

Group #:	C27214 – 56A34V, 56A34W, 56W02U	Plan:	HMO
Group Name:	FORD MOTOR COMPANY – HOURLY (Active Employees)	Name:	UNICARE Health Plans of the Midwest
□□□□□		Address:	233 S. Wacker Drive, Suite 3900 Chicago, IL 60606
Effective Date of Benefits:	03/01/08	Phone #:	312.234.8855 or 888.234.8855

Description of Coverage

Basics	Your Doctor	Each member should choose a primary care physician from the provider directory. That primary care physician is responsible for providing referrals for specialty care. Female members can also designate a network obstetrician/gynecologist or family practitioner as a "woman's principal health care provider." To make these selections, call Customer Services.		
	Annual Deductible (if applicable)	None		
	Out-of-Pocket Maximum	Individual	Aggregate copays for basic health care services will not exceed \$1500 per calendar year.	
		Family	Aggregate copays for basic health care services will not exceed \$3000 per calendar year.	
	Lifetime Maximums (if applicable)	Unlimited		
	Preexisting Condition Limitations	Does not apply		
		Description of Coverage	Health Care Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care		Up to 365 days annually	Over plan limits
	Room & Board	Semi-private room rate	100%	0%
	Surgeon's Fees		100%	0%
	Doctor's Visits		100%	0%
	Medications		100%	0%
	Other Miscellaneous Charges	Laboratory, radiology, and normal daily services and supplies furnished by the Hospital.	100%	

		Description of Coverage	Health Care Plan Covers	You Pay
Emergency Care	Emergency Services (<i>medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions, or serious dysfunction of any organ or part</i>)		100% after \$100 Co-pay (Waived if admitted)	0% after \$100 Co-pay
	Emergency Post-stabilization Services		100%	0%
In the Doctor's Office	Doctor's Office Visits	Primary care physician and specialist	100% after \$25.00 Co-pay	0% after \$25.00 Co-pay
	Routine Physical Exams		100% after \$25.00 Co-pay	0% after \$25 Co-pay
	Diagnostic Tests and X-rays		100%	0%
	Immunizations		100% after \$25.00 Co-pay (if involves an office visit)	0% after \$25.00 Co-pay (if involves an office visit)
	Allergy Treatment & Testing		100% after \$25.00 Co-pay (if involves an office visit)	0% after \$25.00 Co-pay (if involves an office visit)
	Wellness Care		100% after \$25.00 Co-pay (if involves an office visit)	0% after \$25.00 Co-pay (if involves an office visit)
Medical Services	Outpatient Surgery		100%	0%
	Maternity Care			
	<i>Hospital Care</i>		100%	0%
	<i>Physician Care</i>		100%	0%

	Infertility Services	Diagnosis and treatment	100%	0%

		Description of Coverage	Health Care Plan Covers	You Pay
	Mental Health	Evaluation services, crisis-intervention services and care responsive to short-term treatment.	100% up to 20 visits per calendar year	100% for visits over limits
	<i>Outpatient</i>			
	<i>Inpatient</i>	Mental health services	100% up to 45 days per calendar year; renewal after out of the hospital for 60 consecutive days.	100% for days over limits
	Substance Abuse	Evaluation, diagnosis and limited medical treatment.	100% up to 35 visits per calendar year.	100% for visits over limits
	<i>Outpatient</i>			
	<i>Inpatient</i>	Evaluation, diagnosis, rehabilitation and limited medical treatment.	100% up to 45 days per calendar year; renewal if out of the hospital for 60 consecutive days.	100% for days over limits
	Outpatient Rehabilitation Services	Physical, occupational and speech therapy.	100% Each has up to 60 visits per condition, per plan year.	100% for visits over limits
Other Services*	Durable Medical Equipment:	Rental or purchase per plan decision.	100%	0%
	Prosthetic and Orthotic Appliances		100%	0%
	Hearing	Hearing Aid	100% One hearing aid, every 3 years	0%
	Home Health Care	Intermittent Registered Nurse visits.	100%	0%
	Skilled Nursing	Skilled Nursing Facility room and board including daily services and supplies	100% (Unlimited days)	0%

		furnished by the facility.		
		Description of Coverage	Health Care Plan Covers	You Pay
	Hospice	Services and supplies furnished as part of Hospice care. Room and board if in-patient Hospice.	100% to \$10,000 per period of care	0% to \$10,000 and 100% over \$10,000
	Prescription Drugs – Single Tier <i>Up to a 34 day supply of prescription drugs at any network pharmacy, which includes Walgreens, Osco, Dominicks, Target, Cub Foods & Kmart.</i>	Eligible prescription drugs on a preferred drug list (including oral contraceptives & self-injectables). Open formulary and a dispense as written clause (DAW).	100% after \$5.00 Co-pay generic 34 day supply. 100% after \$11.00 Co-pay brand name 34 day supply.	0% after \$5.00 Co-pay generic or \$11.00 Co-pay brand name up to a 34 day supply If selecting a brand name drug when a preferred generic is available, you pay the difference between the generic price and the brand name price of the drug, unless physician has written DAW.
	Mail Order Prescription Drugs	Eligible prescription drugs on a preferred drug list obtained from the network mail order pharmacy. Open formulary and a dispense as written clause (DAW).	100% after \$5.00 Co-pay generic up to a 90-day supply; 100% after \$11.00 Co-pay brand name up to a 90-day supply	0% after \$5.00 or \$11.00 co-pay
	Eye Exams	Screening for and treatment of eye disease, and eye surgery every 24 months.	100%	0%

*Co-payments and deductibles for these services may not apply to your out-of-pocket maximums.

Service Area:

The UNICARE HMO service area includes the counties of Cook, DuPage, Kankakee, Kendall, Kane, Lake, McHenry, and Will in the State of Illinois, and the counties of Porter and Lake in the State of Indiana.

Exclusions and Limitations:**Coverage limitations include:**

- Skilled Nursing facility up to 365 days per lifetime (unless amended by rider)
- Outpatient rehabilitation up to 60 visits per condition, per plan year (unless amended by rider)
- Home Health at 100% (unless amended by rider)
- Hospice care up to \$10,000 per period of care
- Mental health inpatient stays up to 45 days per calendar year; renewable after 60 days (unless amended by rider)
- Mental health outpatient visits up to 20 visits per calendar year (unless amended by rider)
- Substance Abuse inpatient stays up to 45 days per calendar year; renewable if out of hospital 60 consecutive days (unless amended by rider)
- Substance Abuse outpatient visits up to 35 visits per calendar year (unless amended by rider)

Services and Supplies not covered by the health plan include:

- Services and supplies that are not authorized by the primary care physician except treatment for medical emergencies in the first 48 hours of onset
- Fees over usual and prevailing charge for non-participating providers in connection with a medical emergency
- Services and supplies in connection with a medical emergency after 48 hours unless proper notice and primary care physician authorization was given
- Services that are not medically necessary
- Services that are experimental, investigational and/or educational
- Routine exams and immunizations solely for the purpose of insurance, licensure, employment or travel
- Work related illnesses or injuries
- Services and supplies relating to military service connected disabilities
- Services and supplies furnished by the U.S. Government and at public facilities
- Corrective appliances and artificial aids including hearing aids
- Hearing aid exams to determine the need for hearing aids or to adjust them
- Blood or blood plasma including the collection and storage
- Dental and related services
- Treatment for temporo-mandibular joint syndrome
- Treatment of foot conditions except for a open cutting operation, removal of nail root and treatment in connection with metabolic or peripheral vascular disease or of a neurological condition
- Eye surgery to correct myopia, hyperopia or astigmatism

- Cosmetic surgery and supplies
- Custodial care
- Personal comfort and convenience items and services
- Sex changes and reversal of previous voluntary sterilization
- Charges made by the employer or close relative
- Over the counter drugs and items
- Services and supplies for weight loss
- Planned home deliveries and delivery outside the service area against medical advice
- Procedures specific to sex preselection and/or determination
- Collection and storage of sperm, oocytes, or embryos for later use
- Transportation except for emergency transportation
- Services and supplies required by court decree
- Non-medical costs
- Non-eligible drugs
- Visits, days and maximum amounts over the plan limits

Pre-certification and Medical Care Management:

Your primary care physician will make the necessary arrangements if you need to be hospitalized, require surgery or need other outpatient services that require pre-certification. The UNICARE Medical Care Management process reviews your available benefits and coverage before services are provided and throughout on-going treatment. This includes considering if medical necessity, as defined in your certificate, is met.

Emergency Care:

If you have an emergency medical situation, please call your primary care physician. If you are unable to contact your doctor because you reasonably believe immediate medical attention is a must, go directly to the nearest emergency facility or call 911. Be sure to tell the facility that you are a plan member and have someone notify us.

Within 24 hours of emergency treatment, you or a family member should call your primary care physician to coordinate any further care needed. We also ask that you or a family member contact Customer Services at (312) 234-8855 on the first business day following any emergency room visit.

Primary Care Physician Selection:

When you become a member of UNICARE HMO, you must choose a primary care physician to be your personal physician. Each eligible member of your family may select a different primary care physician. Anytime you want to change your selection, simply call Customer Services, and we will update our records to reflect your change. Your new primary care physician selection will be effective the first of the month following your requested change.

Access to Specialty Care:

If you need specialty care, your primary care physician will provide you with a written referral. It will show you the specific provider to contact for service, the type of service(s) authorized and the number of visits and/or length of the treatment. After the specialist first sees you, that specialist may recommend an ongoing course of care for which your primary care physician may issue a referral for an ongoing course of treatment specifying needed services and timeframes. Always call your primary care physician if the specialist recommends treatment, tests or visits not listed on the referral before proceeding with them.

When being referred for care, you can expect your primary care physician to choose a network specialist with whom he or she shares a referral arrangement. To obtain clarification on referral arrangements, you should contact your primary care physician's office. If a referral arrangement does not exist between your primary care physician and the specialist you choose, you may have to choose another primary care physician. In some instances, a non-network specialist may be required.

Female members can also designate a network obstetrician/gynecologist or family practitioner as a "woman's principal health care provider." After a member makes the designation, this provider can be seen without a written referral, providing a referral arrangement exists between the woman's principal health care provider and the member's primary care physician. The member should call Customer Services to designate a provider with a referral arrangement with her primary care physician.

Out-of-Area Coverage:

If you have a medical emergency when you're away from the UNICARE Service Area, seek treatment right away at the nearest emergency medical facility. Inform the hospital or physician that you are a plan member and have someone contact us at 1(800) 782-0180.

If you need urgent care when you are away from home for an injury or illness that's not an emergency, please call us first at 1(800) 782-0180 to arrange for benefit coverage. This service is available seven (7) days a week, twenty-four (24) hours a day.

Once your condition has improved so that you are medically able to travel, you must receive any ongoing or follow-up care in the UNICARE Service Area through your primary care physician in order for benefits to be available.

Financial Responsibility:

As a member you share in some health care expenses. These include copays, deductibles, coinsurance and premium rates. Your employer may pay part of the premium cost. Check with your employer to find out.

Continuity of Treatment:

We will let you know if your physician is leaving the provider network.

If you are receiving on-going treatment or in the third trimester of pregnancy, you may be able to continue with the physician for up to 90 days or in the case of pregnancy until the end of post-partum care.

To make this request, please call Customer Services at (312) 234-8855. The Medical Director will review your request and notify you of the decision within 10 business days. If approved, the physician treating you must follow the same health plan requirements, payment rates and quality assurance standards in place before leaving the network. If denied, you have the right to appeal.

Appeals Process:

If you would like to voice an opinion, concern or complaint, call Customer Services at (312) 234-8855. A Representative will be happy to answer questions or help to resolve any problems you may have. Administrative complaints that can not be resolved immediately by phone will be responded to within 5 business days.

You can also write to us at:

UNICARE Customer Services, 233 S. Wacker Drive, Suite 3900, Chicago, IL, 60606-6309.

To expedite an appeal of denied benefits for medical services that, if not provided by your doctors, could put your health at significant risk, call or write to us. Within 24 hours of receiving your request, we will let you know if additional information is needed to review your file. Once that information is received, a decision will be provided within 24 hours.

To appeal denied benefits for medical services that have already taken place or the absence of which would not be considered to put your health at significant risk, we ask that you write to us. Within 3 business days of receiving your request we will let you know if any additional information is needed to review your file. Once that information is received, a decision will be provided within 15 business days.

To request an external independent review of denied benefits for medical services where the services have been prescribed by your doctor as part of an extended course of treatment or where the absence of the services could put your health at significant risk, call or write to us. As expeditiously as possible, but no more than 2 business days after we receive your request, we will let you know if additional information is needed to review your file. Once that information is received, we will forward it to the independent reviewer and will let you know the independent reviewer's decision within 24 hours of our receiving it.

To otherwise request an external independent review of the denial or medical necessity grounds of benefits for medical services, we ask that you write to us. Your request must be given to us within 30 days from when you received the denial. Within 30 days of your request, we will work with

you and your doctor to select the independent reviewer and will give the reviewer information to review your file. The reviewer's decision will be provided within 5 days after all required information is received.

An enrollee not satisfied with the health plan's resolution of any complaint may file a complaint with the Department of Insurance, through the Consumer Services Section, at one of the following locations:

320 West Washington Street
Springfield, Illinois 62767-0001

OR

100 West Randolph Street
Suite 15-100
Chicago, Illinois 60601-3251

You may also contact the Department electronically at <http://www.state.il.us/ins>.

Note: External grievance determinations in most cases are not appealable through the Department of Insurance.

IMPORTANT: In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

NOTE: You have the right to request a description of the financial relationships between UNICARE HMO and contracted health care providers. You also have the right to request the percent of premiums UNICARE HMO spends on healthcare-related and administrative expenses. Finally, you have the right to request of a physician who has contracted with UNICARE HMO: (1) information related to his/her educational background, experience, training, specialty, and board certification, if applicable; (2) the names of the licensed facilities where he/she presently has privileges for the services or supplies that are the subject of the request; and (3) information regarding his/her participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

What emergency room visits will be paid for by your health care plan.

How specialists (both in and out of network) can be accessed.

How to file complaints and appeal health care plan decisions (including external independent reviews.)

How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. **SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT**, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll-free number on the worksheet. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at: 320 West Washington Street, Springfield, Illinois, 62767-0001 or (877) 527-9431. (Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)