under the new plan would be at least equal to the balance under the TESPHE just before the change.

A change or suspension in the TESPHE may not change your right for the continued investment of your TESPHE account, your right to make approved withdrawals, or your right to a final payout.

The Company may change, suspend or end the TESPHE for employees if the Tax-Efficient Savings Plan Committee finds that the laws of a state or country where they live make the TESPHE disproportionately expensive and inconvenient to administer.

A change, suspension or termination will take effect no sooner than the date the Company notifies the Trustee and participating companies. A retroactive change is allowed, however, if it is required to keep the TESPHE or the trust fund in compliance with legal requirements.

If the TESPHE is terminated, the Company may direct the Trustee to pay out the assets in all accounts as of the termination date. Any Profit Sharing contribution to the Plan for 2011, however, will be administered as described in the TESPHE even if the TESPHE is terminated that year.

Administration

The following information pertains to the administration of the TESPHE.

Administration of the TESPHE

The TESPHE is sponsored by Ford Motor Company, and the Company is the Plan Administrator.

The Company has been designated “named fiduciary” pursuant to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended and has the power to control and manage the operation and administration of the TESPHE.

The Company has established a Tax-Efficient Savings Plan Committee (the Committee), all the members and alternate members of which are employees of the Company. The members of the Committee and the alternate members receive no additional compensation for Committee services as members or as alternate members. Except for non-delegable functions of the Trustee, the Committee administers the TESPHE, interprets its provisions and prescribes regulations and forms in connection therewith. Interpretations of the provisions of the TESPHE by the Committee are final and conclusive.

The Company and Fidelity Management Trust Company (FMTC) have entered into a Trust Agreement pursuant to which FMTC acts as Trustee under the TESPHE. The Company may amend the Trust Agreement and change the Trustee. The Trustee has custody of the funds received from the Company as contributions or received as earnings thereon, and makes all purchases, sales and redemptions of securities in accordance with the provisions of the TESPHE.

The Pension Benefit Guaranty Corporation (PBGC)

TESPHE is a defined contribution pension plan. This means that the TESPHE defines the contribution to be made to your account, but it does not mean that you’ll receive a specific amount when your account is paid out. Since no benefit is guaranteed, TESPHE accounts are not insured by the PBGC.

Investment Process Oversight Committee (IPOC)

The Company, by action of the Board of Directors, created an IPOC. The IPOC is responsible for:

- Reviewing the performance of investment options (based on approved investment guidelines) and fees; and
- Approving any changes to the investments or investment guidelines recommended by the Investment Process Committee.

The IPOC will take action with respect to the Ford Stock Fund, Common Stock Index Fund, Bond Index Fund and Interest Income Fund only to the extent required by ERISA.

The IPOC is responsible for maintaining the investment options under the TESPHE solely in the interest of the TESPHE’s members and their beneficiaries.

Investment Process Committee

The Company, by action of the Chief Financial Officer, the Group Vice President - Human Resources and Corporate Services, and the Senior Vice President and General Counsel created an Investment Process Committee (IPC). The IPC recommends investment process guidelines to the IPOC for its approval. Such guidelines will include:

- The types of investment options to be offered under the TESPHE, with due regard to the risk and return characteristics of such options and the need to offer a reasonable array of such risk and return alternatives;
- The individual investment options to be offered under the TESPHE consistent with the range of risk and return characteristics deemed appropriate;
- Procedures for reviewing the performance of investment options offered under the TESPHE; and
- Criteria mandating the removal of investment options from availability under the TESPHE.

After such guidelines have been approved by the IPOC, the IPC will meet at least quarterly to:

- Review the guidelines for continued appropriateness;
- Review the performance and fees of investment options pursuant to the criteria regarding the removal of investment options from availability under the TESPHE;
- Recommend additional options, the deletion of options, and, if appropriate, the replacement of options to the IPOC for its approval, if changes are required; and
- Recommend changes to the guidelines for approval by the IPOC.

The IPC is responsible for maintaining the investment options under the TESPHE solely in the interest of the TESPHE's members and their beneficiaries.

Employee Stock Ownership Plan (ESOP)

A portion of the TESPHE is designated as an Employee Stock Ownership Plan (ESOP). The ESOP was established in the TESPHE effective January 1, 1989 and consists of all the shares of Company Stock in the TESPHE. The Trustee shall hold, invest, transfer and distribute shares of Company Stock and all other assets in the ESOP in accordance with the TESPHE document.

Other information

The following documents filed or to be filed with the Securities and Exchange Commission are incorporated herein by reference:

- Ford's, and the TESPHE's latest annual reports filed pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 (the "1934 Act") which contain, either directly or by incorporation by reference, certified financial statements for Ford's latest fiscal year for which such statements have been filed
- All other reports filed pursuant to Section 13(a) or 15(d) of the 1934 Act since the end of the fiscal year covered by the annual reports referred to in the preceding paragraph
- The description of Ford's Common Stock contained in Registration Statement No. 333-38352 filed by Ford under the Securities Act of 1933

All documents subsequently filed by Ford pursuant to Sections 13(a), 13(c), 14 and 15(d) of the 1934 Act, prior to the filing of a post-effective amendment which indicates that all securities offered have been sold or which deregisters all securities then remaining unsold, shall be deemed to be incorporated herein by reference and to be a part hereof from the date of filing such documents.

Each person to whom a copy of this material is delivered will be provided without charge, upon written or oral request of such person, a copy of any and all of the information that has been incorporated by reference in this material (not including exhibits to the information that is incorporated by reference unless such exhibits are specifically incorporated by reference into the information that this material incorporates) and any other documents required to be delivered to members. Written or telephone requests for such information related to Ford should be directed to: Ford Investor Relations, P.O. Box 1899, Dearborn, Michigan 48121-1899, telephone: (800) 555-5259 (within the U.S. and Canada or (313) 845-8540 (outside the U.S. and Canada), fax (313) 845-6073.

Written or telephone requests for information about the TESPHE that the Fidelity Service Center for Ford Motor Company is unable to answer or inquiries directed to the Tax-Efficient Savings Plan for Hourly Employees Committee, which administers the TESPHE, should be directed to the National Employee Services Center, Savings Plans Administration, Ford Motor Company, P.O. Box 6214, Dearborn, MI 48121-6214, telephone (313) 248-4444 or 1-800-248-4444.

The TESPHE was established pursuant to the Collective Bargaining Agreement dated October 14, 1984, between the Company and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, UAW (the Union), and was approved by the Board of Directors of the Company on November 8, 1984. The TESPHE was amended and continued pursuant to the Collective Bargaining Agreement dated November 3, 2007, between the Company and the Union. Contributions to the TESPHE commenced in March 1985.

The TESPHE is subject to certain provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), including generally, the reporting and disclosure, participation and vesting, fiduciary responsibility, and administration and enforcement provisions in Title I of ERISA. TESPHE is also qualified under Sections 401 (a) and 401(k) of the Internal Revenue Code of 1986, as amended.

The TESPHE is intended to constitute a plan described in section 404(c) of ERISA. The fiduciaries of the TESPHE are relieved of liability for any losses which are the direct and necessary result of investment instructions given by members of the TESPHE.

The detailed provisions of the TESPHE, not the summary, govern the actual rights and benefits to which you may be entitled. If there is a conflict between this summary and the TESPHE plan document, the TESPHE plan document will control.

Address changes

It is your responsibility to keep your address current in the Company's records. Notices about the TESPHE will be sent to your most recent address.

Claim for Benefits

If you have a **Claim for Benefits** under the TESPHE, or if you think there is an error in the administration of your TESPHE account or an error relating to the amount of your TESPHE deduction from your Profit Share or eligible pay, you should contact the Fidelity Services Center for Ford Motor Company at 1-800-544-3333. The Fidelity Service Center for Ford Motor Company will attempt to resolve your concerns informally. If that does not prove possible, you should submit your claim to the Fidelity Service Center for Ford Motor Company in writing.

Appeal procedure

If Fidelity denies a claim for benefits or participation in whole or in part, you will receive written notification within 90 days from the date the claim for benefits or participation is received. The notice will be deemed given upon mailing, full postage prepaid in the United States mail or on date sent electronically to you. The decision will be in writing and it will include:

- The specific reason or reasons for the denial;
- Reference to the specific plan provision(s) on which the denial is based, along with a copy of the TESPHE provision(s) or a statement that one will be furnished at no charge per your request;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the TESPHE's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, following a claim denial for benefits on review.

If Fidelity determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 90-day period. In no event will such extension exceed a period of ninety (90) days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the TESPHE expects to render the determination.

Review of denial of the claim by the Committee

In the event that Fidelity denies a claim for benefits or participation, you may:

- Request a review by filing a written appeal to the Committee,
- Review pertinent documents, and
- Submit written comments, documents, records and other information relating to the claim for benefits

The Committee must take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. You may send your written appeal to:

National Employee Services Center (NESC),
Savings Plan Administrator,
P.O. Box 6214,
Dearborn Michigan 48121-6214.

You must request a review upon an appeal of the denial of the claim within sixty (60) days after you receive the written notification of denial of the claim. The appeal will be considered at the Committee's next regularly scheduled meeting. If it is filed within thirty (30) days of the next meeting, a decision by the Committee shall be made by the date of the second meeting after receipt of your request for review. Under special circumstances, an extension of time for processing may be required, in which case a decision shall be rendered by the date of the third meeting. If an extension is required because information is incomplete, the review period will be tolled from date the notice was sent to the date information is received. In the event such an extension is needed, written notice of the extension will be provided to you prior to the commencement of the extension.

Written notice of a decision will be made not any later than five (5) days after the Committee has made a decision. The decision will be in writing and it will include:

- The specific reason or reasons for the denial;
- Specific reference to pertinent TESPHE provision(s) on which the denial is based, along with a copy of such TESPHE provisions or a statement that one will be furnished at no charge upon your request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and

- A statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

The notice will be deemed given upon mailing, full postage pre-paid in the United States mail, or on the date sent electronically to you.

Claim for Breach of Fiduciary Duty

Effective April 20, 2005, the following procedure should be followed if you have a **Claim for Breach of Fiduciary Duty** under the TESPHE.

A Member alleging breach of fiduciary duty must file a written claim directed to the National Employee Services Center, Savings Plan Administration, Ford Motor Company, P.O. Box 6214, Dearborn, MI 48121-6214.

The claim must:

- Specifically set forth the facts concerning the alleged breach;
- Clearly identify the TESPHE plan fiduciary who you alleges has committed a fiduciary breach;
- Cite the legal basis for the allegation of fiduciary breach; and
- Specifically set forth the remedy that you request on behalf of the TESPHE.

Savings Plan Administration will review the claim and make a determination within ninety (90) days from the date the claim is received. The notice will be deemed given upon mailing, full postage prepaid in the United States mail, or on the date provided electronically to the claimant.

Any actual denial of a claim will be in writing and it will include:

- The specific reason or reasons for the denial;
- Reference to the specific TESPHE provision(s) on which the denial is based along with a copy of the TESPHE provision(s) or a statement that one will be furnished at no charge, per your request;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the TESPHE's review procedures and the time limits applicable to such procedures, along with a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, following a denial for benefits on review.

If Savings Plan Administration determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which Savings Plan Administration expects to render the determination.

At the discretion of Savings Plans Administration, the claim may be referred to the Committee or to the Senior Vice President - General Counsel for review.

In the event that Savings Plans Administration denies a claim, a claimant may:

- Request a review upon appeal by written application to the Committee;
- Review pertinent TESPHE plan documents; and
- Submit issues and comments in writing.

You must request a review upon appeal of the denial of the claim by Savings Plans Administration under this TESPHE within sixty (60) days after receiving written notification of denial of the claim. The appeal will be considered at the Committee's next regularly scheduled meeting. If the appeal is filed within thirty (30) days of the next meeting, a decision by the Committee, as appropriate, shall be made by the second meeting after receipt of the claimant's request for review.

Under special circumstances, an extension of time for processing may be required, in which case, a decision will be made by the date of the third meeting. If an extension is required because information is incomplete, the review period will be tolled from the date the notice was sent to the date the information is received. In the event such an extension is needed, written notice of the extension will be provided to you prior to the commencement of the extension. In reviewing the claim, the Committee may retain experts or other independent advisors. In such event, an extension of time for processing may be required but a decision on the appeal will be made as soon as is reasonably practicable under the circumstances.

Written notice of the decision will be made to you not any later than five (5) days after the decision has been made by the Committee. At the Committee's discretion, an appeal from a denial of the claim by Savings Plan Administration, or a referral of a claim directly to the Committee by the Savings Plan Administration, may be referred to the Senior Vice President - General Counsel for review.

When a claim for breach of fiduciary duty, or an appeal from a denial of a fiduciary duty claim, is referred to the Senior Vice President General Counsel, he/she will have full authority and sole discretion to determine the manner in which to discharge his/her responsibility with respect to the review of the claim or the appeal. This includes, but is not limited to, retaining the responsibility to review the claim or appeal, appointing an independent fiduciary, seeking a declaratory judgment in federal court or seeking review of the claim or appeal by an existing or specially appointed committee of the Board. The Senior Vice President- General Counsel, or any person who is responsible for making the decision with respect to the claim or appeal as determined by the Senior Vice President-General Counsel as described above ("Appointee"), also may retain experts or other independent advisors in his/her sole discretion with respect to review of the claim or appeal. The claim or appeal will be reviewed on the basis of the written record submitted by you and the record developed by Savings Plans Administration, if any.

A decision will be made as soon as reasonably practicable under the circumstances. Written notice on review of the decision will be made to you not any later than five (5) days after the decision has been made. The notice will be deemed given upon mailing, full postage pre-paid in the United States mail, or on the date sent electronically to you.

The decision on review will include:

- The specific reason or reasons for the denial;
- Specific reference to pertinent TESPHE provisions on which the denial is based, along with a copy of such TESPHE provisions or a statement that one will be furnished at no charge, upon your request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, copies of, all documents, records and other information relevant to your claim; and
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on review.

Savings Plans Administration, the Committee, the Senior Vice President-General Counsel or the Appointees each severally will have full power and discretion under the TESPHE to consider member appeals with respect to fiduciary claims. Decisions of the Committee, the Senior Vice President-General Counsel or the Appointees, as the case may be, are final and conclusive and are only subject to the arbitrary and capricious standard of judicial review and shall bind and may be relied upon by the members, beneficiaries or the estate or legal representative thereof, the Trustee and all other parties in interest.

Decision of the Committee

Decisions of the Committee, the Senior Vice President – General Counsel or the Appointees, as the case may be, are final and conclusive and are only subject to the arbitrary and capricious standard of judicial review and will bind and may be relied upon by you, your beneficiaries, or the estate or legal representative thereof, the Trustee and all other parties in interest.

Exhaustion requirement limitations on claims

No legal actions may be brought by you, your dependent, beneficiary or the estate or legal representative for entitlement to benefits under the TESPHE or for breach of fiduciary duty until after the claims and appeal procedures have been exhausted. Unless a different period of limitation is specifically provided under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, any claim under the TESPHE must be brought no later than two (2) years after the claim arises in order for the review authorities to conduct a timely and effective investigation of the claim. For matters not specifically addressed, no other actions may be brought against the TESPHE more than six (6) months after the claims arise.

Tax Reduction Act Stock Ownership Plan

The Tax Reduction Act Stock Ownership Plan (TRASOP) was terminated on May 31, 1989, and assets in members' accounts were distributed from the trust to members or beneficiaries, or transferred to members' accounts in Company savings plans like the TESPHE in accordance with their elections and provisions established to terminate the plan.

Trustee and record keeper

The Plan Trustee is Fidelity Management Trust Company (FMTC) . Fidelity Investments Institutional Operations Company, Inc. (FIIOC) will provide the recordkeeping and administrative services. Their address is:

FMTC: 300 Puritan Way
Marlborough, MA 01752

FIIOC: 82 Devonshire Street
Boston, MA 02109

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended

The TESPHE is designed to meet the requirements established by ERISA. The TESPHE will be amended to conform with any changes in the law or government regulations.

As a participant in the TESPHE, you're entitled to certain rights and protections under ERISA. Included are the right to receive certain plan information and the right to file a lawsuit if you believe your rights have been violated.

Here is a listing of your rights under ERISA:

- You may visit the National Employee Services Center (NESC) and in some cases Ford World Headquarters, and examine all TESPHE plan documents without charge. Contact the NESC on where you must visit. These include the TESPHE itself, the trust agreement for the TESPHE, the annual financial reports, the TESPHE description, and all other official TESPHE plan documents.
- With reasonable written notice, copies of TESPHE plan documents will be made available for review at other locations.
- You may obtain copies of TESPHE plan documents by writing the Plan Administrator at: National Employee Services Center (NESC), Savings Plan Administrator, P.O. Box 6214, Dearborn, Michigan 48121-6214.
- The Company may make a reasonable charge for copies.
- You will receive a written summary of the TESPHE's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.
- You also may obtain a copy of the annual reports and other TESPHE plan documents at the U.S. Department of Labor's Public Disclosure Room at the Pension and Welfare Benefit Administration in Washington, D.C.
- You may not be discharged or discriminated against to prevent you from obtaining a benefit or for exercising your ERISA rights.

If your claim for a benefit is denied in whole or part:

- You will receive a written explanation from the Plan administrator.
- You have the right to have your claim reviewed and reconsidered.

Besides creating rights for TESPHE members, ERISA also spells out certain duties for people who are responsible for operating the TESPHE. These people are called "fiduciaries". The fiduciaries of a plan have a duty to operate the plan prudently and in the interest of plan members and beneficiaries.

There are steps you can take to enforce your ERISA rights. For example:

- If you request materials from the TESPHE and don't receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials - unless the materials were not sent because of reasons beyond the control of the administrator.
- If your claim for benefits is denied in whole or in part after a final review, you may file suit in a state or federal court.
- If the fiduciaries misuse the TESPHE's money or if you are discriminated against for asserting your ERISA rights, you may seek help from the U.S. Department of Labor or file suit in a federal court. If you file a suit, the court will decide who should pay costs and legal fees. If you win your suit, the court may order the person you have sued to pay the costs and fees. If you lose your suit, or if the court decides your suit was frivolous, the court may order you to pay the costs and fees.

If you have any questions about the TESPHE, you should contact the National Employee Services Center (NESC). If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Securities Administration at 1-866-444-EBSA (3272).

Basic TESPHE Information

Plan Name:	Tax Efficient Savings Plan for Hourly Employees
Plan Sponsor:	Ford Motor Company Henry Ford II World Center Room 1037 One American Road Dearborn, MI 48126-2748
Employer Identification Number:	38-0549190
Plan Number:	025
Type of Plan:	Defined Contribution Pension Plan (401(k), ESOP)
Plan Administrator:	Ford Motor Company (313) 248-4444 (800) 248-4444
Type of Administration:	Administrative services for the Plan are provided by: Ford Motor Company National Employee Services Center, UNICARE (under contract), and Fidelity Management Trust Company (under a trust agreement and supplemental contracts).
Trustee:	Fidelity Management Trust Company 300 Puritan Way Marlborough, MA 01752
Agent for Service of Legal Process:	Ford Motor Company One American Road 1037 Dearborn, MI 48126-2748

Alternatively, legal process may be served on the Plan trustee

Plan Funding:	Company & Employee Funded Assets of the TESPHE are held in trust
Plan Year:	January 1 to December 31

Appendix

How the catch-up contribution feature works and important information to consider

- Your catch-up contribution is a separate election. You may elect to contribute up to 50% (in whole percent increments) of your eligible pay each payroll period on a pre-tax basis as a catch-up Contribution. This election is in addition to your regular TESPHE payroll deduction of up to 50% and is subject to an annual limit that will be communicated to you each year.
- If your regular TESPHE payroll deductions stop because you have reached certain limits during the year (the IRS pre-tax deferral, the TESPHE contribution limit, the IRS 415 limit), you can continue making catch-up contributions for future payroll periods.
- You may make changes to your catch-up contribution deferral percentage at any time. Generally, changes are effective within 1 to 2 pay periods.
- Your catch-up contributions will be invested in the same manner as the investment elections you have chosen for your regular TESPHE pre-tax deferrals. Take this opportunity to review all of your contribution investment choices.
- When you reach the catch-up contribution limit, your catch-up contributions will stop automatically.
- Catch-up contribution elections will carry over from year to year until you change it.

If you would like to take advantage of the catch-up contribution feature:

- Log on to Fidelity NetBenefits at www.netbenefits.com.
- Click the “Access My Benefits” icon and proceed to log in.
- On the Accounts tab, under *Account Management*, select the *Deductions* option.
- Click *Change*.
- Under *Current Payroll Deduction Elections*, click *Change*.
- Select *Employee Pre-Tax Catch-Up* from the drop down list.
- Select the percentage of your eligible pay that you would like to contribute as a catch-up contribution, up to a maximum of 50%.
- Once you have selected the percentage, click on the gray *Update Payroll Deduction* button at the bottom of the page.
- If you elect to receive a paper confirmation, it will be mailed to your home shortly after you make your catch-up contribution election.
- You can also contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333. The voice response system is available virtually 24 hours per day, and representatives are available on business days from 8:30 a.m. to midnight, Eastern Standard Time.

Frequently Asked Questions

Q: What are catch-up contributions?

A: Catch-up contributions are additional pre-tax elective deferrals above the following limits:

- (a) TESPHE limit of 50% of eligible pay;
- (b) annual IRS pre-tax deferral limit (schedule below); or
- (c) the annual IRS 415 defined contribution limit

Q: How do I know whether I can make catch-up contributions?

A: If you are age 50 or older, or will reach age 50 on or before December 31, you can make a catch-up contribution election for the year. Any catch-up contributions you elect will not affect your regular pre-tax contribution amounts.

Q: I am interested in making a catch-up contribution, but I won't be 50 years old until October. Can I participate beginning in January, or do I need to wait until after my 50th birthday?

A: You can elect to make catch-up contributions beginning in January as long as you will be at least 50 years old on or before December 31.

Q: This year, through my regular TESPHE payroll deductions, I have already reached the IRS pre-tax deferral limit, so my regular TESPHE pre-tax deferrals have stopped for the rest of the year. Can I still make a catch-up contribution election?

A: Yes, even though your regular TESPHE pre-tax deferrals have stopped for the remainder of the year, you can still make catch-up contributions.

Q: Once I elect to make catch-up contributions, what will happen if I stop my regular TESPHE payroll deductions and then restart them at a later time?

A: Your catch-up contributions will not stop automatically if you voluntarily stop your regular TESPHE payroll deductions. However, to the extent you have not reached the annual IRS pre-tax deferral limit or the TESPHE contribution limit of 50% by the end of the calendar year, any catch-up contributions will be re-characterized to regular pre-tax deferral contributions.

Q: Can I make catch-up contributions after I take a hardship withdrawal, which results in suspension of TESPHE payroll deductions?

A: No. In order to make catch-up contributions, you must be eligible to make regular payroll deductions under the TESPHE. If you take a hardship withdrawal, your right to make regular TESPHE payroll deductions is suspended temporarily. If you take a hardship withdrawal and you previously elected to make catch-up contributions, your catch-up contributions will stop automatically. Once the suspension expires, you may elect to resume your catch-up contributions. Your catch-up contributions will automatically resume at the deferral rate in effect prior to the suspension. (Note: Other withdrawals that do *not* result in a suspension of TESPHE payroll deductions will not affect catch-up contributions.)

Q: I know that I want to make catch-up contributions every year. Will my catch-up election carry over from year to year?

A: Yes. Your catch-up contribution deferral percentage will carry over each year until you change it.

Q: Can I choose a dollar amount for my catch-up contribution or does it have to be a percentage?

A: At this time, only catch-up contribution elections that are a percentage of your eligible pay will be accepted. You may elect to defer up to 50% of your eligible pay as catch-up contributions. You will be notified if additional methods for calculating catch-up contributions become available.

Q: What will happen when I reach the catch-up dollar limit for any given year?

A: Once you reach the catch-up dollar limit for the year, your catch-up contributions automatically stop. Your contributions will automatically resume in January of the following year, unless you cancel your deductions.

Frequently Asked Questions (con't)

Q: Can my catch-up contribution deferral percentage be different than my regular TESPHE pre-tax payroll deduction?

A: Yes, it can be more or less than your regular TESPHE payroll deduction. For example, if your regular payroll pre-tax deduction is 8%, you may elect to defer between as little as 1% or as much as 50% of your eligible pay to catch-up.

Q: I contributed catch-up contributions to another employer's 401(k) plan. Will I be able to contribute the full annual catch-up amount to the TESPHE, too?

A: A catch-up eligible participant cannot make total catch-up contributions that exceed the annual catch-up limit by participating in more than one eligible plan, whether related or unrelated employers sponsor the plans. Members have a duty to monitor whether their catch-up contributions have exceeded the annual limit; however, if this occurs, please contact the Savings Plan Administration at 1-800-248-4444.

Q: Can I track how much catch-up money I am contributing? Will it appear on my paycheck stub?

A: Your catch-up contribution amounts will not appear on your paycheck stub as a separate line item, but will be included in your pre-tax total. They will also show on your quarterly TESPHE statements from Fidelity. Also, you may track your catch-up contribution dollar amount at anytime by accessing your account online at Fidelity NetBenefits.

Fidelity NetBenefits®:

<https://NetBenefits.Fidelity.com>

Fidelity Service Center: 1-800-544-3333

TDD for the hearing impaired: 1-(888)-343-0860

Plan Designated Default Investment Option

The TESPHE designated default investment option is a target date fund, presently the Barclays Global Investors, N.A. (BGI) LifePath® Index NL Funds. The following is an overview of the BGI LifePath® Index NL Funds.

The BGI LifePath® Index NL Funds are a type of target date fund designed to provide an investment strategy targeted to when you expect to start withdrawing your money, based on an age 65 retirement date. Each LifePath® NL Fund's investment strategy is based on a particular time horizon and level of risk that investors on average would deem appropriate for that timeframe. The investment strategy evolves as the fund approaches its maturity date. For instance, in the early years, when you have more time to bear short-term fluctuations in the stock market, each fund's asset allocation favors stocks to try to maximize returns. Then, as the fund gets closer to its "target date," a team of investment managers at Barclays Global Investors gradually moves more money out of stocks and into more conservative investments, like bonds, to try to preserve the accumulated value of your account. No action is required on your part to rebalance your account; everything is done for you.

When each LifePath® Index NL Fund reaches its target year, assets in that fund will automatically move to the LifePath® Retirement Index NL Fund, intended for people who will be retiring soon, or are already retired. Although the LifePath® Index Retirement NL Fund invests in a greater concentration of lower-risk investments, a portion of its assets will continue to be invested in stock funds so that the portfolio has some protection against inflation during your retirement years. The LifePath® Index Retirement NL Fund holds a blend of investments that is appropriate for retirement years - approximately 1/3 of its assets in stocks; around 2/3 of its assets in fixed-income investments. The Fund seeks current income and moderate long-term growth of capital.

Barclays Global Investors, N.A., a limited purpose national trust bank, manages the LifePath® Index collective investment funds and provides fiduciary and custody services to various institutional investors. Funds custodied with Barclays Global Investors are not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency, and are not guaranteed by BGI or its affiliates. A collective investment fund is privately offered; prospectuses are not required.

There are risks involved with investing, including possible loss of principal. Risk controls and asset allocation models do not promise any level of performance or guarantee against loss of principal. Each LifePath® Index NL Fund has a different level of risk. An investment in the LifePath® Index NL Funds is subject to stock market risk, which means the price of the stocks in which the underlying funds invest may fluctuate or fall in response to economic events or trends. Risks also include bond investment risks, including interest rate risk; credit risk; and prepayment risk, which is the risk that borrowers may prepay their mortgages or loans faster than expected, thereby affecting the security's average life and potentially its yield. Investments in foreign securities are subject to certain special risks and considerations, including potentially less liquidity and greater price volatility than securities traded in the U.S. markets. The funds also may be subject to the additional risk associated with investing in high yield and small cap securities.

The allocation of each LifePath® Index NL Fund's assets is managed using a quantitative model that has been developed based on a number of factors. There is no assurance that the recommended asset allocation will either maximize returns or minimize risk or be the appropriate allocation in all circumstances for every investor with a particular time horizon.

The BGI LifePath® Index NL Fund chosen as the investment option default will be based on your age and the assumption that you will "retire" (or start accessing your TESPHE account) at age 65. **Note: You should verify your birth date of record with Fidelity to assure accuracy. You can do this via Fidelity NetBenefits (from the homepage, click on the *Your Profile* link), or by calling the Fidelity Service Center for Ford Motor Company. If the information is incorrect, contact: (a) your Hourly Personnel Office if you are an active employee; (b) Ford NESC by email (nesc@ford.com) or by phone (1-800-248-4444) if you are separated from the Company**

BGI LifePath® Index NL Fund Default Schedule

If Date of Birth Is...	The Default BGI LifePath Index NL Fund Is...
On or after 1983	BGI Lifepath® Index 2050 NL Fund
On or between 1978 and 1982	BGI LifePath® Index 2045 NL Fund
On or between 1973 and 1977	BGI LifePath® Index 2040 NL Fund
On or between 1968 and 1972	BGI LifePath® Index 2035 NL Fund
On or between 1963 and 1967	BGI LifePath® Index 2030 NL Fund
On or between 1958 and 1962	BGI LifePath® Index 2025 NL Fund
On or between 1953 and 1957	BGI LifePath® Index 2020 NL Fund
On or between 1948 and 1952	BGI LifePath® Index 2015 NL Fund
On or before 1947	BGI LifePath® Index Retirement NL Fund

Managing your account

Accessing and managing your account is easy. Through Fidelity's online account management service, automated phone service, or phone service representatives, you can easily get the information you need whenever you want it. Note that the automated phone service has a speech recognition feature that lets you request most transactions with a simple word or phrase.

NOTE: Fidelity may change the organization of its NetBenefits Website from time to time. As a result, the navigational steps detailed in this document may change. If you have questions regarding how to use Fidelity NetBenefits, contact the Fidelity Service Center for Ford Motor Company at 1-800-544-3333 for assistance.

HOW TO:	USE THIS CHANNEL:		
	<p align="center">Online 24-hour access Log on at netbenefits.fidelity.com</p>	<p align="center">Voice Response System 1-800-544-3333 <i>Virtually any time, day or night</i></p>	<p align="center">Fidelity Service Representatives 1-800-544-3333 <i>Mon.-Fri. 8:30 a.m. to midnight, ET</i></p>
ENROLL IN THE PLAN			
<p>ENROLL IN THE PLAN</p>	<ul style="list-style-type: none"> Select the <i>New User Registration</i> link and follow the prompts to establish PIN#. Click on <u>Ford TESPHE</u> on the Home Page <p>Select the "Begin Enrolling" link on the Welcome page, and complete all of items under the "Steps to Enroll" until you receive an Enrollment Summary. To help you determine your contribution amount, there is a link to a "Take Home Pay Calculator" that shows how various contribution levels could affect your take-home pay and savings over time.</p> <p>(NOTE: If you do not select a specific investment option(s) for your contributions, they will be invested in the Plan default investment option, presently the BGI LlifePath® Index NL Funds, based on your age.)</p>	X	X
ACCOUNT INFORMATION			
<p>Obtain plan information</p>	<p>Click on Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Plan Information and Documents</i>.</p>	X	X
<p>Review investment information (investment option descriptions, mutual fund prospectuses and performance)</p>	<p>Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Performance and Research</i>; select any of the investment options to secure additional detail.</p>	X	X

HOW TO:	USE THIS CHANNEL:		
	Online 24-hour access Log on at netbenefits.fidelity.com	Voice Response System 1-800-544-3333 <i>Virtually any time, day or night</i>	Fidelity Service Representatives 1-800-544-3333 Mon.-Fri. 8:30 a.m. to midnight, ET

ACCOUNT INFORMATION (continued)

Obtain quotes for all investment options	Click on the Savings and Retirement tab from the Home Page; using the “Select Action” menu, scroll down to <i>Performance and Research</i> ; select <i>View Quotes</i> link.	X	X
Check your current account balance	Available on the NetBenefits Home Page. For more detail, click on the Portfolio Investments, Portfolio Research or Portfolio Analysis tabs.	X	X
Review account history	Click on the Savings and Retirement tab from the Home Page; using the “Select Action” menu, scroll down to <i>History</i> .	X	X

INVESTMENT CHANGES

Change your contribution amounts (Pre-Tax, After-Tax or age 50+ catch-up)	Click on the Savings and Retirement tab from the Home Page; using the “Select Action” menu, scroll down to <i>Payroll Deductions</i> .	X	X
Change how future contributions are invested or exchange between investment options	Click on the Savings and Retirement tab from the Home Page; using the “Select Action” menu, scroll down to <i>Change Investments</i> .	X	X

ADMINISTRATIVE CHANGES

Change address: (active employees only)	Change your address in your Labor Relations office	Not Available	Not Available
Set up or change a PIN	Go to NetBenefits at netbenefits.fidelity.com. Select the appropriate link and follow the prompts.	X	X
Order plan literature	Click on the Savings and Retirement tab from the Home Page; using the “Select Action” menu, scroll down to Plan Information and Documents; then select the Forms and Notices link.	X	X

HOW TO:	USE THIS CHANNEL:		
	Online 24-hour access Log on at netbenefits.fidelity.com	Voice Response System 1-800-544- 3333 <i>Virtually any time, day or night</i>	Fidelity Service Representatives 1-800-544-3333 <i>Mon.-Fri. 8:30 a.m. to midnight, ET</i>

LOANS AND WITHDRAWALS

Review amount available for loan	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; select <i>Loans</i> .	X	X
Model a loan and request a general loan	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; select <i>Loans</i> then click on the <i>Model/Take</i> a loan icon.	X	X
Request a home loan (a loan application will be mailed to your home address)	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; select <i>Loans</i> then click on the <i>Model/Take</i> a loan icon.	X	X
Review outstanding loan information	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; select <i>Loans</i> , then click on the <i>Existing Loans</i> icon.	X	X
Establish Electronic Loan Payment (Do not select electronic loan payments while you are receiving a paycheck. Loan repayments are deducted automatically from your paycheck.)	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; click on <i>Loans</i> , click on <i>Existing Loans</i> , then click on the " <i>Make a Single Payment</i> " icon.	X	X
Review amount available to withdraw and request a withdrawal	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Loans or Withdrawals</i> ; select <i>Withdrawals</i>	X	X
Request a full payout (age 59½ and terminated/retired members)	Not Available	X	X
Request a hardship withdrawal	Not Available	Not Available	X
Request a rollover distribution	Not Available	Not Available	X

HOW TO:	USE THIS CHANNEL:		
	Online 24-hour access Log on at netbenefits.fidelity.com	Voice Response System 1-800-544-3333 <i>Virtually any time, day or night</i>	Fidelity Service Representatives 1-800-544-3333 <i>Mon.-Fri. 8:30 a.m. to midnight, ET</i>
ROLLOVER CONTRIBUTIONS			
Inquire about rolling money into the plan	Not Available	Not Available	X
Request a rollover form (form has instructions on how to process a rollover into plan)	Click on the Savings and Retirement tab from the Home Page; using the "Select Action" menu, scroll down to <i>Plan Information and Documents</i> ; select <i>Forms and Notices</i>	X	X
Roll over money into the plan	Not Available	Not Available	X

NOTES

Profit Sharing Plan

After an overview of the Profit Sharing Plan, this section of your handbook answers these questions:

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What is your Profit Share?	282
How do you receive your share?	283
What circumstances might affect your Profit Share?	285
Can the Profit Sharing Plan change?	286

Profit Sharing Plan

An overview of the Plan

Profit Sharing is one of your well-earned rewards. It reflects the importance of your cooperation and performance to Ford's success and is a result of negotiations with the UAW.

The Profit Sharing Plan is designed to reward your efforts which result in Ford's profitability. Through the Plan:

- Each year that the Company generates profits from U.S. Operations, Ford will set aside a portion of these profits.
- The money allocated for Profit Sharing is divided among the Plan participants.
- Each Plan participant receives a portion of these profits, called a "Profit Share."
- Your Profit Share is based on your eligible pay for the year and can be:
 - ◇ paid by check
 - ◇ put in the Tax-Efficient Savings Plan for Hourly Employees (TESPHE)
 - ◇ deposited in your Ford Interest Advantage Account or
 - ◇ a combination of these.

It's your choice.

If you decide to have the Company contribute all or a part of your share to TESPHE, the provisions on investments, transfers, withdrawals, etc., that cover other TESPHE contributions will apply.

More details follow.

Who is eligible for Profit Sharing?

If you were hired on or before December 31 of the Plan year, you may be eligible for Profit Sharing.

Eligibility

You're eligible for Profit Sharing if you:

- Were hired on or before December 31 of the Plan year (the Plan year is the same as a calendar year)
- Are a full-time hourly employee of Ford Motor Company at one of the U.S. Operations included in the Plan and
- Are employed in a Unit to which this Plan is applicable.

Your eligibility is not affected if, during the Plan year:

- You are on layoff or approved leave
- You retire or
- Your employment terminates because the Company sells the operation where you work.

Beneficiaries of eligible employees who die during the Plan year also are eligible for Profit Sharing.

You are not eligible if:

- Your employment terminated during the Plan year (without being reinstated) for reasons other than retirement, death or sale of an operation
- You work on a temporary part-time basis or
- You are employed at certain subsidiaries, including Ford Land (if this is the case, other profit sharing plans may apply)

If you're eligible for Profit Sharing, your individual Profit Share is based on your eligible pay.

How are Profit Shares determined?

Each year that Company profits are generated, Ford will make Profit Sharing payments.

Shortly after the end of the year, the Company determines its profits and sales for the year from U.S. Operations. U.S. Operations does not include profits and sales of Ford Land or Ford Motor Credit Company and certain other subsidiaries and operations.

Profits and sales

The Company makes payments under the Profit Sharing Plan when these profits are generated.

The Plan takes into account profits that Ford earns before income taxes and before calculation of Profit Sharing under the Hourly Profit Sharing Plan, Profit Sharing that would have been paid to eligible salaried employees under the Profit Sharing Plan for Salaried Employees in the U.S. had that plan not been terminated and executive annual incentive compensation. Profits of certain unconsolidated subsidiaries are included on an after-tax basis, although the sales of such subsidiaries are not.

The relationship between profits and sales is important in calculating the amount of profits that will be shared under the Profit Sharing Plan. As profits increase to specific levels, the percentage on which your Profit Share is based also increases.

Determining the Total Profit Share

Ford begins determining your share of profits by calculating the "Total Profit Share." It is figured according to this formula:

6% of profits up to 1.8% of sales	+	8% of profits between 1.8% and 2.3% of sales	+	10% of profits between 2.3% and 4.6% of sales	+	14% of profits between 4.6% and 6.9% of sales	+	17% of profits over 6.9% of sales
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For any year that profits are generated, the Total Profit Share will be at least equal to \$50 times the number of hourly and salaried employees in U.S. Operations.

When the Total Profit Share has been determined, it then is divided between the hourly and salaried employees based on the number of employees in each. For example, if 70% of the employees eligible for Profit Sharing are hourly employees, then 70% of the Total Profit Share will go to the Profit Sharing Plan for hourly employees. The resulting amounts represent the "Allocated Profit Share" for each Profit Sharing Plan.

The amount of the Total Profit Share and the Allocated Profit Share are certified by independent public accountants.

The next section describes how your share of this amount is calculated.

What is your Profit Share?

Your share of the Total Profit Share is based on your eligible pay.

Once the Allocated Profit Share is determined, your Profit Share then can be calculated. Your Profit Share depends on your eligible pay.

Eligible pay

Your Profit Share is calculated using only your “eligible” pay. Eligible pay includes:

- Straight-time hourly base wages (for straight-time hours and overtime hours)
- Straight-time cost-of-living allowance (for straight-time hours and overtime hours)
- Straight-time shift premiums (for straight-time hours and overtime hours)
- Vacation and excused absence allowance
- Holiday pay
- Seven-day operations bonus
- Apprentice training incentive payments
- Bereavement pay
- Jury duty pay
- Short-term military duty pay
- Call-in pay
- Grievance awards (that represent back pay that is eligible pay for any Plan year)
- Performance Bonus Plan
- Christmas bonus and
- Up-front lump sum payments (2007 plan year only).

Special adjustments to eligible pay may be made in the event of compensation received under a gradual return-to-work-program

Eligible pay excludes overtime, Saturday, Sunday and holiday premium payments. These examples show how eligible pay is determined when premium payments are made:

If you work:	Included in Eligible Pay:	Excluded from Eligible Pay:
10 hours on a regularly scheduled workday	8 hours of straight-time pay for regularly scheduled hours, plus 2 hours of straight-time pay for overtime	1 hour of premium pay for overtime
10 hours of overtime on a Saturday	10 hours of straight-time pay for working 10 hours	5 hours of premium pay for a Saturday
10 hours of overtime on a Sunday	10 hours of straight-time pay for working 10 hours	10 hours of premium pay for a Sunday
8 hours on a holiday	8 hours of straight-time pay for working 8 hours of straight-time pay for the holiday	8 hours of premium pay for the holiday

Other excluded pay

All other pay categories are excluded, including:

- Suggestion awards
- Any inputted income as may be required by law, including the cost of group life insurance in excess of \$50,000 and the cost of the Legal Services Plan and
- Participants' Profit Shares

Special provisions

If you are on a qualified local Union leave, you may be credited with straight-time base pay and COLA for up to 40 hours per week.

Special provisions also apply for certain employees who work part of the year and receive Workers Compensation payments. If these provisions apply, you may be credited with straight-time base pay and COLA for up to 40 hours per week.

Your date of participation

If you meet the Plan's eligibility requirements before January 1 of any Plan year, your Profit Share will be based on your eligible pay for the entire year. If you meet the requirements during the year, your share will be based on your eligible pay after your date of participation. Generally, your "date of participation" is your date of hire. If you're eligible but are laid off or on approved leave at the beginning of the year and then return to work, your share will be based on your eligible pay after you return to work.

Your Profit Share

After eligible pay is calculated, your Profit Share is determined by a two-part formula.

First, the Profit Sharing percentage factor is determined:

Allocated Profit Share for hourly employees
divided by
total eligible pay of all eligible hourly employees
equals

Profit Sharing percentage factor

Second, your share is calculated:

Profit Sharing percentage factor
times
your eligible pay
equals
your Profit Share

An example

Suppose your eligible pay for the year totals \$32,000. If the Profit Sharing percentage factor for the year is 5%, here's how your Profit Share is determined:

$$5\% \times \$32,000 = \$1,600$$

When you receive your distribution, your pay stub will show how your Profit Share was calculated.

Keep in mind that the actual Profit Sharing percentage factor will change from year to year, and so will your eligible pay. Also, this amount may be subject to withholding of applicable federal, state and local income taxes, FICA taxes (including Social Security and Medicare) and deductions for Union dues.

How do you receive your share?

You can take your Profit Share by check, have it contributed to TESPHE or Ford Interest Advantage Account, or elect some combination of these options.

How your Profit Share is paid to you is your decision. You can:

- Receive a check for your share
- Have the Company contribute your share on your behalf to the Tax-Efficient Savings Plan for Hourly Employees (TESPHE)
- Have the Company direct your share to your Ford Interest Advantage Account or
- Elect a combination of these options.

If you don't make an election, your Profit Share will be paid by check.

Note: *No election will apply when the average profit sharing payment is \$250 or less. In this event, all participants will receive their profit share by check.*

Direct deposit is not an option.

Because tax issues can be complicated, you may want to talk with a tax advisor for more information before making your Profit Share decision.

Any Profit Sharing payment for the Plan year will be made by March 15 of the following year.

Choosing cash

If you decide to take all or part of your share in cash, you'll receive a check for the net amount from Ford. Checks will be distributed on Profit Sharing Day. Keep in mind that this is your Profit Share based on profits from the previous year.

Profit Shares you receive by check are considered taxable income, so Ford will withhold amounts for applicable federal, state and local income taxes and FICA taxes.

Choosing TESPHE

If you prefer and you are eligible to contribute to TESPHE, you can direct the Company to contribute all or part of your Profit Share, in 1% increments, to TESPHE as a pre-tax contribution.

Any amount contributed to TESPHE is not subject to federal income taxes until you receive a distribution in the future. (The same may be true for state and local income taxes, depending on where you live and work.) In addition, the investment earnings on the amount you save are not taxed while they remain in TESPHE.

Profit Sharing is subject to FICA taxes even if you elect to have the Company contribute your Profit Share to TESPHE. If you have part of your Profit Share contributed to TESPHE, FICA taxes and any required state and local income taxes on the portion contributed to TESPHE will be withheld from your remaining cash payment, or from your next regular paycheck if necessary. Any Profit Share contributed to TESPHE will be invested in accordance with your most recent investment elections, except as noted below.

If you have never made an investment election or if you had ceased to actively contribute to the TESPHE prior to October 1, 1995, and have not made an election since, any contributions from profit sharing will be invested in the plan level default investment option, currently the Fidelity Freedom Funds®. You may then exchange your profit sharing contributions to other investment options, subject to the Plan's exchange rules.

In general, the assets in your TESPHE account may be distributed upon your request when you retire or leave the Company. If you want to withdraw tax-efficient savings assets before you leave the Company or retire, you must be at least age 59½ or prove financial hardship under the tax laws in effect.

For more information on TESPHE, see that section of this handbook.

Choosing Ford Interest Advantage Account

You may authorize the Company to direct all or a portion of your Profit Share to your Ford Interest Advantage Account if you have an account open under that program and are investing in it through payroll deduction. Profit Share directed to your Ford Interest Advantage Account are considered taxable income, so Ford will withhold amounts for applicable federal, state and local income taxes and FICA taxes.

Union dues

Any required Union dues also will be deducted from your Profit Share, whether you take your Profit Share by check, have it contributed to TESPHE, have it directed to your Ford Interest Advantage Account, or a combination of these. If you take all or part of your Profit Share by check, the necessary Union dues will be deducted from your cash payment. If you have the Company contribute all of your Profit Share to TESPHE, Union dues on the full amount of your Profit Share will be deducted from your next paycheck. If you have all or part invested in your Ford Interest Advantage Account, the necessary Union dues will be deducted from any portion received in cash or, to the extent necessary, from the amount contributed to your Ford Interest Advantage Account.

What circumstances might affect your Profit Share?

You should be aware of some circumstances that might affect your benefits from the Profit Sharing Plan.

Naming a beneficiary

If you die while you are eligible for Profit Sharing, the Profit Share you have earned will go to the person or persons who are your beneficiaries. Your beneficiary is the person who receives payment of the Company's Group Life Insurance benefit. You may designate a different beneficiary for this Plan, however, if you wish.

If all or part of your Profit Share was contributed to TESPHE and you die, your TESPHE account (including the amount contributed from your Profit Share) will go to your TESPHE beneficiary.

Designations and changes of beneficiaries must be filed in writing with the Company.

Assignment of benefits

In most cases, benefits from the Plan cannot be assigned. If you become divorced or separated, or if your Profit Share is garnisheed, certain court orders could require that part of your Profit Share be paid to someone else — your former spouse or children, for example. This could apply to benefits paid to you as well as to any beneficiary.

If the Plan Administrator determines that the court order qualifies, payments will be made according to the order.

Prior year payments

If you do not receive a Profit Share because you are terminated during the year for discharge, failure to report or overstaying a leave, and your seniority is reinstated in a later Plan year through the grievance procedure, you will receive your Profit Share after your service is reinstated. The amount will be based on your eligible pay received for the prior Plan year and the percentage factor for that Plan year.

If you receive a retroactive Worker's Compensation payment for a prior year for which you were eligible for a Profit Share, you may be eligible to receive a Profit Share payment based on the time period covered by the retroactive payment.

If you or your beneficiary are incapacitated

If you or your beneficiary are incompetent, incapacitated or have not yet reached the age of majority, the Company may make payment to an appropriate individual and fully discharge its liability. This individual may be a relative by blood or marriage or any other individual or institution appearing to have assumed custody of you or your beneficiary.

If your claim is denied

If you disagree with the Company regarding your eligibility for Profit Sharing or the amount of your Profit Share, you should contact a Human Resources Associate at the National Employee Services Center (NESC) for a full review.

If your Profit Share is underpaid

If an error is made when calculating your Profit Share and you were underpaid more than \$3, the Company will pay the difference within 60 days after determining the error.

If your Profit Share is overpaid

If your Profit Share is overpaid by more than \$3, you will receive a written notice of the amount that you should repay to the Company. If you do not repay this amount, the Company will deduct it from a subsequent paycheck(s). Deductions will not be more than \$30 from any paycheck. If necessary, your Profit Share for the next year will be reduced.

Repayment is not required if:

- The total amount of overpayment is \$3 or less
- or
- You are not given notice of the overpayment within 120 days after the overpayment was made.

Transfers

If you're transferred to the salaried payroll during the year, you'll receive a Profit Share from this Plan based on your eligible pay earned while you participated in this Plan. Your eligibility and earnings as a salaried employee will be covered under the salaried Performance Bonus Plan.

Can the Profit Sharing Plan change?

It is possible the Plan could end or be changed in the future.

The 2007 Collective Bargaining Agreement between Ford Motor Company and the UAW authorizes the Profit Sharing Plan through 2011 at that time; the terms of this Plan are subject to renegotiation.

Any Profit Sharing for 2011 will be administered as described in this Plan even if this Plan is terminated that year.

The Company has the authority to control and manage the operation and administration of this Plan. The Company also has the authority to interpret Plan provisions, except as otherwise specifically provided in the 2007 Agreement.

Any disagreement between the Company and the UAW over the interpretation of the terms of this Plan as provided in the 2007 Agreement may be submitted to a mutually acceptable, impartial person for resolution at the request of either party. If the Company and the UAW can't agree on an acceptable, impartial person, the Umpire under the Agreement will make the appointment. The impartial person's decision will be limited to Profit Share amounts allocated or distributed during the year the decision is made and subsequent Plan years, and will be binding on the UAW, its members, the participants and the Company.

Ford Interest Advantage

***For information about a new Ford Interest Advantage,
call: 1-800-580-4778, or go to
www.fordcredit.com/interestadvantage.***

***For information about an existing Ford Interest Advantage, call
1-800-462-2614.***

NOTES

Administrative, ERISA and Family and Medical Leave Act of 1993 Information

As a Ford hourly employee represented by the UAW, you should be aware of some important administrative details of the Plans. This section of your handbook contains explanations of these Programs and answers these questions:

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What are my ERISA rights?	297
What are my rights under the Family and Medical Leave Act (FMLA)?	299

Administrative, ERISA, and Family and Medical Leave Act of 1993 Information

What are the administrative details of the Plans?

Information regarding your employee benefit Plans is filed with the federal government and must meet certain administrative requirements under government regulations. This section contains administrative details regarding the Plans.

Covered employees

This handbook contains descriptions of benefits available to hourly UAW-represented employees (and their eligible dependents) of Ford Motor Company, AAI Employee Services Company, L.L.C., and Volvo Cars North America, L.L.C. under the Collective Bargaining Agreement effective November 19, 2007. You can obtain a copy of the Collective Bargaining Agreement by writing to the Plan Administrator. You also can review a copy of the Collective Bargaining Agreement at your work location.

Plan Administrator

The Plan Administrator (and point of contact) for all of your benefit Plans except those shown below is:

Plan Administrator
Ford Motor Company
National Employee Services Center
P.O. Box 6214
Dearborn, Michigan 48121-6214
1-800-248-4444
Inside Ford: ext. 84444

The record keeper and third party administrator for the Tax-Efficient Savings Plan for Hourly Employees (TESPHE) is:

Fidelity Investments Institutional Operations
Company, Inc.
82 Devonshire
Boston, MA 02109
1-800-544-3333

The contact number for the Supplemental Unemployment Benefit (SUB) Plan is:

(313) 253-7487

The Plan Administrator for the UAW-Ford Legal Services Plan is:

Administrative Committee
c/o Robert Esler
Director, UAW-Ford Legal Services Plan
7430 2nd Avenue
Detroit, Michigan 48202
(313) 872-5200

Plan Sponsor

Ford Motor Company is the Plan Sponsor of all your Plans.

Employer number

The federal government has assigned Ford Motor Company an employer identification number for tax purposes. It is EIN 38-0549190. The assigned employer identification number for AAI Employee Services Company, L.L.C. is EIN 38-2606038. The assigned employer identification number of Volvo Cars North America, L.L.C. is EIN 31-1814807.

Agent for Service of Legal Process

Legal process may be served upon the Plan Administrator or the Agent for Service of Legal Process:

Secretary
Ford Motor Company
One American Road
Dearborn, Michigan 48126
(313) 322-3000

For SUB, legal process also can be served upon the Trustee of the Plan:

Comerica Bank
P.O. Box 75000
Detroit, Michigan 48243
(313) 222-4000 or
1-800-521-1190 (outside of Michigan)

For the Retirement Plan, legal process also can be served upon the Trustee of the Plan:

The Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60675
(312) 630-6000

For TESPHE, legal process also can be served upon the Trustee of the Plan:

Fidelity Management Trust Company
300 Puritan Way
Marlborough, MA 01752
1-800-544-3333

Plan Year

The Plan Year for all plans is January 1 through December 31.

Plan termination

Ford Motor Company intends for your Plans to continue indefinitely. No changes may be made until the expiration of the 2007 Collective Bargaining Agreement, except as required by law or as mutually agreed between Ford Motor Company and the UAW. The 2007 Collective Bargaining Agreement expires on September 14, 2011.

If the Retirement Plan should terminate, the Pension Benefit Guaranty Corporation (PBGC), a government-owned corporation guaranteeing certain pension benefits, would protect all or a portion of your benefit. See the Retirement Plan section of your handbook for more details.

Further, each section of your handbook has details describing what would happen if a particular Plan should end.

Plan filing and funding information

The Employee Retirement Income Security Act of 1974, as amended (ERISA), requires that additional administrative information about your benefits be provided. A table with more information follows.

Summary of Administrative Information

Plan Name:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:	
UAW H-S-M-D-D-V Program for Hourly Employees				<i>Administrative services for health care are provided by the following organizations:</i>	
Plan Number 520				If you work in:	Your Claims processor is:
National PPO (BCBS) Hospital-Surgical-Medical-Hearing coverage	Welfare plan providing Hospital-Surgical-Medical benefits	Benefits are paid by the Company. The Company pays fees to carriers and other organizations for administrative services and claims processing.	None	All states and the District of Columbia	Blue Cross and Blue Shield Ford Service Center P.O. Box 2089 Detroit, MI 48231-2089 1-800-482-5146
DME and P&O SUPPORT Program for National PPO (Wright & Filippis/BCBS)	Welfare plan providing Durable Medical Equipment and Prosthetic and Orthotic Appliances benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing	None	All states	For Non Hospital Related items: UAW / Ford National DME and P&O SUPPORT Program P.O. Box 82060 Rochester , Michigan 48308-2060 1-800-831-0999 For Hospital related items: Blue Cross and Blue Shield Ford Service Center P.O. Box 2089 Detroit, MI 48231-2089 1-800-482-5146
Prescription Drug coverage for National PPO (BCBS)	Welfare plan providing Prescription Drug benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing.	None	All states and the District of Columbia	Blue Cross and Blue Shield Ford Service Center P.O. Box 2089 Detroit, MI 48231- 2089 1-800-482-5146 Medco Health P.O. Box 2096 Lee's Summit, MO 64063-7096 1-800-778-0735
HMOs , PPOs & DHMOs: Alternative Hospital-Surgical-Medical Prescription Drug or Dental coverages*	Welfare plan providing Hospital-Surgical-Medical Prescription Drug or Dental benefits	Depending upon the plan, the Company (i) pays the benefit and fees to carriers for administrative services and claims processing, or (ii) pays a premium to the carrier to fully insure the benefit.	None	Various states	Various alternative plans (HMOs , PPOs & DHMOs) Visit www.benefitcompanion.com for a list of available plans. Company name: UAW Ford Password: myhealth
Traditional Dental coverage	Welfare plan providing Dental benefits	Benefits are paid by the Company. The Company pays fees to the carrier for administrative services and claims processing.	None	All states and the District of Columbia	Blue Cross and Blue Shield of Michigan Ford Service Center P.O. Box 2089 Detroit, MI 48231- 2089 1-800-482-5146

* Some HMO / PPO plans may include Vision and Hearing Aid coverages — varies by plan.

Summary of Administrative Information

Plan Name:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:	
Health Care Plan				<i>Administrative services for health care are provided by the following organizations:</i>	
Plan Number 520				If you work in:	Your Claims processor is:
Vision Care coverage*	Welfare plan providing Vision Care benefits	The Company pays a monthly premium to the carrier to fully insure the benefit. The carrier pays the claims.	None	All states and the District of Columbia, unless provided by your HMO	SVS, Inc. Ford/UAW Vision Care Program P.O. Box 464 Mt. Clemens, Michigan 48046-0464 (586) 468-7370 1-800-225-3095
National PPO Plan (BCBS) and Blue Preferred Plus PPO Outpatient Physical Therapy	Welfare plan providing Outpatient Physical Therapy benefits	Benefits are paid by the Company. The Company pays fees to carriers for administrative services and claims processing.	None	Michigan	TheraMatrix Physical Therapy Network P.O. Box 321036 Detroit, MI 48232 1-888-638-8786

Summary of Administrative Information

Plan Name:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Group Life and Disability Insurance Program (Plan number 521)				
Life Insurance, Accidental Death and Dismemberment Insurance, Safety Belt and Survivor Income Benefits	Welfare plan providing life insurance	The Company pays premiums to the carrier in amounts reflecting the number and amount of claims paid	None	Life Insurance, Accidental Death and Dismemberment Insurance and Survivor Income Benefits are provided by: Group Policy 17-GCC UNICARE Life and Health Insurance Company P.O. Box 2090 Dearborn, MI 48123-2090 (313) 336-5550 1-800-843-8184
Accident and Sickness Benefits and Extended Disability Benefits	Welfare plan providing disability benefits	Benefits are paid by the Company either directly or through a trust fund established by the Company If you live in New York or New Jersey, benefits are paid by a carrier	Comerica Bank 411 West Lafayette Detroit, Michigan 48226 (313) 222-4000 1-800-521-1190 (outside Michigan)	Except for employees in New York and New Jersey, Accident and Sickness and Extended Disability Benefits are paid by Ford Motor Company either directly or through a trust fund. Claims are reviewed and approved or provided by: UNICARE Life and Health Insurance Company P.O. Box 4479 Dearborn, MI 48122 (313) 336-5550 1-800-572-1581 For employees in New York and New Jersey, benefits are insured by UNICARE Life and Health Insurance Company (Group Policy 17-GCC)
Optional Group Life Insurance Plan	Welfare plan offering life insurance	Participating employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215
Dependent Group Life Insurance Plan	Welfare plan offering life insurance for your dependents	Participating employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215
Optional Accident Insurance Plan	Welfare plan offering accident insurance for you and your dependents	Participating employees	None	Ford Hourly Optional Insurance Plan Suite 116 2720 South River Road Des Plaines, Illinois 60018 (847) 299-9393 1-800-742-8215

Summary of Administrative Information

Plan Name:	Plan Number:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Group Life and Disability Insurance Program					
Supplemental Unemployment Benefit (SUB) Plan	503	Welfare plan providing supplemental income benefits to eligible employees for certain periods in the event of a qualifying layoff	Ford Motor Company pays full cost of the Plan up to the limits of the Plan	Comerica Bank P.O. Box 75000 m/c 3464 Detroit, Michigan 48243 (313) 222-4000 1-800-521-1190 (outside Michigan)	Plan Administrator Ford Motor Company Human Resources One American Road Dearborn, Michigan 48126 313.253.7446 1-800-248-4444
Ford Motor Company-UAW Retirement Plan	001	Pension plan providing defined benefits (a defined benefit plan)	Ford Motor Company makes contributions to the Pension Fund to fund the normal and amortized past-service cost, as determined by an independent actuary – based on ERISA and the Retirement Agreement	The Northern Trust Company 50 S. LaSalle Street Chicago, Illinois 60675 (312) 630-6000 1-800-248-4444 (outside Michigan)	Plan Administrator Ford Motor Company National Employee Services Center P.O. Box 6214 Dearborn, Michigan 48121-6214 1-800-248-4444

Summary of Administrative Information

Plan Name:	Plan Number:	Type of Plan:	Cost Paid By:	Trustee:	Benefits Administered or Insured Through:
Ford Motor Company Tax-Efficient Savings Plan for Hourly Employees (TESPHE)	025	Defined contribution Plan	Generally, Ford Motor Company pays Plan administrative expenses. For eligible employees who elect a wage reduction or contribution from 1% to 50% of pay and /or those who elect to deposit their annual Profit Share, the Company will contribute those funds to a trust fund.	Fidelity Management Trust Company 300 Puritan Way Boston, MA 01752 1-800-544-3333	Fidelity Investments Institutional Operations Company, Inc. 82 Devonshire Boston, MA 02109 1-800-544-3333
Ford Motor Company Profit Sharing Plan for Hourly Employees in the United States	None	Unfunded arrangement for employee profit sharing; not an ERISA plan	Ford Motor Company makes payments under the Profit Sharing Plan when profits are generated	None	Plan Administrator Ford Motor Company National Employee Services Center P.O. Box 6214 Dearborn, Michigan 48121-6214 1-800-248-4444
UAW-Ford Legal Services Plan for UAW-Represented Hourly Employees of Ford Motor Company in the United States	540	Welfare plan providing legal services	Ford Motor Company	Comerica Bank 100 Renaissance Center Detroit, Michigan 48243 (313) 222-4000 1-800-521-1190 (outside Michigan)	Administrative Committee c/o Robert Esler Director, UAW-Ford Legal Services Plan 7430 2nd Avenue Detroit, Michigan 48202 (313) 872-5200
Dependent Care Assistance Plan	None	Wage reduction program to provide pre-tax savings on the cost of eligible dependent care expenses	Participating employees	None	FBD Consulting, Inc. P.O. Box 7955 Shawnee Mission, KS 66027-0955(888) 537-4643

What are my ERISA rights?

You have certain rights under the Employee Retirement Income Security Act of 1974.

The Employee Retirement Income Security Act of 1974 (ERISA), as amended, entitles you to certain rights and legal protections. It allows you and all other Plan participants to:

Receive information about your plan and benefits

- Examine, without charge, and during regular working hours, all Plan documents, copies of all documents filed with the Internal Revenue Service and the U.S. Department of Labor. Documents are kept in the office of the Plan Administrator, but may be sent to you within 10 days after your written request is received.
- Obtain a copy of all Plan documents and other Plan information by writing to the Plan Administrator. The Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
- Obtain an annual statement telling you whether you have a right to receive a benefit from the Retirement Plan at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to have a right to such a benefit.
- You also have a right to a statement of your benefits under TESPHE. Your TESPHE account statement is prepared quarterly. If you elected to receive your statement online, you will receive a notification that the statement is available. Otherwise, one will be provided in the mail. If you elect to receive your quarterly statements online, a statement covering the entire year will be mailed to you annually.

Continue group health plan coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

For additional information, see "May I obtain a Certificate of Creditable Coverage for Credit Against Another (Non-Ford) Plan's Pre-existing Condition Clause?" in the Other Health Care Plan Information section of this handbook.

Prudent actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plans. These people are called "fiduciaries" of the Plans. They have a duty to act prudently in your interest and the interests of other Plan participants and beneficiaries.

No one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for any benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, there are steps you may take to enforce all these rights. For instance:

- If you request materials in writing from the Plan Administrator and you do not receive them within 30 days, you may file suit in a federal court; in such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the delay is because of reasons beyond the Administrator's control
- If your claim for benefits is improperly denied, in whole or in part, you may file suit in a state or federal court
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court
- If the Plan fiduciaries misuse a Plan's money or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor or you may file suit in a federal court

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have questions about this statement of your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA(3272).

If you have any questions about the Plans, you should contact the NESC by mail at:

National Employee Services Center
P.O. Box 6214
Dearborn, Michigan 48121-6214
Or you may call 1-800-248-4444
Within Ford: ext. 84444

What are my rights under the Family and Medical Leave Act (FMLA)?

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care (this leave must conclude within 12 months of birth or placement);
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

The 12 week entitlement as described above is per calendar year.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Other Information

The Company is responsible for determining if your leave will be considered as FMLA leave, based on information you provide. Generally, leave cannot be credited as FMLA leave after the leave has ended.

In some instances, FMLA leaves will be concurrent with Personal or Medical Leaves of Absence.

Under the 2007 Collective Bargaining Agreement, qualifying FMLA time that is comparable under the Accident and Sickness Insurance provisions of the Group Life and Disability Insurance Program will not be counted against your 12 week FMLA entitlement unless you elect to have it so counted. You will continue to have all your FMLA rights for qualifying leave without regard to whether you elect to have the leave count against your 12 week entitlement.

Vacations and FMLA Leaves

Absence from work due to a Family and Medical Leave Act leave to care for a family member identified above, with a serious health condition, or due to the birth of an employee's child or the placement of a child with the employee for adoption or foster care, will not be counted in computing the 35 days of absence for purposes of vacation eligibility.

Continuation of health care coverage for You and Your Dependents

The Company will continue health care coverage for you, your spouse and your eligible dependents while you are on leave if such coverage was provided by the Company before the FMLA leave began.

Such coverage will be on the same terms as if you had continued to work. You also may be entitled to continue health care coverage for other dependents at your own expense while on FMLA leave (such as Sponsored Dependent coverage). However, the Company may recover premiums paid to maintain your health care coverage if you fail to return to work from FMLA leave for a reason other than the continuation of a serious health condition or circumstances beyond your control.

Future changes in FMLA procedures

The Company may change the above procedures to reflect relevant changes in the law and the gaining of additional administrative experience; however, any changes will not reduce leave provided by the Collective Bargaining Agreement.

NOTES

Dependent Care Assistance Plan

After an overview of the Dependent Care Assistance Plan, this section answers these questions:

	Page
What is the Dependent Care Assistance Plan?	304
How do I enroll?	305
How does the Dependent Care Assistance Plan Work?	306
What rules apply to the Dependent Care Assistance Plan?	307
How do I get reimbursed from the Dependent Care Assistance Plan?	310
What situations affect participation?	311

Dependent Care Assistance Plan

An Overview of the Plan

The Dependent Care Assistance Plan helps you stretch your budget by letting you set aside tax-free dollars to pay for the cost of dependent care and elder care expenses for qualified dependents.

The Dependent Care Assistance Plan

You may use the Dependent Care Assistance Plan to reimburse yourself for eligible child care or elder care expenses you have during the year. You use the money you contribute to this account to pay yourself back for services you receive from providers such as nursery schools and licensed day care centers.

What is the Dependent Care Assistance Plan?

Your Dependent Care Assistance Plan

Ford offers you tax-savings opportunities through the Dependent Care Assistance Plan. You designate a specified amount of your wages, up to \$5,000 annually (\$2,500 for a married person filing separately), from your pay on a pre-tax basis for eligible child care or elder care expenses you have during the year. You determine the amount of before-tax dollars to contribute from your paycheck to a Dependent Care Assistance Plan. Then you may use that money during the plan year to reimburse yourself for eligible dependent care expenses. You pay for your eligible expenses yourself and submit your paid receipts or cancelled checks and claims documentation (i.e., signed claim form and itemized bill) for reimbursement.

The Dependent Care Assistance Plan has a number of advantages. It helps you save and pay for anticipated expenses. It also lets you set aside money on a before-tax basis. That means dollars are contributed from your paycheck to the Dependent Care Assistance Plan before taxes are taken out. Money is never taxed — not even when you take a reimbursement. This reduces your taxable income.

No Coverage

You may choose not to participate.

How do I enroll?

Participation in the Dependent Care Assistance Plan is optional. You may enroll if this plan meets the needs of you and your qualified dependents.

Eligibility

Ford employees are eligible to participate in the Dependent Care Assistance Plan. You may use the Dependent Care Assistance Plan to reimburse yourself for eligible dependent care expenses for your qualified dependents.

Your dependents must meet the definition of qualified dependents for you to be reimbursed for their eligible dependent and elder care expenses.

Qualified dependents

You may cover certain expenses for the care of your qualified dependents through the Dependent Care Assistance Plan. To be eligible, a qualified dependent must be:

- A child, under age 13, who
 - ◊ Lives with you more than half of the tax year, and
 - ◊ Does not provide more than half of his or her own supportor
- A relative of any age who
 - ◊ Is mentally or physically unable to care for himself or herself,
 - ◊ Lives with you more than half of the taxable year, and
 - ◊ Does not have an annual gross income exceeding the exemption amount (\$3,500 for 2008)

In addition, special eligibility rules apply to dependents for which you claim expenses under the Dependent Care Assistance Plan. See the "What rules apply to the Dependent Care Assistance Plan?" section for complete details.

Enrollment

To participate in the Dependent Care Assistance Plan, you must enroll during the annual enrollment period. You may enroll each plan year, and make new elections for each plan year, during the annual enrollment period held in the month of December. Once you have enrolled and made elections for a plan year, you may change your Dependent Care Assistance Plan elections during the plan year only if you have a "change in status" (such as marriage, divorce, spouse's death, a change in your spouse's employment, the birth, adoption, or death of a child, etc.).

Cost

To participate in the Dependent Care Assistance Plan, you must make weekly contributions from your paycheck throughout the plan year to your account. You may not make lump-sum contributions. You contribute dollars to the Dependent Care Assistance Plan on a before-tax basis.

When account participation is effective

- If elected during the annual enrollment period, participation becomes effective on January 1 and continues through the end of December
- If elected during the plan year (for example, in the case of a new hire or rehire), participation becomes effective when you become eligible for health care or the first day of the eighth month following your date of hire or rehire
- If elected as a result of a "change in status," as soon as practicable after the "change in status", the Plan Administrator will advise you when your contributions will start based on the timing of your notification of the "change in status."

How does the Dependent Care Assistance Plan work?

Dependent Care Assistance Plan is like a checking account. You deposit before-tax payroll deductions, and then use the account to pay yourself back for certain expenses.

Dependent Care Spending Accounts

The Dependent Care Assistance Plan lets you set aside dollars that you can use throughout the plan year to reimburse yourself for eligible elder care and dependent care expenses. These accounts have special tax advantages; the money you set aside in them is never taxed, so your dollars go further to help you pay for eligible expenses.

Using spending accounts

- Estimate your expenses — estimate in advance how much your eligible expenses will be for the plan year
- Decide how much you want to contribute — you can deposit from \$50 to \$5,000 (\$2,500 for married individuals filing separately) into your account during each plan year; some limits apply however (these are explained later); your contributions will be deducted in equal amounts from each paycheck throughout the plan year
- File a claim — when you have eligible expenses, pay for them as you normally would; then submit your paid receipts or cancelled checks and claim documentation (i.e., itemized bill) — along with a signed claim form to WageWorks, the Plan Administrator
- Receive your reimbursement — any reimbursements you receive from the Dependent Care Assistance Plan will be tax free, meaning they won't be taxed when you receive them

Tax Advantages

The money you deposit in the Dependent Care Assistance Plan is never taxed — not when it goes into your account and not when you receive reimbursement for an eligible expense. Here are the taxes you save:

- Federal income taxes
- Social Security taxes
- State and local income taxes (in most cases)

When you save on taxes, your dollars go further to help you pay for the cost of eligible elder care or dependent care expenses, as the following example shows. Suppose you contribute \$1,000 to the Dependent Care Assistance Plan and are in the 15% tax bracket. You could save \$150 in federal income taxes and \$76 in Social Security (FICA) taxes for a total of \$226. Your savings could be even greater when you add state and local tax savings.

POSSIBLE TAX SAVINGS

Total amount contributed to spending accounts	Estimated annual federal income and Social Security tax savings		
	15% bracket	28% bracket	31% bracket
\$ 100	\$ 22	\$ 35	\$ 38
\$ 250	\$ 56	\$ 88	\$ 96
\$ 500	\$ 113	\$ 175	\$ 193
\$1,000	\$ 226	\$ 350	\$ 386
\$2,500	\$ 566	\$ 875	\$ 966
\$5,000	\$1,132	\$1,750	\$1,932

These are estimates. Your actual savings will depend on your income and filing status. These estimates are based on federal income and Social Security taxes only. Your state and local taxes also may be reduced. Figures are based on 2007 tax rates. This example is based on an employee's wages only.

Before-tax contributions reduce the amount of your pay that is subject to Social Security taxes. If your earnings are less than the Social Security wage base, you'll pay lower Social Security taxes and may receive a smaller Social Security benefit when you retire. However, the tax advantages generally offset any slight reduction in Social Security benefits.

If you have any questions about taxes and how you could be affected, contact your personal tax advisor.

What rules apply to the Dependent Care Assistance Plan?

Because the Dependent Care Assistance Plan offers special tax advantages, certain rules apply to using the account.

These rules are:

- In general, you may not change the amount you contribute to your account during the plan year; however, if you have a "change in status," you may change the amount you contribute to your account
- You can be reimbursed from the accounts only for services provided during the plan year — from January 1 through December 31; if you join the plan mid-year because you are a new hire or rehire, you can file claims only for services provided after you become a plan participant and your account is active
- Other limitations for receiving reimbursements from the Dependent Care Assistance Plan may apply if you end your employment during the plan year
- **Under IRS rules, if you don't use all of the money in your account during the plan year, you must forfeit the excess; you have until March 31 to file claims for services received during the plan year ending the prior December 31; claims postmarked after March 31 cannot be accepted**

Maximum contribution limits

Because of IRS rules, your maximum contribution to the Dependent Care Assistance Plan may be limited. If you're married:

- And file your personal income taxes separately from your spouse, your annual contribution to the Dependent Care Assistance Plan is limited to \$2,500 (instead of \$5,000)
- And file a joint income tax return and your spouse also contributes to a Dependent Care Assistance Plan, the combined limit for the family is \$5,000 per calendar year
- And your spouse is disabled or a full-time student, special limits apply; check with the Internal Revenue Service at 1-800-829-3676, consult IRS Publication 503 and talk to your tax advisor

In any event, you may not contribute more than 50% of your earnings or 100% of those of your spouse, whichever is less.

If you are not married, your maximum contribution is \$5,000 annually.

Eligible expenses

The IRS requires that dependent care expenses meet certain criteria to be eligible for reimbursement from a Dependent Care Assistance Plan.

Working or looking for work

To be work related, a dependent must receive care when:

- You're at work or searching for work and
- If you're married, your spouse must be:
 - ◊ At work or
 - ◊ Searching for work or
 - ◊ In school as a full-time student or
 - ◊ Mentally or physically disabled and unable to provide the care

Services may be provided either inside or outside your home by a licensed day care or elder care center, babysitter or companion, including relatives, but excluding your dependent children under age 19 and relatives you claim as exemptions on your federal income tax return. The caregiver will be required to claim the income they receive from you on their own taxes.

Whether your expenses allow you to work or look for work depends on the facts. For example, the cost of a babysitter while you and your spouse go out to eat is not normally a work-related expense. Expenses are not considered work related merely because you incurred them while you were working. They must enable you to be gainfully employed. For example, you are not gainfully employed if you do unpaid volunteer work or volunteer work for a nominal salary.

Work for part of year

If you work for only part of the year, you must figure your expenses only for the periods worked.

Payments while you're out sick

Amounts you pay for child and dependent care while you are off work because of illness do not count as work-related expenses.

Detail summary of eligible expenses

The following is a summary of dependent care expenses that generally would be deductible on your federal income tax return and, therefore, are reimbursable through the Dependent Care Assistance Plan. It's important to note that you can't claim a deduction on your tax return for expenses reimbursed through the Dependent Care Assistance Plan. See IRS Publication 503 for an explanation of eligible and ineligible expenses. This publication changes annually, and some of the expenses listed below may not be reimbursable in future years. You can obtain a copy of the current complete list at your local IRS office, by calling the IRS toll free at 1-800-829-3676, or by viewing their website at www.irs.gov.

Care of a qualifying person

To be work related, your expenses must be to provide care for a qualifying person. You don't have to choose the least expensive way of providing the care.

Expenses for household services qualify if part of the services is for the care of qualifying persons. See the "Household Services" explanation.

Expenses are for the care of a qualifying person only if their main purpose is the person's well being and protection. Expenses for care do not include amounts you pay for food, clothing, and entertainment. However, if these amounts are incident to, and can not be separated from, the cost of caring for the qualifying person, you can count the total cost.

Schooling

You can count the total cost of sending your child to school if:

- Your child is in a grade level below first grade and
- The amount you pay for schooling is incident to, and can not be separated from, the cost of care

You can use the total cost of schooling before first grade only if the cost of schooling can not be separated from the cost of the child's care. If your child is in the first grade or higher, or if the cost of schooling can be separated, you must take the total cost and separate the cost of care and the cost of schooling. You can count only the cost of care in figuring your contributions.

Example 1

You take your three-year-old child to a nursery school that provides lunch and educational activities as a part of its pre-school child care service. You can count the total cost in figuring your contributions.

Example 2

Your five-year-old child goes to kindergarten in the morning. In the afternoon, she attends an after-school day care program at the same school. Your total cost for sending her to the school is \$3,000, of which \$1,800 is for the after-school program. Only the \$1,800 qualifies for figuring your contributions.

Example 3

You place your ten-year-old child in a boarding school so you can work full time. Only the part of the boarding school expense that is for the care of your child is a work-related expense. You can not count any part of the amount you pay the school for your child's education.

Care outside your home

You can count the cost of care provided outside your home if the care is for your dependent under age 13, or any other qualifying person who regularly spends at least eight hours each day in your household.

- Dependent care center — you can count care provided outside your home by a dependent care center if the center complies with all applicable state and local regulations: a dependent care center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment, or grant for providing services for any of those persons, even if the center is not run for profit.
- Camp — the cost of sending your child to an overnight camp is not considered a work-related expense

Transportation

The cost of getting a qualifying person from your home to the care location and back or from the care location to school and back is not considered a work-related expense. This includes the cost of bus, subway, taxi, or private car. Also, if you pay the transportation cost for the care provider to come to your home, you can not count this cost as a work-related expense.

Household services

Expenses you pay for household services meet the work-related expense test if they are at least partly for the well-being and protection of a qualifying person. Household services are ordinary and usual services done in and around your home that are necessary to run your home. They include the services of a housekeeper, maid, or cook. However, they do not include the services of a chauffeur, bartender, or gardener.

Expenses partly work related

If part of an expense is work related (for either household service or the care of a qualifying person) and part is for other purposes, you have to separate the expense. To figure the amount that may be reimbursed, count only the part that's work related. However, you do not have to separate the expense if only a small part is for other purposes.

Example

You pay a housekeeper to care for your nine-year-old and 15-year-old children so you can work. The housekeeper spends most of the time doing normal household work and spends 30 minutes a day driving you to and from work. You can treat the entire expense of the housekeeper as work related because the time spent driving is minimal. You do not have to separate the expenses between the two children because the household expense is partly for the care of your nine-year-old child, who is a qualifying person.

Meals and lodging provided for housekeeper

If you have expenses for food that your housekeeper eats in your home, count these as work-related expenses. If you have extra expenses for your housekeeper's lodging, count these as work-related expenses also.

Example

You move to an apartment with an extra bedroom for a housekeeper. You can count the extra rent and utility expenses for this bedroom as work related. If your housekeeper moves into an existing bedroom in your home, you can count the extra utility expenses as work related.

Taxes paid on wages

The taxes you pay on wages for qualifying child and dependent care services are work-related expenses.

Ineligible expenses

Certain expenses may not be reimbursed through a Dependent Care Assistance Plan. Be careful not to include these expenses when you determine your contribution amount:

- Expenses you incur while away from work due to illness, leave, or vacation
- Payments to a person who could be claimed as a dependent on your tax return or your spouse's tax return
- Payments to your child or stepchild who is under age 19 at the end of the taxable year
- Tuition for kindergarten
- Caregiver's transportation expenses
- Expenses claimed under the Federal Dependent Care Tax Credit
- Expenses incurred before or after your participation in the account
- Expenses for overnight camp
- Health care expenses for dependents
- Child support or family maintenance payments
- Dependent care expenses that exceed the earned income of the lower-paid spouse

How the account coordinates with the federal tax credit

You can also save taxes on dependent care expenses by claiming a tax credit on your federal income tax return. Both the tax credit and the Dependent Care Assistance Plan are intended to offer you tax savings. You may not use both for the same expense. However, you may use the account for some expenses and the tax credit for other expenses, subject to the limits described below. The better method for you depends on your income, the number of dependents you have, and other factors.

Every dollar reimbursed through your Dependent Care Assistance Plan reduces, dollar-for-dollar, your maximum eligible expenses under the federal tax credit. That maximum is \$3,000 a year if you have one qualifying dependent and \$6,000 a year if you have two or more qualifying dependents. So, if you have one qualifying dependent and you contribute \$3,000 or more to a Dependent Care Assistance Plan, you wouldn't be able to use the tax credit for any other eligible expenses.

Consult a professional tax advisor, or refer to IRS publication 503 for a complete discussion of the tax credit. To order a copy, call the IRS toll free at 1-800-829-3676.

How do I get reimbursed from the Dependent Care Assistance Plan?

You must submit a claim form for reimbursement of dependent care expenses.

If you make contributions to a Dependent Care Assistance Plan, funds will be deducted from each paycheck. Your contributions will be credited to an account set up in your name by the Plan Administrator.

When you incur an eligible expense, complete a claim form and send it with your paid receipt or cancelled check to:

Claims Administrator
P.O. Box 14053
Lexington, KY 40511

Claims are processed and reimbursement checks are issued as they are processed throughout the month. You will receive an Explanation of Benefits (EOB) statement and a new claim form with each reimbursement check.

According to tax law requirements, the rules for reimbursements from Dependent Care Assistance Plan are as follows:

Dependent care claims

When you have eligible dependent care expenses, simply fill out a claim form. You must furnish proof of payment for the services provided, such as canceled check or signed receipt.

When you file claims against your Dependent Care Assistance Plan, you must provide your caregiver's taxpayer identification number or social security number, or identify your caregiver as a tax-exempt organization. Claims will not be reimbursed without this information. The Plan Administrator will then pay your dependent care claim in full if there are sufficient funds in your account.

If your claim exceeds your present account balance, you will receive a check only for the amount presently in your account. The remaining amount will be pended and automatically resubmitted for payment when your next payroll deduction is credited to your account. Assuming more contributions are credited to your account, you will receive another reimbursement check.

Submitting your claim

You can request a reimbursement for dependent care expenses at any time. There's no minimum amount. Just request a reimbursement by using the specially designed claim form that's available by calling 1-877-353-9236. Complete the entire form and mail it in for processing along with claim documentation.

Dependent care expenses are paid to you on a reimbursement basis. With the claim form, you must submit proof that the expense has already been paid, such as a canceled check or a signed receipt.

WageWorks administers dependent care claims. Your reimbursement will be processed if you do the following:

- Use the WageWorks claim form, complete the Employee's Statement, and sign and date the form; or, use the electronic form available at <https://www.wageworks.com/forms/dcpaymeback.pdf>
- If not indicated on your receipts, be sure to add the name of the person for whom the services were rendered
- Provide a telephone number where WageWorks may contact you for additional information, if needed
- Finally, if you have a question about dependent care expenses or procedures, simply call WageWorks for assistance

If you submit a properly completed claim form to WageWorks, you'll be reimbursed within three weeks after your claim form is received.

Only services rendered during the plan year are eligible for reimbursement. The plan year begins January 1 and ends on the following December 31.

You have until March 31 to submit claims for reimbursement of dependent care expenses incurred during the prior plan year. Claims postmarked after March 31 can not be accepted. Under IRS rules, any unspent dollars remaining in your account after that date will be forfeited.

Account statements

You will receive a statement of your Dependent Care Assistance Plan four times per plan year. The statement shows contributions, payments made, and account balances. In addition, each time you receive a reimbursement, you will receive a summary of year-to-date activity and a blank claim form.

What situations affect participation?

Some situations could affect your participation in the Dependent Care Assistance Plan, as summarized here:

- You are not eligible for reimbursements of expenses that were incurred during a period that you were not at work (i.e., illness, vacation, leaves of absence, etc.)
- Generally if you're married, both you and your spouse must be at work in order to receive eligible dependent care expenses
- If you are on unpaid leave of absence, you're not eligible to continue participation in the Dependent Care Assistance Plan while on leave, nor would you receive any reimbursement for eligible work-related expenses during the period of your leave
- If you return from your unpaid leave of absence within the same plan year, your spending account payroll deductions resume
- If you return from your unpaid leave of absence in a different plan year, you may make a new spending account election after you return to work
- Your participation in the Dependent Care Assistance Plan ends with your termination and can not be continued; you may be reimbursed up to the balance in your account for expenses incurred prior to termination

Where to call for information

If you have questions about the Dependent Care Assistance Plan, call WageWorks at 1-877-353-9236. Normal business hours are from 8:00 a.m. to 8:00 p.m. Eastern time, Monday through Friday.

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