WHAT YOU SHOULD KNOW ABOUT YOUR BENEFITS

SUMMARY PLAN DESCRIPTION
A Handbook for Hourly Employees as set forth in supplemental agreements between GM and the UAW dated November 23, 2015
Dear General Motors Hourly Employee:

This booklet, “What You Should Know About Your Benefits,” is provided to you as a UAW-represented hourly employee working for General Motors in the United States. It contains information to help you understand and receive the full value of the GM benefits that are available to you. We hope that you take the time to read this booklet carefully, and keep it readily available for future reference.

In the event that you should have any questions after reading this material, contact the appropriate administrative Carrier for the benefit plan in question or your local Union Benefit Representative.

Sincerely,

Catherine L. Clegg
Vice President
NA Manufacturing and Labor Relations
General Motors

Cindy Estrada
Vice President and Director
UAW General Motors Department
The information in this “What You Should Know About Your Benefits” booklet is based upon the benefit plan provisions in effect through termination of the 2015 UAW-GM Agreement. This booklet is not a contract. However, it is intended to summarize the ways your GM benefit Plans can help you, and members of your family.

The information contained in this booklet is intended only to provide a general overview of your employee benefits and does not establish your eligibility for any particular benefit or reflect all limitations with respect to the level or scope of any benefit that may apply to your situation. This booklet 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 and this booklet, the Plan texts and negotiated Agreements always will govern. Your eligibility for any benefit described in this booklet is determined exclusively by your personal circumstances and the terms of the applicable benefit plan or program as interpreted by the plan or program administrator.

The information in this booklet with respect to the Pension Plan applies to employees with seniority on or after November 23, 2015, employees retired with benefits payable commencing after November 23, 2015, and eligible surviving spouses of active employees who died after November 23, 2015. The Life and Disability Benefits Program changes generally are applicable to employees at work on or after November 23, 2015. The effective dates for the Health Care Program are described in the Health Care section of this booklet.

General Motors intends for your benefit plans to continue as agreed upon between the Company and the UAW, and your coverage in the plans will continue as you remain eligible as defined by each plan. No changes may be made until the expiration of the 2015 Collective Bargaining Agreement, except as required by law or as mutually agreed between General Motors and the UAW.

Absent an express delegation of authority from the General Motors Board of Managers, no one has the authority to commit the Company to any benefit or benefit provision not provided for under the applicable benefit plan, or to change the eligibility criteria or any other provisions of such benefit plan. Such amendments, modifications, increases, decreases, or termination may occur whenever the entities named above deem it to be appropriate. If an amendment, modification, increase, or decrease occurs, the Plan(s) will implement the change consistent with the action of the entities named.

As reflected in the 2015 Negotiated Agreement between General Motors and the UAW, General Motors reserves the right to amend, modify, suspend or terminate the Plans and Programs described in this booklet. Only those officers or committees of GM who have been expressly delegated authority in writing by the General Motors Company Board of Directors or the GM Board of Managers, as applicable, may by written action exercise the right to amend, modify, suspend, or terminate the Plans and Programs and then only to the extent of such delegation. No other person or entity is authorized to alter the terms of these Plans or Programs or has authority to commit GM to any benefit or benefit provision or to create or establish eligibility criteria or entitlement to any benefit other than as specified in the applicable Plan or Program.
TABLE OF CONTENTS

CONTACT INFORMATION FOR GM BENEFITS ........................................................................................................... 1

SECTION 1: PLANNING FOR YOUR FUTURE ........................................................................................................... 3

PERSONAL SAVINGS PLAN ........................................................................................................................................ 3
  Eligibility ................................................................................................................................................................. 3
  Enrollment ............................................................................................................................................................... 3
  Automatic Enrollment ............................................................................................................................................... 3
  Access to Your Account .......................................................................................................................................... 3

HOW THE PLAN WORKS ......................................................................................................................................... 3
  Catch-up Contributions ........................................................................................................................................... 4
  Company and Retirement Contributions .................................................................................................................. 4
  Vesting of GM Contributions ................................................................................................................................ 5
  Rollover Contributions from Other Eligible Retirement Plans .............................................................................. 5
  Roth In-Plan Conversion ......................................................................................................................................... 5
  Investment of Your Contributions ............................................................................................................................ 5
  Information About Investment Options .................................................................................................................. 6
  Fund Exchanges ..................................................................................................................................................... 7
  Available Investment Options ................................................................................................................................. 7
  Excessive Trading Policy ......................................................................................................................................... 7
  Loans ....................................................................................................................................................................... 8
  Withdrawals ............................................................................................................................................................ 9
  How Assets Are Distributed .................................................................................................................................. 10
  Distribution Upon Termination of Employment From GM ...................................................................................... 10
  Age 70½ Minimum Required Distributions (MRD) ............................................................................................... 11
  Restoration of Forfeited GM Contributions ......................................................................................................... 11
  Account Statements and Tax Information ............................................................................................................... 12
  Tax Considerations ................................................................................................................................................ 12
  Disqualification, Ineligibility, Denial, Loss, Offset, Forfeiture, Suspension Reduction or Recovery of Benefits ....... 14
  Claims Review Procedure ..................................................................................................................................... 14

SECTION 2: IF YOU HAVE HEALTH CARE EXPENSES ............................................................................................ 15
  Eligibility of your Dependents: ............................................................................................................................... 15
  Dependent Children .................................................................................................................................................. 15
  Documentation Requirements for Adding Your Dependents to Your Coverage: ................................................ 16

MEDICAL PLAN OPTIONS ...................................................................................................................................... 17
  Traditional Care Network (TCN) Option .................................................................................................................. 17
  The Health Maintenance Organization (HMO) Option ............................................................................................ 21
TABLE OF CONTENTS

MEDICAL COVERAGE.................................................................................................................. 22
Hospital Coverage ......................................................................................................................... 22
Skilled Nursing Facility Coverage ................................................................................................ 23
Physical, Occupational and Speech Therapy Coverage ............................................................. 24
Home Health Care ........................................................................................................................ 24
Pre-Hospice and Hospice Coverage ............................................................................................. 24
Medical and Surgical Coverage .................................................................................................. 25
Preventive Services ..................................................................................................................... 25
Office Visit Coverage ................................................................................................................ 26
Ambulance Coverage .................................................................................................................. 27
Durable Medical Equipment (DME) and Prosthetic and Orthotic Appliance (P&O) Coverage ........................................... 27
Hearing Aid Coverage ............................................................................................................... 28
Prescription Drug Coverage ..................................................................................................... 28
Medical Plan Exclusions and Limitations .................................................................................... 31
Mental Health and Substance Abuse Treatment Coverages ...................................................... 32
DENTAL COVERAGE .................................................................................................................... 33
Accidental Dental Injury ............................................................................................................. 34
Payable Benefits ........................................................................................................................ 34
Limitations ................................................................................................................................ 35
VISION COVERAGE ................................................................................................................... 37
Vision Network ............................................................................................................................ 38
Summary ..................................................................................................................................... 39
GENERAL INFORMATION ABOUT YOUR HEALTH CARE COVERAGES ........................................... 40

SECTION 3: DEPENDENT CARE REIMBURSEMENT PLAN ............................................................ 45
DEPENDENT CARE SPENDING ACCOUNT DEPOSITS ............................................................... 45
What Are Eligible Expenses for Reimbursement From a Dependent Care Spending Account? .................................................. 45
Requests for Reimbursement ...................................................................................................... 46
Forfeitures .................................................................................................................................. 46
Planning to Use a Spending Account .......................................................................................... 46

SECTION 4: IF YOU ARE DISABLED ............................................................................................ 48
SICKNESS AND ACCIDENT BENEFITS ....................................................................................... 48
Eligibility to Receive Sickness and Accident Benefits ............................................................... 48
EXTENDED DISABILITY BENEFITS .......................................................................................... 51
Receipt of Extended Disability Benefits .................................................................................... 51
DISABILITY BENEFIT LAWS ....................................................................................................... 52
OTHER BENEFIT PROGRAM COVERAGES WHILE ON DISABILITY LEAVE ............................. 53
Life and Disability Coverages While You Are Disabled ............................................................... 53
Health Care Coverage While You Are Disabled (applicable to Traditional Employees Only) .................................................. 53
In Case You Become Totally and Permanently Disabled .......................................................... 54
Social Security Disability Insurance Benefits ............................................................................. 54
TABLE OF CONTENTS

SECTION 5: IF YOU ARE LAID OFF ................................................................................................................. 56
SUPPLEMENTAL UNEMPLOYMENT BENEFIT (SUB) PLAN ............................................................................ 56
  Regular SUBenefit – For a Full Week of Layoff From GM ........................................................................ 56
  Short Week Benefit – When Laid Off From GM for Part of a Week ............................................................. 58
  Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability ... 59
SUB PLAN OVERPAYMENTS .......................................................................................................................... 61
LIFE AND DISABILITY COVERAGE FOR EMPLOYEES ON LAYOFF ........................................................... 61
HEALTH CARE CONTINUATION FOR LAID OFF EMPLOYEES ................................................................. 62
TRANSITION SUPPORT PROGRAM (TSP) ....................................................................................................... 63

SECTION 6: WHEN YOU RETIRE .................................................................................................................. 64
PENSION BENEFIT - ELIGIBILITY .................................................................................................................. 64
  Retirement at Age 62 or Later ..................................................................................................................... 64
  Early Voluntary Retirement – Prior to Age 62 ............................................................................................. 65
  Mutually Satisfactory Retirement and Temporary Benefits ........................................................................ 67
  Total and Permanent Disability Retirement .............................................................................................. 67
CREDITED SERVICE ........................................................................................................................................ 68
PROVIDING BENEFITS FOR SURVIVING SPOUSE IN THE EVENT OF YOUR DEATH AFTER RETIREMENT ... 69
OTHER BENEFIT PROGRAM COVERAGES IMPACTED WITH RETIREMENT ............................................... 70
  Workers’ Compensation Offset .................................................................................................................. 70
  Application for Pension ............................................................................................................................... 70
  Social Security ............................................................................................................................................ 70
  Life Insurance ............................................................................................................................................ 70
  Health Care Coverages ............................................................................................................................... 71

SECTION 7: IN THE EVENT OF DEATH OR DISMEMBERMENT .................................................................... 72
LIFE AND DISABILITY BENEFIT PROGRAM COVERAGES ......................................................................... 72
  Beneficiaries and Payment of Benefits ....................................................................................................... 72
  Application for Benefits ............................................................................................................................. 75
  Survivor Income Benefits ........................................................................................................................... 75
  Transition Benefit ....................................................................................................................................... 75
  Bridge Benefit ............................................................................................................................................ 75
  Application for Survivor Income Benefits ................................................................................................ 75
  Eligible Widow or Widower ....................................................................................................................... 75
PENSION SURVIVOR BENEFITS .................................................................................................................... 76
  Death Prior to Retirement — If Eligible to Retire ......................................................................................... 76
  Pre-Retirement Survivor Protection for Death Prior to Retirement — If Not Eligible to Retire ....................... 76
  Survivor Benefits After Retirement .......................................................................................................... 76
  If Your Spouse Dies or You Are Divorced After Retirement .................................................................... 77
  Joint and Survivor Coverage ..................................................................................................................... 78
  Contingent Annuity Option ......................................................................................................................... 78
  Health Care Coverage for Survivors ......................................................................................................... 79
IN ADDITION TO THE COVERAGES PROVIDED ABOVE, THE FOLLOWING PROTECTION IS AVAILABLE UNDER THE LIFE AND DISABILITY BENEFITS PROGRAM: ................................................................. 80
  Accelerated Benefits Option ..................................................................................................................... 80
TABLE OF CONTENTS

SECTION 8: GENERAL INFORMATION ......................................................................................................................... 91

RECOVERY OF BENEFIT OVERPAYMENTS ................................................................................................................... 91
ELIGIBILITY OF SAME-SEX DOMESTIC PARTNERS .................................................................................................... 91
LIFE AND DISABILITY BENEFITS AND HEALTH CARE COVERAGE ................................................................. 92
   For Employees Returning From Permanent Layoff ......................................................................................... 92
   For Employees on Non-Disability Leave ......................................................................................................... 92
   For Employees Terminating Employment ...................................................................................................... 93
PROGRAM CONVERSION PRIVILEGES ................................................................................................................... 94
   Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits ................................................................................................................................. 95
QUALIFIED DOMESTIC RELATIONS ORDER (QDRO) .................................................................................... 97
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) .................................................................................. 97

SECTION 9: PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES ABOUT YOUR BENEFITS .......... 98

LIFE AND DISABILITY BENEFITS PROGRAM ........................................................................................................ 98
   Disability: Appeal of a Denied Claim ............................................................................................................... 98
   Appeal of Denied Life Insurance Claim and Voluntary Review of Disability Claims ........................................ 99
HEALTH CARE ......................................................................................................................................................... 100
   Health Care Mandatory Appeal Procedure .................................................................................................. 100
   External Review Process .................................................................................................................................. 101
   Voluntary Review Process ............................................................................................................................ 102
PENSION PLAN ...................................................................................................................................................... 103
TOTAL AND PERMANENT DISABILITY RETIREMENT APPEAL PROCESS ......................................................... 104
SUB ...................................................................................................................................................................... 106
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) ................................................................. 106
WHAT IS COBRA CONTINUATION COVERAGE? ................................................................................................. 110
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) ........................................ 113

SECTION 10: GLOSSARY OF TERMS ........................................................................................................................ 117

SECTION 11: A LIST OF IMPORTANT ITEMS TO REMEMBER ........................................................................... 127
## CONTACT INFORMATION FOR GM BENEFITS

<table>
<thead>
<tr>
<th>CONTACT INFORMATION FOR GM BENEFITS</th>
<th>Website</th>
<th>Phone #</th>
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<tbody>
<tr>
<td><strong>GM Benefits &amp; Services Center (GMBSC)</strong></td>
<td><a href="http://www.gmbenefits.com">www.gmbenefits.com</a></td>
<td>1-800-489-4646</td>
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<td></td>
<td>1-877-347-5225 (TTY)</td>
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**DISABILITY** *(When calling the GMBSC, you will be rerouted to Sedgwick for Disability related topics)*
- Sickness & Accident Benefits
- Extended Disability Benefits
- Family Medical Leave (FMLA)
- Workers’ Compensation

**HEALTH CARE RELATED SERVICES**
- Eligibility and Enrollment
- COBRA Continuation

**FLEXIBLE SPENDING ACCOUNT** *(Eligibility, Enrollment or Payroll Deduction Changes only)*
- Dependent Care Spending Account

**LAYOFF BENEFITS (SUB)**

**LIFE INSURANCE** *(When calling the GMBSC, you will be rerouted to MetLife for Life Insurance related topics)*
- Basic Life & Extra Accident
- Optional Life, Dependent Life & Personal Accident
- Survivor Income Benefit Insurance

**PENSION PLAN**

**PERSONAL SAVINGS PLAN (PSP)**

**OTHER SERVICES**
- Reporting a Death/Survivor Services
- Service Awards
- Tuition Reimbursement
- Wage & Employment Verification

### Health Care - Related Customer Service

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<tr>
<th>Health Care - Related Customer Service</th>
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<td>Accredo Specialty Pharmacy <em>(Prescription Drug)</em></td>
<td><a href="http://www.accredo.com">www.accredo.com</a></td>
<td>1-877-222-7336</td>
</tr>
<tr>
<td>Anthem Blue Cross of Ohio, Indiana, and Kentucky <em>(Medical)</em></td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>1-800-482-2210</td>
</tr>
<tr>
<td>Anthem 24/7 Nurseline</td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>1-800-337-4770</td>
</tr>
<tr>
<td>Anthem MyHealth Coach <em>(Case &amp; Disease Mgmt)</em></td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>1-800-311-2924</td>
</tr>
<tr>
<td>AudioNet America <em>(Hearing)</em></td>
<td><a href="http://www.audionetamerica.com">www.audionetamerica.com</a></td>
<td>1-866-701-1535</td>
</tr>
<tr>
<td>Blue Care Network HMO (BCN) <em>(Medical)</em></td>
<td><a href="http://www.mibcn.com">www.mibcn.com</a></td>
<td>1-800-662-6667</td>
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<tr>
<td>Blue Cross &amp; Blue Shield of Michigan <em>(BCBSM)</em> <em>(Medical)</em></td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>1-800-482-2210</td>
</tr>
<tr>
<td>BCBSM BlueHealth Connection &amp; 24/7 Nurseline <em>(Population Health Management)</em></td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
<td>1-800-775-2583</td>
</tr>
<tr>
<td>Beacon Health Options <em>(Mental Health &amp; Substance Abuse)</em></td>
<td><a href="http://www.beaconhealthoptions.com">www.beaconhealthoptions.com</a></td>
<td>1-800-235-2302</td>
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<tr>
<td>Davis Vision <em>(Vision)</em></td>
<td><a href="http://www.davisvision.com">www.davisvision.com</a></td>
<td>1-888-672-8393</td>
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<tr>
<td>Delta Dental Plan of Michigan <em>(Dental)</em></td>
<td><a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a></td>
<td>1-800-942-0667</td>
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<tr>
<td>Express Scripts <em>(Prescription Drug)</em></td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
<td>1-800-464-4679</td>
</tr>
<tr>
<td>Health Alliance Plan of Michigan HMO <em>(HAP)</em> <em>(Medical)</em></td>
<td><a href="http://www.hap.org">www.hap.org</a></td>
<td>1-800-422-4641</td>
</tr>
<tr>
<td>HealthPlus HMO <em>(Medical)</em></td>
<td><a href="http://www.healthplus.org">www.healthplus.org</a></td>
<td>1-800-332-9161</td>
</tr>
<tr>
<td>LifeSteps <em>(Wellness)</em></td>
<td><a href="http://www.lifesteps.com">www.lifesteps.com</a></td>
<td>1-800-711-8656</td>
</tr>
<tr>
<td>MercyCare Health Plan of Wisconsin <em>(Medical)</em></td>
<td><a href="http://www.mercycarehealthplans.com">www.mercycarehealthplans.com</a></td>
<td>1-800-895-2421</td>
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<tr>
<td>TheraMatrix <em>(Physical &amp; Occupational Therapy)</em></td>
<td><a href="http://www.theramatrix.com">www.theramatrix.com</a></td>
<td>1-888-638-8786</td>
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# CONTACT INFORMATION

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<th>Additional Resources</th>
<th>Website</th>
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<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
<td>1-800-633-4227</td>
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<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
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<td>College 529 Plans</td>
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<td>- Fidelity</td>
<td><a href="http://www.fidelity.com/529-plans/overview">www.fidelity.com/529-plans/overview</a></td>
<td>1-800-544-1914</td>
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<tr>
<td>- TIAA-CREF</td>
<td><a href="http://www.529michigan.com">www.529michigan.com</a></td>
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<tr>
<td>Retiree Health Care Connect</td>
<td><a href="http://www.uawtrust.org">www.uawtrust.org</a></td>
<td>1-866-637-7555</td>
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<tr>
<td>(UAW Retiree Medical Benefits Trust)</td>
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<tr>
<td>Social Security Administration</td>
<td><a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a></td>
<td>1-800-772-1213</td>
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<td>1-800-325-0778 (TTY)</td>
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<td>Tuition Assistance Plan</td>
<td><a href="http://www.uaw-gm.org">www.uaw-gm.org</a></td>
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<td>Vehicle Programs</td>
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<tr>
<td>- GM Protection Plan</td>
<td><a href="http://www.gmppdirect.com">www.gmppdirect.com</a></td>
<td>1-800-981-4677</td>
</tr>
<tr>
<td>- Vehicle Purchase Program</td>
<td><a href="http://www.gmfamilyfirst.com">www.gmfamilyfirst.com</a></td>
<td>1-800-235-4646</td>
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SECTION 1: PLANNING FOR YOUR FUTURE

PERSONAL SAVINGS PLAN

The purpose of the Personal Savings Plan ("PSP" or "the Plan") is to help you accumulate retirement savings.

For complete information about the PSP, including plan provisions and investment options, please refer to the GM Savings Plans Participant Guide on www.gmbenefits.com or the Personal Savings Plan for Hourly Employees, which can be requested from the PSP Plan Administrator at Mail Code: 482-C32-C66; 300 Renaissance Center; Detroit, MI 48265-3000

Eligibility
You are eligible to participate in the Plan the Monday following 90 days of employment.

Enrollment
To enroll in the Plan, or change your existing Plan elections, login to your General Motors PSP account on www.gmbenefits.com. You may also call the GM Benefits & Services Center toll-free at 1-800-489-4646.

Automatic Enrollment
Newly hired employees who have not enrolled in the Plan will be automatically enrolled unless you opt-out of Automatic Enrollment prior to the first contribution. Employees are automatically enrolled at a 3% pre-tax contribution rate of eligible weekly earnings. This contribution will be made through payroll deductions. The amount of PSP employee contributions can be increased or decreased by contacting the GM Benefits & Services Center.

Employees who are automatically enrolled in the PSP can request to have their contributions refunded, if such request is made within 90 days of their first contribution. The return of such contributions will be adjusted for gains and losses and, therefore, the actual refund may be more or less than the actual contributions. If you do not otherwise make an investment election, Automatic Enrollment contributions will be invested in the Plan’s Qualified Default Investment Alternative (QDIA). You may select an alternative investment option by contacting the GM Benefits & Services Center. For any contribution or investment elections changes, contact the GM Benefits & Services Center by calling 1-800-489-4646 or by accessing the Plan’s website at: www.gmbenefits.com.

Access to Your Account
When you participate in the Plan, you must establish, through the GM Benefits & Services Center, a confidential username and password. You may only access your own account information and initiate transactions by telephone or the Internet using your username and password. You should not give anyone your username and password.

HOW THE PLAN WORKS

You may elect to contribute up to 100% of your eligible weekly earnings, after legally required deductions, into the Plan through payroll deductions only. Your contributions may be made on an after-tax basis (Regular Savings) a pre-tax basis (Deferred Savings) or an after-tax Roth basis (Roth Savings) or any combination of Regular, Deferred or Roth Savings. Your total contributions may not exceed 100% of your eligible weekly earnings or the federal
deferral and contribution limits. For 2016, the federal tax deferral (which includes pre-tax and Roth contributions) limit is $18,000 and the limit on all contributions is $53,000, and thereafter indexed for inflation as provided by the Internal Revenue Code (IRC). Catch-up Contributions, which are described later, are not subject to these limits.

If you are eligible to receive a payment from the General Motors Profit Sharing Plan for Hourly-Rate Employees in United States, you may elect to have GM contribute to your PSP account as Deferred Savings a flat dollar deferral amount or an amount up to 100%, in 1% increments, less legally required and other deductions, of the amount of such payment. To the extent all or a portion of the award, if contributed, would exceed federal limits on pre-tax contributions, the excess amount will be returned to you in your pay check when profit sharing is paid.

You may make Regular, Deferred and Roth Savings through payroll deductions only. You may change the amount of your contributions at any time. The amount you elect to contribute may be limited by federal tax law. You should review the section on Tax Considerations in the GM Savings Plans Participant Guide for more detail.

**Catch-up Contributions**

If you are age 50 or over, or will attain age 50 by the end of the calendar year, you may be eligible to make Catch-up Contributions to your PSP account to the extent allowed by federal tax law. Catch-up Contributions are in addition to your regular PSP payroll contributions. You may elect to contribute up to 100% of your eligible weekly earnings, after legally required deductions, as Catch-up Contributions. The maximum annual amount of Catch-up Contributions you may be eligible to contribute is $6000 in 2016, and thereafter indexed for inflation, as provided by the IRC. Catch-up Contributions may only be made on a pre-tax basis or on a Roth basis. You may have Deferred or Roth contributions and Catch-up Contributions deducted simultaneously. However, your Catch-up Contributions will only be counted as such after your regular contributions become subject to specific limitations as described in the GM Savings Plans Participant Guide (“Participant Guide”) under Tax Considerations. The Participant Guide can be obtained from the GM Benefits & Services Center at 1-800-489-4646 or www.gmbenefits.com.

**Company and Retirement Contributions**

**Company Contributions**

If you were hired on or after October 15, 2007 and you have attained Seniority, as well as for certain other employees who may be covered by other Union agreements, GM will automatically contribute to your account each pay period a contribution in an amount equal to $1 per hour for each of your straight-time hours, (up to 40 hours per week), including hours compensated for certain eligible time not worked. If you are eligible to receive any Company Contributions, they will be credited to your account whether or not you contribute to the PSP.

**Retirement Contributions**

If you were hired on or after October 15, 2007, and have attained Seniority, GM will automatically contribute to your account each pay period an amount equal to 6.4% of your base hourly straight-time pay received up to 40 compensated hours in any one work week.

Company and Retirement Contributions and related earnings will be invested in the same investment options as elected for your regular employee contributions. If you have no investment option election in effect, any Company and Retirement Contributions will be invested in the Plan’s Qualified Default Investment Alternative (QDIA).
**Vesting of GM Contributions**
Company and Retirement Contributions made by the Company shall vest upon the attainment of three years of Vesting Service. In the event that you separate from service with less than three years of Vesting Service, all Company and Retirement Contributions and related earnings, if any, shall be forfeited.
If you are rehired within 60 months following the month in which your termination of employment occurred, the Administrator will automatically restore the forfeited Company and Retirement Contributions to your account.

**Rollover Contributions from Other Eligible Retirement Plans**
Once you are eligible to participate in the PSP, you may make a rollover contribution to the Plan. The rollover amount may not exceed the taxable portion of cash proceeds received from a traditional Individual Retirement Account (IRA). Also you may make a rollover contribution to the Plan of the taxable and/or nontaxable cash proceeds from other eligible retirement plans as described in the Participant Guide. Additionally, cash proceeds received under a Qualified Domestic Relations Order from another eligible retirement plan may also be contributed to the Plan. Rollover contributions must be made (1) by a “direct rollover,” or (2) within 60 days from the date you receive a distribution from the other plan.

**Roth In-Plan Conversion**
Roth In-Plan Conversion options are available, which provides you with the opportunity to convert all, or a portion of your non-Roth assets to Roth assets. The amount eligible for such direct rollover shall include all of a Participant’s vested assets, including, without limitation, Deferred Savings, After-tax Savings, Company Contributions, and Retirement Contributions, as well as related earnings thereon.

Special tax rules apply to a Roth In-Plan Conversion and are an important consideration in determining whether to do such a conversion. Generally, the taxable amount of a conversion is determined as if the converted assets were distributed to you from the Plan, although the assets will only be transferred to the Roth portion of your account and no amount will be actually distributed to you. The taxable amount (determined as if actually distributed to you) is taxable to you in the year of the conversion, and should be reported on your income tax return for that year. For more information related to the tax consequences of a conversion, you should consult the Savings Plan Participant Guide and your tax or financial advisor before undertaking such a conversion. You may contact the GM Benefits & Services Center at 1-800-489-4646 to process a Roth In-Plan Conversion.

**Investment of Your Contributions**
100% of your contributions may be invested in 1% increments in any of the Plan’s investment options elected by you. Your investment option elections will remain in effect until you change them subject to Plan provisions. The Plan provides you with the flexibility to change your investment options on any business day subject to any limitations on the frequency of exchanges applicable to the different investment options in the Plan.

The PSP provides you with a broad range of investment options, each with different risk and return characteristics. GM encourages you to familiarize yourself with the Plan’s investment features. You should carefully read the Plan materials, including the GM Savings Plans Participant Guide that you may obtain by either calling the GM Benefits & Services Center at 1-800-489-4646 or by accessing the Plan’s website at www.gmbenefits.com. Familiarization with the Plan’s investment features, coupled with the flexibility to change your investment options, as well as generally being able to exchange assets among investment options on any business day, will allow you to make informed investment decisions to help you meet your financial goals.

As a Plan Participant, **you are solely responsible for the selection of your investment options**. When making your investment decisions, you are assuming the risks of potential losses, which may result from your decisions. GM, its
employees and agents, the trustee and any appointed fiduciary are not empowered to advise you as to the amount of your contributions, the manner in which your investments should be made or any allocation or reallocation of those investments that may be appropriate for you.

Additionally, the fact that an option is available for investment under the Plan should not be construed by you as a recommendation by GM or General Motors Investment Management Corporation (GMIMCo), or anyone else, for investment in that option.

You should note that the market value and the rate of return on each investment option may fluctuate over time and in varying degrees. Accordingly, the proceeds, if any, you realize from these investments depend on the prevailing value of the investments at a particular time, which may be more or less than the amount you invested initially. There is no assurance that any of the investment options will achieve their objectives or your objectives.

You should note that each investment option is subject to varying degrees of risk which are discussed in the GM Savings Plans Participant Guide. Also, past performance of any investment option is not predictive of its future performance.

Information About Investment Options

General Motors Investment Management Corporation (GMIMCo), an indirect wholly owned subsidiary of GM and an SEC-registered investment advisor, advises GM regarding the Plan’s investment options.

To help you choose, the PSP investment options are organized into two Pathways. Although the two Pathways contain different groups of investment options, all the investment options in the PSP are generally available to you at any time. You can mix options from either of the two Pathways.

Pathway One:
This Pathway includes Target Date Funds which are designed to make it easy for you by providing a balanced investment strategy where the investments are professionally managed for you. To take advantage of the fund options in this Pathway, choose a Target Date Fund that is closest to your anticipated retirement date.

Target Date Funds use an asset allocation methodology that is intended to change over time, gradually becoming more conservative as the target retirement year approaches. Over time, exposure to equities is reduced, and replaced by fixed income and short-term investments. Like all investments, these funds involve risk, and principal in the funds is not guaranteed at any time, including the fund’s target date. Loss of money is possible by investing in these funds.

Pathway Two:
This Pathway may be appropriate if you want a more hands-on approach to managing your investments. You may want to consider this Pathway if you have some knowledge of investing and asset allocation and wish to select from a group of style-specific funds, or if you are an experienced investor who wishes to build a customized portfolio from a selection of investment options and you have the time to select and actively monitor your portfolio. This Pathway is segmented into “core” and “specialty” funds.

“Core” funds include a selection of investment choices across major asset classes that can help create a diversified portfolio that meets your personal level of investment risk tolerance. You may consider “core” funds to be the primary building blocks of your portfolio.
Pathway Two also includes several “specialty” funds that, in conjunction with the “core” funds offered, may help you further diversify your portfolio. Specialty funds may add further diversification, risk and growth return potential.

Like any investment, it is possible to lose money by investing in these funds.

**Fund Exchanges**
Except as provided below, you may generally exchange all, or part, of your assets from one investment option to other investment options on any business day of the year. Certain funds may impose a redemption fee on your exchange if you held that investment for less than a stated period (this fee is paid to the fund). Additionally, there are general limits on frequent trading which can also limit exchanges.

- An exchange may be made in 1% increments or whole dollar amounts. An exchange must consist of assets having a Current Market Value of at least $250, or if less, all the assets in the investment fund.

**Available Investment Options**
A listing of the investment options with descriptions of the funds by Pathway category is available in the Participant Guide. A description of the Fidelity and other mutual funds is also included in each such mutual fund’s Prospectus. Prospectuses and Participant Guides can be obtained from the GM Benefits & Services Center by either calling 1-800-489-4646 or accessing the Plan’s website at www.gmbenefits.com. You should carefully review these materials before you make any investment decisions.

**Excessive Trading Policy**
An excessive trading policy that includes a monitoring process based upon the concept of a “roundtrip transaction” within an investment option is currently in place for all investment options in the PSP in which exchanges are permitted with the exception of the Income Fund. Except with respect to the Income Fund, a “roundtrip transaction” occurs when you exchange into and then out of an investment option within a 30-day period. Please note that systematic contributions and withdrawals (i.e. regular payroll contributions, loan payments, and hardship withdrawals) as permitted under the PSP do not count as exchanges under the policy, and only Participant-initiated exchanges in amounts greater than $1,000 per investment option are counted.

Under the excessive trading policy, you are limited to one roundtrip transaction per investment option within any rolling 90-day period, subject to an overall limit of four roundtrip transactions across all investment options in the PSP over a rolling 12-month period. If you effect two roundtrip transactions in the same investment option within a rolling 90-day period, you will be blocked from making additional purchases of that investment option for 85 days and, during the 12-month period following the end of the 85-day suspension, any additional roundtrip transaction in the same investment option will immediately result in a new 85-day suspension on purchases of that investment option.

A restriction is also triggered if you effect four or more roundtrip transactions (as described above) across all investment options that are subject to the excessive trading policy during any rolling 12-month period. In this case, you will be permitted to make exchanges on only one day per calendar quarter (commencing the calendar quarter after the block is instituted) for a one-year period. You may select one quarterly exchange day at your discretion. Once this 12-month exchange limitation expires, any additional roundtrip transaction effected in any investment option in the ensuing 12-month period will result in another 12-month limitation of one exchange day per quarter. Participant exchanges affected on a quarterly exchange day are also subject to any suspension by an investment option of purchases, redemptions and/or exchanges and payment of any applicable redemption fees.
Frequent or significant withdrawals from, or inflows of capital into, a fund over a short period of time may adversely impact the value of a fund and, correspondingly, its investors. For example, the fund may be required to sell its more liquid portfolio investments in order to meet a larger than normal redemption. In that situation, the fund’s remaining assets may be less liquid, more volatile, and more difficult to price. Significant withdrawals or inflows of capital could also impact a fund’s ability to achieve its investment strategy and objectives.

To guard against these and other possible adverse consequences from frequent or high-volume trading, a fund may have authority to delay, limit, restrict or reject redemptions from, and contributions or exchanges into, the fund, potentially for an extended period of time. Any such decision may be imposed in response to market factors or actual or anticipated activity, whether related to a plan level event, individual participant actions, aggregate participant actions, or actions taken on an individual or collective basis by or upon the advice of Participants’ investment managers, newsletters or investment models, among other scenarios. The fund may also have authority to determine whether to make redemptions in cash, in-kind, or partly in cash and partly in-kind, or to impose upon the relevant participants the additional costs, charges or expenses associated with frequent or high-volume trading activity (for example, brokerage commissions, fees, expenses, stamp taxes and trading costs) associated with the activity. In certain instances, there could be interest charges associated with high-volume trading activity and related delays in processing trade requests, and relevant participants would be required to bear these charges. These costs, charges and expenses may be deducted from redemption or investment amounts, paid by liquidating the appropriate number of fund units, or charged to investors outside of the fund, among other methods. Events giving rise to these protective measures and the implementation of these measures may occur suddenly or unpredictably, and investors in the fund may not receive prior notice.

Where a participant’s redemption, contribution or exchange cannot be completed as expected due to a fund-imposed restriction, it is anticipated that the request will need to be delayed, cancelled, reversed and/or re-processed. In certain instances, additional direction from the participant could be required to re-submit the relevant request. If any of the foregoing actions occurs with respect to a transaction, depending on market fluctuations between the time of the activity and the responsive action, affected participants may not be returned to precisely the same position in which they would have been if the request had not been made.

As a result of any of the foregoing, participants may not be able to redeem their investments from, or make contributions or exchanges into, a fund at a particular time or on the terms they might otherwise have expected.

**Loans**

Once each calendar year you may borrow from assets in your account. If you are a former employee or a surviving spouse of an employee and you have assets in the Plan, you may also take a loan from your account. You may have up to five outstanding loans at any one time. The loan may be for any reason. No credit statement is required. Amounts borrowed are not subject to income tax, except in the case of a loan default.

The minimum loan amount is $1,000. You may not have at any time loans outstanding exceeding the maximum of $50,000. You may apply for a loan for an amount which is the lesser of:

- $50,000 less the highest amount of loans you had outstanding during the prior 12 months; or
- One-half of the current market value of your total vested assets.

Additionally, while you remain actively employed at GM, the maximum amount available to you for a loan will be reduced by an amount equal to the outstanding principal, including accrued interest, deemed to be a distribution to you. However, while you remain an active employee of GM you may repay a loan after it has been declared a deemed distribution, thus eliminating the restriction on the amount available to you for any future loan.
The interest rate charged on your loan will be the Prime Rate prevailing as of the last Business Day of the calendar quarter immediately preceding the date on which your request for the loan is received and confirmed by the GM Benefits & Services Center. The interest rate remains fixed for the duration of the loan.

Cash for your loan is obtained by selling assets in your account. The assets to be sold are selected by you. If you do not make a selection, a pro-rata amount of the assets in your account will be sold.

Amounts repaid are allocated to your account based on the investment options you elect for your current contributions.

Repayment of a loan is made through after-tax payroll deductions. The minimum repayment is $10 per pay period, over a period of time you elect. Generally, the repayment period ranges from six months to five years. You have up to 10 years if the loan is to purchase or build your principal residence. If you are an active employee of GM, seeking to repay a defaulted loan after it has been declared a deemed distribution or if you are a former employee or the surviving spouse of an employee, your loan repayment will be through payments made directly by you to the GM Benefits & Services Center. There are no prepayment penalties if you repay the loan earlier than scheduled.

The Electronic Loan Payment service (also known as ACH) allows you to make loan payments electronically by transferring funds from your personal bank account directly to your PSP account. Active Participants may use this service to make partial loan repayments and full loan payoffs. To take advantage of this convenient repayment method, log on to www.gmbenefits.com, and select "Electronic Payments" from the Savings & Retirement page under “Act”. You may also call the GM Benefits & Services Center to enroll.

In the event you fail to make required loan payments and your failure to make such loan payments continues beyond the last day of the calendar quarter following the calendar quarter your required loan payments are due, your loan shall be considered in default and you shall be irrevocably deemed to have received a distribution of assets in an amount equal to the outstanding balance of the loan, plus any accrued interest, calculated to the date the loan is deemed distributed. Prior to defaulting on an outstanding loan, a notice will be sent to you providing you with a repayment opportunity unless the failure to repay the loan is a result of your bankruptcy. Please note that defaulting on your outstanding loan balance may result in tax consequences to you.

Withdrawals
A withdrawal of assets is permitted, subject to certain limitations. These limitations are designed to comply with federal regulations. Withdrawals may also be subject to tax penalties.

While an active employee, generally you may withdraw part, or all, of your Regular Savings and earnings thereon, at any time, without restrictions. You may withdraw your Deferred Savings and Roth Savings only as described below. You may not withdraw GM contributions or earnings thereon until vested. No forfeiture of any GM contributions will occur solely as a result of your withdrawal.

You may withdraw from your account part, or all, of your assets subject to certain limitations on the withdrawal of Deferred Savings and Roth Savings, and the vesting requirement described above.

Company and Retirement Contributions and related earnings, if any, that are vested are only available to be withdrawn before Normal Retirement Age after you terminate employment.
You may withdraw from your account part, or all, of your Deferred or Roth Savings and earnings thereon for any reason after you attain age 59½ (and for Roth Savings, the contributions must be in your account for at least five taxable years for favorable tax treatment).

You have the option of taking a separate Roth distribution if you are otherwise eligible for a Plan withdrawal or distribution (e.g., following separation from service or attainment of 59 ½). Under this distribution option, you may receive a distribution limited to your Roth assets without having to withdraw amounts attributable to pre-tax, after-tax or company contributions.

Prior to age 59½, the withdrawal of Deferred Savings and Roth Savings may be made by you only in the event you have a “financial hardship” as defined by federal rules and the withdrawal is in order to:

- Purchase, or construct, your principal residence;
- Prevent foreclosure on, or eviction from, your principal residence;
- Pay medical expenses for you, your spouse, or your dependent(s) that are not covered under the GM Health Care Program;
- Pay tuition for the next 12 months of post-secondary education for you, your spouse, or your dependent(s);
- Funeral expenses for your deceased parents, spouse, children, or dependent(s);
- Repairs to your principal residence due to casualty loss (as provided under IRS regulations); or
- Any other reason permitted under IRS rulings and notices.

Any withdrawal of Deferred or Roth Savings for a hardship will be limited to the amount of your contributions. Earnings on Deferred or Roth Savings are not available for a hardship withdrawal. If you request a hardship withdrawal, you may include in the withdrawal any amounts necessary to cover the anticipated taxes and early withdrawal penalties resulting from the withdrawal. Before Deferred or Roth After-Tax Savings can be withdrawn for a hardship; however you must take all available asset distributions, withdrawals, and loans under all applicable Plans maintained by GM. If you withdraw Deferred or Roth Savings because of a hardship, you will be suspended from making further contributions under this Plan and certain other GM benefit and compensation Plans for a period of six months following the withdrawal.

**How Assets Are Distributed**

Units or Shares in your investment options will be settled in cash.

**Distribution Upon Termination of Employment From GM**

Generally, in the event of termination of employment from GM, after you have three or more years of credited service, you will be entitled to receive a full distribution of all assets in your account, including all vested GM contributions, regardless of the reason for termination of employment.

If your GM employment ends and you have less than three years of credited service at the time of separation, you will be entitled to receive a full distribution of all vested assets attributable to your contributions and related earnings. Any GM contributions and related earnings not vested will be forfeited.

If, at the time of your termination, the value of your vested assets is not greater than $1,000 (including rollover contributions) you shall receive a distribution of the entire amount of your Account, less any required Federal and State taxes, not later than 60 days following the month in which the termination of employment occurred. If the net non-forfeitable value of the Participant’s Account balance exceeds $1,000 (including rollover contributions) but is less than or equal to $5,000 (excluding rollover contributions) as of the most recent Date of
Valuation coinciding with or immediately following the Participant’s termination, and the Participant does not elect to have such distribution paid directly to an Eligible Retirement Plan specified by the Participant in a Direct Rollover in accordance with the terms of the Plan, or to receive the distribution directly, then the Plan Administrator shall pay such distribution in a Direct Rollover to an individual retirement plan designated by the Plan Administrator. Any such Direct Rollover to an individual retirement plan designated by the Plan Administrator shall be made in accordance with procedures established by the Plan Administrator as soon as practicable after the Date of Valuation coinciding with or immediately following the Participant’s date of termination.

During the period your assets remain in the Plan, you may (1) exchange assets among the various investment funds, and (2) borrow from your assets, as permitted under Plan provisions. Any outstanding PSP loans you have at the time of termination, or any new loans you may take thereafter, must be repaid by making monthly cash payments. The GM Benefits & Services Center will automatically send you loan repayment coupons for use when submitting your cash payments.

Furthermore, during the period your assets remain in the Plan, you may elect to receive periodic installment payments from your account. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installsments must be in whole dollar amounts and total at least $1,200 each year. You may, at any time, revise the amount and frequency of any such installments or you may discontinue installment payments. Additionally, you may take a partial distribution of your assets at any time, either in addition to any installment payments you may elect or without installment payments. For more information about distributions, please refer to the PSP Distribution Guide available on www.gmbenefits.com under Plan Information.

**Age 70½ Minimum Required Distributions (MRD)**

If you are actively employed by GM and you attain age 70½, and you have not terminated employment from GM, legally required minimum annual distributions will begin following your termination of employment from GM.

If you terminate your employment from GM, and you (1) defer receipt of your PSP assets and (2) later attain age 70½ and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The amount of your annual minimum required distribution will be determined consistent with prevailing federal regulations and paid to you from your account beginning not later than April 1 of the year following your attaining age 70½. You will be notified, in writing, prior to receipt of your first minimum required distribution. Thereafter, depending upon the amount you withdraw voluntarily during the calendar year from your PSP account, a minimum distribution payment will be made to you in December each year.

When a MRD is required from your PSP account, this requirement will be satisfied in one of two ways. First, absent any installment payments or partial distribution(s) from your account in the year, a distribution equal to the minimum required amount will be paid to you in December of the year. Second, the cumulative amount of any voluntary (1) installment payments and (2) partial distribution(s) that you take from your account during the year will first be used to satisfy the legally required minimum amount applicable for such year.

**Restoration of Forfeited GM Contributions**

If you terminate your employment from GM and are subsequently rehired and consequently become eligible to participate in the PSP before incurring five consecutive one-year breaks in service following termination, previously forfeited GM contributions will be restored, subject to the applicable 3-year vesting requirement. You should contact the GM Benefits & Services Center for additional information.
Account Statements and Tax Information
You may create, at any time, your own online account statement covering any monthly, quarterly or specified time periods going back 24 months by accessing the Plan’s website at www.gmbenefits.com.

Tax information will be furnished to you from time to time during your participation in the Plan.

Tax Considerations
The Defined Contribution Limits for 2016 are reflected in the chart below. These amounts are adjusted periodically under Federal regulations.

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<table>
<thead>
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<tbody>
<tr>
<td>Elective Deferral Limit</td>
<td>Includes combined pre-tax and Roth contributions</td>
<td>$ 18,000</td>
</tr>
<tr>
<td>Catch-up Contribution Limit</td>
<td>Individuals age 50 or over (or who will be age 50 by year-end) have an opportunity to save additional pre-tax and/or Roth savings</td>
<td>$ 6,000</td>
</tr>
<tr>
<td>Defined Contribution Limit</td>
<td>The maximum amount of combined employee and GM contributions</td>
<td>$ 53,000</td>
</tr>
<tr>
<td>Highly Compensated Employee Limit</td>
<td>The amount of income to define a highly compensated employee</td>
<td>$ 120,000</td>
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GM is required under current federal tax law to limit the combined amount of your annual pre-tax and Roth contributions. This limit is **$18,000 in 2016** and thereafter indexed for inflation, as provided by the IRC. Other federal limits also apply and may result in a reduction of your pre-tax, Roth and/or after-tax contributions. If you are affected, your subsequent contributions until the end of the calendar year may be (1) re-categorized from pre-tax to after-tax, (2) reduced, or (3) refunded to you.

If you are age 50 or over, or will attain age 50 by the end of the calendar year, you may be eligible to elect additional pre-tax and/or Roth Catch-up Contributions of up to **$6,000 in 2016** and thereafter indexed for inflation, as provided by the IRC. Catch-up Contributions are not subject to certain tax law limits, including the $18,000 limit described above for 2016.

**GM may not give tax advice to you and recommends that you seek the advice of a tax advisor.**

Your PSP contributions are subject to Social Security (FICA) taxes. Also, you should be aware that under current tax laws, income taxes on (1) pre-tax contributions, (2) GM contributions, and (3) all earnings credited to your account are delayed until you receive a withdrawal or distribution. When you do elect a withdrawal or distribution, federal income tax will be withheld at a mandatory rate of 20% on the taxable amount of any withdrawal or distribution that is not directly rolled over, at your direction, into an Individual Retirement Account (IRA) or another eligible retirement plan.

Under current tax law, your Roth contributions are made after income taxes are deducted. At the time of withdrawal, you will owe no taxes if you withdraw the assets from your Roth account at or after 59½ or upon disability or death, and as long as the Roth account existed for at least five taxable years beginning with the year you make your first Roth contribution.
Under current tax law, a 10% additional early distribution tax will be imposed on the taxable or Roth portion of any Plan withdrawal or distribution made when you are under age 59½. The additional tax does not apply to (1) the non-taxable portion of a withdrawal or distribution, or (2) taxable monies you roll over, or elect to have directly rolled over, into an IRA or another eligible retirement plan.

Moreover, the 10% tax does not apply to distributions that are:

- Made to you after you separate from service by retirement during or after the calendar year in which you attain age 55;
- Made to you because you have tax-deductible medical expenses (whether or not you itemize deductions);
- Paid to an alternate payee under a Qualified Domestic Relations Order;
- Made to you as a result of a federal tax levy;
- Paid to your beneficiary after you die;
- Made to you because you are totally and permanently disabled;
- Made to you as part of a series of substantially equal periodic (at least annual) payments over your lifetime or the joint lives of you and your beneficiary and such payments begin after your separation from service and continue for five years or until age 59½, whichever is later; Roth distributions that are made to you after you attain age 59½ and have held the assets in the Roth account for five taxable years; or
- Made to you as a qualifying reservist distribution during periods of active military service.

Under current tax law, if you take a lump-sum distribution and you were at least age 50 on January 1, 1986, special averaging rules may apply. Under these special averaging rules, you can make a one-time election, at any age, to use capital gains treatment and/or 10-year income averaging under 1986 income tax rates.

As an alternative to receiving a distribution, you can elect a “direct rollover” of all, or any portion, of your PSP distribution into an IRA, or another eligible retirement plan. If you do this, under current tax law, you would pay no tax at the time of distribution on the amount rolled over. However, if you choose to have all, or a portion, of your PSP assets paid to you, federal income tax will be withheld at a mandatory rate of 20% on the taxable amount of the distribution. If, after you receive your PSP distribution, you decide to roll over 100% of the taxable amount of such distribution into an IRA, or another eligible retirement plan, you must provide the funds to replace the 20% that was withheld. This tax-free rollover must be accomplished within 60 days after your receipt of the distribution. Any amount rolled over will not be taxed under current tax law until you withdraw it from the IRA, or another eligible retirement plan. However, any amounts withdrawn from an IRA at a later date would be subject to tax at ordinary income tax rates.

**NOTE:** Hardship distributions may not be rolled over to an IRA or another eligible retirement plan, and Roth distributions can only be rolled over to a Roth IRA or another plan that maintains Roth accounts.

If you terminate your employment from GM you may continue to defer distribution of all your assets, provided the vested value of these assets is greater than $5,000, until April 1 of the year following the year you attain age 70½ (the time minimum annual distributions must commence for retired and terminated Participants).
Disqualification, Ineligibility, Denial, Loss, Offset, Forfeiture, Suspension Reduction or Recovery of Benefits

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, forfeiture, suspension, reduction or recovery of benefits:

- The maximum loan amount available to you will be reduced by an amount equal to the outstanding principal, including accrued interest, of any outstanding loans you may have at the time of application including any loans defaulted after December 31, 2001 and deemed to be a distribution to you;
- If at the time of your separation from service the value of your vested assets is not greater than $5,000, you will receive a distribution of the entire amount in your PSP account;
- If your GM employment ends and you have less than three years of credited service at the time of separation, any GM contributions not vested will be forfeited; or
- In the event the Plan should be disqualified or GM makes a decision to terminate the Plan, such disqualification or termination may result in tax consequences to you as a Participant in the PSP.

Claims Review Procedure

The Plan Administrator will provide adequate notice, in writing, to any Participant or beneficiary whose claim for benefits under the Plan has been denied setting forth the specific reasons for such denial.

The Participant or beneficiary will be given an opportunity for a full and fair review by the Personal Savings Plan Board of Administration, herein referred to as the “Board”, of the decision denying the claim. The Participant or beneficiary will be given 60 days from the date of the notice from the Administrator denying such claim within which to request such review utilizing the following appeal procedure:

- Any Participant who disputes a Plan Administrator determination with respect to a Participant’s Personal Savings Plan account may file, with the GM Benefits & Services Center, a written claim on form SA1, “Participant Claim to Personal Savings Plan Board of Administration.” Such claim shall be filed within 60 days of receipt of such determination from the Plan Administrator.
- In all cases where the Participant has filed a claim on form SA1, the Board, shall review such claim, return one copy of form SA1 to the Participant with a written signed statement setting forth all the facts and circumstances surrounding the case, and any material pertinent to the case shall accompany the decision within 60 days of the Participant’s appeal, however that if special circumstances arise, as determined by the Board, in its sole discretion, such decision shall be made no later than 120 days after receipt of such request.
- Subject to any rights to remedies accorded by applicable law, the final decision of the Board, with or without the Impartial Chairperson, if applicable, shall be binding upon the Company, the claimant and all other persons interested in the claim.
- A Participant may not bring a civil action contesting the Board’s denial of a benefit claim more than 24 months following the date of the Board’s denial of such benefit claim. If a court determines that this provision allows an unreasonably short period of time to bring a civil action, then the court shall enforce this provision as far as possible and declare the civil action barred unless it was started within the minimum reasonable time that the action should have been started.
- Form SA1 for each appeal must be requested from the Secretary, Personal Savings Plan Board of Administration, Mail Code 482-C32-A68, General Motors LLC, 300 Renaissance Center, P.O. Box 300, Detroit, Michigan 48265-3000.
SECTION 2: IF YOU HAVE HEALTH CARE EXPENSES

The General Motors Health Care Program for Hourly Employees (the Program) provides protection for you and your eligible dependents against a wide range of health care expenses. While coverages provided under the Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances. Therefore, you should seek guidance from your health care Carrier (for example, Blue Cross Blue Shield) if you have questions as to whether or not a particular health care service or expense is covered under the Program.

Effective with the 2015 UAW-GM Agreement, eligibility for coverage in the Medical, Dental, and Vision Plans will be effective on the ninety-first calendar day.

Eligibility of your Dependents:
Certain individuals may be eligible for coverage as a “dependent” of an employee or a surviving spouse.

Eligible family members that may be enrolled for coverage with GM contributions may include:
- Your current spouse*;
- You or your current spouse’s natural or adopted children;
- You or your current spouse’s children by legal guardianship;
- Your same-sex domestic partner**; and
- Your same-sex domestic partner’s natural or adopted children – if they qualify as your dependents under the Program.

*Spouse
As a result of a June 26, 2013 ruling by the U.S. Supreme Court, with respect to Plan administration, the term “spouse” shall include the parties to a marriage of two persons of the opposite sex or of two persons of the same sex provided the marriage was lawful in the jurisdiction in which it occurred. If a marriage was lawful in the jurisdiction in which it occurred, it will be deemed lawful for Plan administration purposes thereafter regardless of whether the Participant or spouse later establish residence or become domiciled in a jurisdiction in which such marriage is not recognized or is otherwise deemed unlawful.

**Same Sex Domestic Partner
With the 2015 Supreme Court decision, (Obergefell v. Hodges), health care coverage under the Program is now available to same-sex spouses in all 50 states. Program eligibility of Same-Sex Qualified and Non-Qualified Domestic Partner (SSDP) dependent classifications will end on December 31, 2016. Beginning January 1, 2017, only spouses, both same-sex and opposite sex, will be recognized as being eligible for coverage in the Health Care Program.

Dependent Children
Effective January 1, 2011, in accordance with the Patient Protection and Affordable Care Act, (PPACA):
Dependent children by birth or legal adoption of the primary enrollee or spouse of the primary enrollee must meet the following requirements:
- The child(ren) must be under the age of 26 (coverage ceases at the end of the month in which the child turns age 26), or
- The child(ren) that is “totally and permanently disabled” and meets Program eligibility criteria for coverage.
Dependent child(ren) by **Legal Guardianship** are required to meet eligibility requirements found in Article III, 9(c) of the Program:

- A child who has reached the end of the calendar year in which such child has turned age 19, but not beyond the end of the calendar year in which age 24 is attained, must be a full-time student at least one school term during the calendar year; and
- The child(ren) must be unmarried; and
- The child(ren) must reside with the primary enrollee, or the primary enrollee must be legally responsible for providing health care coverage for the child(ren).

**Documentation Requirements for Adding Your Dependents to Your Coverage:**

The primary enrollee is required to provide documentation necessary to substantiate the eligibility of enrolled dependents within sixty (60) days of calling the GM Benefits & Services Center to request coverage. If documentation is not received within the 60 days the dependent will lose coverage. If documentation is later provided, coverage in such cases will be reinstated retroactive to the date the dependent was originally enrolled (maximum of one year), following receipt of all required documentation.

Applicable for **adding a spouse, and dependent child(ren) and/or stepchildren:**

- Establish relationship to the primary enrollee or his/her current spouse,
- Required documentation establishing the relationship includes marriage certificate, birth certificate.

Applicable for adding a Dependent by **Legal Guardianship:**

- Establish blood relationship to the primary enrollee or his/her current spouse, residency with the primary enrollee, and student status if the child is between the ages of 19 and 24; and
- Legal documentation establishing the Guardianship must be provided to the GM Benefits & Services Center; and
- **NOTE:** Health Care coverage is effective the date the Guardianship becomes final as provided in the legal court documents, however a retroactive effective date is limited to twelve (12) months.

Applicable for adding a **Same-Sex Domestic Partner and his/her eligible child(ren):**

- Documents required include, 1) signed and notarized affidavit of a same-sex domestic partnership (applicable to partner only), 2) proof of joint property ownership (applicable to partner only), 3) proof of joint residency (applicable to partner and child), 4) proof of full-time student status, if child is between the ages of 19 and 24 (applicable to child only).
- **Note:** Health Care coverage for eligible dependents is effective the first of the month following receipt of all appropriate documentation by the GM Benefits & Services Center.

**Ongoing Documentation Requirements**

Any enrollee receiving benefits under the Program shall furnish any documentation necessary for administering the eligibility provisions as requested, such as a dependent verification audit.
MEDICAL PLAN OPTIONS

Based on your employee status, and your address of record, you may be offered a choice of health care options, to the extent they are in effect and available in your area, as follows:

- The Traditional Care Network (TCN) Preferred Provider Options, (PPO) option
- Health Maintenance Organization (HMO) option, where available

The options are designed to provide quality care on a cost-effective basis. Descriptive materials concerning benefits provided under each option are available through the GM Benefits & Services Center. Although coverages may differ slightly under the various options, in general, covered expenses include the items detailed below. **This is a general description only and the provisions of the Program control your eligibility for coverage and specific benefits.** A glossary of terms is provided at the end of the health care section.

**Traditional Care Network (TCN) Option**

Under the TCN option, General Motors provides financing of the Plan, and partners with selected Carrier to provide administrative services and claims processing.

TCN is an option that is based on a network of providers. This option allows services to be received from both in-network and out-of-network providers. However, in order to receive the highest level of benefits with little or no out-of-pocket cost, **you are encouraged to receive services from in-network providers.**

The following terms are used to describe certain elements of the TCN option:

- **Network Providers:** Preferred physicians and facilities who contract with the Carrier to provide services at a discount to TCN enrollees.
- **Out-of-Network Providers:** Physicians and facilities that are not contracted with the Carrier to provide services in the TCN network. Participants of the Plan will generally pay more for out-of-network providers than if services are received from an in-network (preferred) provider.
- **Annual Out-of-Pocket Maximum:** The maximum dollar amount you may be required to pay during a Plan (calendar) year for your share of the costs for covered services.
- **Carrier’s Allowed Amount:** The maximum amount of payment made by Carriers to reimburse in-network providers for covered services.
- **Annual Deductible:** Means an aggregate amount an enrollee may be responsible for paying each Plan (calendar) year for covered services prior to the Program making a payment. “Single” and “family” deductibles may apply. Once the deductible is met, coinsurance may apply.
- **Coinsurance:** The amount an enrollee may be required to pay for covered services or supplies that is calculated a percentage of the allowed amount. The coinsurance percentage may vary depending on whether or not the services were obtained from network providers.
- **Copayment:** The fixed-dollar amount that an enrollee may be required to pay for a covered service or supply. Enrollees are responsible for required copayments, regardless of whether deductibles or out-of-pocket maximums have been met.
If you are enrolled in the TCN and you incur charges for covered services because you go to an out-of-network provider, you may be responsible for paying additional costs unless the service is for emergency care, you receive a referral, or you do not have the ability or control to select a network provider to perform the service. For those services that require a referral, you need to receive the referral from an in-network provider before you receive covered services from an out-of-network provider. If an advance referral is not obtained, you will be responsible for the out-of-network coinsurance, and if the provider is non-participating, you will be responsible for any amount charged by the non-participating provider that is higher than the Carrier’s allowed amount. Amounts over the Carrier allowed amount, do not apply to the out-of-pocket maximum.

In addition, enrollees who have Medicare as their primary coverage will not be subject to the out-of-network copayments when network providers are not used, however you should use providers that participate with Medicare.

The TCN option requires prior authorization (predetermination) and review procedures to help you and your covered family members avoid unnecessary or prolonged hospitalization. Specifically, the appropriateness of the setting is reviewed as well as the proposed length of stay. If your hospital or physician fails to follow the predetermination process, the reimbursement may be reduced. You will not be responsible for the amount of the reduction, unless you have agreed with your doctor or hospital to accept such responsibility. If prior authorization is not granted, but you nevertheless elect to have the services performed, such services will only be payable at 80% of the allowed amount after the first $100 of charges for such services. The reimbursement to providers will be reduced to reflect any waiver or forgiveness by a provider of the $100 or remaining 20%. This benefit adjustment is limited to $750 per calendar year for an individual and $1,500 per calendar year for a family.

You should inform your physician or hospital that prior authorization can be obtained by calling the toll-free telephone number printed on your health care identification card.

Prior authorization is not required in cases of a medical emergency or maternity hospital admissions. However, emergency hospital admissions must be reported by your physician or hospital within 24 hours after the admission calling the toll-free telephone number printed on your health care identification card.
Tradional Care Network Cost Sharing

**TRADITIONAL EMPLOYEES:**
Effective with the 2016 Plan Year, cost-sharing obligations for the Medical and Prescription Drug Plans for Traditional and In-Progression employees is shown on the chart below. Please note that Prescription drug copayments may be adjusted on an annual basis. See the Dental Coverage and Vision Coverage sections for applicable copayments sharing obligations.

**IN-PROGRESSION EMPLOYEES:**
Effective January 1, 2016, all In-Progression employees (formerly classified as Entry Level employees), are eligible for the same Medical Plan as Traditional employees. In-Progression employees however, that are receiving Extended Disability benefits will have health care coverage cease at the end of the month in which the maximum EDB amount is payable.

**Traditional and In-Progression Employee Cost Sharing**

<table>
<thead>
<tr>
<th>Traditional Care Network - Network Providers</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>In-network</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>In-network</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Out-of-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>In-network</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Out-of-network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>$25 copayment per visit (not applied to out-of-pocket maximum)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copayment (Waived if transferred directly from UCC to Emergency Room)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail (34 day supply)</td>
</tr>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Brand Name</td>
</tr>
<tr>
<td>Erectile Dysfunction (ED)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail (90 day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
</tr>
<tr>
<td>Brand Name</td>
</tr>
<tr>
<td>ED</td>
</tr>
</tbody>
</table>
**Temporary Employees:**
The 2016 Medical and Prescription Drug Plans cost sharing for Temporary employees is shown on the chart below. Temporary employees are not eligible for dental or vision coverage, and are not eligible to enroll in an HMO option, if available in their region.

### Temporary Employee Cost Sharing

<table>
<thead>
<tr>
<th>Temporary Health Care Plan – Network Providers</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-network</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>$1,200</td>
<td>$2,100</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-network</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>35% coinsurance</td>
<td>35% coinsurance</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-network</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>No limit</td>
<td>No limit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>In Network</strong></th>
<th><strong>Out of Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits</td>
<td>100% copayment</td>
<td>100% copayment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered without a referral</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and in network coinsurance</td>
</tr>
</tbody>
</table>

### Prescription Drug

<table>
<thead>
<tr>
<th></th>
<th>Copayments</th>
<th>Copayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Generic</td>
<td>$7.50</td>
<td>$7.50</td>
</tr>
<tr>
<td>Brand Name</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>ED</td>
<td>No coverage for ED</td>
<td>No coverage for ED</td>
</tr>
<tr>
<td>Mail Generic</td>
<td>$7.50</td>
<td>$7.50</td>
</tr>
<tr>
<td>Brand Name</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>ED</td>
<td>No coverage for ED</td>
<td>No coverage for ED</td>
</tr>
</tbody>
</table>
The Health Maintenance Organization (HMO) Option

Health Maintenance Organizations (HMOs) are health care delivery systems or organizations which emphasize preventive health care and early treatment, as well as provide medically necessary care for illness and injury. The scope and level of benefits and coverages provided by an HMO may differ from the TCN option. With an HMO Plan, you may be required to choose one primary care physician (PCP). All your health care services go through that doctor. That means that you need a referral before you can see any other health care professional, except in an emergency. Your PCP will generally refer you only to HMO providers. Unlike the TCN option, non-emergency services obtained from providers outside of the HMO network of providers are not covered unless the primary care physician makes the referral or the HMO pre-authorizes treatment. Visits to health care professionals that are not referred by your PCP, or outside of your network, typically aren’t covered by your insurance.

Traditional and In-Progression employees are eligible for the HMO Option, where available. Temporary employees are not eligible for the HMO option.

A brief summary of the coverages provided by each HMO offered under the Program is located at www.gmbenefits.com.

If you are enrolled in (or considering enrolling in) an HMO, the HMO should provide you with a certificate describing the scope and level of benefits that are available through that HMO. The applicable information in the certificate you receive from the HMO is incorporated in this Summary Plan Description handbook by reference.

Generally, the certificate will describe:

- Additional information regarding any cost-sharing provisions for which the Participant will be responsible;
- Any annual or lifetime caps or other limits on benefits under the Plan;
- The extent to which preventive services are covered under the Plan;
- How new and existing drugs are covered under the Plan;
- Whether and under what circumstances, coverage is provided for medical tests, devices and procedures;
- Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services, and any conditions or limits for selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care;
- And any provisions requiring preauthorization or utilization review as a condition to obtaining a benefit or service under the Plan.

The HMOs also provide information on procedures for filing claims, providing notifications of benefit determinations, and reviewing denied claims. Some of these features may vary from one HMO to another. HMO benefits must be consistent with the level of benefits negotiated by the Company and/or with the union, as applicable.

Provider directories are available, without charge, at the HMO’s website, or by calling their toll-free number.

HMOs have monitoring systems to assess quality of care, necessity of treatment, and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you.
HMOs also provide for prescription drugs, mental health, substance abuse and other coverages. Since coverage of services may vary from the TCN option and between HMOs themselves, it is important to review HMO materials carefully to become familiar with the scope and level of benefits and coverages that are available through a particular HMO.

Generally, HMOs are offered based on your residential address of record with the Company. To obtain information regarding the HMOs available to you, please contact the GM Benefits & Services Center. Additional literature can be obtained by contacting an HMO offered by GM in your area and requesting the membership handbook that describes its benefits and the provider directory which lists the doctors, hospitals, laboratories and pharmacies that participate in that HMO.

General Motors pays the HMO premiums and each HMO handles administration and claims processing.

**MEDICAL COVERAGE**

**Hospital Coverage**

Inpatient hospital coverage is provided for:

- Up to 365 days of covered care in a semiprivate room in a **participating** hospital for general conditions, including maternity care. Predetermination of non-emergency, non-maternity hospitalizations is a requirement for payment of benefits. Predetermination must be obtained within 24 hours for emergency admissions. If predetermination is not obtained, payment is reduced by 20% after the $100 deductible.

- With regard to maternity care, under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable) after consulting with the mother.

In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods;

Covered **inpatient** hospital services include, but are not limited to:

- Semiprivate room, general nursing services, meals, and special diets. Charges for a private room are covered at the Hospital’s standard rate for a semiprivate room, unless a private room is Medically Necessary;
- Medical/surgical supplies, drugs and medicines;
- Use of operating rooms, other surgical treatment rooms, delivery rooms, and recovery rooms;
- Anesthesia services;
- Blood products and their administration (blood or component preservation and storage for future use are not covered);
- X-rays, EKGs, CT scans, ultrasounds, Magnetic Resonance Imaging, and Magnetic Resonance Angiography (MRA);
- Laboratory and pathology services.
Covered **outpatient** hospital services (restrictions may apply) include, but are not limited to:

- Medical emergencies;
- Observation care immediately following outpatient surgery or diagnostic testing;
- Medical/surgical supplies, drugs, biological, and solutions;
- Physical therapy, speech therapy and functional occupational therapy;
- Chemotherapy treatments;
- Pulmonary functions evaluation;
- Hyperbaric oxygenation;
- Hemodialysis;
- Laboratory test;
- Use of operating rooms, other surgical treatment rooms, delivery rooms, and recovery rooms;
- Anesthesia services;
- Blood products and their administration (blood or component preservation and storage for future use are not covered);
- X-rays, EKGs, CT scans, ultrasounds, Magnetic Resonance Imaging, and Magnetic Resonance Angiography (MRA)

**What is Not Covered**

- Services that are not medically necessary;
- Services that are domiciliary, custodial, or convalescent in nature;
- Facility charges for care received in an urgent care center (charges for physician services are generally covered);
- Inpatient or outpatient services related to non-covered plastic, cosmetic and reconstructive surgery;
- Services that are considered experimental/investigational;
- Emergency room visits that do not qualify as a medical emergency;
- Hospital services consisting principally of dental treatment or extractions.

**Non-Participating Hospital Reimbursement (exclude psychiatric hospitals)**

- **Inpatient:**
  - $500 per day for room and board
  - $50 per day for ancillary charges
  - Full coverage is provided for the first 5 days of an emergency admission
- **Outpatient:**
  - $50 for each outpatient visit
  - Full coverage is provided for medical emergency and accidental injury services

**Skilled Nursing Facility Coverage**

Medically necessary admissions to a participating skilled nursing facility are covered for up to 730 days (reduced by 2 for each inpatient hospital day used during a benefit period) of care, including:

- Semiprivate room, general nursing service, meals, and special diets;
- Use of special treatment rooms;
- Routine laboratory examinations;
- Physical, speech, or occupational therapy when medically necessary for the treatment of the enrollee;
- Oxygen and other gas therapy;
- Drugs, biologicals, and solutions used while the enrollee is in the facility;
- Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts;
- Durable medical equipment.
Benefits are not provided for:
- Conditions that are not Medically Necessary and do not require skilled nursing services;
- Admissions that are principally Custodial or Domiciliary in nature or for treatment of tuberculosis;
- Patients who have reached their maximum level of recovery possible for their particular condition and no longer require treatment other than routine supportive care.

**Physical, Occupational and Speech Therapy Coverage**

Up to 60 combined visits (per qualifying condition) per calendar year are covered for outpatient physical, functional occupational, and/or speech therapy provided by a Hospital or by a Carrier approved Freestanding Outpatient Therapy Facility, Home Health Care Agency, Skilled Nursing Facility, or independent physician or therapist participating with and approved by the Carrier.

Coverage for physical therapy is available only if it is provided with the expectation that the condition will improve in a reasonable and generally predictable period of time, or improvement is noted on a periodic basis in the patient’s record.

Speech therapy is covered on an outpatient basis or in an office setting when related to the treatment of an organic medical condition or to the immediate post-operative, or convalescent state of the enrollee’s illness. Such services are subject to the sixty (60) visit limitation. Speech therapy for congenital and severe developmental speech disorders is a covered service when not available through other public agencies, up to sixty (60) visits annually.

The outpatient physical therapy benefits are administered by TheraMatrix Physical Therapy Network (TPTN). To find an in network provider, enrollees should contact TheraMatrix at 1-888-638-8786 or access their website at www.theramatrix.com.

**Home Health Care**

Coverage, up to the Allowed Amount, for Medically Necessary services is provided by an approved home health care program for general nursing services, physical therapy, speech therapy, social service guidance, dietary guidance, functional occupational therapy, and part-time health aide service.

You may receive home health care benefits for up to three visits for each remaining unused day of the inpatient hospital day during a benefit period. The maximum number of visits under the home health care benefit is 1,095 per benefit period (which is 365 Hospital care days times three).

**Pre-Hospice and Hospice Coverage**

An enrollee is eligible for pre-hospice care of up to twenty-eight visits when certified by a physician that the patient has been diagnosed with a terminal illness. Pre-hospice services must consist of evaluation, consultation and education, and support services. Hospice coverage is available for up to 365 days of hospice services for terminally ill enrollees when provided through an approved hospice program. The benefit period can be extended beyond 365 days, if authorization is obtained from the Carrier’s case management program.
Medical and Surgical Coverage
Under Medical and Surgical provisions, coverage is provided for medically necessary:

- Surgery and anesthesia, including pre- and post-operative care;
- Obstetrical delivery, including pre- and post-natal care provided by a physician, or by a nurse mid-wife when received in a hospital or birthing center affiliated with a hospital;
- In-hospital consultation;
- In-hospital medical care by the doctor in charge of the case;
- Doctor’s medical visits, at the rate of two per week, for up to 730 days in an approved skilled nursing facility for general conditions;
- Audiometric tests and hearing evaluation services when used to diagnose any condition, disease or injury of the ear;
- Radiation therapy and chemotherapy for certain types of malignant conditions;
- Certain human organ transplants (some of which may be subject to coverage limits);
- Laser surgery which replaces a cutting procedure;
- Necessary and appropriate diagnostic x-ray, laboratory and pathology services;
- Outpatient treatment of accidental injuries and certain medical emergencies and observation care (following a medical emergency);
- Immunizations for the treatment for rabies exposure, Respiratory Syncytial Virus (RSV), and Herpes Zoster (Shingles);
- Voluntary sterilization (but not reversals);
- Medical services required for contraceptives;
- In the case of an enrollee who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage includes:
  — reconstruction of the breast on which the mastectomy has been performed;
  — surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  — prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient;
- The first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence (after the first set, eyeglasses or contact lenses are covered under the Program’s vision coverage).

Preventive Services
The services listed below are covered as preventive service. If rendered by an in-network provider, they are exempt from deductibles, copayments, or coinsurance that might otherwise apply, when rendered by non-network providers they are subject to applicable cost-sharing provisions. In instances where the coverage within a time period is limited, the first such service rendered in the time period will be considered preventive. Other covered services including diagnostic services, services provided outside any specified age-related windows, additional services within the specified periods, or services provided outside the specified periods will be subject to any applicable cost-sharing features.

- Mammography screenings:
  — one routine screening mammogram per calendar year, starting at age 40
  — the maximum benefit payable for digital mammography is the Carrier allowed amount for the alternative film mammography;
- Pap smear: Laboratory and pathological service for one (1) test per calendar year;
- BRCA Testing, 1 per lifetime;
IF YOU HAVE HEALTH CARE EXPENSES

- Women’s Contraceptive Methods: IUD, Diaphragm, Cervical Cap (other methods may be covered, limitations may apply);
- Proctoscopic Examinations Without Biopsy: One (1) screening exam every three (3) calendar years, after age 40 is attained;
- Well Baby Care: Up to six (6) visits for babies under one (1) year of age; up to five well baby visits from age 13 months through age 35 months;
- Hearing loss screening for newborn through age 21, once per calendar year;
- Vision screening for newborn through age 21, once per calendar year;
- Cholesterol screening for children age 24 months to 21 years; for men over age 35; for men age 20-35 and women over age 20 if at an increased risk for coronary heart disease;
- One well child visit per calendar year for children from 36 months of age through age 17;
- One routine physical examination per calendar year for enrollees age 18 and older;
- One routine gynecological examination per calendar year for female enrollees;
- Additional screening tests for newborns, children, adults and pregnant women;
- Immunizations and vaccinations: Coverage is provided for administration of certain immunizations and vaccinations;
- Prostate Specific Antigen (PSA): One (1) screening PSA test per year for enrollees ages forty (40) and older;
- Fecal Occult Blood Test or Fecal Immunochemical Test: One (1) test per year, beginning at age 50;
- Flexible Sigmoidoscopy, Barium Enema and Colonoscopy: Coverage is provided for one (1) flexible sigmoidoscopy OR one (1) barium enema every 5 years, OR one colonoscopy every 10 years, beginning at age 50;
- Infectious Disease Screening
  - Chlamydia: 1 per year for men and women through age 21 (women over age 21 if risks factors present);
  - Gonorrhea: 1 per year for men and women through age 21 (women over age 21 if risk factors present);
  - Syphilis: screening once per year for men and women at any age;
  - HIV: screening once per year for men and women of any age;
  - Hepatitis B screening once per year for men and women of any age with risk factors;
  - High-risk human papillomavirus (HPV): DNA testing for women of any age, once per year;
- Consultations for issues like breastfeeding, obesity, healthy diet, alcohol misuse, tobacco use, skin cancer behavioral consultation, contraceptive use and domestic violence (conditions and limitations apply).

Office Visit Coverage

Office visits for in-network providers are covered subject to cost-sharing. Copayment for an office visit will not be applied to the out-of-pocket maximum.

Office visits are not covered for out-of-network providers, unless an enrollee lives outside of the defined service area.
Ambulance Coverage
Coverage is provided for medically necessary ground, air, or boat transportation to the closest available facility for:

- One-way or round trip for transfers between hospitals, because the originating hospital lacks necessary treatment facilities, equipment, or staff;
- One-way or round-trip transfer for a hospital inpatient who must be taken to a non-hospital facility for a covered CAT scan, MRI or PET examination (provided the facility meets the Program standards for providing such services), when the services are not available in the hospital to which the patient is admitted or in a closer local hospital;
- Emergency transportation for:
  - transporting a patient one-way from home or scene of incident in cases of medical emergency or accidental injury to the nearest available facility qualified to treat the patient; and
  - round-trip transfer of a homebound patient from the home to the nearest available facility qualified to treat the patient in the case of a medical emergency or accidental injury, or for treatment at a facility when other means of transportation cannot be used without endangering the patient’s life;
- Air and boat ambulance services are covered only when deemed to be medically necessary, and ground ambulance or other means of transport could not be used without endangering the patient’s health. Enrollees will be protected from balance billing for non-participating air or boat ambulance rides when medically necessary.

Durable Medical Equipment (DME) and Prosthetic and Orthotic Appliance (P&O) Coverage
When a doctor prescribes medical equipment or appliances, the items may be covered by your medical Plan — whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment and the Carrier approves it. Durable medical equipment and prosthetic and orthotic appliances should be obtained through Blue Cross Blue Shield of Michigan.

If covered items and services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the Carrier. The Carrier will then send the payment to you, based on the amount that would have been paid to a network provider. You may be required to pay the amount charged by the non-network provider which is in excess of the network fee schedule. Additionally, GM payments toward the Medicare deductible or co-insurance for those individuals enrolled in the Medicare program will only be made when services are received from a Network Provider.

You, your physician, or your provider may contact Blue Cross Blue Shield of Michigan, at 1-800-482-2210 for preauthorization, claims processing, assistance in locating participating providers, and for any other questions or concerns.

Durable Medical Equipment (DME) Coverage Includes

- Equipment that meets Program standards, which generally include being approved for reimbursement under Medicare Part B, and being appropriate for use in the home;
- Equipment used in a hospital or skilled nursing facility and rented or purchased from such hospital or facility;
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);
- Neuromuscular stimulators;
• Positioning transportation chairs as alternatives to traditional wheelchairs for children under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities;
• External electromagnetic bone growth stimulators, in certain approved cases;
• Phototherapy (bilirubin) light for patients under the age of one (1);
• Continuous passive motion device for use on elbow and shoulder following surgical treatment:
• Pressure gradient supports for certain patients;
• Pronged and standard canes (when purchased);
• Continuous Glucose Monitors, and insulin pumps, including the OmniPod, are covered for diabetics who meet Carrier standards;

Prosthetic and Orthotic (P&O) Appliances Coverage Includes:
• P&O appliances that are furnished by an accredited facility and meet Program standards, which generally include being approved for reimbursement under Medicare Part B and the replacement, repair, fitting and adjustments of the appliance;
• One pair of medically necessary orthopedic shoes, inserts, arch supports, and shoe modifications will be covered once per calendar year.
• Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital;
• Wigs and appropriate related supplies for those enrollees who are suffering hair loss from the side effects of chemotherapy, radiation or other treatments for cancer:
  — for the first purchase of a wig and supplies, the maximum benefit will be $200; and
  — thereafter, a maximum annual benefit of $125 will be provided for such purchases.

Hearing Aid Coverage
For benefits for hearing aids to be covered you first must have a medical examination of the ear by a physician prior to receiving your initial hearing aid. Subsequent medical examinations are not required in connection with a replacement hearing aid. However, enrollees under the age of 18 must continue to have a medical examination of the ear each time a hearing aid is dispensed. If it is determined that your hearing problem may be corrected by use of a hearing aid, benefits can be provided. Payment will be made for the Carrier allowed amount for the following services, once every 3 calendar years:
• Audiometric examination;
• Hearing aid evaluation test (up to $161, effective 10/1/2015 and subject to change each October);
• Hearing Aid and Ear Molds: Up to a maximum of $2,200 every three years for the acquisition cost and dispensing fee to purchase hearing aids and ear molds (as applicable), plus replacements, adjustments and repairs (as required).

Prescription Drug Coverage
If you are enrolled in TCN option, Prescription drug coverage provides payment of the prescription charge, less the applicable copayment, for each separate prescription order or refill for the purchase of:
• Covered drugs (including contraceptive medications) and diaphragms which require a prescription by a licensed physician;
• Injectable insulin, self-injectable anti-neoplastic agent, or other self-injected drug meeting Program standards and disposable syringes and needles when prescribed and dispensed with them;
Covered vitamins are limited to 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 and potassium chloride.

Coverage does not include:

- Any research or experimental agent including Federal Food and Drug Administration approved drugs which may be prescribed for research or experimental treatment;
- Any medication prescribed for cosmetic purpose;
- Any charge for devices other than diaphragms;
- Any vaccine;
- Any charge for the administration of covered drugs;
- Any charge for a covered drug in excess of the amount specified by the physician or an refill dispensed more than one year from the physician’s order;
- Any charge for more than a thirty-four day supply at retail;
- Dapoxetine;
- Non-sedating antihistamines.

See TCN COST SHARING FOR 2016 for the applicable drug copayments.

Preventive Medication with $0 Copayment:
The following preventive medications are covered at no copayment, subject to Carrier standards, if they have a prescription order and are dispensed by a participating mail or retail pharmacy:

- Aspirin;
- Fluoride preparations;
- Iron replacement;
- Tobacco cessation products;
- Folic acid;
- Vitamin D supplementation for community-dwelling enrollees age 65 and older;
- Breast cancer primary prevention medications prescribed for prevention of invasive breast cancer in female enrollees at high risk who do not have a prior history of a diagnosis of breast cancer, age 35 or older;
- Oral and other contraceptive methods for female enrollees of reproductive capacity.

The following terms are used to describe certain elements of Prescription Drug Coverage:

- Brand Name Drug: A drug which is covered by a patent and for which an equivalent version cannot be manufactured, marketed, or a drug which is no longer covered by a patent and for which chemically equivalent versions can be manufactured and marketed;
- Generic Drug: A drug that is chemically equivalent to a brand name drug;

A 34-day supply is the maximum you can receive at a retail pharmacy for one copayment. A 90-day supply is available through mail order for one copayment.

Certain covered drugs come in pre-packaged quantities exceeding these day limits. If these pre-packaged drugs cannot be repackaged, the copayment will be pro-rated to account for the additional supply.
If disposable syringes and needles are dispensed at the same time as either injectable insulin self-injectable anti-neoplastic agent, or other self-injected drug meeting Program standards, they will continue to be covered at retail or mail order and will not require a separate copayment.

The Prescription Drug Network

For TCN enrollees, prescription drug coverage is administered by Express Scripts through a national network of participating retail pharmacies dedicated to providing prescription drug services that meet high quality standards. Charges for prescription drugs purchased from a network pharmacy are billed directly to the Carrier. You may use any of the pharmacies in the network when purchasing prescription drugs.

If prescription drugs are purchased from a non-network pharmacy, you will be required to pay the full charge. You then should file a claim with Express Scripts. You will be reimbursed 75% of the Carrier allowed amount for the generic, brand name, or ED drug, as applicable, after your appropriate copayment has been deducted. However, if prescription drugs are purchased from a non-network pharmacy due to (1) an emergency or (2) your being away from home, you will be required to pay the full charge, which will be reimbursed at 100% of the Carrier allowed amount for the generic, brand name, or ED drug as applicable, after your appropriate copayment has been deducted. You may incur additional expense if a brand name drug rather than the generic is dispensed at your request or when not medically necessary.

Using Mail Order

If you are enrolled in the TCN mail order is an option available to you any time you have a prescription to be filled. Mail order can be particularly helpful and cost-effective when you require maintenance drugs over an extended period of time, or when you do not need to have a prescription filled immediately.

You should consult with your physician prior to starting mail order. If your physician believes your medication regimen is likely to change in the near-term, it may be preferable to fill your prescriptions at retail. Once your physician determines that your medication regimen has stabilized, you should consider using mail order.

When you start using mail order, you can expect to receive your first filled prescription about two weeks from the time you mail in your prescription. If you need a medication right away, make sure your physician provides you with two prescriptions: one prescription for use at a retail pharmacy to bridge the two week mail-order start-up period, and a second prescription for a 90-day supply to be sent to mail order.

You can begin using mail order by calling Express Scripts at 1-800-464-4679 or by using Express Script’s website www.express-scripts.com. Using this site is easier and faster than mailing your prescription requests to Express Scripts.

Dispensing of Brand-Name Drugs with Generic Versions

Whether at retail or mail order, if a brand-name drug is dispensed instead of its generic version, you must pay the appropriate copayment plus the difference in price between the brand-name and generic drug. Your doctor or pharmacist can advise you about whether a generic drug is available.

- At retail, if your doctor has specified a brand-name drug (by indicating “Dispense As Written” or DAW), your pharmacist may contact your doctor to authorize the generic version. If your doctor agrees, you will receive the generic drug for the generic copayment. If the doctor disagrees or cannot be contacted, you will be given the brand-name drug and charged the brand copayment plus the difference in cost between...
the brand and generic, up to a maximum of $10, for the first fill. After that, you will pay the generic copayment plus the full difference in Program cost between the brand-name and the generic drugs.

- Either you or your doctor, may initiate a review at Express Scripts of the medical necessity for dispensing a brand name drug rather than a generic. If it is found that the dispensing of the brand name drug was medically necessary, you will be refunded the appropriate amount automatically and Express Scripts will allow for dispensing of the brand-name drug thereafter. If the review is denied, you and your doctor will be informed and provided information on the appeals process.

There are a small number of brand-name drugs that have generic equivalents, but for which small variation in the dose could result in changes in drug safety. These drugs are not subject to the generic dispensing provision. When these brand-name drugs are dispensed, only the brand copayment will apply.

If your doctor has not indicated “Dispense As Written” or DAW, your prescription automatically will be filled with a generic drug. If you still want the brand-name drug, you will continue to pay the generic copayment plus the full difference in Program cost between the brand-name and generic drug.

**Medications Used On an Ongoing Basis**
At retail, prescription drug coverage is limited to a maximum 34-day supply of covered drugs. However, you may require medications on a long-term basis (3 months or more) to treat chronic conditions such as high blood pressure or high cholesterol. There is a select list of such medications which should be purchased through mail order. You will be advised by Express Scripts if you are taking a medication on this list. If you decide to continue to purchase a medication on this list at retail, after the first three fills, you will have to pay a 100% copayment.

If you decide you want to avoid paying a 100% copayment at retail, you can obtain your prescription through mail order. Using mail order allows up to a 90-day supply for one mail-order copayment.

**Utilization Management**
To promote safety and clinically appropriate care while maintaining the costs of prescription drug coverage, the Carrier will administer utilization review processes. Examples of these processes include step therapy edits, prior authorization edits, dose and quantity edits, dose duration edits, dose optimization edits, and coverage restrictions related to select drugs or drug classes.

**Medical Plan Exclusions and Limitations**
Certain health care services and charges are excluded or limited. A description of general exclusions, and limitations applicable to each benefit provided under the GM Health Care Program, may be found in the appropriate Program language, or similar documents provided by GM or the Carriers.

In general, programs and/or surgical procedures that are considered to be research, investigational or experimental in nature are not covered services.

The following are examples of additional excluded services:

- Hospital charges — related to domiciliary, custodial, convalescent, nursing home or rest care;
- Certain skilled nursing facility charges;
- Private duty nursing — nursing care which is privately contracted by, or on behalf of, an enrollee with a nurse, or agency, independent of the program;
- Services, care or treatment that are not medically necessary according to accepted medical standards;
IF YOU HAVE HEALTH CARE EXPENSES

- Services that are not related to specific diagnosed illness or injury such as pre-marital or pre-employment examinations;
- Services available through other programs;
- Personal convenience items;
- Charges for the completion of any claim forms; and
- Services provided by family members.

**Mental Health and Substance Abuse Treatment Coverages**

For TCN option enrollees, mental health and substance abuse coverages are administered through a managed care program called CareLine, administered by Beacon Health Options, (formerly known as Value Options). Beacon Health Options has a network of qualified panel providers, and promotes the delivery of care in appropriate settings.

The following terms are used to describe certain elements of the Mental Health and Substance Abuse Coverages:

- Panel providers: mental health or substance abuse providers who participate in, and make up the Carrier’s network. May also be referred to as a network provider.
- Non-panel providers: mental health or substance abuse providers that are not part of the Carrier’s network.

CareLine has a toll-free telephone number which is available 24 hours a day. If you have any questions regarding your mental health/substance abuse coverages or need services, call CareLine at 1-800-235-2302. **Remember, you must use panel providers to receive full amount of available benefits.**

CareLine uses an integrated mental health and substance abuse delivery system which includes:

- A national central review organization (CRO) which is designated to: (1) confirm the eligibility of the patient for coverage under the Program; (2) authorize and approve all inpatient and outpatient mental health treatment, certain courses of outpatient substance abuse treatment and outpatient psychological testing; and (3) evaluate panel providers;
- A network of central diagnostic and referral agencies (CDRs) located in most communities, responsible for making assessments required under the Program for the development of substance abuse continuing care treatment plans. In addition, they make determinations regarding whether the patient’s condition requires mental health and/or substance abuse treatment. The CDRs also make referrals to panel providers, provide short-term counseling (up to two visits) and perform aftercare planning and follow-up. In addition, CDRs may provide up to three short-term counseling sessions for enrollees. The CDR may communicate with Work/Family program representatives about assessment and referral activities related to an enrollee, where appropriate, and when authorized by the enrollee;
- An extensive nationwide network of inpatient and outpatient mental health and substance abuse professionals, including psychiatrists, Ph.D. psychologists, masters degreeed and licensed psychiatric social workers, masters degree behavioral health clinicians who are licensed in their state at the highest independent practice level for that license, clinical nurse specialists, hospitals, day/night programs, halfway houses, and detoxification facilities.
The combined mental health/substance abuse coverage provides for:

- Outpatient Mental Health visits are covered in-network at 100% for visits 1-20; at 75% for visits 21-36 (max $25 copayment); and visits 36+ are covered with a $25 copayment;
- Outpatient Substance Abuse in-network benefits will be covered at 100% for visits 1-35, with subsequent visits covered with a $25 copayment;
- Inpatient Mental Health/Substance Abuse benefits
  - Eligible for up to 365 days (renewable after 60 days of non-treatment);
  - In-network care is covered at 100%;
  - Out-of-network care is covered with a 10% co-insurance with an Out-of-Pocket Maximum (OOPM) of $250/$500 (single/family).

If outpatient mental health services are rendered by a non-panel physician, then the first visit will be covered. Any additional visits must be authorized by the CRO. **Unauthorized visits to a non-panel physician will be paid at 50% of the amount which would have been paid to a panel provider.** These payments will be made to the enrollee, not the provider. The enrollee is responsible for paying the provider. Mental health services rendered by non-panel, non-physician providers, (psychologists, social workers, etc.) are not covered under the Program.

Coverage is not available for treatment of mental disorders which are not amenable to improvement (except that coverage is available to determine that the disorder is not amenable to favorable modification) or for the evaluation and diagnosis of mental deficiency or retardation.

The coverage is structured in such a way that every enrollee will have easy access to the panel of providers. Therefore, if **substance abuse services are rendered by a non-panel provider**, the off-panel substance abuse services **are not covered**, unless an out-of-network authorization is secured from the CRO prior to treatment.

**DENTAL COVERAGE**

*Traditional and In-Progression employees are eligible for coverage in the Dental Plan. Temporary employees are not eligible for the coverage.*

If you are eligible for dental coverage, enrollment into the Plan provides benefits up to an annual maximum of $1,850 per enrollee, for services other than orthodontics (teeth straightening) during any calendar year (January 1 through December 31).

For orthodontic treatment, the lifetime maximum is $2,200 per enrollee, and is available for enrollees whose course of treatment begins before age 19. Coverage is not available for treatment begun after attainment of age 19.

Dental coverage for UAW-represented employees is administered through Delta Dental Plan of Michigan (Delta Dental). Benefits are payable based on the Carrier’s allowed amount. Benefits for services performed by a non-participating dentist are based on an established fee for services performed. These fees may be lower than the fees payable to participating dentists.
Furthermore, Delta Dental has developed a network of “preferred” (PPO) dentists, available in most states, who have agreed to accept reimbursement based on a dental fee schedule instead of reasonable and customary charges. Enrollees who receive covered services from “preferred” dentists are eligible for enhanced benefit levels. There is no special enrollment required for enrollees to utilize the preferred provider network. These enhanced benefits will be paid anytime an enrollee receives covered services from a preferred provider. Information about “participating” and “preferred” providers is available by calling Delta Dental at 1-800-942-0667 or on Delta Dental’s website, www.deltadentalmi.com.

**Accidental Dental Injury**

Additional coverage is available for the repair of accidental dental injury to sound natural teeth due to sudden unexpected impact from outside the mouth. If applicable in a given case, the copayments referenced above will apply (depending upon the nature of the service(s), but benefit payments will not count against annual or lifetime maximums. For this component to apply, the annual maximum benefit must be exhausted; the accident must be documented, e.g. police report; the services received must be a direct result of the accident and are provided within one year of the accident.

**How Do I File a Claim and find Additional Information for Dental Benefits?**

Participating dentists generally will submit claims electronically to Delta Dental on the same day that services are received. If you are enrolled in the dental coverage, you can find additional information on available benefits, and status of your claims online at www.deltadentalmi.com, by selecting the “member” tab, then accessing Delta Dental’s Consumer Tool Kit or by going directly to the Consumer Tool Kit at www.consumertoolkit.com. You can also download Delta’s mobile app, available in the App Store (Apple) or Google Play (Android) by searching “Delta Dental’, to view your available benefits, review claims, and conduct a dentist search.

**Note that if a course of treatment is expected to involve dental expenses amounting to $200 or more, your dentist should file a description of the procedures to be performed and an estimate of the charges with Delta Dental Plan of Michigan prior to the commencement of treatment.** Delta Dental will notify the dentist of estimated benefits payable, with consideration given to alternative procedures that may be performed to accomplish the desired results.

**Payable Benefits**

Benefits are payable at 100% of the Carrier’s allowed amount for:

- Oral examinations and prophylaxis (cleaning of teeth) but not more than twice in a calendar year (three cleanings per calendar year if you have a documented history of periodontal disease or four cleanings per calendar year for two full calendar years following periodontal surgery);
- One (1) topical application of fluoride for persons under age 15, unless a specific dental condition makes such treatment necessary;
- Space maintainers that replace prematurely lost teeth for persons under age 19;
- Emergency treatment for temporary relief of pain;
- Fluoride trays used in the delivery of topical fluoride for enrollees undergoing radiation therapy of the head and neck due to cancer, payable once with the initial diagnosis of cancer and once thereafter with each recurrence of cancer, as medically necessary;
- Once Oral Brush Biopsy per calendar year for enrollees presenting with un-resolving oral lesions / ulcerations or having a history of behaviors placing the enrollee at risk for oral cancer. Covered services include collection of the biopsy specimen and it interpretation.
BENEFITS ARE PAYABLE AT 90% OF THE CARRIER’S ALLOWED AMOUNT FOR:

- Dental x-rays, including full mouth x-rays (but not more than once in any period of five consecutive calendar years), and bitewing x-rays once every calendar year for enrollees age 14 and younger and once every two years for enrollees age 15 and older;
- Extractions and oral surgery;
- Amalgam, silicate, acrylic synthetic porcelain and composite fillings;
- General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- Endodontic (nerve and pulp) and periodontal (gum) treatment;
- Injection of antibiotic drugs by the attending dentist;
- Repair of crowns, inlays, onlays, gold fillings, bridgework or dentures; and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of three consecutive calendar years;
- Initial installation of Inlays, onlays, gold fillings, or crowns, but only when the tooth cannot be restored with an amalgam or other filling;
- Replacement of inlays, onlays, gold fillings or crown restorations on the same tooth, if at least five (5) years have elapsed since initial placement. Replacements earlier than five years are not covered;
- Cosmetic bonding of 8 front teeth when certain conditions exist for children 8-19 years of age, but not more than once in any period of three consecutive calendar years;
- Occlusal guard (maxillary or mandibular) is a covered supply for the palliative treatment of bruxism and/or acute pain of the muscles of mastication, but not more than one (1) in a five year period.

You are responsible for the remaining 10% of the allowed amount.

BENEFITS ARE PAYABLE AT 50% OF THE CARRIER’S ALLOWED AMOUNT FOR:

- Initial installation of fixed bridgework;
- Initial installation of removable dentures, including any adjustments during the six-month period following installation;
- Replacement of an existing denture or fixed bridgework, but only when:
  (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or,
  (b) the existing denture or bridgework cannot be made serviceable and, if it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
  (c) the existing denture is an immediate temporary denture which cannot be made permanent, and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture;
- Orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for any person whose course of treatment begins before age 19 subject to a maximum lifetime payment of $2,200. Coverage is not available for treatment begun after attainment of age 19;
- The placement of an endosteal single tooth implant, the implant abutment, and crown, including any supportive services. Coverage does not include bone grafts or specialized implant surgical techniques.

Limitations

If you select a more expensive service than is customarily provided, or for which Delta Dental determines there is not a valid dental need, Delta Dental’s reimbursement will be based on the fee for the customarily provided
service and you are responsible for the difference in cost plus applicable co-pays. If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services, to the extent remaining, shall be resumed. The benefit payment for orthodontic services shall be only for months that coverage is in force.

What is Not Covered
Covered dental expenses do not include and no benefits are payable for:

- Charges for services for which benefits are provided under other health care coverages;
- Charges for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;
- Charges for veneers or similar properties of crowns and pontics placed on, or replacing teeth, other than the ten upper and lower anterior teeth;
- Charges for services or supplies that are cosmetic in nature;
- Charges for prosthetic devices (including bridges), crowns, inlays, and onlays, and the fitting thereof which were ordered while the enrollee was not covered for dental coverage or which were ordered while the enrollee was covered for dental coverage but are finally installed or delivered to such enrollee more than sixty (60) days after termination of coverage;
- Charges for the replacement of a lost, missing, or stolen prosthetic device;
- Charges for failure to keep a scheduled visit with the dentist;
- Charges for replacement or repair of an orthodontic appliance;
- Charges for services or supplies which are compensable under a Workers Compensation or Employer's Liability Law;
- Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the enrollee's employer;
- Charges for services or supplies for which no charge is made that the enrollee is legally obligated to pay or for which no charge would be made in the absence of dental 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, including charges for services or supplies which are experimental in nature;
- Charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- Charges for services or supplies from any governmental agency which are obtained by the enrollee without cost by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body;
- Charges for any duplicate prosthetic device or any other duplicate appliance;
- Charges for any services to the extent for which benefits are payable under any health care Program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;
- Charges for the completion of any insurance forms;
- Charges for sealants and for oral hygiene and dietary instruction;
- Charges for a plaque control program;
- Charges for services or supplies related to periodontal splinting.
VISION COVERAGE

Traditional and In-Progression employees are eligible for benefits available under the Vision Plan. Temporary employees are not eligible for Vision coverage.

Vision coverage provides assistance toward the cost of routine eye exams, lenses, and frames through a national network of participating providers, which includes ophthalmologists, optometrists, and optical facilities.

What Is Covered

Services covered under vision provisions include, but are not necessarily limited to, the items below:

- One vision examination (by an optometrist or an ophthalmologist) per calendar year including refraction, case history, coordinating measurements, and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting, and adjusting of:
  - Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
  - Number 1 or 2 tint for lenses;
  - Contact lenses in lieu of regular lenses:
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature;
    - Up to $80 when prescribed for any other reason than those listed above;
    - Frame allowance up to $80 once during two consecutive calendar years.

Limited coverage for corrective eye surgery (e.g. LASIK, PRK, RK). Upon proof of payment to a corrective eye surgery provider, the vision Carrier will reimburse an enrollee for covered expenses, up to the lesser of the provider’s charges or the maximum benefit of $295 in any four year period. The enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year. If the enrollee receives benefits for corrective eye surgery in any calendar year, the enrollee will not be eligible for lenses (including contact lenses) and/or frame benefits for that year and for three subsequent years. Nevertheless, during that time, that enrollee will be eligible for benefits for an annual eye exam, will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefit is available, and other covered family members will remain eligible for full vision benefits.

What Is Not Covered

Services not covered under vision provisions include, but are not necessarily limited to:

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the Carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you;
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.
Vision Network
The vision network is made up of vision providers who have agreed to accept reimbursement based on a regional fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to GM enrollees at no cost.

Going to a participating network vision provider will reduce your out of pocket expenses. First of all, you will have no copayments or out of pocket expense for covered vision services such as a routine vision exam, regular size lenses, certain designated frames that cost less than $80, or medically necessary contacts. Secondly, if you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Finally, there are many popular non-covered lens features whose prices are discounted under the participating provider agreement.

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the vision Carrier. Information about participating providers in your area is available by calling Davis Vision at 1-888-672-8393.

Out of Network
Generally, if you choose to receive covered vision services from a non-participating vision provider you will have to reimburse the provider and file your own claim with the vision Carrier. The Carrier will reimburse you directly based on a fee schedule. There is one exception. Your reimbursement for vision exams provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the Carrier minus a $7 co-pay.

Out of Area
If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on reasonable and customary charges as determined by the Carrier.
Summary
The chart on this page summarizes the benefit frequency and the level of reimbursement for covered vision services (in the absence of corrective eye surgery) when received in network, out of network, or out of area.

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Out-of-Area (No network provider within 25 miles of residence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam (Including refractions)</td>
<td>One exam annually (Between Jan. 1 – Dec. 31)</td>
<td>Optometrist: 100% Covered</td>
<td>Optometrist: $7 copay, then reimbursed up to $39</td>
<td>Optometrist: Reimbursed based on R&amp;C*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ophthalmologist: 100% Covered</td>
<td>Ophthalmologist: $7 copay, then reimbursed based on R&amp;C*</td>
<td>Ophthalmologist: Reimbursed based on R&amp;C*</td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Once every other calendar year</td>
<td>100% Covered for frames with retail value of up to $80**</td>
<td>$10 copay***, then reimbursed up to $24</td>
<td>Reimbursed up to $24</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
<td>Once annually (Between Jan. 1 – Dec. 31)</td>
<td>100% Covered (Basic lenses and tints #1 &amp; #2, additional lens options are covered and subject to specific copays)</td>
<td>$10 copay***, then reimbursed based on fee schedule</td>
<td>Reimbursed based on R&amp;C*</td>
</tr>
<tr>
<td>Note: Enrollee may not have eyeglass lenses and contact lenses covered in the same year</td>
<td>Reimbursed up to $80</td>
<td>$10 copay, then Enrollee reimbursed $170 if medically necessary, or $65 for elective</td>
<td>Reimbursed R&amp;C* if medically necessary, otherwise $80</td>
<td></td>
</tr>
<tr>
<td>Corrective Eye Surgery</td>
<td>Following date of service the member is ineligible for materials benefits in that year and three subsequent years</td>
<td>Reimbursed up to $295**** (Corrective eye surgery claim form is necessary for reimbursement)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Out of Area occurs when there is no network provider within 25 miles of the enrollee’s residence.
** R&C stands for reasonable and customary charges.
*** There is a combined annual copayment of $10 for lenses and frames.
 **** An enrollee receiving benefits for corrective eye surgery will be ineligible for material benefits (frames, lenses and contact lenses) for three (3) subsequent years. A corrective eye surgery claim form is necessary for reimbursement.
EFFECT OF MEDICARE
When you become eligible for Medicare at age 65, whether or not you choose to continue working, the GM Benefits & Services Center will alert you to your Medicare eligibility approximately three months prior to you becoming age 65. Enrollment in Medicare is not necessary as long as you remain actively employed. However, if you continue to work past the age of 65, Social Security will not continue to notify you of your eligibility to enroll for Medicare. It is your responsibility to contact the local Social Security Administration office to apply for Medicare. It is recommended you do so prior to terminating your employment with General Motors.

If you, or one of your dependents, have a long-term disability, you may be eligible for Medicare coverage prior to age 65 even though you remain actively employed. If this is applicable to you or one of your dependents you should contact your nearest Social Security Administration office to have your case evaluated to possibly enroll in Medicare.

COORDINATION OF BENEFITS
A coordination of benefits (COB) provision is included in all coverages under the Program. The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one employer’s health care plan. For example, if expenses are incurred by your spouse who is covered by another plan, the other plan may have the primary responsibility of payment. If so, your overall coverages may be enhanced and the cost to the GM Program will be reduced.

If COB is done properly, you and your dependents will receive no fewer benefits than you would have received under the GM Program alone and you may receive more or enhanced benefits.

When the GM Program is secondary, the following provisions apply:
(1) Certain requirements under the GM Program, such as predetermination of hospital admissions, are waived. If you are enrolled in an HMO option, you are required to obtain services from the HMO panel of providers, or obtain a referral from the HMO in advance, for services to be covered (you should always check with the HMO);
(2) Only those services covered under the GM Program will be considered for additional benefit payment. For example, if the primary plan covers office visits, no additional payment will be considered for a TCN enrollee, because office visits are not covered under the GM Program TCN option.

NOTE: Enrollees should always choose the maximum level of benefits available under the Primary Plan to enhance benefits available through COB.

The GM Carrier should be notified of other plans or programs which may cover you or your dependents. No notice is required for insurance policies issued in your name, or a dependent’s name, for which you pay more than 1/2 the cost. In some cases, you may be required to provide the Carriers with additional information.

Once you have identified whether other coverage is involved, you should determine which plan is primary for the individual having a claim. If another plan or program is primary, the claim should be filed first with the primary plan or carrier. If the primary plan does not cover the health care expenses in full, the unpaid balance can be
considered under the GM Program. You should provide your GM Carrier with information on the payments made by the other plan or authorize the other carrier to do so. From that point, COB is handled between the carriers. If the remaining balance is for services covered under the GM Program, it will pay the balance, up to the maximum permitted under the GM Program.

**Reimbursement for Third Party Liability (Subrogation)**

Occasionally a person may sustain an injury and incur health care expenses because of another party’s wrongdoing. If benefits are paid under the GM Program, and it is later determined that another party should have been responsible for the expenses, the GM Program is entitled to reimbursement. Subrogation is the legal process used to seek reimbursement for claims that have been paid when expenses are incurred because of another party’s actions or inactions. While GM does not suspend coverage while liability is being determined, the GM Plan should not bear the financial responsibility if another party is responsible. In that way, financial liability remains where it belongs, with the party responsible incurring the expenses and GM Program costs are reduced.

The Plan has the right of reimbursement from any recovery by judgment, settlement, or otherwise, in which you, your estate, or your dependents may receive or be entitled to receive from any source, including but not limited to, liability or other insurance covering third party, and direct recoveries from liable parties.

If you, or one of your covered dependents, are involved in such a situation, you are required to provide the Plan with information regarding the event. Trover Solutions is the current administrator for subrogation on behalf of the Plan. Should you or your dependent receive a letter of inquiry from Trover Solutions, you must provide all requested information to help assure that the Plan does not pay for expenses caused by a third party.

If you, or any of your dependents, receive payment for medical expenses, you will be required to reimburse the Plan, in an amount not in excess of the benefits paid by the Plan. The Plan shall have a first priority lien on any recovery from a third party. The Plan must be repaid in full of expenses incurred regardless of whether the settlement or judgment specifically designates the recovery, or a portion of the recovery as medical expenses.

If you are enrolled in an HMO, this provision does not apply to you. The HMO will utilize its own subrogation and reimbursement process.

**The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

COBRA is a federal law which provides certain eligible employees and dependents the opportunity to continue GM group health care coverages, on a self-paid basis, when eligibility otherwise would end under the GM Program. COBRA Continuation Coverage is generally the same health care coverage the enrollee had the day before the COBRA qualifying coverage occurred.

In some cases, an employee whose eligibility for coverage as an active employee ceases, may be eligible for limited continuation under the GM Program provisions. In such a case, you, and your eligible dependents, will have a choice between (1) GM Program continuation and (2) COBRA continuation. If you are involved in such a situation, you will be advised of both options (GM Program and COBRA), including cost, available at that time. The cost for COBRA Continuation will not exceed 102% of the cost to provide this coverage. Payments are due to the GM Benefits & Services Center by the first of the month for which payment is being made. If a monthly payment is made on or before its due date, coverage under the Plan will continue for that month without a break. If payment is not made by the required due date, coverage under the Plan will end.
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Each dependent that is eligible for COBRA Continuation Coverage has an independent right to elect this coverage. In general, a parent may elect to continue coverage for dependent children. However, a dependent child who is eighteen (18) years of age or older has the right to elect COBRA Continuation Coverage independently, regardless of whether or not the parent /employee elects Continuation coverage. Call the GM Benefits & Services Center at 1-800-489-4646 for further information.

When health care continuation is discussed in the remaining sections of this booklet, the reference will be to GM Program continuation.

**THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to improve the availability and portability of health care coverage.

This certificate may be used by former enrollees if they become covered under a new health plan which has preexisting condition limitations. The plans that have such limitations are required to reduce the length of time individuals have to wait for coverage to take effect for the preexisting condition by the period of time they were covered under a prior plan.

HIPAA also established federal requirements to protect the privacy of certain medical information. See the Notice of Privacy Practices for the GM Health Care Programs at the back of this booklet for more information.

**CESSATION OF COVERAGES**
With the exception of discharge for gross misconduct, health care coverages cease at the end of the month in which you are last in active service.

**HOW TO FILE A CLAIM FOR SERVICES RECEIVED**
Your Social Security number, your GM employer identification number, or alternate identification number issued to you by the Carrier may be needed when you communicate with any of the Carriers. If you are a dependent, the Social Security or alternate identification number of the employee, retiree, or surviving spouse through whom you have coverage will be needed.

**Hospital, Medical and Surgical Claims**
If your Carrier is a Blue Cross Blue Shield plan, show your health care identification card when you go to the hospital, outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Usually, the provider is paid directly by Blue Cross Blue Shield for covered services. In any situation where a provider of a service is not paid directly by Blue Cross Blue Shield, you should submit the charges to Blue Cross Blue Shield.

If you utilize non-network providers, you may be required to file a claim. Instructions and forms can be obtained by calling your Carrier.

**Prescription Drug Claims**
When you use a network provider, the appropriate charges will be filed electronically by the pharmacy. If you obtain services from a non-network provider you will be required to pay the full charge and file a claim.
forms may be obtained by calling Express Scripts. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

**Mental Health and Substance Abuse Claims**

Because the mental health and substance abuse coverages utilize a closed panel of approved providers only, the facility, or other provider, generally will have a supply of claim forms.

Claim forms also may be obtained from (1) the GM Benefits & Services Center, or (2) an authorized Central Diagnostic and Referral agency (CDR). If it becomes necessary for you, instead of the facility or provider, to submit a claim form (e.g., you receive outpatient mental health treatment from a non-panel physician provider to whom you must make payment before you may seek 50% reimbursement for yourself), you are required to send the originals of either (1) approved itemized bills, (2) statements, or (3) receipts for each of the medical expenses for which you are claiming payment.

The substance abuse assessment section of the claim form must be completed by the assessment coordinator from the CDR agency. Otherwise, benefits for that treatment will not be payable.

To be considered, a claim MUST be submitted before the end of the calendar year following the calendar year in which expenses related to the claim were incurred.

**Hearing Aid Claims**

Providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the Carrier.

**Dental Claims**

Dentists that participate with Delta Dental generally submit claims electronically to Delta Dental at the point services are received. If you receive services from a non-participating dentist, generic dental claim forms and instructions generally are available from dentists and can be submitted for appropriate processing. Claim forms also are available from Delta Dental’s website.

**Vision Claims**

Davis Vision is the vision coverage Carrier. Network vision providers will have necessary claim forms. In addition, a claim form may be obtained from the Carrier. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to the vision Carrier. Payment will be made directly to participating providers, unless you have paid all, or part, of the charges for covered services, or you received covered services from a non-participating provider. In that case, Davis will pay you the appropriate amount.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT**

The Plan Administrator believes that the medical plan offered to Temporary employees under the GM Health Care Program for Hourly Employees is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to
other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at Mail Code 482-C32-A68, 300 Renaissance Center, Detroit MI 48265-3000. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272.

HEALTH CARE ENROLLMENT

Once you become eligible for health care coverage, you may include protection for: (1) yourself only (single), (2) yourself plus your spouse, your same-sex domestic partner or your child (two-party), or (3) yourself and two or more dependents (family). With regard to coverages selected, you may elect: (1) core coverages alone, (2) core coverages plus any or all non-core coverages for which you may be eligible, (3) any or all non-core coverages for which you are eligible without core coverages or (4) to waive all coverages. Your coverage elections determine coverage for all of your dependents.

Once enrolled, the health care enrollment process allows you to change your health care elections any time during the year. Once you have made a coverage option change, no further “elective changes” to that coverage will be allowed for 12 months. Additional changes in coverage options are allowed, as exceptions to the 12-month waiting period, for “Life Events” (e.g., if you relocate, add or drop a dependent), for non-elective events (e.g., if you become enrolled for Medicare-primary coverage) or for mid-year changes in offerings.

The current calendar-year-based “Plan Year” continues and changes in options (e.g., adding new coverage options, dropping options, changing option benefit design features, etc.) are targeted to occur on January 1st of each year. If you change medical, dental or vision options during the year, you will have applicable calendar year maximums continued on a calendar year basis, with integration between Carriers.

Changes in enrollment will be prospective and generally occur on the first day of the second month following receipt by the GM Benefits & Services Center of your completed enrollment change information. In the event the change is delayed, you will be informed of the effective date. If your coverage option is eliminated (for whatever reason) and you subsequently do not select another coverage option within the time period provided, you will be assigned to default coverages; however, you will be allowed to make subsequent proactive option selections without regard to the normal 12-month waiting period.
The **Dependent Care Reimbursement Plan** is a Flexible Spending Account (FSA) that can save you money by allowing you to reimburse yourself for eligible expenses such as daycare and/or elder care expenses, with pre-tax dollars you set aside through payroll deduction. A Dependent Care FSA enables you to reimburse yourself for expenses that may be necessary for you, and if you are married, for your spouse, to be gainfully employed. If your spouse is disabled or a full-time student, you may also use this account for eligible expenses.

**Dependent Care Spending Account Deposits**

Deposits into your Dependent Care Spending Account come from pre-tax contributions from your pay. A Dependent Care Spending Account can save you money because your contribution to your account is **not taxed** and generally you are not taxed when you reimburse yourself from this account. This means you do not pay federal, Social Security, state, and local taxes on the money you contribute. The result is a tax savings for you, which increases your disposable income throughout the year.

If you decide to establish a Dependent Care Spending Account, you may elect to contribute up to $5,000 each year in a spending account, dependent upon your tax filing election. Under current tax law, each year you must allocate a specific amount for your account. If you are married and file federal income taxes separately, your contribution to a dependent care spending account is limited to $2,500. If you file jointly, your maximum contribution to an account cannot exceed $5,000 or the smaller of your income or your spouse’s income.

You should be aware that you cannot use the same expenses for both reimbursement from your Dependent Care Spending Account and claiming a federal dependent care tax credit.

**Special Note:** In order to receive reimbursement for your expenses the services must be rendered during the Plan Year for which the spending account was established. The Plan Year, including the “grace period”, is January 1st through March 31st of the following year. Expenses must be incurred before March 31st of the following year, and requests for reimbursement must be received by April 30th of the following year. Funds that are not used during the Plan Year, including Grace Period, will be forfeited.

Upon retirement or other termination of employment, pre-tax contributions to the Account will cease with the employee’s last pay. The Participant may continue to file claims for services that are received, up to the available Account balance, at the time employment ceases for services incurred during the Plan Year, including the Grace Period.

**What Are Eligible Expenses for Reimbursement From a Dependent Care Spending Account?**

Listed below are examples of eligible and non-eligible dependent care spending account expenses. **This is not intended to be a complete listing.** If you would like to review additional information about eligible expenses, you should call the IRS at 1-800-TAX-FORM and request IRS Publication #503 (Child and Dependent Care Expenses). The publication can also be downloaded by visiting [www.irs.gov](http://www.irs.gov).
Eligible Expenses Include:

- Baby-sitting expenses for care inside or outside the home;
- Care provided by a housekeeper whose services include care of an eligible dependent;
- Licensed elder care center, child care center, and nursery school charges, if the facility complies with local, state, and federal regulations;
- Social Security and other taxes you pay for a care provider.

Expenses that are Not Eligible Include:

- Care provided by someone you claim as a dependent on your federal income tax return;
- Expenses claimed under the federal dependent care tax credit for the calendar year;
- Expenses incurred before participation;
- Overnight camp expenses;
- Transportation to or from a dependent care provider.

Requests for Reimbursement

You can obtain reimbursement claim forms by calling the toll-free number at 1-800-476-1457. Your requests for reimbursements can be submitted as often as once each week to the claims paying administrator. Each request must be for at least $25, with a copy of your paid receipts attached to the claim form, except that your last request at the end of each year may be for less. You will receive your reimbursement checks tax-free.

Your Dependent Care claims can be paid after service is rendered but only up to the balance available in your account at the time the claim is submitted. If your expenses exceed that amount, there will be a time lapse for reimbursement until sufficient funds are available in your account.

You have until March 31st of the following year to submit expenses for services rendered during the prior Plan Year. Claims that are submitted after that time for a prior year cannot be reimbursed.

If you submit a reimbursement claim form and you are reimbursed for expenses that are not covered, or for more than should be allowed, federal law requires that such reimbursement is taxable income to you. You will be responsible for paying any tax required on those amounts.

Forfeitures

You should use the spending accounts only for eligible expenses that you can reasonably predict. That is because federal regulations require that unused amounts in your spending account must be forfeited at the end of each calendar year (commonly referred to as use-it-or-lose-it).

Planning to Use a Spending Account

Getting the most out of your spending account takes some planning. Although there are tax advantages from using one, the tax laws – governing both personal taxes and benefits – may create confusion. The following chart summarizes the current tax rules as a reference tool for your use.
**IRS Rules for a Spending Account**

| **Tax-free** | You do not pay Social Security, federal, and most state or local income taxes on contributions and reimbursements. |
| **Alternative personal federal income tax treatment** | Spending Account in lieu of federal dependent care tax credit |
| **Eligible expenses** | Dependent care expenses necessary for you and your spouse to work (or your spouse to attend school full-time). Remember, services must be rendered within that Plan Year. |
| **Eligible dependent** | Your child(ren) under age 13; a dependent parent; a disabled dependent or disabled spouse unable to care for himself/herself. |
| **Pre-paid care ineligible** | Services for eligible expenses must be received during the calendar year; pre-paid care or services to be received during the previous or following calendar year do not qualify for reimbursement. |
| **Contribution maximum** | $5,000 if you are a single parent or married filing jointly  
$2,500/person, if married and filling taxes separately  
The lesser of your income or your spouse’s income |
| **Reimbursement availability** | Up to amount accumulated in your account |
| **Unused balance** | Money not used for reimbursement of expenses will be forfeited after March 31st of the following Plan Year. |
SECTION 4: IF YOU ARE DISABLED

If you are unable to work because of sickness or injury and you are being treated by a physician legally licensed to practice medicine, weekly Sickness and Accident benefits can provide you with income for as long as 52 weeks. Treatment may also be provided by a physician assistant, psychologist, or nurse practitioner, however, certification of disability must be provided by a physician legally licensed to practice medicine. In certain circumstances, certification and treatment must be provided by a licensed psychiatrist.

Sickness and Accident benefits also may be payable if you are (1) disabled from surgery for sterilization, or (2) hospitalized for testing to determine your suitability to be a donor for an organ or tissue transplant.

If you continue to be disabled after the period for which you are entitled to receive Sickness and Accident benefits, you may be eligible for monthly Extended Disability Benefits.

Sickness and Accident and Extended Disability Benefit coverages begin the first day of the sixth month following the month in which your employment commences. If you are not at work on the day your Sickness and Accident and Extended Disability Benefit coverages otherwise would begin, these coverages begin the day you return to work.

The amounts of your Sickness and Accident and Extended Disability Benefits are shown in the following pages.

SICKNESS AND ACCIDENT BENEFITS

Benefits are payable for up to 52 weeks. If you have less than 52 weeks of GM employment, benefits are payable on a time-for-time basis which commences on your date of hire. This means benefits will be payable for a period equal to your length of employment (or your years of participation as defined under the Life and Disability Benefits Program, if longer) at the time you become disabled. If you have less than 52 weeks of employment when you become disabled, benefits may continue beyond the time-for-time period (but not beyond 52 weeks) while you are hospitalized, or while you are receiving workers compensation payments from GM.

Eligibility to Receive Sickness and Accident Benefits
In order to receive benefits, you must be wholly and continuously disabled as a result of any injury or sickness so as to be prevented thereby from performing any and every duty of your occupation. You must provide medical evidence satisfactorily to the Carrier that substantiates total disability (Medical Substantiation). Absent Medical Substantiation, the claim for benefits will be denied. You must not be engaged in any employer or occupation for remuneration or pay which is the same or similar to your job classification duties, and which is inconsistent with your disability and/or restrictions. You must give written notice of any sickness or injury within 20 days after (1) the onset of the sickness, or (2) the accident causing your injury. Also, you must provide proof of your injury or sickness to the Carrier within 90 days after the termination of the period for which weekly benefits are payable.

Commencement of Sickness and Accident Benefits
Benefits commence immediately in case of an accident if you are (1) hospitalized, (2) treated by a physician legally licensed to practice medicine or the plant medical department during the first seven days of disability, or (3)
treated by a physician assistant, psychologist, or nurse practitioner during the first seven days of disability, where certification of disability is provided by a physician legally licensed to practice medicine. In case of sickness, benefits begin (1) after a waiting period of seven days, (2) when hospitalized, including observation stays of 24 or more hours, or (3) when confined in an approved substance abuse treatment facility.

Benefits can begin the day after surgery in case of outpatient surgery where a surgical benefit of $25, or more, is payable under the GM Health Care Program for Hourly Employees. In addition, if you undergo oral or maxillofacial surgery performed by a Doctor of Dental Surgery (DDS) that is medically substantiated, the waiting period will not extend beyond the day of surgery.

If you return to work before the end of the maximum period for which you are eligible to receive sickness and accident benefits, and are absent again within three months because of the same or a related disability, benefits resume where they left off. For example, if you were disabled and received sickness and accident benefits for 20 weeks, returned to work and then became disabled again 8 weeks later from the same condition, you would be eligible for 32 additional weeks of benefits, without a new waiting period. If your second absence results from a different cause, the first absence does not affect the benefits or waiting period, if any, for the second absence.

Examinations to Verify Disability
You may be asked to be examined by an impartial doctor, clinic, or other medical authority for the purpose of verifying disability at any time you may be eligible to receive Sickness and Accident or Extended Disability Benefits. Generally, if you are found able to work your benefits will be discontinued. Failure to report for the examination may affect any eligibility you may have for benefits. Upon request, you will be reimbursed the rate allowable by the IRS, for travel to and from the examination, if your residence is more than 30 miles (one-way) from the examiner’s office.

Reductions in Benefits
Sickness and Accident Benefits are reduced by: (1) primary Social Security Disability Insurance Benefits (SSDIB) or unreduced Social Security Retirement Insurance Benefits (including retroactive amounts paid for the same period of disability), (2) certain Workers’ Compensation payments, and (3) any Unemployment Compensation payments to which you are entitled for the same period you receive Sickness and Accident Benefits. You may be required to apply for SSDIB if your disability is expected to continue for 52 weeks, or longer.

Application for Benefits
You and your attending physician must complete a claim form provided by the GM Benefits & Services Center. You should contact the GM Benefits & Services Center toll-free at 1-800-489-4646 or TDD: 1-877-347-5225 (for hearing/speech impaired) as soon as possible if you become disabled.
# Schedule of Disability Benefits

**For Employees at Work on or After November 23, 2015**

<table>
<thead>
<tr>
<th>Base Hourly Rate (1)</th>
<th>Weekly Sickness and Accident Benefit (Maximum 52 Weeks) (2)</th>
<th>Monthly Extended Disability Benefit</th>
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<tbody>
<tr>
<td></td>
<td>Schedule I</td>
<td>Schedule II (3)</td>
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## SCHEDULE OF DISABILITY BENEFITS

FOR EMPLOYEES AT WORK ON OR AFTER November 23, 2015

<table>
<thead>
<tr>
<th>Base Hourly Rate (1)</th>
<th>Weekly Sickness and Accident Benefit (Maximum 52 Weeks) (2)</th>
<th>Monthly Extended Disability Benefit Schedule I</th>
<th>Monthly Extended Disability Benefit Schedule II (3)</th>
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<td>37.40 &amp; Over</td>
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</table>

(1) For this purpose, Base Hourly Rate includes premium for necessary continuous 7-day operations, but does not include overtime, night-shift premium, or any cost of living allowance.

(2) Weekly Sickness and Accident Benefits will be adjusted for disability occurring prior to the day one year of seniority is attained. [See Article II, Section 6(e)].

(3) Schedule II applies to eligible employees who on their last day worked preceding a continuous period of disability have 10 or more Years of Participation under the Plan. Schedule I applies to all other employees eligible for Extended Disability Benefits.

## EXTENDED DISABILITY BENEFITS

Benefits are payable for a period based on your years of participation under the Life and Disability Benefits Program.

- **If you have 10 or more years of participation when you become disabled** benefits are payable until recovery, but generally not beyond the end of the month in which you attain age 65.
- **If you have less than 10 years of participation when you become disabled** benefits are payable until recovery, or, if less, for a period equal to your years of participation at the commencement of disability (less the period during which sickness and accident benefits are received), but generally not beyond the end of the month in which you attain age 65.

If you become disabled after age 63, you may receive extended disability benefits for a period of time beyond age 65.

If your employment terminates for any reason while receiving Sickness and Accident Benefits, you will not be eligible to receive Extended Disability Benefits.

**Receipt of Extended Disability Benefits**

To receive benefits you must (1) not be regularly employed, and (2) be totally disabled so as to be unable to perform any job at the plant or plants where you have seniority. In addition, you must provide medical evidence satisfactory to the Carrier that substantiates total disability (Medical Substantiation). Absent Medical Substantiation the claim for benefits will be denied.

**Reduction of Extended Disability Benefits**

Extended Disability Benefits are reduced by any benefit for which you are eligible under any GM Pension Plan or Retirement Program. In addition, governmental benefits such as Workers’ Compensation, certain Social Security benefits, or any federal or state lost-time disability benefits, are deductible. Increases in any of these benefits payable after Extended Disability Benefits commence will not be deducted, unless the increase represents an...
adjustment in the original determination of the amount of such benefit. A retroactive award of such benefits creates an overpayment of Extended Disability Benefits which were paid for the same period of disability. You will be required to apply for Social Security Disability Insurance Benefits (SSDIB) under a special procedure designed to handle the offset of SSDIB against Extended Disability Benefits. You also will be required to repay any overpayment incurred due to receipt of a SSDIB award.

Application for Extended Disability Benefits
To apply for benefits, complete a claim form provided by the GM Benefits & Services Center. You may contact the GM Benefits & Services Center toll-free at 1-800-489-4646 or TTY: 1-877-347-5225 (for hearing/speech impaired).

Examinations to Verify Disability
You may be required to be examined by an impartial doctor, clinic, or other medical authority for the purpose of verifying disability at any time you may be eligible to receive Sickness and Accident or Extended Disability Benefits. Generally, if you are found able to work your benefits will be discontinued. Failure to report for the examination may affect any eligibility you may have for benefits. Upon request, you will be reimbursed the rate allowable by the IRS, for travel to and from the examination, if your residence is more than 30 miles (one-way) from the examiner’s office.

DISABILITY BENEFIT LAWS

In certain states, employees in hourly positions may be eligible under a statutory disability benefits law for disability benefits for time lost from work. If you are an employee working in California, New Jersey or New York, certain modifications in your Sickness and Accident Benefits during disability are explained below.

If any Federal or state legislation is in effect or is enacted or amended to provide disability benefits similar to those described in this booklet, appropriate modifications may be made in the benefits provided under the Program. Accordingly, if you are an employee working in the state of California, New Jersey or New York, your benefits are the same as for any other GM employee except as set forth below. You are not required to contribute for disability benefits coverage provided in accordance with the state of commonwealth law.

EMPLOYEES IN CALIFORNIA
As an employee in the state of California, you are automatically covered, as of the date you are hired, for disability benefits under the State Plan provided by the California Unemployment Insurance Code. These benefits are described in the State Plan folder, DE-2515, issued by the California Employment Development Department. A copy of this document will be given to you.

If you become disabled, you should file a claim form DE-2501 at once with the Employment Development Department. Failure to file your claim immediately could result in a loss of benefits. After you file a claim under the State Plan, the Employment Development Department will furnish you with a “Notice of Computation”, with respect to your eligibility for benefits under the State Plan. This “Notice of Computation” should be referred at once to the GM Benefits & Services Center for determination as to whether supplemental Sickness and Accident benefits may be payable under GM Life and Disability Benefits Program.
**Employees in New Jersey**

As an employee in the state of New Jersey, you are automatically covered, as of your first day of work for GM, for disability benefits under the GM Private Plan, in accordance with the New Jersey Temporary Disability Benefits Law. **These benefits are outlined in the bulletin board notice posted in your employing location.**

If you leave GM, your coverage under the GM Private Plan will remain in force for up to two weeks following the date you last work, if you are still unemployed.

**Employees in New York**

As an employee in the state of New York, you are automatically covered, as of your first day at work for GM, for disability benefits under the GM Private Plan, in accordance with the New York Disability Benefits Law.

To receive Private Plan benefits, you must give written notice and proof of disability within 30 days after the commencement of disability.

If you leave GM, your coverage under the GM Private Plan will remain in force for up to 28 consecutive calendar days following the date you last work, if you are still unemployed.

**Other Benefit Program Coverages While on Disability Leave**

**Life and Disability Coverages While You Are Disabled**

Your Basic Life Insurance, Extra Accident Insurance, and Survivor Income Benefit Insurance, as well as Sickness and Accident and Extended Disability Benefit coverages, will be continued for any period during which you are:

1. Entitled to receive Sickness and Accident Benefits while totally disabled, or
2. Totally and continuously disabled and remain on an approved disability leave of absence, but not to exceed the period equal to your years of participation under the Life and Disability Benefits Program refer to General Information About Your Benefits Years of Participation Under the Life and Disability Benefits Program section as of the first day of disability.

Also, such coverages may be continued while you are entitled to receive monthly Extended Disability Benefits after cancellation of your disability leave because the period of the leave equaled your seniority.

If your disability leave is canceled because you recovered, and you again become totally disabled so as to be unable to work within three working days of the date your leave was canceled, all coverages to which you were entitled will be continued at no cost to you while you remain totally disabled.

If eligible to continue, you must pay the required monthly contributions to continue any Optional Life Insurance, Dependent Life Insurance, and/or Personal Accident Insurance.

Basic Life Insurance must remain in force to continue Optional Life Insurance and Dependent Life Insurance.

**Health Care Coverage While You Are Disabled (applicable to Traditional Employees Only)**

In most cases, Company contributions for health care coverages will be continued for the duration of an approved disability leave of absence. If your disability leave is canceled because the period of the leave equals your seniority
prior to the leave, the coverages may be continued while you remain an employee and entitled to receive Sickness and Accident or Extended Disability Benefits. Exceptions to the above include, but are not necessarily limited to, the following cases:

1. If you are off work because of layoff, or personal leave of absence, and your coverages have been discontinued while you are off, and if upon reporting for work you are found disabled and are placed on disability leave, you will be deemed to have returned to work effective with the date you would otherwise have returned to work but for the disability leave; and
2. If you are recalled from permanent layoff, return to work, and become disabled prior to working 12 pay periods during the calendar year, you will be limited to the number of health care continuation months you had remaining as of the end of the month prior to your return to work from layoff, plus two additional months.

If you become “totally and permanently disabled” and retire under the provisions of the Pension Plan, health care coverages under the GM Hourly Health Care Program will cease upon retirement, though you may be eligible for health care coverage from the UAW Retiree Medical Benefits Trust, which is completely separate and independent from GM. If you are unable to retire because you have insufficient credited service, and if you elect to take a SUB Separation Payment thereby breaking seniority with GM, you will be permitted to continue coverages on a self-paid basis. You can continue for the period of time you could have had coverages continued had you not taken the separation payment.

In Case You Become Totally and Permanently Disabled
Pension benefits may be payable upon application, if you are a GM employee at the time of application, you have been on a disability leave for at least five months, you have at least 10 years of credited service and you become totally and permanently disabled before age 65. An employee with seniority who has a terminal condition may apply immediately for T&PD retirement in accordance with Plan provisions.

Survivor benefits may be provided for your spouse under the (1) Life and Disability Benefits Program, and/or (2) Pension Plan, if you die while you are totally disabled.

Separation Payments
If you have one or more years of seniority and are totally and permanently disabled but do not have the years of credited service required for a Total & Permanent Disability pension, a separation payment may be provided under the SUB Plan. A SUB Separation Payment would be in addition to any Extended Disability Benefits you may be eligible to receive under the Life and Disability Benefits Program. (See the schedule of SUB Separation Payments.)

Social Security Disability Insurance Benefits
If you become disabled before age 65, you may be eligible for disability insurance benefits from Social Security. Your nearest Social Security office can tell you if you qualify. To locate the nearest Social Security office, call toll free at 1-800-772-1213 or TTY at 1-800-325-0778 or visit its website at www.socialsecurity.gov. Benefits may be payable after you have been disabled for five full calendar months.

The amount of Social Security benefits payable because of disability generally is in accordance with benefits payable at age 65.
IF YOU ARE DISABLED

It is important for you to apply for Social Security Disability Insurance Benefits (SSDIB) for these reasons:

- Failure to claim a Social Security disability award may result in a lesser Social Security Retirement Insurance Benefit.
- Your dependents also may qualify for Social Security benefits.
- Your Social Security benefits may be increased annually to reflect cost-of-living increases.
- Social Security disability awards are given favorable federal tax treatment.
- You become eligible for Medicare after 24 months of Social Security Disability Insurance Benefits. Medicare can provide additional coverage (office visits for TCN option enrollees for example).
- If you are receiving Social Security Disability Insurance Benefits and return to work, you may be eligible to continue these benefits, in addition to your wages, up to 12 months. You may contact your nearest Social Security office for additional information.

If you are receiving Sickness and Accident or Extended Disability Benefits, you may be required to complete an authorization form which allows the Social Security Administration to inform GM of the status of your claim for Social Security Disability Insurance Benefits. If you fail to complete this authorization, your Sickness and Accident or Extended Disability Benefits will be suspended until the authorization is received.

In addition, failure to provide proof of either an SSDIB award or denial by the 52nd week of disability will result in a suspension of future disability benefits until such proof is received.

**IN-PROGRESSION EMPLOYEES**

For employees who last worked on or after November 23, 2015 and who are In-Progression employees, Sickness and Accident and Extended Disability Benefits coverage are effective after an employee acquires one year of seniority.

Sickness and Accident benefit duration is as follows:
- 1 year seniority but less than 3 years seniority up to 26 weeks
- 3 or more years seniority, up to 52 weeks

Extended Disability Benefit duration is as follows:
- 1 year seniority but less than 3 years seniority, 13 weeks
- 3 years seniority but less than 5 years seniority, 26 weeks
- 5 or more years seniority, time for time if less than 10 years,
- 10 or more years of seniority, the lesser of recovery, death, 10 years or age 65

All other disability Plan provisions as described in this Summary Plan Description apply.
SECTION 5: IF YOU ARE LAID OFF

SUPPLEMENTAL UNEMPLOYMENT BENEFIT (SUB) PLAN

In the event of layoff, the SUB Plan provides a very substantial level of income security to supplement any state unemployment compensation you receive. Under the SUB Plan you may receive the following benefits:

- **REGULAR SUBEFIT** for a full week of layoff from GM;
- **SHORT WEEK BENEFIT** when you are laid off from GM for part of a week; and
- **SEPARATION PAYMENT** upon termination of employment because of layoff or total and permanent disability.

*Regular SUBenefit – For a Full Week of Layoff From GM*

**Eligibility**

You may be eligible for a regular SUBenefit for a full week of layoff if you have one or more years of seniority under the SUB Plan and are laid off due to:

- Reduction in force;
- Discontinuance of a plant or operation;
- Temporary layoff; or
- Being unable to do work offered by the plant but able to do other available work in the plant if you had more seniority.

To be eligible, you must receive a state system benefit such as state Unemployment Compensation (UC) or Unemployment Insurance (UI), or be denied such a benefit only for an acceptable reason under the SUB Plan.

You will not be eligible for a regular SUBenefit if your layoff was for disciplinary reasons or was a consequence of:

- Any strike, slowdown, work stoppage, picketing or concerted action, at a Company plant or plants, or any dispute of any kind involving, generally, employees covered by this Plan;
- Any fault attributable to you, the employee; or
- Sabotage (including arson) or insurrection.

Generally, if you refuse a GM employment interview or job offer within your Area Hire area, SUBenefit eligibility will be terminated until you return to work for GM. However, if such refusal results in denial of state Unemployment Compensation (UC) benefits for one or more weeks of layoff thereafter, you will either (1) be denied SUB for such weeks, or (2) have your payment limited to the maximum amount of $200 per week.

**Duration of Benefits**

If you are laid off with at least one year of seniority as of your last day worked prior to a qualifying layoff, and are otherwise eligible, you may receive SUB based on your seniority as of your last day worked. Benefit durations are applicable for periods of “indefinite layoff” as follows:

- Traditional employees and all Skilled Trades:
  - 1 but less than 10 years seniority: 26 weeks
  - 10 but less than 20 years seniority: 39 weeks
  - 20 years or more seniority: 52 weeks
**IF YOU ARE LAID OFF**

- **In-Progression Employees:**
  - 1 but less than 3 years seniority: 13 weeks
  - 3 years or more seniority: 26 weeks

**To apply for SUBenefits:**
- The toll free number is: 1-800-489-4646.
- The website is: [www.gmbenefits.com](http://www.gmbenefits.com).

If a written application is required, you will be advised by a GM Benefits & Services Center benefit analyst and an application form will be provided to you.

For each week of layoff for which you apply, you must have reported to the state employment office (as required by the state) and provide to the GM Benefits & Services Center satisfactory evidence that you have received a state UC benefit, or be ineligible for a state UC benefit only for an acceptable reason under the SUB Plan.

If you are laid off from a GM location covered by an “AutoSUB” Program, your application for a state UC benefit will be considered to be your SUBenefit application. The state UC agency will provide UC payment data to GM based upon your application. This information will be used to process your SUBenefit. As a result, no SUB application is required as long as you are receiving UC.

**Amount of Regular SUBenefit**

The amount of your Regular SUBenefit is an amount which, when added to the following, will equal 74% of your Gross Weekly Wage:

- The amount of any state system benefit (UC, UI, TRA, EUC, etc.) received or receivable, plus,
- Any GM pay (excluding call-in pay and Sunday earnings), plus
- Any earnings from another employer, or from the military, up to your UC weekly benefit amount.

A maximum regular SUBenefit of $200 will apply to any week for which you refused available GM work and for which you either (1) had exhausted your state UC benefits, or (2) were denied UC because of such refusal, provided that you refused a job offer you had an option to refuse under your local seniority agreement.

If you are serving a state UC “Waiting Week” while on a layoff, if otherwise eligible, you will be paid a regular SUBenefit for such “Waiting Week.” The SUBenefit will be unreduced for any estimated state UC benefit amount.

**Example**

An employee is laid off, having an hourly pay rate of $28.71.

- 40 hours’ gross pay: $1,148.40
- Total income level for week (74%): $849.82

The totals income level for the week, of $849.82, consists of a $362 state (MI) UC benefits and a $487.82 SUBenefit. The SUBenefit amount is subject to any federal additional compensation, federal income tax withholding and, in certain areas, state and local withholding taxes. The SUBenefit amount also is subject to reduction by the amount of any outstanding debts owed to GM or the Trustee of any GM benefit Plan or Program.
Disability Benefits While Laid Off
If you become disabled while on a layoff, and your Sickness and Accident benefit coverage is no longer in force, your Sickness and Accident benefit coverage may be reinstated.

To qualify for reinstated Sickness and Accident Benefits while on layoff, you must:
- Submit satisfactory evidence on a claim form provided by GM for that purpose, certifying that you are disabled (call the GM Benefits & Services Center at 1-800-489-4646);
- Be insured for Basic Life Insurance;
- Be on a qualifying layoff; and
- Be eligible for either a regular SUBenefit, or a Trade Readjustment Allowance benefit, or be employed by another employer immediately prior to becoming disabled.

You may receive up to 52 weeks of reinstated Sickness and Accident Benefits. If you still are disabled after the period for which you are entitled to receive reinstated Sickness and Accident Benefits, you may be eligible for monthly Extended Disability Benefits.

Short Week Benefit – When Laid Off From GM for Part of a Week
Eligibility
You may be eligible for an Automatic Short Week Benefit for a week if:
- You had less than 40 hours of work or pay made available to you by GM;
- You were laid off at any time during the week for a qualifying reason, as described in the information provided under Regular SUBenefits or you were ineligible for GM pay for (1) jury duty, (2) bereavement, or (3) short-term National Guard duty, because you would have been on a qualifying layoff;
- You have one or more years of seniority as of the last day of the week (or have broken your seniority during the week only by reason of death or retirement under the GM Hourly Rate Employees Pension Plan); and
- You worked for GM during the week, or received from GM bereavement, jury duty, military or (under certain circumstances) holiday pay, for part of the week.

Additional hours worked, or made available, during the week will be excluded in the short week benefit calculation for such week, unless (1) such additional hours were worked prior to layoff, or (2) notice of intent to work such additional hours had been given prior to the layoff. Also excluded from a short week benefit calculation will be any additional hours available to certain employees medically restricted as to the number of weekly and daily working hours. Applicable provisions of the 2015 National Agreement on overtime or additional hours will be taken into consideration.

Application Requirements
Automatic Short Week Benefits will be paid to you, without application, in your regular paycheck for the week, or shortly thereafter.

If you do not receive an Automatic Short Week Benefit to which you believe you are entitled, you must file an application within 60 days after the date you normally would have received the benefit payment. SUB application forms are available from the GM Benefits & Services Center, P.O. Box 5078, Southfield, Michigan 48086-5078, or toll-free, 1-800-489-4646.
Amount of Short Week Benefits
Automatic Short Week Benefits are payable at 80% of your straight-time pay for each hour less than 40 for which you (1) were not offered work, or (2) did not receive pay.

Example
An employee earning $28.71 per hour worked 23 hours and received holiday pay for 8 additional hours (which were not worked) for a total of 31 hours. The employee is 9 hours short of 40 and was on a qualifying layoff during the week:

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<th>Day</th>
<th>Hours Worked</th>
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<td>Thursday</td>
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<td>Friday</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Therefore, the employee is entitled to an automatic Short Week Benefit of 80% of 9 hours pay $206.71 ($28.71 an hour x 9 hours x 80%).

Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability
Eligibility
You may be eligible for a Separation Payment if you have one or more years of seniority on the last day you are on the active employment roll, and:

- Are laid off from GM for 12 or more continuous months, provided you have not refused a GM offer of work or broken your seniority within the first 12 months of layoff, or
- Become totally and permanently disabled but are not eligible for a disability pension solely because you do not have sufficient years of credited service.

You must not have broken seniority as of the earliest date you may be eligible to apply for a Separation Payment.

Application Requirements
To be eligible, you must apply between 12 and 24 months (36 months if you have 10 or more years of seniority) after the first day of layoff, or at any time up to 24 months (36 months, if applicable) after the date you are determined by GM to be totally and permanently disabled (or, if you then are receiving extended disability benefits under the Life and Disability Benefits Program, within 30 days after the last month for which you are eligible for such benefit).

Cancellation of Seniority
If you receive a Separation Payment, (1) you no longer are a GM employee, and (2) your seniority is canceled at all GM plants.

Amount of Separation Payment
The amount of your Separation Payment is determined by multiplying your base hourly rate (including cost-of-living allowance) by the number of hours of pay, according to your years of seniority, as shown in the table on the next page, less any SUBenefits paid to you for weeks following your last day worked.
The amount of your Separation Payment may be offset by such things as, but not limited to, the amount of any payment received, or receivable, under any other GM “SUB” Plan, or under any GM Plan or Program to which GM has contributed, for layoff or separation from GM subsequent to the last day you worked for GM.

**Allocation Period**

If you are eligible to retire under the provisions of the GM Hourly-Rate Employees Pension Plan at the time you apply for a Separation Payment, you will not be eligible to commence such retirement until the end of an “Allocation Period.” The length of the Allocation Period (in weeks) is determined by dividing the amount of your Separation Payment by one-half of your unreduced regular weekly SUBenefit amount applicable to the current period of layoff.

During the Allocation Period you will not be eligible to participate in GM health care coverages. COBRA or health care coverage conversion privileges may be available during the Allocation Period depending on your status prior to separation. If you retire following the Allocation Period, and are eligible for health care coverage in retirement, any coverage will be provided by the UAW Retiree Medical Benefits Trust.

<table>
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<th>Years of Seniority on Last Day on the Active Employment Roll</th>
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<th>Years of Seniority on Last Day on the Active Employment Roll</th>
<th>Number of Hours of Pay</th>
</tr>
</thead>
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<td>1 but less than 2</td>
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<tr>
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<td>350</td>
<td>24 but less than 25</td>
<td>1455</td>
</tr>
<tr>
<td>10 but less than 11</td>
<td>400</td>
<td>25 but less than 26</td>
<td>1560</td>
</tr>
<tr>
<td>11 but less than 12</td>
<td>455</td>
<td>26 but less than 27</td>
<td>1665</td>
</tr>
<tr>
<td>12 but less than 13</td>
<td>510</td>
<td>27 but less than 28</td>
<td>1770</td>
</tr>
<tr>
<td>13 but less than 14</td>
<td>570</td>
<td>28 but less than 29</td>
<td>1875</td>
</tr>
<tr>
<td>14 but less than 15</td>
<td>630</td>
<td>29 but less than 30</td>
<td>1980</td>
</tr>
<tr>
<td>15 but less than 16</td>
<td>700</td>
<td>30 and over</td>
<td>2080</td>
</tr>
</tbody>
</table>
SUB PLAN OVERPAYMENTS

Any SUB Plan overpayment must be repaid unless (1) the cumulative overpayment is $3 or less, or (2) notice of the overpayment was not given to you within 60 days from the date the overpayment was established or created. In cases involving legislative changes, no repayment is required if notice has not been given within 60 days of notification from the applicable government agency. Notification of overpayment time limits do not apply in any case of fraud or willful misrepresentation in applying for benefits under the Plan.

If you fail to promptly return the amount of the overpayment, a maximum of $100 per week, but not more than 1/2 of your weekly SUBenefit or paycheck, will be deducted from your future SUBenefits or paychecks until the overpayment is recovered in full. No overpayment recovery limits apply in cases of fraud or willful misrepresentation.

LIFE AND DISABILITY COVERAGES FOR EMPLOYEES ON LAYOFF

Coverages may be continued for the following periods, after the month in which you last worked prior to layoff:

- For the first month, all Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance, as well as Sickness and Accident and Extended Disability Benefit coverages in force, are continued with GM paying the full cost.
- After the first month, Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance coverages are continued at no cost to you, if you are on a qualified layoff, for up to 12 months (24 months, if you have 10 or more years of seniority). The period these coverages will be continued without cost to you is based on your years of seniority, and is shown in the chart on the next page.
- After the period of GM-paid continuation described above, you may continue Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance coverages up to an additional 12 months of layoff, while your seniority remains unbroken, by making the required monthly contribution.

If you are placed on layoff immediately upon your return to work from a disability leave of absence, the day you return from such leave will be deemed to be the day you last worked prior to layoff. However, only those life and disability coverages in force on your last day at work prior to your disability leave can be continued.

Personal Accident Insurance may be continued during layoff whether or not Basic Life Insurance remains in effect, provided you make the required contributions. The maximum period that coverage may be continued after the month in which you last worked prior to layoff is based on your years of seniority as of your last day worked as shown on the following chart.
If you are laid off, your coverage as an active employee ceases at the end of the month in which you last are in active service, as defined under the Health Care Program.

Thereafter, generally you are entitled to a number of months of GM contributions for health care coverages based upon your seniority at the time of layoff, as shown in the chart below.

After the period of GM contributions described below, you will be given a notice explaining your health care continuation rights under COBRA.

The information below does not apply if you return to work from permanent layoff and are laid off again or become disabled before receiving earnings for 12 pay periods during a calendar year. In such a case, you will be limited to the number of health care continuation months you had remaining as of the end of the month prior to your return to work from layoff, plus two additional months.

### Basic Life Insurance

<table>
<thead>
<tr>
<th>Years of Seniority As of Last Day Worked Prior to Layoff</th>
<th>Maximum Number of Months of Company-Paid Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than</td>
<td>0</td>
</tr>
<tr>
<td>1 but less than</td>
<td>4</td>
</tr>
<tr>
<td>2 but less than</td>
<td>6</td>
</tr>
<tr>
<td>3 but less than</td>
<td>8</td>
</tr>
<tr>
<td>4 but less than</td>
<td>10</td>
</tr>
<tr>
<td>5 but less than</td>
<td>12</td>
</tr>
<tr>
<td>10 and over</td>
<td>24</td>
</tr>
</tbody>
</table>

### Personal Accident Insurance

<table>
<thead>
<tr>
<th>Years of Seniority As of Last Day Worked Prior to Layoff</th>
<th>Maximum Number of Months for Which Personal Accident Insurance Can Be Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than</td>
<td>0</td>
</tr>
<tr>
<td>1 but less than</td>
<td>16</td>
</tr>
<tr>
<td>2 but less than</td>
<td>18</td>
</tr>
<tr>
<td>3 but less than</td>
<td>20</td>
</tr>
<tr>
<td>4 but less than</td>
<td>22</td>
</tr>
<tr>
<td>5 but less than</td>
<td>24</td>
</tr>
<tr>
<td>10 and over</td>
<td>36</td>
</tr>
</tbody>
</table>
IF YOU ARE LAID OFF

Health Care Continuation

<table>
<thead>
<tr>
<th>Years of Seniority As of Last Day Worked Prior to Layoff</th>
<th>Maximum Number of Months of Company Contributions for Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1</td>
<td>1</td>
</tr>
<tr>
<td>1 but less than 2</td>
<td>4</td>
</tr>
<tr>
<td>2 but less than 3</td>
<td>6</td>
</tr>
<tr>
<td>3 but less than 4</td>
<td>8</td>
</tr>
<tr>
<td>4 but less than 5</td>
<td>10</td>
</tr>
<tr>
<td>5 but less than 10</td>
<td>13</td>
</tr>
<tr>
<td>10 and over</td>
<td>25</td>
</tr>
</tbody>
</table>

If you are placed on layoff from disability leave of absence or military leave of absence, the date you report to return from such leave and are placed on layoff will be deemed to be the last day worked prior to layoff, for the purposes of determining continuation.

TRANSITION SUPPORT PROGRAM (TSP)

The TSP is available to Traditional employees (and all skilled trades) who are on a qualifying layoff and exhaust their maximum regular SUB duration (i.e.: 26, 39 or 52 weeks). The TSP shall provide a weekly benefit payment calculated as 50% of the employee’s gross weekly wages, based on a 40-hour week, with durations based on the seniority of the employee, as of their last day worked. The durations are as follows:

- 1 but less than 10 years seniority: 26 weeks
- 10 but less than 20 years seniority: 39 weeks
- 20 years or more seniority: 52 weeks

In calculating the weekly TSP Benefits for an employee, the offsets for State UC Benefits received for that week shall apply.

An employee may elect, prior to becoming eligible for TSP benefits, to opt out of TSP benefits and receive a lump sum cash payment; in doing so, the employee shall forfeit eligibility for weekly TSP benefit payments, and also shall forfeit all recall rights and be considered a Voluntary Quit from the company.

The gross (pre-tax) amount of the opt out lump-sum cash payment is calculated as $10,000 plus the maximum TSP benefit for which the employee would otherwise be eligible (i.e., 50% of the employee’s gross weekly wages, based on a 40-hour week, multiplied by either 26, 39 or 52, depending on the employee’s seniority). An employee who elects to opt out of the TSP will continue to receive healthcare coverage for the remainder of the months of extended coverage for which he or she would have been eligible, based on years of seniority at the time of layoff, had he or she not elected to opt out of the TSP.
SECTION 6: WHEN YOU RETIRE

PENSION BENEFIT - ELIGIBILITY

If you were hired before October 15, 2007, you are eligible to participate in the Pension Plan. The Pension Plan provides certain monthly pension benefits when you retire with 5 or more years of credited service. Monthly pension benefits also are payable when you retire at age 65, or older. If you were hired after October 15, 2007, please see the provisions of the Personal Savings Plan.

Normal retirement age is 65. Early voluntary retirement however, may be as early as age 60 and prior to age 65 with 10 or more years of credited service. It may be as early as age 55 and prior to age 60, if your years of credited service and age total 85 or more, or you may retire at any age if you have 30 or more years of credited service.

Mutually satisfactory retirement may be as early as age 55 (age 50 in the closing of a “remote” plant or under a negotiated special separation program) and prior to age 65 with 10 or more years of credited service, if you are otherwise eligible, are not working at another GM location and meet all other required Standards.

Total and Permanent Disability retirement may be at any age prior to age 65 with 10 or more years of credited service if you become totally and permanently disabled. (This type of retirement requires medical approval)

Pension Plan lifetime benefits are payable in addition to any Social Security benefits you may receive. Contact the Social Security Administration to learn more about your social security benefits.

Retirement at Age 62 or Later
Your monthly basic (lifetime) pension benefit is determined by your basic benefit rate times your years of credited service.

Your basic benefit rate depends on your benefit class code and your retirement date.

<table>
<thead>
<tr>
<th>For Job Classification Having a Maximum Base Hourly Rate of</th>
<th>Benefit Class Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>On or after October 1, 2015</td>
<td></td>
</tr>
<tr>
<td>$29.03</td>
<td>A</td>
</tr>
<tr>
<td>$29.03 but less than $29.31</td>
<td>B</td>
</tr>
<tr>
<td>$29.31 but less than $30.51</td>
<td>C</td>
</tr>
<tr>
<td>$30.51 and over</td>
<td>D</td>
</tr>
<tr>
<td>On or after October 1, 2017</td>
<td></td>
</tr>
<tr>
<td>$29.90</td>
<td>A</td>
</tr>
<tr>
<td>$29.90 but less than $30.19</td>
<td>B</td>
</tr>
<tr>
<td>$30.19 but less than $31.42</td>
<td>C</td>
</tr>
<tr>
<td>$31.42 and over</td>
<td>D</td>
</tr>
</tbody>
</table>
When You Retire

Your GM Benefits
2016 Summary Plan Description – UAW Active

Page 65

WHEN YOU RETIRE

Basic Benefit Rate Per Year of Credited Service for Months Commencing

<table>
<thead>
<tr>
<th>Retirement With Benefits Payable Commencing</th>
<th>Benefit Class Code</th>
<th>10-1-07 through 9-1-08</th>
<th>10-1-08 through 9-1-09</th>
<th>10-1-09 through 9-1-10</th>
<th>10-1-10 and After</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2007 and After</td>
<td>A</td>
<td>$52.90</td>
<td>$53.10</td>
<td>$53.30</td>
<td>$53.55</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>$53.15</td>
<td>$53.35</td>
<td>$53.55</td>
<td>$53.80</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>$53.40</td>
<td>$53.60</td>
<td>$53.80</td>
<td>$54.05</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>$53.65</td>
<td>$53.85</td>
<td>$54.05</td>
<td>$54.30</td>
</tr>
</tbody>
</table>

For example, an employee with a Benefit Class Code of C with 30 years of credited service who retires June 1, 2016, at age 62, would receive a monthly basic benefit as follows:

Basic benefit rate $54.05
Years of credited service x 30
Monthly basic benefit $1621.50

If you have any remaining outstanding disability benefit overpayment under the Life and Disability Benefits Program, you are eligible to receive only 50% of the amount of any otherwise applicable increase to your monthly basic benefit in effect on or after October 1, 2007.

Early Voluntary Retirement – Prior to Age 62

If you have 30 or more years of credited service

Until age 62 and one month, your monthly basic benefit amount will be reduced for age. The reduced basic benefit will be supplemented so that you will have a total monthly benefit amount as shown in the following table:

Retirement Date and Total Monthly Benefit Amount for Determining Early Retirement Supplement Prior to Age 62 and One Month

<table>
<thead>
<tr>
<th>Retirement Date</th>
<th>Total Monthly Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-1-07 through 9-1-08</td>
<td>$3,140.00</td>
</tr>
<tr>
<td>10-1-08 through 9-1-09</td>
<td>$3,150.00</td>
</tr>
<tr>
<td>10-1-09 through 9-1-10</td>
<td>$3,160.00</td>
</tr>
<tr>
<td>10-1-10 and After</td>
<td>$3,170.00</td>
</tr>
</tbody>
</table>

After age 62 and one month, the early retirement supplement will cease and monthly basic benefits, no longer will be reduced because of your age at retirement.
WHEN YOU RETIRE

IF YOU HAVE LESS THAN 30 YEARS OF CREDITED SERVICE

If you retire voluntarily before age 62 and one month with less than 30 years of credited service, you will receive a monthly basic benefit. This basic benefit amount will be reduced for age at retirement. In addition, if you are at least age 60 with 10 or more years of credited service or have 85 points (age plus credited service), you will receive a monthly “interim” supplement, payable until age 62 and one month. The amount of this supplement is based on your age at retirement, as follows:

<table>
<thead>
<tr>
<th>Age at Retirement</th>
<th>Monthly Amount * and Effective Date of Interim Supplement Payable Prior to Age 62 and One Month for Each Year of Credited Service Retires With Benefits Payable Commencing on or After October 1, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-1-07 through 9-1-08</td>
</tr>
<tr>
<td>55</td>
<td>$</td>
</tr>
<tr>
<td>56</td>
<td>22.35</td>
</tr>
<tr>
<td>57</td>
<td>26.35</td>
</tr>
<tr>
<td>58</td>
<td>31.90</td>
</tr>
<tr>
<td>59</td>
<td>37.35</td>
</tr>
<tr>
<td>60</td>
<td>41.65</td>
</tr>
<tr>
<td>61</td>
<td>48.25</td>
</tr>
</tbody>
</table>

*Prorated for intermediate ages computed on the basis of the number of complete calendar months by which you are under the age you will attain on your next birthday.

After age 62 and one month, the interim supplement will cease and you will continue to receive a monthly basic benefit reduced for age, if your age and credited service at retirement total less than 85. If your age and credited service at retirement total 85 or more, you will receive, at age 62 and one month, a monthly basic benefit unreduced because of your age at retirement.

If you retire under any type of retirement after age 62 with less than 30 years of credited service, you will receive a monthly basic benefit.

“Early Retirement” and “Interim” Supplements — Limitations

If you retire voluntarily and become eligible for a Social Security Disability Insurance Benefit (SSDIB), your monthly supplement will be reduced by the temporary benefit amount in effect at the time of your SSDIB award. This temporary benefit amount will be computed the same as for retirement under mutually satisfactory conditions, as described below.
Mutually Satisfactory Retirement and Temporary Benefits
You may be eligible for a mutually satisfactory retirement as early as age 55 (age 50 in the event of a closing of a GM plant in an area where no other GM plant is located), if you are otherwise eligible and meet all the required Standards set forth in the Pension Plan. In such event, you will receive a monthly basic benefit unreduced for age.

In addition, you may receive a monthly temporary benefit until you reach age 62 and one month. The amount of your monthly temporary benefit will be based on your years of credited service, up to 30, and your retirement date, as shown in the chart on this page.

If you retire with 30 or more years of credited service, you also could receive a monthly early retirement supplement, payable until age 62 and one month.

<table>
<thead>
<tr>
<th>Retirement Date</th>
<th>Monthly Temporary Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-1-07 to 9-1-08</td>
<td>$50.80</td>
</tr>
<tr>
<td>10-1-08 to 9-1-09</td>
<td>$51.00</td>
</tr>
<tr>
<td>10-1-09 to 9-1-10</td>
<td>$51.20</td>
</tr>
<tr>
<td>10-1-10 &amp; After</td>
<td>$51.40</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
</tr>
<tr>
<td></td>
<td>$1,524.00</td>
</tr>
<tr>
<td></td>
<td>$1,530.00</td>
</tr>
<tr>
<td></td>
<td>$1,536.00</td>
</tr>
<tr>
<td></td>
<td>$1,542.00</td>
</tr>
</tbody>
</table>

Total and Permanent Disability Retirement
You may be eligible, upon application, for a monthly total and permanent disability (T&PD) pension benefit. To be eligible, you (1) need to be currently employed with at least 10 years of credited service, (2) must become totally and permanently disabled before age 65, and (3) must have been on a disability leave for five months (except in the case of an occupational injury or disease or in the case of a terminal condition). If you become eligible, this T&PD benefit will cease if, prior to age 65, you (1) recover from total and permanent disability, or (2) become gainfully employed for purposes other than rehabilitation. (Except for purposes of rehabilitation or employment necessary to avoid a reduction or termination of Workers’ Compensation benefits under state law.)

Your monthly basic benefit rate will be the same as if you had retired at or after age 62. Your rate will be multiplied by your credited service at the time of your disability retirement. In addition, if Social Security determines that you are not eligible for disability benefits under the Social Security Act, you may receive a temporary benefit from GM each month.

This monthly temporary benefit will be computed in the same way as for retirement under mutually satisfactory conditions, as described previously. The temporary benefit is payable to age 62 and one month.

If you have 30 or more years of credited service, you also may be eligible to receive a monthly early retirement supplement, payable to age 62 and one month.

Upon attaining age 65, a total and permanent disability retirement will be reclassified to a normal retirement.
CREDITED SERVICE

Any calendar year in which you have 1,700 compensated hours will count as a full year of credited service. Holiday pay, jury duty pay, bereavement pay and vacation pay are included in compensated hours. If you have less than 1,700 compensated hours, you will receive proportionate credit, to the nearest 1/10 of a year, based on your compensated hours.

In determining your credited service, hours at premium pay are considered as straight-time hours.

If you are on an approved military leave, or on a disability leave and receive Workers’ Compensation, you may receive credited service for such absence.

Commencing with the calendar year 1968, you are eligible for credited service for each calendar week of sick leave or layoff in a year during which you receive pay for 170 or more hours. After 1970, up to 1,530 hours may be credited for a sick leave or layoff, which continues into the following year. An employee placed on layoff on or after March 1, 1982, with 10 or more years of seniority, may be credited with up to 1,700 additional hours for the period of continuous absence due to the layoff.

If you are on leave from work, on or after October 1, 1993, for reasons established under the Family and Medical Leave Act of 1993, your absence may be counted to prevent a break in “service.”

For retirement with benefits payable commencing on or after October 1, 2007, your credited service for the period prior to January 1, 1996 will not be less than seniority as of December 31, 1995.

FOUNDRY/ASBESTOS SERVICE
An employee with seniority on or after October 1, 2007, who at retirement has more than 10 years of credited service accrued on certain job classifications in foundry or asbestos operations, at designated GM locations, will receive additional credited service.

Credited Service Information
Credited service information may be obtained at any time by accessing your records through www.gmbenefits.com or by contacting the GM Benefits & Services Center at 1-800-489-4646.

Loss of Credited Service
You will lose all credited service under the Pension Plan if you quit, are discharged, or break seniority for any other reason. However, if you have worked one hour on or after January 1, 1989, and you have 5 or more years of credited service, your pension benefits are vested. If you are vested and are re-employed by GM, your credited service will be reinstated. If you have prior credited service, which has not been reinstated, you should contact the GM Benefits & Services Center at 1-800-489-4646.
ALTERNATIVE “SERVICE” TO DETERMINE VESTED PENSION

If you break seniority before age 65 and have less than 5 years of credited service, but have 5 years of “service,” as determined below, you would be eligible for a vested pension benefit. For example, if you have only 4 years of credited service, but have 5 years “service,” the 5 years “service” would provide you a vested pension benefit. However, the monthly benefit amount would be based on 4 years of credited service.

You first become eligible to be covered for the “service” provision when you (1) attain age 21, or (2) complete 1 year of “service,” whichever is later. You receive 1 year of “service” when you complete 750 hours of “service” in a 12 consecutive month period, beginning with your employment commencement date. You complete an hour of “service” for each hour for which you are paid by GM for working, or for having been entitled to work.

No “service” is granted for any (1) period of employment prior to age 18, or (2) year in which you are paid by GM for working less than 750 hours.

A 1-year break in “service” will occur if you do not complete 375 hours of “service” in any 12 consecutive month period. Hours paid for vacation and sickness or disability, which are not worked, may be counted to prevent a break in “service.” In addition, certain periods of absence because of pregnancy, childbirth, adoption or child care immediately following birth or placement of a child related to adoption, may be counted after October 1, 1985, to prevent a break in “service.” You will lose your years of “service” if the number of consecutive 1-year breaks equals, or exceeds, the greater of (1) the aggregate years of “service” you had before such break, or (2) 5 years.

PROVIDING BENEFITS FOR SURVIVING SPOUSE IN THE EVENT OF YOUR DEATH AFTER RETIREMENT

After retirement, an automatic monthly benefit for your surviving spouse will be provided in the event of your death. Survivor benefits will not, however, be payable unless (1) you have been married to your spouse for one year, and (2) you and your spouse both are living on the date the coverage otherwise would be effective. You will have the surviving spouse coverage at retirement unless you reject it. Applicable survivor spouse coverage cost will apply and be deducted from your monthly pension benefit.

If you retire under a normal or early retirement or as a T&PD Retirement or with a deferred vested benefit, you may elect instead a Contingent Annuitant Option, which provides a survivor benefit to any person (spouse or non-spouse) that you designate. If you are married at the time of your retirement, written consent of your spouse must be obtained.

An employee separated with deferred vested benefits has automatic surviving spouse protection at commencement of vested benefits.

If you retire due to total and permanent disability before age 55 with less than 30 years of credited service, you will have an actuarially determined 50% joint and survivor coverage for your spouse.

These survivor benefits can be rejected by a married employee only with the written consent of the spouse, witnessed by a notary public, during the 90 days prior to its effective date.
If survivor coverage is rejected, it will not be available in the future, and, if you predecease your spouse, your spouse will not receive any surviving spouse benefits.

**Military** - An employee on an approved United States military leave who dies while in active service, will be treated as having returned to work the day before their date of death for purposes of determining survivor benefits, if applicable.

**OTHER BENEFIT PROGRAM COVERAGE IMPACTED WITH RETIREMENT**

**Workers' Compensation Offset**
Workers’ Compensation benefits paid to retired employees may be deducted from GM pension benefits otherwise payable. No such deduction will be made where Workers’ Compensation payments are paid under a claim filed within two years after breaking seniority.

Effective January 1, 2010, for employees who are injured and retire prior to January 1, 2010, Michigan Workers’ Compensation payments for such employees shall be reduced by disability retirement benefits payable under the Hourly Rate Employees Pension Plan to the extent that the combined Workers Compensation payments, initial Social Security Disability Insurance Benefit amount, and the initial disability retirement benefit (per week) exceed the employee’s gross Average Weekly Wage at the time of injury. In no event shall such reduction be greater than the disability retirement benefit payable. Additionally, for employees who retire on and after January 1, 2010, Michigan Workers’ Compensation payments shall be reduced by pension or retirement, payments made under the Hourly Rate Employees Pension Plan.

**Application for Pension**
You may apply for pension benefits by contacting the GM Benefits & Services Center at the following phone number: 1-800-489-4646. You should contact the GM Benefits & Services Center at least 30 days but no more than 90 days prior to your planned retirement date.

**Social Security**
Social Security benefits are in addition to your GM lifetime pension benefits. You and GM contribute equally to the cost of your Social Security benefits. Your share of the cost is deducted from your pay.

Your GM basic pension benefits are not affected by your eligibility for Social Security old-age benefits. However, the supplements and temporary benefit are reduced, or eliminated, when you become eligible for Social Security Disability Benefits.

**Life Insurance**
In most cases, when you are retired from active service and are receiving benefits under the Pension Plan (except deferred vested benefits), or you are an In-Progression employee who separated from employment after attaining age 55 and 10 years seniority, your Basic Life Insurance and Extra Accident Insurance, may be continued subject to the applicable Program’s provisions. If your Basic Life Insurance is canceled while you were on a layoff or leave of absence, such coverage may be reinstated. Basic Life Insurance will be subject to the Plan provisions in effect at the time of your retirement or separation.
For Traditional employees, Extra Accident Insurance ceases eighteen months following the employee’s retirement date. For In-Progression employees who have attained age 55 and 10 years of seniority, Extra Accident Insurance does not cease, but will reduce to $7,500 immediately upon separation.

Survivor Income Benefit Insurance ceases when you retire or when you separate from employment as an In-Progression employee. However, Survivor Income Benefit Insurance is continued to age 65 for retirees receiving total and permanent disability benefits under the Pension Plan.

Optional and/or Dependent Life Insurance in force when you retire or separate from employment as an In-Progression employee may be continued, provided (1) your Basic Life Insurance remains in force, and (2) you pay the required monthly contributions.

Personal Accident Insurance in force when you retire or separate from employment as an In-Progression employee after attaining age 55 and 10 years of seniority may be continued provided you pay the required contributions. However, if you are insured for an amount greater than $150,000, such amount shall be automatically reduced to $150,000 on the effective date of your retirement or separation from employment. Additionally, Personal Accident Insurance in force for a dependent family member also will automatically reduce as may be appropriate. Personal Accident Insurance may be continued during retirement or separation from employment whether or not Basic Life Insurance is in effect.

Amount of Life Insurance following Retirement or Separation:

If you are a Traditional Employee and have 10 or more years of participation at retirement, your Basic Life Insurance will be continued, without cost to you. However, the amount of your Basic Life Insurance will be reduced by 2% each month beginning 18 months after retirement, until the continuing amount equals 1-1/2% for each year of participation, times the amount in force at retirement.

For example, an employee with 30 years of participation, who has $49,000 of Basic Life Insurance at retirement, would have the amount of coverage reduced by $980 each month beginning 18 months after retirement:

\[
\text{\$49,000} \times 2\% = \text{\$980}
\]

and $22,050 of continuing life insurance after all reductions, as follows:

\[
1-1/2\% \times 30 = 45\% \times \text{\$49,000} = \text{\$22,050}
\]

If you are an In-Progression employee and separate from employment after attaining age 55 and 10 years of seniority, your Basic Life Insurance will be continued without cost to you. However, the amount of your Basic Life Insurance will be reduced to $15,000 immediately upon separation.

**Health Care Coverages**

Effective January 1, 2010, GM no longer provides company sponsored health care to UAW affiliated retirees or their eligible dependents. UAW affiliated retirees (and their eligible dependents) may be eligible to receive health care coverage from the UAW Retiree Medical Benefits Trust (the “Trust”), which is completely separate and independent from GM. The Trust is responsible for providing Retirees information on plan provisions coverage and eligibility. UAW members or affiliated Retirees should direct any questions regarding Trust coverages and eligibility directly to the Trust at Retiree Health Care Connect 1-866-637-7555.
SECTION 7: IN THE EVENT OF DEATH OR DISMEMBERMENT

LIFE AND DISABILITY BENEFIT PROGRAM COVERAGE

You are eligible for Basic Life Insurance, Optional Life Insurance, Dependent Life Insurance, Personal Accident Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance coverages on the day your employment commences. If you are not at work on the day your coverages otherwise would begin, these coverages begin the day you return to active work.

“Years of Participation”, and “Years of Seniority” - See Glossary of Terms

Beneficiaries and Payment of Benefits
Your beneficiary will receive the Basic Life Insurance benefit (less any Accelerated Benefits Option payment). You may name anyone you wish as your beneficiary (or beneficiaries). You may change or view your beneficiary designation at any time by accessing the Life Insurance link at www.gmbenefits.com. This life insurance beneficiary application provides the capability for you to designate and submit your life insurance beneficiary online and receive immediate confirmation of its acceptance.

You may change your beneficiary at any time. If circumstances in your life change, such as marriage, birth of a child, death of a spouse or divorce, you may want to consider the appropriateness of your beneficiary designation.

It is very important that you take the time to make sure that your life insurance beneficiaries are up to date and reflect the people that you desire to receive the life insurance proceeds in the event of your death. This is especially important for those who have been divorced. It is critical that you update your beneficiary as a divorce decree does not change your beneficiary of record.

You may still obtain a beneficiary designation form by contacting the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

MetLife Total Control Account®
The MetLife Total Control Account® (TCA) is an insurance settlement option, which is a method for paying insurance or annuity benefits in full. The TCA gives beneficiaries immediate access to their insurance proceeds. If the amount of proceeds payable is $5,000 or more, a TCA will usually be established in the beneficiary’s name once their claim is approved. The beneficiary will receive a personalized “draft book” and a kit that includes a Customer Agreement and provided additional information regarding their account. By using one of the personalized “drafts”, the beneficiary can draw on their own TCA for up to the entire amount at any time.

With the Total Control Account® your beneficiary earns interest on the insurance proceeds at a rate guaranteed to equal or exceed a leading national index of money market rates. There are no monthly maintenance fees, service charges or transaction charges and there are no charges for withdrawals or drafts, or for printing or reordering drafts. Fees may be charged for special services or for an overdrawn TCA. Beneficiaries receive quarterly
In the Event of Death or Dismemberment

statements detailing the activity on the account and statements will be sent monthly if there has been withdrawal activity. The account is guaranteed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. The Total Control Account® is not available to beneficiaries residing outside of the United States. Details regarding the Total Control Account® will be provided to the beneficiary when a claim is filed.

An additional benefit called Extra Accident Insurance, may be payable to your Basic Life Insurance beneficiary for your death, or to you for loss of certain bodily members, or loss of eyesight as the result of an accident. For Extra Accident Insurance to be payable, (1) the loss must occur within two years of the accident, or (2) your death must occur within one year following the accident. Your loss or death must not in any way result from or be caused or contributed to, wholly or partly, directly or indirectly, by (1) disease or bodily or mental infirmity, or by medical or surgical treatment or diagnosis thereof, (2) any infection, except infection caused by an external visible wound accidentally sustained, (3) hernia, no matter how or when sustained, (4) war or any act of war or (5) intentional self-destruction or intentionally self-inflicted injury, while sane or insane.

Notwithstanding the provisions above and, other than for medical malpractice or other medical errors, a claim for Extra Accident Insurance will not be denied on the basis that a physical illness or infection either (1) contributed to an accidental covered Loss or (2) hastened the occurrence of an accidental covered Loss.

Three times the scheduled benefit amount of Extra Accident Insurance in force may be payable if death results from an accidental bodily injury caused solely by employment with GM. The above Extra Accident Insurance exclusions also apply to death resulting from employment with GM.

<table>
<thead>
<tr>
<th>Base Hourly Rate (1)</th>
<th>Active Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Life Insurance</td>
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<tr>
<td>Under 14.30</td>
<td>$32,500</td>
</tr>
<tr>
<td>14.30 — 14.64</td>
<td>$33,500</td>
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<tr>
<td>14.65 — 14.99</td>
<td>$34,000</td>
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<td>15.00 — 15.34</td>
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<tr>
<td>15.35 — 15.69</td>
<td>$36,000</td>
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<tr>
<td>15.70 — 16.04</td>
<td>$36,500</td>
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<td>16.05 — 16.39</td>
<td>$37,500</td>
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<tr>
<td>16.40 — 16.74</td>
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<td>16.75 — 17.09</td>
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<td>20.95 — 21.29</td>
<td>$48,500</td>
</tr>
<tr>
<td>21.30 — 21.64</td>
<td>$49,000</td>
</tr>
</tbody>
</table>
### IN THE EVENT OF DEATH OR DISMEMBERMENT

<table>
<thead>
<tr>
<th>Basic Hourly Rate</th>
<th>Basic Life Insurance</th>
<th>Extra Accident Insurance (2)</th>
<th>Total Basic: Life and Extra Accident Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>45,000</td>
<td>22,500</td>
<td>67,500</td>
</tr>
</tbody>
</table>

(1) For this purpose, base hourly rate includes premium for necessary continuous 7-day operations, but does not include overtime, night shift premium, or any cost-of-living allowance.

(2) Three times the scheduled amount may be payable for an occupation-related death.
IN THE EVENT OF DEATH OR DISMEMBERMENT

**Application for Benefits**
A beneficiary needs to make a claim on a form provided by the GM Benefits & Services Center. The GM Benefits & Services Center may be reached by calling 1-800-489-4646 the Life Insurance prompt should be selected and they will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

**Survivor Income Benefits**
Survivors may be eligible for monthly Survivor Income Benefit Insurance in addition to Basic Life Insurance and Extra Accident Insurance benefits, if you die before you retire. Coverage is continued to age 65 for an employee receiving Total and Permanent Disability Benefits under the Pension Plan.

Two types of monthly Survivor Income Benefits are provided under the Life and Disability Benefits Program: a Transition Benefit and a Bridge Benefit.

**Transition Benefit**
Benefits of $700 per month may be payable to your eligible survivors for up to 24 months.

However, the monthly Transition Benefit will be $375 if the survivors are, or become, eligible for certain Social Security benefits.

**Bridge Benefit**
Benefits of $700 per month may be payable to your surviving spouse who has received 24 monthly payments of Transition Benefits. Bridge Benefits cease if the surviving spouse (1) remarries, (2) attains either age 62 or the age at which full widow’s or widower’s insurance benefits or Retirement Insurance Benefits become payable under Social Security, or (3) dies.

The Bridge Benefit shall be reduced by an amount equal to the full amount of any monthly benefit payable to a surviving spouse under any pension plan or retirement program then in effect to which the company or any of its subsidiaries has contributed.

Bridge Benefits are not payable for any month for which a surviving spouse could qualify for a mother’s or father’s insurance benefit under Social Security, whether or not your surviving spouse actually receives the mother’s or father’s benefit.

**Application for Survivor Income Benefits**
An eligible survivor needs to make a claim on a form provided by the GM Benefits & Services Center. The GM Benefits & Services Center may be reached by calling 1-800-489-4646. The Life Insurance prompt should be selected and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

**Eligible Widow or Widower**
An eligible widow or widower will have Survivor Income Benefits reduced by any benefits to which the surviving spouse is entitled under the Pension Plan.
IN THE EVENT OF DEATH OR DISMEMBERMENT

PENSION SURVIVOR BENEFITS

Death Prior to Retirement — If Eligible to Retire
The surviving spouse of an employee who dies before retirement can be automatically provided a monthly income for life under the Pension Plan. To be eligible, the surviving spouse must have been married to the deceased employee at least one year prior to the employee’s death. This benefit is available if the deceased employee would have been either eligible or approved to retire under the total and permanent retirement provisions* or if the deceased employee were eligible to retire voluntarily, immediately prior to the employee’s death, as follows:

- At age 65 or older, or
- At age 60 or older with 10 or more years of credited service, or
- At age 55 or older with years of age and credited service totaling 85 or more, or
- Under age 55 with 30 or more years of credited service.

The monthly benefit for the eligible survivor is determined as though the employee had retired voluntarily on the date of death and had not rejected the pension survivor coverage. This survivor benefit amount would be the same as under the survivor coverage available during retirement.

*Note: The requirement for an employee to be on a disability leave for five months in order for the spouse to be eligible for pension benefits is waived if the employee’s death was directly or indirectly a result of the condition for which the disability leave was granted.

Pre-Retirement Survivor Protection for Death Prior to Retirement — If Not Eligible to Retire
If an employee dies before retirement and was not eligible to retire voluntarily immediately prior to death, pre-retirement survivor coverage can provide a monthly income for life to the eligible surviving spouse, provided:

- The employee has at least 5 years of credited service.
- The spouse has been married to the employee for at least one year immediately prior to the employee’s death.

An employee separated with deferred vested benefits has this pre-retirement coverage in effect until commencement of deferred vested benefits.

Any monthly benefit amount payable to an eligible surviving spouse is based on the monthly deferred vested benefit amount that would have been payable at age 65 to the deceased employee. Any monthly benefit amount payable to an eligible surviving spouse is equal to 50% of the deferred vested benefit amount. The survivor benefit can be commenced, unreduced for age, when the deceased employee would have attained age 65. At the election of the eligible surviving spouse, the benefit can be commenced, reduced for age, at the earliest age the deceased employee could have retired voluntarily.

Survivor Benefits After Retirement
If you have (1) been married at least one year when the survivor coverage becomes effective (generally at retirement), and (2) not rejected the coverage with your spouse’s written consent, a lifetime monthly benefit will be provided automatically for your surviving spouse in the event of your death. An employee separated with
deferred vested benefits will receive information about this coverage when benefits commence. To provide a survivor benefit, there will be a reduction in the amount of your lifetime monthly basic benefit.

If Your Spouse Dies or You Are Divorced After Retirement
You may revoke the regular survivor coverage after it becomes effective if (1) your designated spouse dies, or (2) you are divorced by final court decree and a Qualified Domestic Relations Order so provides. If you revoke this coverage, your Basic Benefit would be restored to the amount payable without the coverage. Restoration is effective after proper notice and documents are received by the Company. Your previously designated survivor no longer will be eligible for a benefit following your revocation.

If you have a Qualified Domestic Relations Order, you should send it to:

GM Benefits & Services Center
P.O. Box 770003
Cincinnati, OH 45277-0066
Telephone Number: 1-800-489-4646

If you marry, or remarry, after retirement and you had not previously rejected the survivor coverage when it was available to you, you may elect, or re-elect, the coverage with respect to your new spouse. You must contact the GM Benefit Services Center prior to the date you have been married 18 months at 1-800-489-4646. Effective with the one-year anniversary of your marriage or remarriage, the applicable reduction in your monthly basic benefit will commence, provided eligibility is met. In no event shall such coverage be effective if you previously rejected survivor coverage. You must contact the GM Benefits & Services Center if you wish to revoke the survivor coverage, and spousal consent will be required.

This chart provides answers to some of the more common questions asked about pension survivor coverage.

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the pre-retirement survivor benefit the same as the regular surviving spouse benefit?</td>
<td>No. The pre-retirement survivor benefit is 50% of your age 65 deferred vested benefit. The regular, post-employment, survivor benefit is 65% of your reduced age 62 basic benefit.</td>
</tr>
<tr>
<td>How do I elect the pre-retirement survivor coverage?</td>
<td>The pre-retirement survivor coverage is automatic. You do not need to elect it.</td>
</tr>
<tr>
<td>How long is the pre-retirement survivor coverage in effect?</td>
<td>The pre-retirement survivor coverage is in effect until you become eligible for the regular survivor coverage. The regular survivor coverage is available when you attain the earliest age at which you would be eligible to retire voluntarily.</td>
</tr>
</tbody>
</table>

POST-EMPLOYMENT

| When does the regular survivor coverage become effective? | The regular survivor coverage becomes effective at the latest of: (1) your retirement, (2) one year of marriage, if married when the coverage otherwise would have been effective, or (3) your attainment of age 55 following disability retirement with less than 30 years of service. |
IN THE EVENT OF DEATH OR DISMEMBERMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What information must I supply to GM?</td>
<td>Proof of your marriage, proof of your spouse’s age and your spouse’s Social Security number.</td>
</tr>
<tr>
<td>What would be the reduction in my basic pension benefit while I am living if my spouse and I are within five years of the same age?</td>
<td>5% of your age 62 basic pension benefit.</td>
</tr>
<tr>
<td>What would be the reduction if my spouse is more or less than five years younger than I am?</td>
<td>The 5% reduction would increase or decrease by 1/2% for each 12 months of age difference in excess of five years.</td>
</tr>
<tr>
<td>What monthly benefit would be payable to my surviving spouse after my death?</td>
<td>The regular survivor benefit is 65% of your reduced age 62 basic benefit.</td>
</tr>
<tr>
<td>Can I revoke the regular survivor coverage after I retire if (1) my spouse dies, or (2) we are divorced?</td>
<td>Yes, in both cases. To do so, you must provide GM (1) a copy of the death certificate, or (2) a Qualified Domestic Relations Order which provides for the revocation of the coverage.</td>
</tr>
<tr>
<td>If I remarry after I retire, may I elect the regular survivor coverage for my new spouse?</td>
<td>Yes, provided you previously had not rejected the regular survivor coverage when it was available to you. You must apply prior to the date you have been married 18 months for the coverage to be effective.</td>
</tr>
</tbody>
</table>

**Joint and Survivor Coverage**

If you retire due to total and permanent disability, before age 55 with less than 30 years of credited service, joint and survivor (J&S) coverage will be provided automatically for your spouse. The J&S coverage would pay your spouse 50% of your actuarially reduced monthly benefit, in the event you die before your spouse. The automatic survivor coverage may be waived during the 90 days prior to its effective date, by specific written rejection which includes written consent of your spouse witnessed by a Notary Public.

The J&S coverage is applicable only if you are married (1) on the date the coverage becomes effective, and (2) throughout the one-year period ending on the date of your death. J&S benefit payments to your survivor commence on the first of the month following the month you would have attained age 55.

You can revoke the J&S coverage after it becomes effective if (1) your spouse dies, or (2) you are divorced by final court decree and a Qualified Domestic Relations Order so provides. Otherwise, this coverage cannot be canceled until you attain age 55.

The regular survivor coverage becomes available on the first of the month following your attainment of age 55, whether or not you reject the J&S coverage. This means that you may (1) reject the J&S coverage prior to age 55, and (2) still be eligible for the regular survivor coverage at age 55.

**Contingent Annuitant Option**

If you retire under a normal or early retirement as a T&PD Retirement or with a deferred vested benefit, you may elect a Contingent Annuitant Option, which provides a survivor benefit to any person (spouse or non-spouse) that you designate. The Contingent Annuitant Option is in lieu of regular survivor coverage (if applicable). If you are married at the time of your retirement, written notarized consent of your spouse on appropriate Plan forms must be obtained. For normal or early retirements, the monthly benefit payable after your death to your designated contingent annuitant can equal any amount, in 5% increments, up to and including 100% of your actuarially reduced age 62 basic benefit. For T&PD Retirements or deferred vested retirement benefits, a 75% Contingent
IN THE EVENT OF DEATH OR DISMEMBERMENT

Annuitant Option is applicable. While you are living, your monthly basic benefit will be reduced by an actuarial value in order to provide this contingent annuitant benefit. Once the Contingent Annuitant Option becomes effective, it cannot be rescinded unless at the time of your retirement you are not married, designate a contingent annuitant, and then subsequently marry in retirement. Designation of a contingent annuitant does not create eligibility for any other benefit Plan or Program.

Health Care Coverage for Survivors
Because health care coverage is not available to any (1) surviving spouse of a former employee eligible only for deferred vested pension benefits, (2) spouse or former spouse receiving, or eligible to receive, only a pre-retirement survivor benefit under the Pension Plan or (3) surviving spouse of an employee hired on or after October 15, 2007, the following paragraphs of this section do not apply to any such surviving spouse. Continuation provisions for an eligible and enrolled surviving same-sex domestic partner generally track those for surviving spouses. Contact the GM Benefits & Services Center for additional information if required.

If You Die Prior to Attaining Eligibility for Health Care, your surviving spouse may enroll, on a self-paid basis, for core health care coverages (no dental or vision) provided you were married for at least one full year immediately preceding the date of your death. Self-paid core coverages can be elected by your survivor for a period of 24 months. Dependents who are eligible as of the employee’s date of death can be included if the surviving spouse elects such coverages.

If You Die While an Active Employee, After Becoming Eligible for Health Care and Leave No Surviving Spouse, coverage for your dependents will cease at the end of the month in which you die. Surviving dependent children will be eligible for COBRA continuation.

If You Die Before You Are Eligible to Retire Voluntarily, your surviving spouse will be eligible to continue core health care coverages (no dental or vision), on a self-paid basis, for the first 24 months following the month in which you die, provided you were married for at least one full year immediately preceding the date of your death. Additionally, if on the date of your death, your spouse’s age is at least 45, or your seniority at that date, when added to your spouse’s age, totals 55 or more, your spouse will be eligible for:

- GM contributions for core health care coverages for the first twelve months following the month in which you die, and, thereafter,
- Continuation of core coverages, on a self-paid basis, until the earlier of (a) remarriage, (b) the end of the month in which age 62 is attained, or (c) death. Coverage for dependent children may be continued while your surviving spouse is eligible to continue coverage and while they continue to meet the eligibility criteria for dependent children.

If You Die While An Active Employee 65 or Older, After Terminating Your Seniority At or After Age 65 or Older (For Any Reason Other Than Discharge For Cause), After You Become Eligible to Retire, or After Retirement, GM no longer provides company sponsored health care to the surviving spouse or their eligible dependents of UAW affiliated retiree eligible employees. Such UAW affiliated surviving spouses (and their eligible dependents) may be eligible to receive health care coverage from the UAW Retiree Medical Benefits Trust (the “Trust”), which is completely separate and independent from GM. The Trust is responsible for providing Retirees information on plan provisions, coverage and eligibility. UAW members or affiliated Surviving Spouses should direct any questions regarding Trust coverages and, eligibility directly to the Trust at Retiree Health Care Connect 1-866-637-7555.
If You Die As a Result of an Accidental Injury Caused Solely by Employment with GM, and your spouse was not retirement eligible, health care coverages that were available to you will be provided, subject to all Program provisions, for your surviving spouse until the earlier of the date when your spouse (1) dies, or (2) remarries. Eligible dependent children may be included as indicated earlier. If your spouse was retirement eligible, GM no longer provides company sponsored health care to the surviving spouse or their eligible dependents of UAW affiliated retirement eligible employees. Such UAW affiliated surviving spouses (and their eligible dependents) may be eligible to receive health care coverage from the UAW Retiree Medical Benefits Trust (the “Trust”), which is completely separate and independent from GM. The Trust is responsible for providing Retirees information on plan provisions, coverage and eligibility. UAW members or affiliated Surviving Spouses should direct any questions regarding Trust coverages and, eligibility directly to the Trust at Retiree Health Care Connect 1-866-637-7555.

IN ADDITION TO THE COVERAGES PROVIDED ABOVE, THE FOLLOWING PROTECTION IS AVAILABLE UNDER THE LIFE AND DISABILITY BENEFITS PROGRAM:

**Accelerated Benefits Option**

If you are diagnosed as having a terminal illness with a life expectancy not to exceed 12 months, you may be eligible to receive an Accelerated Benefits Option payment of up to 80%, but not less than $1,000, of your Basic Life Insurance. However, if your Basic Life Insurance would be reduced within 12 months following the date the Accelerated Benefits Option is approved for payment, such payment will be limited to 80% of the fully reduced amount of your Basic Life Insurance.

Additionally, you may be eligible to receive an Accelerated Benefits Option payment of up to 80%, but not less than $1,000 of your Optional Life Insurance. An Accelerated Benefits Option payment will not affect any Extra Accident Insurance benefits to which you may be entitled.

If your dependent spouse is diagnosed as having a terminal illness with a life expectancy not to exceed 12 months, you may access a portion of your spouse Dependent Life Insurance coverage.

**An Accelerated Benefits Option payment will be made** (1) as of the date the insurance company certifies all eligibility requirements are met, (2) only once, under each coverage, regardless of the amount elected, (3) only in one lump sum (4) only if you are living when payment is made (Basic Life Insurance and Optional Life Insurance) or (5) only if your spouse or surviving spouse is living when the payment is made (Dependent Life Insurance).

**An Accelerated Benefits Option payment will be reduced by** any benefits paid to you under any GM benefit Plan which should not have been paid or should have been paid in a lesser amount.

**An Accelerated Benefits Option payment will not be made if** (1) your Basic Life Insurance, Optional Life Insurance and spouse Dependent Life Insurance is not in force, (2) you are making contributions for Basic Life Insurance, (3) all or a portion of your Basic Life Insurance or Optional Life Insurance is to be paid to a former spouse and/or child(ren) as part of a divorce agreement, (4) you previously received payment of Basic Life Insurance, Optional Life Insurance or spouse Dependent Life Insurance as an Accelerated Benefits Option,
IN THE EVENT OF DEATH OR DISMEMBERMENT

regardless of the amount paid, (5) you are not living as of the date the insurance company certifies all eligibility requirements are met (Basic Life Insurance or Optional Life Insurance), (6) your spouse is not living as of the date the insurance company certifies all eligibility requirements are met (spouse Dependent Life Insurance) or (7) you are totally and permanently disabled drawing out your life insurance benefits.

You may be required to be examined by a physician or physicians designated by the insurance company, at the insurance company’s expense, for the purpose of determining if you are terminally ill and have a life expectancy not to exceed 12 months for Basic Life Insurance or Optional Life Insurance.

Your dependent spouse or surviving spouse may be required to be examined by a physician or physicians, designated by the insurance company, at the insurance company’s expense, for the purpose of determining if your spouse is terminally ill and has a life expectancy not to exceed 12 months.

Upon your death Basic Life Insurance and/or Optional Life Insurance proceeds payable to your beneficiary will be reduced by the amount of any Accelerated Benefits Option payment. Upon the death of your spouse, spouse Dependent Life Insurance proceeds payable to you will be reduced by the amount of the Accelerated Benefits Option payment.

The total of an Accelerated Benefits Option payment and the amount of Basic Life Insurance and Optional Life Insurance payable at your death may never exceed the amount of Basic Life Insurance and Optional Life Insurance which would otherwise have been payable without the Accelerated Benefits Option payment.

The total of an Accelerated Benefits Option payment and the amount of spouse Dependent Life Insurance coverage payable at your spouses’ death may never exceed the amount of Dependent Life Insurance which would otherwise have been payable without the Accelerated Benefits Option payment.

An accelerated benefit under spouse Dependent Life Insurance will not be payable to a surviving spouse if such a benefit was paid to you.

If you elect to receive an accelerated benefit, the maximum amount is 80% of the amount of your Basic Life Insurance and 80% of the amount of your Optional Life Insurance in force as of the date the insurance company accepts that all requirements are met. The combined accelerated benefit amounts under Basic Life Insurance and Optional Life Insurance may not exceed $500,000.

The maximum amount of the accelerated benefit for your dependent spouse or surviving spouse is 80% of the amount of your Dependent Life Insurance in force as of the date the insurance company accepts that all requirements are met.

To apply for an Accelerated Benefits Option payment, you need to make a claim on a form provided by the GM Benefits & Services Center. The GM Benefits & Services Center may be reached by calling 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.
OPTIONAL LIFE INSURANCE

To provide additional protection for your beneficiary, you may enroll for Optional Life Insurance in amounts of $10,000, $20,000, $30,000, $40,000, $50,000, $75,000, $100,000, $125,000, $150,000, $175,000, $200,000, $250,000, $300,000, $350,000, and $400,000.

**Eligibility**

You are eligible for Optional Life Insurance on the first day of your employment with General Motors, provided Basic Life Insurance is in force. This is considered your eligibility date.

If you enroll on your eligibility date, Optional Life Insurance will become effective on your eligibility date.

If you enroll within 60 days of your eligibility date, Optional Life Insurance becomes effective on the first day of the calendar month following the date of your enrollment.

If you enroll after 60 days following your eligibility date, you must furnish proof of good health before your Optional Life Insurance will become effective. Proof of good health may be waived if you notify the GM Benefits & Services Center within 31 days of an increase in your family status (marriage, birth, or adoption).

If you become insured for Optional Life Insurance and decide to increase the amount of coverage, you must furnish proof of good health before your Optional Life Insurance will become effective.

If proof of good health is required, your coverage will become effective on the first day of the month following approval by the insurance company.

If you enroll in Optional Life Insurance and Basic Life Insurance is not in force the date the coverage would have been effective, Optional Life Insurance will become effective on the date Basic Life Insurance becomes effective.

Coverage, or an increased amount of coverage, becomes effective if you are actively at work when coverage would otherwise begin, or the first day you are actively at work thereafter. This coverage may be continued while Basic Life Insurance is in force.

**Beneficiaries**

You may name anyone you wish as your beneficiary or beneficiaries. The beneficiary need not be the same as you designate for your Basic Life Insurance.

You may change or view your beneficiary designation at any time by accessing the Life Insurance link at www.gmbenefits.com. This life insurance beneficiary application provides the capability for you to designate and submit your life insurance beneficiary online and receive immediate confirmation of its acceptance. If your beneficiary is entitled to a benefit of $5,000 or more, benefits will be payable automatically under the beneficiary’s Total Control Account Program®.
IN THE EVENT OF DEATH OR DISMEMBERMENT

You may still obtain a beneficiary designation form by contacting the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

Contributions
You contribute the full cost of Optional Life Insurance. Your monthly contribution during any calendar year will be based on your age as of December 31 of such year and will automatically increase when you reach a higher age bracket. The GM Benefits & Services Center, which processes administration of all of your life insurance coverages, can inform you of the current monthly contribution rate for your age group. You may contact the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing /speech impaired can call MetLife at 1-888-688-2860. Rates are guaranteed by the insurance company during the term of the 2015 Agreement.

DEPENDENT LIFE INSURANCE

You may enroll for Dependent Life Insurance covering your spouse/same-sex domestic partner, and each eligible dependent child. You can choose from one of the following schedules:

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Schedule I</th>
<th>Schedule II</th>
<th>Schedule III</th>
<th>Schedule IV</th>
<th>Schedule V</th>
<th>Schedule VI</th>
<th>Schedule VII</th>
<th>Schedule VIII</th>
<th>Schedule IX</th>
<th>Schedule X</th>
<th>Schedule XI</th>
<th>Schedule XII</th>
<th>Schedule XIII</th>
<th>Schedule XIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$15,000</td>
<td>$20,000</td>
<td>$25,000</td>
<td>$30,000</td>
<td>$35,000</td>
<td>$40,000</td>
<td>$45,000</td>
<td>$50,000</td>
<td>$60,000</td>
<td>$75,000</td>
<td>$100,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>Child</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$6,000</td>
<td>$8,000</td>
<td>$10,000</td>
<td>$12,000</td>
<td>$14,000</td>
<td>$16,000</td>
<td>$18,000</td>
<td>$20,000</td>
<td>$24,000</td>
<td>$30,000</td>
<td>$40,000</td>
<td>$50,000</td>
</tr>
</tbody>
</table>

Eligibility
You are eligible for Dependent Life Insurance on the first day of your employment with General Motors, provided you have an eligible dependent and Basic Life Insurance is in force. This is considered your eligibility date.

If you enroll on your eligibility date Dependent Life Insurance will become effective on your eligibility date, except for the amount of coverage on any dependent that exceeds $75,000. If you enroll at any time for an amount of coverage that exceeds $75,000, you must furnish for each dependent whose coverage amount exceeds $75,000, proof of good health on that dependent.

If you enroll within 60 days of your eligibility date, Dependent Life Insurance becomes effective on the first day of the calendar month following the date of your enrollment, except for the amount of coverage on any dependent that exceeds $75,000. You must furnish for each dependent whose coverage amount exceeds $75,000, proof of good health on that dependent.

If you enroll after 60 days following your eligibility date, you must furnish proof of each dependent’s good health before your Dependent Life Insurance will become effective. Proof of good health may be waived if you notify the GM Benefits & Services Center within 31 days of first acquiring an eligible dependent.
IN THE EVENT OF DEATH OR DISMEMBERMENT

If you become insured for Dependent Life Insurance and decide to increase the amount of coverage, you must furnish proof of each dependent’s good health before your Dependent Life Insurance will become effective. If proof of good health is required, your coverage will become effective on the first day of the month following approval by the insurance company.

If you enroll in Dependent Life Insurance and Basic Life Insurance is not in force the date the coverage would have been effective, Dependent Life Insurance will become effective on the date Basic Life Insurance becomes effective.

Coverage, or an increased amount of coverage, becomes effective if you are actively at work when coverage would otherwise begin, or the first day you are actively at work thereafter providing you have at least one eligible dependent.

Definition of Dependent
Eligible dependents are defined as follows:

- Your spouse.
- Any unmarried child
  1. Of yours from the moment of live birth, legal adoption, or legal guardianship, while such child legally resides with and is dependent upon you. “Live Birth” means that the child is born with spontaneous respiration or a heartbeat. Live birth does not include a stillbirth, miscarriage, spontaneous abortion or induced abortion,
  2. Of your spouse while such child is in the custody of and dependent upon your spouse and is residing in and a member of your household,
  3. As defined in (1) or (2) who does not reside with you but is your legal responsibility for the provision of health care,
  4. Who resides with and is related by blood or marriage to you, for whom you provide principal support as defined by the Internal Revenue Code of the United States, and who was reported as a dependent on your most recent income tax return or who qualifies in the current year for dependency tax status, or
  5. Who was eligible on the date of your death and following your death, resides with your surviving spouse, for whom the surviving spouse provides principal support as defined by the Internal Revenue Code of the United States, and was reported as a dependent on the surviving spouse’s most recent income tax return or who qualifies in the current year for dependency tax status.
- A child as defined in (1), (2), (3), (4), or (5) is included until the end of the month in which the child attains age 26, or regardless of age if totally and permanently disabled. “Totally and permanently disabled” means having any medically determinable physical or mental condition which prevents the child from engaging in substantial gainful activity and which can be expected to result in death or to be of long-continued or indefinite duration.

For the purposes of Dependent Life Insurance continued by your surviving spouse after your death, a child born after your death shall be an eligible Dependent only if such child is the issue of your surviving spouse’s marriage to you and was conceived prior to your death. Any such child shall be eligible on the same basis as a child born prior to your death.
In the event that you no longer have an eligible dependent for the spouse and/or child coverage, you are responsible for contacting the GM Benefits & Services Center at 1-800-489-4646, select the Life Insurance prompt, to cancel Dependent Life Insurance and/or dependent Personal Accident Insurance coverages. Consequently, if you do not cancel dependent coverage and a dependent claim is filed when you have no eligible dependents, the only payment for which you may be eligible will be a reimbursement of any overpaid premiums.

Same-sex domestic partners and their children shall continue to be treated as Dependents as defined under Article II, Section 10(c) of the 2011 Program with respect to claims incurred related to deaths which occurred through and including December 31, 2016. Thereafter such same-sex domestic partners and their children shall be ineligible for treatment as a Dependent under the Plan unless otherwise covered as a Dependent in accordance with the revised definition thereof contained in Article II, Section 10(c) of the 2015 Program.

**Beneficiary**
You are the beneficiary for Dependent Life Insurance. If an eligible dependent should die from any cause while you have Dependent Life Insurance in force, benefits are payable to you in a lump-sum or, if the benefit from a single claim is $5,000 or more, benefits will be payable automatically under the beneficiary’s Total Control Account Program®.

**Contributions**
You contribute the full cost of Dependent Life Insurance. Your monthly rate of contribution during any calendar year will be based on your age as of December 31 of such year and will automatically increase when you reach a higher age bracket. The GM Benefits & Services Center, which administers all of your life insurance coverages, can inform you of the current monthly contribution rate for your age group. You may contact the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

Rates are guaranteed by the insurance company during the term of the 2015 Agreement.

You may continue Dependent Life Insurance while Basic Life Insurance is in force. However, you are responsible for canceling your Dependent Life Insurance if you no longer have any eligible dependents.

If you die while Dependent Life Insurance is in effect, your surviving spouse may continue this coverage. Your surviving spouse must pay the required monthly contribution. Your surviving spouse may continue this coverage until the earlier of remarriage, or death. Contribution rates for a surviving spouse will be based on the surviving spouse’s progressing age.

**PERSONAL ACCIDENT INSURANCE**

You may be eligible to enroll for Personal Accident Insurance in units of $10,000 up to a maximum benefit of $500,000. You also may enroll your spouse and any eligible dependent children for this insurance. The maximum family coverage available is $500,000. Your spouse may be covered for 50% of your coverage amount and each eligible dependent child may be covered for 10% of your coverage amount. However, when you retire, insurance in force on any person insured may not exceed $150,000.
IN THE EVENT OF DEATH OR DISMEMBERMENT

Eligibility
You are eligible for Personal Accident Insurance on your account (personal coverage) and on the account of your family (family coverage) on the first day of your employment with General Motors, provided Basic Life Insurance is in force. This is considered your eligibility date. You may enroll for family coverage if you have at least one eligible dependent.

If you enroll on your eligibility date, Personal Accident Insurance will become effective on your eligibility date.

If you enroll after your eligibility date, Personal Accident Insurance becomes effective on the first day of the calendar month following the date of your enrollment.

If you become insured for Personal Accident Insurance and decide to increase the amount of coverage, insurance will become effective on the first day of the calendar month following the date of your change.

If you enroll in Personal Accident Insurance and Basic Life Insurance is not in force the date the coverage would have been effective, Personal Accident Insurance will become effective on the date Basic Life Insurance becomes effective.

Coverage, or an increased amount of coverage, becomes effective if you are actively at work when coverage would otherwise begin, or the first day you are actively at work thereafter. You are eligible for family coverage on the date you become eligible for personal coverage provided, you have at least one eligible dependent.

Generally, an eligible dependent includes your spouse and dependent children. The definition of an eligible dependent is contained in the Guide to Dependent Eligibility, which can be found in your enrollment kit. Additional copies of the guide may be obtained upon request by contacting the GM Benefits & Services Center at 1-800-489-4646 or TTY: 1-877-347-5225 (for the hearing/speech impaired).

Beneficiaries
You may name anyone you wish as your beneficiary or beneficiaries. The beneficiary will be the same as you designate for your Basic Life Insurance unless you designate a different beneficiary.

You may change or view your beneficiary designation at any time by accessing the Life Insurance link at www.gmbenefits.com. This life insurance beneficiary application provides the capability for you to designate and submit your life insurance beneficiary online and receive immediate confirmation of its acceptance.

Contact the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing / speech impaired can call MetLife at 1-888-688-2860.

You are the beneficiary if you suffer accidental bodily injury resulting in one of the losses described in the table below. You also are the beneficiary if your spouse or eligible dependent child suffers accidental loss of life or other loss as described in the table on the next page.
## Schedule of Losses

<table>
<thead>
<tr>
<th>Loss</th>
<th>Amount Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of life</td>
<td>The full amount</td>
</tr>
<tr>
<td>Presumption of death benefit for loss of life**</td>
<td>The full amount</td>
</tr>
<tr>
<td>Loss of both hands or both feet</td>
<td>The full amount</td>
</tr>
<tr>
<td>Loss of one hand and one foot</td>
<td>The full amount</td>
</tr>
<tr>
<td>Loss of the entire sight of both eyes</td>
<td>The full amount</td>
</tr>
<tr>
<td>Loss of speech and hearing</td>
<td>The full amount*</td>
</tr>
<tr>
<td>Loss of the entire sight of one eye and one hand or foot</td>
<td>The full amount</td>
</tr>
<tr>
<td>Loss of one hand or one foot</td>
<td>½ the full amount</td>
</tr>
<tr>
<td>Loss of the entire sight of one eye</td>
<td>½ the full amount</td>
</tr>
<tr>
<td>Loss of speech or hearing</td>
<td>½ the full amount*</td>
</tr>
<tr>
<td>Loss of thumb and index finger (of the same hand)</td>
<td>¼ the full amount*</td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>The full amount</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>¾ the full amount</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>½ the full amount</td>
</tr>
</tbody>
</table>

* No benefit amount payable following the employee’s retirement/separation from employment or under coverage continued by a surviving spouse.

**“Presumption of death” means an assumption will be made that the covered person died as a result of an accidental injury if: (1) the aircraft or other vehicle the covered person was traveling in disappears, sinks, or is wrecked; and (2) the body of the person who disappeared is not found within one year of (i) the date the aircraft or other vehicle was scheduled to arrive at its destination, if traveling in an aircraft or other vehicle operated by a common Carrier; or (ii) the date the person is reported missing to the authorities, if traveling in any other aircraft or vehicle.

** Benefits are payable to your beneficiary if you should die as a result of an accident. However, benefits are only payable if you, your spouse or dependent child sustains an accidental loss within one year of the accident.

** The loss must not in any way result from or be caused or contributed to, wholly or partly, directly or indirectly, by:

1. Suicide or self-destruction or any attempt thereat, whether sane or insane,
2. Bodily infirmity, sickness or disease,
3. Medical or surgical treatment (except medical or surgical treatment necessitated only due to an injury sustained in an accident),
4. War, declared or undeclared, or any act of war except while the employee is outside the United States and Puerto Rico on Company assignment or while insured dependents are outside the United States and Puerto Rico because of the employee’s assignment,
5. Injury sustained while serving in the armed forces of any country, for which premiums will be refunded; provided, however, that a member of an Organized Reserve Corps or National Guard Unit shall be covered during short periods of training or participation in public ceremonies,
(6) Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft. Coverage is provided when 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,

(7) The insured person’s act of aggression, participation in a felonious enterprise or illegal use of drugs.

Notwithstanding the provisions above and, other than for medical malpractice or other medical errors, a claim for Personal Accident Insurance will not be denied on the basis that a physical illness or infection either (1) contributed to an accidental covered Loss or (2) hastened the occurrence of an accidental covered Loss.

In the event of an accidental death of any insured person, if the amount payable is $5,000 or more, benefits will be paid automatically under the beneficiary’s Total Control Account Program®.

The following benefits also are available:

- **Comatose**
  If you have personal or family coverage and if you, your insured spouse, or insured dependent child become comatose within 365 days of the accident, a monthly benefit equal to 1% of the amount of coverage in force will be paid starting on the 32nd day of the coma and will continue to be paid until the earlier of 100 months or death. If the covered person regains consciousness, benefits shall cease and coverage for Personal Accident Insurance would resume only upon re-enrollment and payment of premiums.

- **Common Disaster**
  If family coverage has been elected and if you and your insured spouse suffer a loss of life in the same accident or separate accidents which occur within 48 hours of each other, the amount payable by reason of the spouse’s death will be the same as the amount payable due to your death. The maximum benefit payable for you and your spouse will not exceed $1,000,000.

- **Special Child Care Center**
  If family coverage has been elected, and if you or your insured spouse suffer an accidental loss of life, a Special Child Care Center benefit is provided in an amount equal to 5% of your full benefit or the actual amount of child care costs incurred, whichever is less, but not to exceed $6,000 per year. Benefits will be paid for up to four years for each eligible child under age 13 who is enrolled or enrolls within 90 days of the accident 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 beneficiary.
IN THE EVENT OF DEATH OR DISMEMBERMENT

- **Special Education**
  If family coverage has been elected and if you suffer an accidental loss of life, a Special Education benefit is provided for each eligible child for tuition expenses in an amount equal to 5% of your full benefit or the actual amount of the tuition, whichever is less, but not to exceed $6,000 per year. Benefits will be paid for up to four consecutive years for each child who is enrolled or enrolls within 365 days of your death as a full-time student in an accredited college or university. 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.

- **Spousal Occupational Training**
  If family coverage has been elected and if you suffer an accidental loss of life, a Spousal Occupational Training benefit is provided for your spouse to attend a formal occupational training program to qualify for active employment in an occupation for which your spouse would not otherwise qualify. Benefits are provided for expenses incurred within three years of your death and will be paid in an amount equal to 5% of your full amount or the actual amount of expenses incurred, whichever is less, but not to exceed $6,000.

  No benefit is payable after you retire/separate from employment or under coverage continued by a surviving spouse for Special Child Care Center, Special Education, or Spousal Occupational Training.

- **Seat Belt and Air Bag Benefit**
  If you, your covered spouse or your covered child suffers a loss of life as a result of a covered accident while in a private passenger car and the covered person’s seat belt was properly used, an additional benefit of ten percent (10%) of the covered person’s full amount (subject to a maximum of $25,000) will be paid. An additional benefit of ten percent (10%) of the covered person’s full amount (subject to a maximum of $25,000) will also be payable if an air bag is deployed for the seat which such person occupied and while properly using a seat belt.

- **Repatriation Expense Benefit**
  If you, your covered spouse or your covered child suffers a loss of life as the result of a covered accident, a repatriation benefit of $5,000 will be paid for the preparation and transportation of the covered person’s body to the city of such person’s principal residence, provided the death occurred at least one hundred (100) miles away from such person’s principal residence.

  Only one amount will be paid (i.e., the greatest amount) for all losses resulting from any one accident. For example: You suffer an accidental bodily injury resulting in one of the losses described in the Schedule of Loss table located in the Personal Accident Insurance - Beneficiaries section, entitling you to a payment of ½ the full amount of your coverage (e.g., loss of one hand). In the same accident, you suffer another bodily injury resulting in one of the losses described in the Schedule of Loss table located in the Personal Accident Insurance - Beneficiaries section, entitling you to a payment of the full amount of your coverage (e.g., loss of sight in both eyes). The amount paid to you will only equal the full amount (i.e., the greater amount) because the total amount paid to you for losses resulting from the same accident cannot exceed the total amount of Personal Accident Insurance in force.
IN THE EVENT OF DEATH OR DISMEMBERMENT

**Contributions**
You pay the full cost of Personal Accident Insurance.

If you die while family coverage under Personal Accident Insurance is in effect, your surviving spouse may continue this coverage for up to twelve (12) months following the month of your death at no expense. Coverage may be continued beyond twelve (12) months, provided your surviving spouse pays the required contribution. The monthly rate of contribution for any such surviving spouse will be determined as set forth in the schedule applicable to a retiree and will be based on the amount of coverage which would have been in force on the employee, as if living.

The GM Benefits & Services Center, which processes the administration of all of your life insurance coverages, can inform you of the current monthly contribution rate for Personal Accident Insurance (personal or family coverage).

You may contact the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860. Rates are guaranteed by the insurance company during the term of the 2015 Agreement.
SECTION 8: GENERAL INFORMATION

GM pays the full cost of the Pension Plan, SUB Plan, Profit Sharing Plan, Life Insurance (other than Optional Life Insurance, Dependent Life Insurance and Personal Accident Insurance) and disability benefit coverages after you become eligible while you are in active service. General Motors also contributes to the cost of legal services and to the cost of health care coverages. Contributions for health care may be required for self-paid continuation or for copayments or sanctions or as otherwise required under the rules of the Health Care Program. The amounts of the Pension Plan contributions are determined actuarially. GM SUB Plan contributions are determined under Program provisions and paid to the Trust Fund subject to the SUB Maximum Financial Liability Cap. The amount of GM’s contribution to the Profit Sharing Plan is determined by a formula set forth in the Plan. The contribution amounts under the Life and Disability Benefits Program are determined by the Carrier and GM based on claims experience. The contribution amounts for the self-insured Health Care Program also are based on claims experience. Optional Life Insurance, Dependent Life Insurance and Personal Accident Insurance coverages are made available by GM, but the full cost is borne by employees. The amount of any employee contributions to the Personal Savings Plan is determined by provisions set forth in the Plan.

RECOVERY OF BENEFIT OVERPAYMENTS

If any benefit paid to you or on your behalf (or to one of your dependents or on his or her behalf) should not have been paid, or should have been paid in a lesser amount and you fail to promptly repay the amount, to the extent permitted by applicable law the overpayment or loan may be recovered from any monies then payable, or which may become payable, to you in the form of wages or benefits, except health care benefits, payable under a GM benefit Plan. Health Care Program overpayments may be recovered from wages or other benefit Plans or Programs, as appropriate. Overpayments under other Plans or Programs will not be offset against health care benefits.

If you wish, you may direct GM to withhold an amount up to 10% of your (1) Personal Savings Plan, or (2) monthly pension benefit, to repay the benefit overpayment or the full amount of the loan.

Amounts of life insurance under the Life and Disability Benefits Program will be administered in compliance with state insurance laws, that conflict with insurance policy provisions, to the extent legally required and to the extent such laws are not preempted by federal law.

ELIGIBILITY OF SAME-SEX DOMESTIC PARTNERS

With regard to all welfare benefit and pension Plans effective with retirements July 1, 2013 and later, lawfully married same-sex couples will have the same options and be subject to the same restrictions as lawfully married heterosexual couples. With respect to plan administration, the term ‘spouse’ shall include the parties to a marriage of two persons of the opposite sex or of two persons of the same sex provided the marriage was lawful in the jurisdiction in which it occurred. If a marriage was lawful in the jurisdiction in which it occurred, it will be deemed lawful for plan administration purposes thereafter regardless of whether the Participant or spouse later establish residence or become domiciled in a jurisdiction in which such marriage is not recognized or is otherwise deemed unlawful.
**GENERAL INFORMATION**

**LIFE AND DISABILITY BENEFITS AND HEALTH CARE COVERAGE**

**For Employees Returning From Permanent Layoff**

- **Life and Disability Coverages**
  
  If you return to active work from permanent layoff, you will be eligible for Sickness and Accident and Extended Disability Benefit coverage on the first day you returned to active work.

  Upon return to active work with seniority from layoff, your Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance coverages, if discontinued while on layoff, will be reinstated the day you return to active work.

- **Health Care Coverages**
  
  Upon return to active work from layoff, any coverages discontinued while on layoff with seniority will be reinstated the day you return to active work. GM contributions also will resume at that time.

**For Employees on Non-Disability Leave**

If you are granted a non-disability leave of absence, you will be given a notice explaining (1) your Life and Disability Benefit and Health Care Program continuance privileges, and (2) any monthly contributions you may have to make.

- **Life and Disability Coverages**
  
  Coverage may be continued for the following periods, after the month in which you last worked prior to an approved leave of absence, other than for disability.

  — For the first month, Basic Life Insurance, Extra Accident Insurance, Survivor Income Benefit Insurance, Sickness and Accident, and Extended Disability Benefit coverages in force are continued at no cost to you.

  — Thereafter, you may continue Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance coverages, up to 11 months, provided you contribute 50¢ per month per $1,000 of Basic Life Insurance.

  If you are granted a non-disability leave of absence because of a medical condition that may be expected to result in total disability in the future (e.g., anticipated surgery or termination of pregnancy), Sickness and Accident and Extended Disability Benefit coverages, which are discontinued at the end of the month following the month in which you last worked, may be reinstated. or disability coverages to be reinstated, you must (1) have been making contributions to continue your Basic Life Insurance, and (2) present medical evidence satisfactory to GM that you are totally disabled. Reinstatement will be made effective as of the date you present satisfactory medical certification of your disability. GM will contribute the full cost of your life and disability coverages. Such contributions will start the first of the month in which you present evidence satisfactory to GM of your total disability.

  If eligible to continue, you must make the required monthly contributions to continue Optional Life Insurance, Dependent Life Insurance, and Personal Accident Insurance. Basic Life Insurance must remain in force in order to continue Optional Life Insurance and Dependent Life Insurance.
Health Care Coverages

Your health care coverages as an active employee end at the end of the month in which you are last in active service.

— Thereafter you may continue coverages under the applicable provisions of federal law (see COBRA Section. If for some reason you are ineligible to continue coverage under COBRA, you may continue coverages on a self-paid basis, for up to 12 months while your seniority remains unbroken.

— If you are granted a non-disability leave of absence in anticipation of a later disability, and if you continue your coverages on a self-paid basis, you will be eligible for reinstatement of GM contributions for coverages, and for continuation of such coverages during the period you are disabled.

For Employees Terminating Employment

If you cease active work (other than for quit, discharge or retirement) at or after age 60 and were insured from age 60 to the date you cease active work or cease active work prior to age 60, but are insured at age 60, and in either case have five or more years of credited service at the end of the month in which you attain age 60, you may continue your Basic Life Insurance and Extra Accident Insurance for a period of five years from your last day worked by making the required contribution of 50¢ per month per $1,000 of Basic Life Insurance.

If you terminate employment with GM at age 65 or older for any reason other than discharge for cause, GM no longer provides company sponsored health care to UAW affiliated retirees or their eligible dependents. UAW affiliated retirees (and their eligible dependents) may be eligible to receive health care coverage from the UAW Retiree Medical Benefits Trust (the “Trust”), which is completely separate and independent from GM. The Trust is responsible for providing Retirees information on plan provisions coverage and eligibility. UAW members or affiliated Retirees should direct any questions regarding Trust coverages and eligibility directly to the Trust at Retiree Health Care Connect 1-866-637-7555.

Cessation of Coverage

Health Care coverages cease at the end of the month in which you quit voluntarily or are discharged. Thereafter, if eligible, health care coverages may be continued under COBRA. Basic Life Insurance, Extra Accident Insurance, and Survivor Income Benefit Insurance, as well as Sickness and Accident and Extended Disability Benefit coverages, cease on the day you quit voluntarily or are discharged. If your employment is terminated for any other reason, except retirement, all coverages continue until the end of the month in which your seniority is broken.

However, in any case where an employee files a grievance protesting loss of seniority, Life Insurance and Disability coverages will remain in effect until the end of the month in which seniority is broken. While the grievance is pending, an employee may continue life insurance, and all health care coverages, by making any required monthly contributions.

Optional Life Insurance and Dependent Life Insurance cease on the earlier of the following dates: (1) on the date that your Basic Life Insurance ceases, or (2) on the last day of the calendar month preceding the month for which a required contribution was due, but not paid. Dependent Life Insurance also ceases when you no longer have an eligible dependent. You are responsible for notifying the GM Benefits & Services Center when you no longer have an eligible dependent. You may contact the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.
Personal Accident Insurance ceases on the earlier of the following dates: (1) on the date your Basic Life Insurance ceases, except when your Basic Life Insurance ceases during periods of layoff or leave of absence or retirement, or (2) on the last day of the calendar month preceding the month for which a required contribution was due but not paid. Personal Accident Insurance on account of a dependent ceases for any person when that person no longer is an eligible dependent.

**PROGRAM CONVERSION PRIVILEGES**

During the 31 days following cancellation of your life insurance, you may convert, at your expense, all or part of your Basic Life Insurance, Optional Life Insurance, and Survivor Income Benefit Insurance to an individual policy without proof of good health. Dependent Life Insurance may be converted to an individual policy only by a covered dependent or the dependent's legal guardian. Optional Life Insurance and Dependent Life Insurance may not be converted if the insurance ceases due to failure to pay the required contributions. Term insurance is not available for conversion policies.

To convert your life insurance, you should contact the GM Benefits & Services Center immediately by calling 1-800-489-4646. Select the Life Insurance prompt you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860. MetLife will arrange for a Financial Services Representative to follow up with you and assist you and/or your dependent(s) in the application process.

**The conversion privilege is not applicable to any Personal Accident Insurance and Extra Accident Insurance coverage.**

You may obtain, at your expense, whatever “direct pay” individual contract for health care coverage then available from the Carriers through which you have been enrolled. You must contact the Carriers in order to determine whether a conversion policy is available to you.

**Life Insurance Certificates**

Certificates containing all the detailed provisions of insured benefit coverages you have under the group policies issued to General Motors by its insurance Carriers will be made available to you, upon request to the GM Benefits & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

Application may be made to the GM Benefits & Services Center on a form furnished to you after you lose credited service. You also may call the GM Benefits & Services Center at 1-800-489-4646.

Your monthly pension benefit, commencing at age 65, will be based on the deferred vested basic benefit rate in effect for your job classification on the date your seniority is broken, times your years of credited service.

Eligibility for a deferred vested pension is not affected by receipt of a Separation Payment under the SUB Plan, nor is any Separation Payment affected by eligibility for a deferred vested pension.

Prior to commencement of deferred vested pension benefits, survivor protection is provided for your spouse.
Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

Disability Plan
The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to: insufficient credited service; break in seniority; Impartial Medical Opinion Examinations; offset due to Social Security, Workers’ Compensation, and retirement benefits; failure to comply with Program eligibility rules; falsification of disability claim forms; discharge; gainful employment; termination of the Plan; any benefit Plan overpayments due to any reason subject to any applicable limitations; quit; discharge; and end of continuance period.

Life Insurance Plan
The following circumstances may result in disqualification, ineligibility, loss, reduction or recovery of benefits. The circumstances include but are not limited to: failure to comply with Program eligibility rules, non-payment of premium, any benefit Plan overpayment due to any reason subject to any applicable limitations, end of continuance period, termination of the Plan, quit, discharge, proof of good health denial for Optional Life Insurance and Dependent Life Insurance, and insufficient years of participation, credited service or years of seniority for Basic Life Insurance.

Personal Savings Plan
The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to:

- Failure to comply with eligibility rules will result in your ineligibility to contribute to the PSP.
- While actively employed, the maximum amount available to you for a loan will be reduced by an amount equal to the outstanding principal, including accrued interest, of any loan defaulted and deemed to be a distribution to you.
- If you withdraw pre-tax contributions because of a hardship, you will be suspended from making further contributions to the PSP for a period of 6 months from the hardship withdrawal date.
- In the event the PSP should be terminated, your assets under the PSP may continue to be administered and then subsequently distributed to you upon your termination of employment, or such assets may be distributed as soon as administratively possible upon Plan termination. In such event, a distribution of your account assets will have tax consequences to you.

Pension Plan
The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to:

- Insufficient credited service; Impartial Total & Permanent Disability Retirement Examinations; offsets due to Social Security, Workers’ Compensation; failure to comply with Program eligibility rules; gainful employment; termination of the Plan; tax levy; any benefit Plan overpayments due to any reason subject to any applicable limitations.
- Supplements are not payable to you if you are discharged.
- If the total of your monthly benefits exceeds 70% of your final monthly base pay, the monthly early retirement or Interim Supplement will be reduced to the extent required so that such benefits would equal 70% of your final base pay.
- If you retire voluntarily and become eligible for Social Security Disability Insurance Benefits (SSDIB), your monthly supplement will be reduced by the temporary benefit amount in effect at the date of your SSDIB award.
Supplements are payable only if you retire within five years of your last day worked for General Motors.

If you have any outstanding disability benefit overpayments under the Life and Disability Benefits Program, you are eligible to receive only 50% of the amount of any otherwise applicable increase to your monthly basic benefit in effect on or after January 1, 2008.

In the event, a court determines that an employee, surviving spouse, or lawfully designated payee to whom a benefit is payable under the Plan lacks the capacity to handle their own affairs due to illness, accident, or other infirmity, any monthly pension or survivor benefit payable under the Pension Plan may be paid to any person or party the court has granted authority to receive the Pension benefit on behalf of the employee, surviving spouse, or lawfully designated alternate payee.

**Deferred Vested Pension, If Separated**

Applicable to employees who hired prior to October 15, 2007, if you (1) lose your credited service for any reason other than retirement, and (2) have at least 5 years of credited service or “service”, you will be eligible for a deferred vested pension benefit. The benefit is payable at age 65 without reduction. It is payable after age 55, and prior to age 65, on a reduced basis. You may apply for the deferred vested pension benefit within 60 days of your earliest eligibility, or at any time thereafter.

**Health Care**

The following may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include but are not limited to the following. Generally, your eligibility for coverage ceases at the end of the month you are last in active service. Any continuation beyond that point is based upon your employment status. Continuation opportunities when your status is “disability leave” are described in the chapter entitled “While You Are Disabled,” in the section entitled “Health Care Coverage While You Are Disabled.” Continuation opportunities when your status is “laid off” are described in the chapter entitled “If You Are Laid Off” in the section entitled “Health Care Continuation for Laid Off Employees.” Continuation opportunities when your status is “Retirement” are described in the chapter entitled “When You Retire” in the section entitled “Life Insurance and Health Care Coverages.” Continuation opportunities when your status is “non-disability leave” are described in the chapter entitled “General Information About Your Benefits,” in the section entitled “Life and Disability Benefits and Health Care Coverages,” under the paragraphs entitled “For Employees on Non-Disability Leave.”

Benefit payments are subject to Coordination of Benefits. If another plan or program is primary, the claim should be filed first with the primary plan or carrier.

For services that require predetermination, if prior authorization is not given, and you elect to have the services performed, such services will be payable at 80% of the Carrier’s allowed amount.

If any benefits are paid for non-covered services or on behalf of ineligible dependents, you will be notified, and you will be responsible for repaying the overpayment. If you should fail to repay the overpayment promptly, the Health Care Program will deduct the amount from your wages or benefits, or may recover the overpayment by other legal means.

If a Medicare eligible surviving spouse of an active enrollee who was not retirement eligible fails to enroll in Medicare Part B, the surviving spouse will not be eligible for company contributions for health care coverage.
SUPPLEMENTAL UNEMPLOYMENT BENEFIT (SUB)

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, suspension, reduction or recovery of benefits. The circumstances include, but are not limited to insufficient seniority; ineligibility or failure to apply for state or federal unemployment compensation benefit; layoff resulting from disciplinary reasons, any strike, slowdown, work stoppage, picketing or concerted action, at a Company plant or plants, or any dispute of any kind involving, generally, employees covered by the Plan, fault attributable to the employee, war or hostile act of a foreign power, sabotage (including arson) or insurrection, act of God; refusal to accept Company employment interview or job offer; eligibility for, claim for, or receipt of statutory or Company accident, sickness or any other disability benefit, pension or retirement benefit; offset due to monies received or receivable from unemployment compensation, wages, or other remuneration from the Company or other employer, military pay, or Social Security Benefit; any benefit Plan overpayment due to any reason subject to any applicable limitations; willful misrepresentation of any material fact in connection with the application for benefits; termination of the Plan; quit or discharge.

QUALIFIED DOMESTIC RELATIONS ORDER (QDRO)

Following is the address/phone number where Participants can obtain additional information, about QDRO procedures:

**Personal Savings Plan & Pension Plan**

GM Benefits & Services Center
P.O. Box 770003
Cincinnati, OH 45277-0066

Telephone Number: 1-800-489-4646  Website Address: [www.gmbenefits.com](http://www.gmbenefits.com)  [https://qdro.fidelity.com](https://qdro.fidelity.com)

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCOSO)

Following is the address/phone number where Participants can obtain enrollment information pursuant to a QMCOSO, without charge:

GM Benefits & Services Center
Attn: QMCOSO Processing
P.O. Box 770003
Cincinnati, OH 45277-0071

Telephone Number: 1-800-489-4646  Website Address: [www.gmbenefits.com](http://www.gmbenefits.com)
SECTION 9: PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES ABOUT YOUR BENEFITS

If you have questions, or would like further information about your benefits, you should contact the GM Benefits & Services Center at 1-800-489-4646.

Each employee pension and welfare benefit Program described in this booklet contains a procedure for appealing the denial, in whole or in part, of any application for benefits. Should you disagree with a decision denying you benefits, you may appeal the decision under the applicable benefit Program’s appeal procedure. If that procedure does not apply to your claim for benefits, you may appeal in writing within sixty (60) days to the Plan Administrator.

You also may wish to discuss your questions with one of the local union benefit representatives.

Provisions with respect to such discussion, and procedures for making appeals, are set forth below.

LIFE AND DISABILITY BENEFITS PROGRAM

To receive benefits, you (or your designated beneficiary following your death) must file an application or claim form obtained from the Carrier, in accordance with the instructions provided. Appropriate forms are available by contacting the GM Benefit & Services Center at 1-800-489-4646. Select the Life Insurance prompt and you will be transferred to a MetLife Customer Service Associate. Additionally, the hearing/speech impaired can call MetLife at 1-888-688-2860.

Eligibility for benefits will be determined and the claim application will be processed by the Carrier. You will be notified of benefits paid or, if the application for benefits is denied in whole or in part, written notice of such denial will be provided within a reasonable time but not later than 90 days (unless special circumstances require an extension), or 45 days in the case of a claim for disability benefits (unless special circumstances require an extension), following receipt of the claim application. The notice will include specific reasons for the denial and will refer to the Plan provisions upon which the denial is based. The notice will also include a description of any additional information that may be needed if the claim is to be resubmitted and an explanation of the procedure to be followed to have the claim reviewed if the claim has been denied.

The procedure for review of denied claims follows.

Disability: Appeal of a Denied Claim
To afford you a means by which you can seek review and possible reconsideration of a disability claim, denied by the Carrier, internal procedures of General Motors will provide a procedure as follows:

You will have at least 180 days, but in no event more than 210 days following receipt of the formal notification letter from the Carrier by which you will be advised of the reasons for the denial of the claim, to request in writing to have the claim reviewed. The request for review should be submitted in writing directly to the Carrier. As part
of the review, you may submit any data or written comments to support the claim. A written decision on your request will be furnished within a reasonable time but not later than 45 days (90 days if special circumstances require an extension of time and written notice of the need of an extension is provided) after the request for review is received.

This written decision on the review will include specific reasons for the decision and will set forth specific reference to Plan provisions upon which the decision is based.

If you are not satisfied with the decision of the Carrier under the appeal procedure described above, General Motors provides for an additional voluntary level of review as detailed in Steps 1 through 6 described below. As part of the review, you may submit any data or written comments to support the claim.

Any decision resulting from this voluntary procedure is intended to be final and binding upon General Motors, the Union if applicable, the Carrier and you or your beneficiary. Pursuant to ERISA, you may seek court review subject to the above.

Appeal of Denied Life Insurance Claim and Voluntary Review of Disability Claims
To afford yourself a means by which you can seek review and possible reconsideration of a denied claim for life insurance or a further review of a denied claim for disability benefits, internal procedures of General Motors will provide a procedure along the following lines:

With respect to claims denied by the Carrier:

Step 1: Following receipt of the formal notification letter from the Carrier by which you (or your beneficiary, following your death) is advised of the reasons for the denial of your or your beneficiary’s claim, you or your beneficiary may request the representative whom your local union has designated to discuss Life and Disability Benefits Program matters to review the reasons for the denial with the management representative.

Step 2: The management representative will review your case with the local union benefit representative. If needed, more details with respect to the reasons for the denial will be obtained from the Carrier by the management representative and, if appropriate, the management representative will advise what, if anything, you or your beneficiary can do to support the claim for payment of benefits. At this meeting, there will be furnished to the local union benefit representative copies of all of the material pertinent to the claim which the Carrier has made available for examination.

Step 3: If after discussion with the management representative, the local union benefit representative contests the position of the Carrier as reflected by the management representative, the local union representative may refer the case on an appeal form provided for that purpose to the International Union for review with General Motors. A copy of such appeal form shall be presented to the management representative.

Step 4: The International Union will notify General Motors of its intent to review a case on a Step 4 appeal form provided for such purpose. General Motors will request a review by the Carrier and will attempt to resolve the case with the International Union by providing a written answer with respect to the Carrier’s determination on such form.
Step 5: If General Motors and the International Union are unable to resolve their differences, General Motors upon written request of the International Union, will request a review by the Carrier. Such request to the Carrier will be in writing and will incorporate the Union’s position. The Carrier’s review of the claim will be conducted by a committee of three employees of the Carrier, at least one of whom shall be an officer of the Carrier. A 5th Step meeting will take place with a representative of the International Union, General Motors and the Carrier to discuss the claim under consideration.

Step 6: The Carrier will report to the International Union and to General Motors its action as the result of such review.

In conjunction with the additional voluntary level of review for disability claims described above:

(i) The Program waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to such additional voluntary level of review; and

(ii) The Program agrees that any statute of limitations or other defense based on timeliness is tolled during the time such additional voluntary review is pending.

Information regarding any undue delay in the issuance of a Sickness and Accident Benefit check, in the release of a determination by the Carrier with respect to a suspended claim, lack of coverage, insufficient payment of a claim, or an anticipated claim, may be requested by the local union benefit representative in the same manner as set forth in Steps 1 and 2 of the procedure outlined herein. In such instances, the management representative shall expedite either the benefit check or the Carrier determination, or shall provide the requested information with respect to lack of coverage, insufficient payment of a claim, or an anticipated claim. Any such issue which cannot be resolved locally may be appealed as set forth in Step 4 of the procedure outlined herein.

HEALTH CARE

If you (1) disagree with a Carrier or local Plan disposition concerning your benefit claim, (2) have any question regarding lack of coverage, or (3) are concerned about an anticipated claim, you may request the assistance of one of the local benefit representatives or the GM Benefits & Services Center to provide information about your concern.

Health Care Mandatory Appeal Procedure
A mandatory appeal procedure has been established for review of denials of eligibility and/or of claims for benefits under the Health Care Program for Hourly Employees. When services are received, the Carrier will provide you with an Explanation of Benefits (EOB) which will show payment of benefits and any specific reasons for a denial of benefits. If there is a denial of benefits you may appeal to the Carrier at the address provided in the EOB. The initial written request to review the denied claim is the Mandatory Appeal Procedure. The response that you receive from the Carrier will refer you to the Program provisions on which the denial is based. If your appeal is related to an eligibility issue, you should send it to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-1060 or call the GM Benefits & Services Center at 1-800-489-4646.
After you receive notice that a claim was denied, in whole or in part, you have 180 days to make a written request to the applicable Carrier to have the claim reviewed. If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as follows:

**Urgent Care Claims** - In the case of a claim involving urgent care, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

**Pre-service Claims** - In the case of a pre-service claim, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review within a reasonable period of time, appropriate to the medical circumstances, but not later than 30 days after receipt by the Carrier your request for review of an adverse benefit determination. In the case of a Carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the Carrier of your request for review of the adverse benefit determination.

**Post-service Claims** - In the case of a post-service claim, as defined by applicable regulations, the Carrier shall notify you of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt by the Carrier of your request for review of an adverse benefit determination. In the case of a Carrier that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the Carrier of your request for review of the adverse benefit determination.

The time periods specified for each category of claims above may be extended in accordance with applicable regulations. The written decision on the review will include the specific reasons for the decision and will set forth specific reference to Program provisions upon which the decision is based. If the review by the Carrier results in an adverse determination, you may initiate an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

As an alternative to immediately initiating such civil action, if you receive a final determination denying eligibility for coverage under the Program or a claim for benefits, you may request further review by the Plan Administrator under a voluntary review process (as described below). In connection with an applicable voluntary review process, the Program:

(1) Waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to such process; and,

(2) Agrees that any statute of limitations or other defense based on timeliness is tolled during the time such review is pending.

**External Review Process**

Following the completion of the Mandatory Appeals process, and if the benefit denial was upheld, you may further appeal through the External Appeals Process. Effective January 1, 2012, pursuant to the Patient Protection and Affordable Care Act (PPACA), individuals may pursue an external review through the Independent Review Organization (IRO).

When a determination is provided to your Mandatory appeal, you will be provided information on how to pursue the next level of the appeal through the IRO. Following receipt of the notice to uphold the denial, you will have
**PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES**

**four months** to make a request of the Carrier for an external review. Upon receipt of the request, the Carrier will send the case to an IRO. Once received, the IRO will make a determination of the claim, based on whether the case involves “Medical Judgement”. If the determination is “yes”, the IRO will make a determination to either uphold or overturn the Carrier’s decision. If the determination of medical judgement is “no”, then the IRO will notify the Carrier that a determination cannot be made and the case will be referred for a Voluntary Review. If the IRO is able to make a determination, the claim will be not be reviewed further under the Voluntary Review process.

**Note:** The External Review process does not apply to employees and their eligible dependents enrolled in the following Plans: Temporary Employee Health Care Plan, or Vision Plan. The External Review process is also not available to employees enrolled in an HMO, or appeals to determine eligibility in the Plan.

**Voluntary Review Process**

The following describes the steps followed by the voluntary review process:

**Step 1.** Following receipt of a final determination from the Control Plan, Carrier, or IRO with regard to the appeal of a denial of a claim in full or in part, you may request the local union benefit representative to review the disputed claim with a designated Plans Workforce representative by writing to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-1060. If requested to do so, the Plans Workforce representative will endeavor to obtain additional information from the Control Plan or Carrier regarding the disputed claim. The Control Plan or Carrier will advise the Plans Workforce representative what, if anything, can be done to support your claim for payment of benefits.

**Step 2.** If local union benefit representatives contest the position of the Control Plan or Carriers as reported by the Plans Workforce representatives, they may refer the case to the International Union for review with the Plan Administrator.

**Step 3.** The International Union may review the disputed claim with the Plan Administrator, Control Plan or Carrier. At the request of the International Union, the Plan Administrator will request either the Control Plan or Carrier, as appropriate, to review such claim.

**Step 4.** The Control Plan or Carrier will be requested to report in writing to the Plan Administrator and International Union its action as a result of such review. If payment of the claim is denied in full or in part, the Control Plan or Carrier will be requested to include in its report the pertinent reasons for the denial.

Disputes related to health care claims or questions of coverages through a health maintenance organization may be reviewed in the same manner as outlined in the preceding four steps, as applicable, subject to the following:

1. Following the denial of a claim, an enrollee must file any appeal with the health maintenance organization through the member services department (or a similar department). Health maintenance organizations provide members with a formal procedure through which members can have denied claims reviewed. Formal appeal procedures within health maintenance organizations vary, but usually include multiple steps in which a denied claim is reviewed.

2. When the formal appeal procedure has been exhausted, upon request, the health maintenance organization will be required to provide the Plan Administrator or the International Union with information concerning its actions as a result of the findings of the investigation.
PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES

PENSION PLAN

If you are about to retire and have questions with respect to your eligibility, or computation of your pension benefits, or if you have applied for additional credited service and do not agree with the determination with respect to your application, you may (1) contact the GM Benefits & Services Center at 1-800-489-4646, or (2) contact your union benefit representative

If your application for benefits is denied in whole or in part, the following procedure is to be utilized:

1. Any employee who disputes a determination with respect to such employee’s (i) age, (ii) credited service under the Pension Plan, (iii) computation of pension benefits or supplements under the Pension Plan, (iv) partial or complete suspension of supplements, or (v) whether such employee is engaged in gainful employment except for purposes of rehabilitation, or for purposes of avoiding a reduction or elimination of Worker’s Compensation benefits under state law, may file with the GM Benefits & Services Center a written claim on form BA 1, “Employee Claim to Pension Committee.” Such claim shall be filed within 60 days of receipt of such determination.

2. In all cases where the employee has filed a claim on form BA 1, the Pension Committee shall review such claim with the employee, return one copy of form BA 1 to the employee, with a written answer to the claim and, if the claim is rejected, the reasons therefore.

3. If the employee is not satisfied with the answer, such employee may request the Pension Committee, in writing on form BA 1, to refer the case to the Board for decision. Such claim shall be filed with the Pension Committee within 60 days of the employee’s receipt of such answer. The Pension committee shall then forward form BA 1, with material pertinent to the case and the answer to the employee’s claim’s, to the Board.

4. If the Pension Committee should fail to agree upon the disposition of any application or authorization, or of any claim filed by employee, the case shall be referred to the Board for determination on form BA 2, “Notice of Appeal to the Board of Administration.” A written signed statement setting forth all the facts and circumstances surrounding the case, and any material pertinent to the case, shall accompany the referral. Such statement may be submitted jointly by the members of the Pension Committee or separate signed statements may be submitted provided such statements are exchanged by the Pension Committee members prior to being submitted to the Board.

5. All material with respect to cases referred to the Board shall be submitted in duplicate and shall be mailed to the Secretary, Pension Board Administration, 300 Renaissance Center, Mail Code, 482-C32-A68 P.O. Box 300, Detroit, Michigan 48265-3000.

6. The Board shall advise the Pension Committee in writing of the disposition of any case referred to the Board by the Pension Committee. The Pension Committee shall forward a copy of such disposition to the employee. Each such ruling shall be final and binding on the Union and its members, the employee or employees involved, and on the Company, subject only to the arbitrary and capricious standard of judicial review.

7. Forms BA 1 and BA 2 for each appeal must be requested from the Secretary, Pension Board of Administration, Mail Code 482-C32-A68, P.O. Box 300, Detroit, Michigan 48265-3000.

Issues involving mutual retirement are not subject to review by the Pension Board of Administration but will be subject to review by the Plan Administrator by writing to Mail Code 482-C32-A68, 300 Renaissance Center, P. O. Box 300, Detroit, MI 48265-3000.
TOTAL AND PERMANENT DISABILITY RETIREMENT APPEAL PROCESS

Appealing the Initial Determination
When it becomes necessary to determine whether an employee is totally and permanently disabled within the meaning of the Pension Plan, the following procedure shall govern:

(1) The Company will make such determination upon the basis of medical evidence satisfactory to it within 45 days of receipt of the employee’s application for T&PD retirement (unless special circumstances require an extension of time and written notice of the need of an extension is provided). If it is determined that the employee is totally and permanently disabled, the GM Benefits and Service Center will process the application in accordance with the procedures set out in the Pension Plan language Appendix D, Section D, “Authorization for Pension Benefits.”

If it is determined that the employee is not totally and permanently disabled, the GM Benefits & Services Center will prepare form HRP-22, “Notice of Company Determination - Application for Total and Permanent Disability Benefits.” Copies of such form will be furnished to the employee and the Union member of the Pension Committee. The GM Benefits & Services Center also will furnish the Union member of the Pension Committee with a copy of the reverse side of form HRP-15, “Statement of Employee’s Physician.”

(2) If the employee is denied a T&PD retirement due to medical disqualification as defined in Article II, Section 3(b) of the Pension Plan, the employee will have at least 180 days, but in no event more than 210 days, following receipt of the denial to appeal such denial by writing to the Plan Administrator at P.O. Box 5078, Southfield, MI 48086-5078. The Plan Administrator has the authority to construe and interpret Plan language and render decisions on behalf of the Company. The employee should include in the appeal the reason(s) the employee believes the application was improperly denied, along with any additional comments, documents and medical records relating to the employee’s appeal. If the employee is denied a T&PD retirement for reasons other than medical disqualification, the employee may appeal by initiating the procedure set forth in Section K of the Pension Plan Appendix D within the 180 day period, including the 180th day. The response to the appeal will be provided within a reasonable time but not later than 45 days (90 days if special circumstances require an extension of time and written notice of the need of an extension is provided) after the request for review is received.

The GM Medical Director will evaluate the medical information pertaining to the employee’s T&PD appeal and make a determination in accordance with the provisions of the Plan. The GM Medical Director has discretionary authority in this process to construe, interpret, and make medical evaluation on behalf of General Motors regarding the employee’s T&PD application.

The Plan Administrator will advise the employee of the appeal determination on form HRP-21B, “Plan Administrator’s Appeal Determination of Total and Permanent Disability,” within a reasonable time, but not later than 45 days (90 days if special circumstances require an extension of time and written notice of the need of an extension is provided) after the employee’s appeal is received, a copy of form HRP-21B will be provided to the
Union member of the Pension Committee. Upon written request, the employee may request, free of charge, copies of relevant documents, records and other pertinent information pertaining to their appeal.

In the event the employee’s appeal is denied, in whole or in part, the employee may follow the Voluntary Appeal Process under Appendix D, Paragraph B(3)(e)(3) of the Pension Plan or the employee has the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974.

(3) Voluntary Appeal Process - If the employee or the Union member of the Pension Committee disagrees with the GM Medical Director’s determination regarding medical disqualification for a T&PD retirement, an appeal of such determination may be made in writing to the GM Benefits & Services Center within 30 days, including the 30th day, of receipt of the determination on form HRP-21B, “Plan Administrator’s Appeal Determination of Total and Permanent Disability.” A copy of form HRP-21B will be provided to the Union member of the Pension Committee. The Pension Committee shall then designate a clinic in the area, which is on the approved list (Appendix D-1), to examine the employee and determine whether the employee is totally and permanently disabled pursuant to Article II, Section 3(b) of the Pension Plan.

(4) Prior to the clinic examination referred to above, the GM Benefits & Services Center will prepare form HRP-21, “Determination of Total and Permanent Disability,” and will furnish one copy to the clinic, one copy to the employee and one copy to the Union member of the Pension Committee. An employee, whose General Motors employing unit is more than 40 miles one way from the clinic in the area on the approved list designated by the Pension Committee to examine the employee to make a determination as to whether the employee is totally and permanently disabled, will be reimbursed, upon written request, at the rate allowable by the IRS, for miles actually driven from the employee’s residence to such clinic and back, using the most direct route available.

(5) The clinic, after examining the employee, shall make a determination if the employee is totally and permanently disabled. Such determination shall decide the question and shall be final and binding on the employee, the Company and the Union. Pursuant to ERISA, the employee may seek court review subject to the above.

(6) Upon receipt of any clinic determination, the GM Benefits & Services Center will complete form HRP-21A, “Notice of Clinic Determination - Total and Permanent Disability,” furnish copies to the employee and the Union member of the Pension Committee, and retain a copy in the employee’s pension file. If the clinic determination is that the employee is not totally and permanently disabled, form HRP-21A shall instruct such employee to report to the Plant Medical Director for examination.

(7) If the clinic, after examining the employee, determines that the employee is not totally and permanently disabled, the Plant Medical Director will examine the employee to determine whether the employee is able to perform a job in the plant. Where the employee has no home unit, the clinic determination will be final and binding on the employee, the Company, and the Union. The employee’s name will be submitted to the National Employee Placement Center for placement.

(8) If the Plant Medical Director, after examining the employee, determines that the employee is able to perform a job in the plant, the employee will be deemed by the Company not to be totally and permanently disabled within the meaning of the Pension Plan. Such job will be identified in writing to the employee with a copy to the Union member of the Pension Committee.
(9) If the Plant Medical Director, after examining the employee, determines that the employee is not able to perform any job in the plant, the employee will be deemed by the Company to be totally and permanently disabled within the meaning of the Pension Plan.

In connection with this Voluntary Appeal Process, the Plan waives the right to assert that a claimant has failed to exhaust administrative remedies because the employee did not elect to submit their appeal to this voluntary level of appeal. The Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time the voluntary appeal is pending.

**SUB**

You may request the presence of one of the local union benefit representatives, to provide information concerning the payment, denial, or appeal of a SUBenefit or separation payment.

If you disagree with a GM determination as to eligibility for, or amount of, benefits, you may appeal to your local SUB committee within 30 days of determination.

If your local SUB committee cannot resolve your claim, you may request the committee to refer your claim to the UAW-GM SUB Board of Administration. In the absence of a local SUB committee at your location, you may appeal directly to the Board of Administration. If the Board members cannot agree, the Board may appoint an impartial chairman to resolve the dispute. The Board or the impartial chairman’s decision will be final and binding on all parties.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

**Types of Plans**
The GM Pension Plan is a defined benefit plan providing trusted pension benefits to employees who retire, and to their eligible survivors. The GM Personal Savings Plan is a defined contribution plan providing benefits to employees who elect to participate in this Plan. The GM Life and Disability Benefits Program is a welfare benefit plan providing life and disability coverages to employees. The GM Health Care Program is a welfare benefit plan that provides self-insured and HMO coverages for employees and their eligible dependents. The GM SUB Plan is a welfare benefit plan, and provides benefits while employees are absent from work due to layoff.

Pension and PSP benefits are provided through trusts. All life Insurance coverages are provided through the Metropolitan Life Insurance Company. Disability coverages are administered through Sedgwick CMS. Health care coverages are administered through Carriers, such as Blue Cross Blue Shield of Michigan, a number of local plans providing these coverages, and Health Maintenance Organizations. General Motors is responsible for administration of the benefit plans described in this booklet.

**Plan Year**
December 31 is the end of the Plan Year for the Life and Disability Benefits Program, Health Care Program, SUB Plan, Personal Savings Plan, and the Legal Services Plan. Records of these Plans are kept on a calendar year basis. The Pension Plan operates on a fiscal year basis ending September 30.
Named Fiduciary
Except as set forth below, the Investment Funds Committee of the General Motors Board of Managers is the named fiduciary for all other ERISA governed benefit plans described in this booklet. Benefits not governed by ERISA have no named fiduciary. General Motors Investment Management Corporation (GMIMCo) is the named fiduciary of several of the plans for the purposes of investment of plan assets for the Hourly Pension Plan, Personal Savings Plan, SUB Plan and Health Care Program, except that for purposes of the Personal Savings Plan any Participant or beneficiary, who makes an investment election permitted under the Plan or otherwise exercises control permitted under the Plan over the assets in their account, shall be deemed the named fiduciary under ERISA responsible for such decisions to the extent that such designation is permissible under applicable law and that the investment election or other exercise of control is not protected by Section 404(c) of ERISA, as amended.

Administrator
General Motors LLC is the sponsoring employer and the Plan Administrator of the ERISA governed benefit plans described in this booklet. The administrator’s address is Mail Code 482-C32-A68, 300 Renaissance Center, P.O. Box 300, Detroit, Michigan 48265-3000.

Identification Number
GM’s employer’s identification number is 27-0383222. Plan numbers are as follows:

<table>
<thead>
<tr>
<th>PLAN</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Pension</td>
<td>003</td>
</tr>
<tr>
<td>Personal Savings</td>
<td>014</td>
</tr>
<tr>
<td>Life &amp; Disability</td>
<td>503</td>
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<tr>
<td>SUB</td>
<td>505</td>
</tr>
<tr>
<td>Health Care</td>
<td>525</td>
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Legal Process
Service of legal process on General Motors may be made at any office of the CT Corporation. The CT Corporation, which maintains offices in all 50 states, is the statutory agent for service of legal process on GM. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon GM, at the Service of Process Office, GM Legal Staff, 400 Renaissance Center, Mail Code 482-C24-A36, Detroit, Michigan 48265-4000.

Participant Rights
As a Participant in the GM benefit Plans which are governed by ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:
PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a retirement benefit 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 retirement benefit, the statement will tell you how many more years you have to work to get a right to a retirement benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- 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. Review the “Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage section of this Summary Plan Description booklet to learn more about your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You may request 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of employee benefit plans.
- The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
PROCEDURES FOR HANDLING QUESTIONS OR DISPUTES

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and 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 materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, 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 it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance 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 any questions about your Plan, you should contact the Plan Administrator.

- If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Benefit Guarantee

Your pension benefits under the Pension 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 receive all of the pension benefits they would have received under their Plan, but some people may lose certain benefits. For more information about the PBGC and the benefits it guarantees, go to the PBGC’s website, www.pbgc.gov or call the PBGC toll free at 1-800-400-7242.

Hourly-Rate Employees Pension Plan

In the event that the Pension Plan is partially or totally terminated, the amount of assets available to provide benefits shall be allocated in the levels of priorities stated below, less expenses for administration or liquidation.

1. In the case of benefits payable as an annuity:
   (i) in the case of benefits in pay status three years prior to termination (at the lowest pay level in that period and at the lowest benefit level under the Plan during the three years prior to termination) and
   (ii) in the case of benefits which would have been in pay status three years prior to termination had the Participant been retired (and had benefits commenced then, at the lowest benefit level under the Plan during the three years prior to termination),

2. All other benefits of individuals under the Plan which are guaranteed under the Plan termination insurance provisions of ERISA, determined without regard to Section 4022 of ERISA,

3. All other nonforfeitable benefits under the Plan, and

4. All other benefits under the Plan.
In the event of termination or partial termination of the Plan, the right of all affected employees to benefits accrued to the date of such termination, partial termination or discontinuance, to the extent funded as of such date, is nonforfeitable.

**Life and Disability Benefits Program and Health Care Program**
Upon termination or partial termination of the Program, coverage will cease as of the effective date of termination, or partial termination.

**Supplemental Unemployment Benefit Plan**
Upon termination of the Plan, for one year, unless the fund is sooner exhausted, assets remaining in the trust fund shall be used to pay expenses of administration and to pay benefits to eligible employees. After one year, assets remaining in the trust fund will be used to benefit Participants.

**Personal Savings Plan**
Upon termination or partial termination of the Personal Savings Plan, no further contributions or savings will be contributed to the accounts of Participants. Participants will maintain entitlement to vested benefits held in their respective accounts.

**Trustees**
Trustees of the Pension Plan, who accumulate assets through which pension benefits are provided, are as follows:
- State Street Bank and Trust Company
  1200 Crown Colony Drive
  Quincy, MA  02169

The Trustee of the Personal Savings Plan, who accumulates assets through which Personal Savings Plan benefits are provided, is:
- State Street Bank and Trust
  2 Avenue de Lafayette
  Boston, MA 02111-2900

**Collective Bargaining Agreement**
The Hourly-Rate Employee’s Pension Plan, Life and Disability Benefits Program, Health Care Program, Supplemental Unemployment Benefit Plan, and the Personal Savings Plan, each as described in this booklet, are maintained pursuant to a collective bargaining agreement with the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

**WHAT IS COBRA CONTINUATION COVERAGE?**

This notice applies to you if you are covered under the General Motors Health Care Program for Hourly Employees (the Program). This notice contains important information about your right to COBRA Continuation coverage, which is a temporary extension of coverage under the Program. **This notice generally explains COBRA Continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**
The right to COBRA Continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Program when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Program and under federal law, you can request a copy of the Plan Document from the GM Benefits & Services Center by calling 1-800-489-4646.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Program coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Under the Program, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Program because either one of the following qualifying events happens:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Program because any of the following qualifying events happens:
- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:
- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Program as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to General Motors, and that bankruptcy results in the loss of coverage of any retired employee covered under the Program, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Program.

When is COBRA Coverage Available?
The Program will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or
reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Call the GM Benefits & Services Center at 1-800-489-4646.

How is COBRA Coverage Provided?
Once the GM Benefits & Services Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage may be available for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration’s determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences a second qualifying event during the initial 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Program. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets
divorced or legally separated, or if the dependent child stops being eligible under the Program as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Program had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646.

If You Have Questions
Questions concerning your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes
In order to protect your family’s rights, you should keep the GM Benefits & Services Center informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the GM Benefits & Services Center.

Contact Information
You should contact the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the GM Benefits & Services Center at 1-800-489-4646, Monday through Friday between 7:30 a.m. and 6:00 p.m. Eastern Time zone, to speak with a Customer Service Associate.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the General Motors Health Care Programs, collectively referred to in this Notice as the “Programs,” may use and disclose protected health information about you for purposes of payment of health care claims and health care operations. The Programs may also use and disclose protected health information for other purposes that are permitted or required by law as described below.

Portability
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to:

- Improve the availability and portability of health care coverage for workers and their families when they change or lose jobs; and
- Provide administrative simplification of the health care industry through national standards for conducting electronic administrative and financial health care transactions, such as enrollment, eligibility inquiries, referrals and health care claims along with privacy and security requirements for personal health information.
Regarding the portability requirement under HIPAA, employers are required to provide make a certificate of prior health care coverage available, upon request, to enrollees when coverage is lost.

A certificate may be provided to: (1) an individual who is entitled to elect COBRA continuation coverage when a notice is provided for a qualifying event under COBRA; 2) an individual who loses coverage but is not entitled to elect COBRA Continuation coverage; and 3) an individual who has elected COBRA Continuation coverage when COBRA Continuation ceases. The certificate is provided upon the request of the enrollee within 24 months after coverage ceases.

This certificate may be used by former enrollees if they become covered under a new health plan which has preexisting condition limitations. The plans that have such limitations are required to reduce the length of time individuals have to wait for coverage to take effect for the preexisting condition by the period of time they were covered under the prior plan.

Privacy Practices

THE NOTICE of PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Protected Health Information (or “PHI”) is individually identifiable health information collected from you that is created or received by a health care provider, a health plan, or a health care clearinghouse, and that relates to (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Access to PHI is restricted to persons who need it to carry out their job duties in administering the Plans. Use and disclosure is limited to the minimum necessary to accomplish the intended purpose.

This Notice applies to covered dependents as well as primary enrollees.

Our Responsibilities

In accordance with the law, the Plans are required to implement reasonable measures to preserve the privacy of your PHI and to provide notice to you regarding:

1. Uses and disclosures of PHI;
2. The Plans’ obligations relating to the privacy of your PHI;
3. Your health information rights concerning your PHI;
4. Your right to file a complaint with either the Plans or the Secretary of the U.S. Department of Health and Human Services; and
5. Contact information for use in obtaining additional information with respect to the Plans’ policies and procedures for handling PHI. The Plans are required to abide by the terms of this Notice until a revised notice is issued in accordance with HIPAA.

Your Rights with Respect to PHI

You have the following individual rights with respect to your PHI:

1. You have a right to access your PHI. You have a right to inspect and copy your PHI. Generally, the Plans’ records containing your PHI are claims payment records and associated documents.
2. If you believe that your PHI is incorrect or incomplete, you may request an amendment to the information. The Plans are not required to agree to the amendment, but if it is denied, you have a right to submit a statement of disagreement to be kept with the disputed record.
(3) You have the right to request restrictions on certain uses and disclosures of PHI. For example, you may request that the Plans refrain from disclosing your PHI to other persons, such as family members, even for permitted uses. Under certain circumstances, the Plans are not required to agree to a requested restriction.

(4) If you believe that a disclosure of your PHI may endanger you, you may request that the Plans communicate with you regarding your PHI in an alternative manner or at an alternative location.

(5) You have a right to an accounting of certain disclosures of your PHI if your PHI has been disclosed for reasons other than treatment, payment for health care or health care operations.

(6) You have a right to a paper copy of this notice.

To exercise these rights you may write to the address listed in the Contact Information section of this notice. To request claim payment records containing your PHI, you may also contact the customer service department of your health care Carrier directly. You may be asked to submit your request in writing.

How Your Protected Health Information May Be Used

Treatment: While the Plans generally do not engage in treatment, the Plans are permitted to use or disclose your PHI for that purpose.

Payment: The Plans may use and disclose your PHI to pay claims associated with treatment and services that you receive by virtue of your enrollment in the Plans. Such purposes include, but are not limited to, eligibility determinations, claims processing, precertification or pre-authorization, billing, coordination of benefits, and subrogation. For example, PHI may be used to pay a doctor’s bill for covered services rendered by that doctor while treating you.

Health Care Operations: The Plans may use and disclose PHI about you for day-to-day plan operations. Such purposes include, but are not limited to, business management and administration, customer service, enrollment, audit functions, fraud and abuse detection, quality assurance, and disease management. For example, the Plans may use claims information to respond to claims appeals or audit the accuracy of claims processing.

Business Associates: The Plans contract with Business Associates to provide certain types of administrative services. To perform these functions or to provide the services, the Business Associates may receive, create, maintain, use, or disclose PHI. For example, the Plans may disclose your PHI to a Business Associate to administer claims or to provide customer service. The Business Associates will be required to agree in writing to appropriately safeguard your PHI. Examples of our Business Associates are Blue Cross Blue Shield of Michigan, and Express Scripts. In some cases, Business Associates may also contract with third parties to perform certain functions or to provide services.

Plan Sponsor: The Plans may disclose PHI to General Motors LLC in its capacity as plan sponsor for purposes associated with sponsorship of the Plans. For example, the Plans may disclose PHI to General Motors LLC in its capacity as plan sponsor for the purpose of considering plan enhancements. Generally, the information disclosed is summarized data and does not identify individuals personally.

Required by the Law: The Plans may use or disclose PHI about you as required by state and federal law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws. The Plans are required to disclose your PHI to the Secretary of the U. S. Department of Health and Human Services when the Secretary is investigating or determining the Plans’ compliance with HIPAA.
Legal Proceedings: The Plan may disclose your PHI: (1) as required by law in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal; and (2) in response to a subpoena, discovery request, or other lawful process, under the conditions required by applicable law.

Workers’ Compensation: The Plans may disclose your PHI to comply with workers’ compensation laws and other similar programs that provide benefits for work-related injuries.

Other Permitted Uses and Disclosures: The law permits the Plans to make the following types of uses and disclosures under certain circumstances. While the Plans generally do not use or disclose PHI for these purposes, they may disclose PHI to: a health oversight agency (such as Medicare or Medicaid); for government functions (for reasons of national security); to avert serious health or safety threat; or for post-mortem identification.

Other Uses: Other uses and disclosures require your written authorization. For example, an authorization is required for any use or disclosure of psychotherapy notes, except in connection with a legal action or other proceeding brought by the Individual who is the subject of the notes. If you provide an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI requiring authorization.

Complaints and Inquiries
You may file a complaint with the Plans or the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plans, you may write to the address below. You will not be retaliated against for filing such a complaint.

Future Changes in the Notice
The Plans reserve the right to change their privacy practices and the terms of this Notice, making the new notice provisions effective for all PHI maintained by the Plans. The revised Notice will be provided by mail. In the future, you may have the option of receiving the Notice electronically.

Contact Information
To obtain a copy of the HIPAA Privacy Notice, you may also access the GM Benefits & Services Center at www.gmbenefits.com, call 1-800-489-4646 or write to:

GM Health Care Privacy Office, Mail Code 482-C9-B84, 300 Renaissance Center, Detroit, MI 48265-3000
SECTION 10: GLOSSARY OF TERMS

Sometimes, in order to accurately describe a benefit plan, it is necessary to utilize technical terms. To help you better understand them, the following are brief definitions of some of the most commonly used terms. They are not meant to be all inclusive as each Plan or Program may have specific use which may vary.

Benefits for GM UAW-represented employees referenced here are:
- Personal Savings Plan (PSP),
- Health Care Program,
- Severance Program, and
- Life and Disability Benefits Program.

Ambulance Services – Medically necessary transportation and life support services provided to sick, injured, or incapacitated patients by a licensed ambulance provider meeting Program standards, utilizing ambulance vehicles, and personnel recognized as qualified to perform such services at the time and place where rendered.

Allowed Amount – The maximum amount on which payment is based for covered health care services by carriers, plan administrators, preferred providers or similar organizations to reimburse participating or contracted providers for covered services or the actual amount charged by the provider if less than the maximum. This may be called “eligible expense,” “payable allowance,” “reasonable and customary amount,” “allowable amount,” “negotiated rate,” or “payment allowance.”

Approved Facility or Treatment Program – A facility or a treatment program that has met criteria established by the Carrier to provide certain services covered by the GM Health Care Program for Hourly Employees. The following are examples of facilities and treatment programs which must be approved by the applicable Carrier for full benefits to be paid:
- Hospitals
- Skilled nursing facilities
- Outpatient mental health facilities
- Substance abuse treatment facilities
- Outlets for prosthetic or orthotic appliances
- Freestanding physical therapy facilities
- Home health care programs
- Hospice programs
- Freestanding ambulatory surgical centers (FASCs)
- Hemodialysis programs

In addition, certain services are not payable under the GM Health Care Program for Hourly Employees unless rendered by approved facilities or on approved equipment. Some services also must meet certain medical criteria. The following are examples of services which must be rendered by approved providers:
- Magnetic resonance imaging (MRI)
- Extracorporeal shock wave lithotripsy (ESWL)
- Positron emission tomography (PET scans)
In addition, Computerized Axial Tomography (CAT) scan services must be rendered on approved equipment. If you have any doubts about the approved status of a facility or treatment program, you should contact the appropriate health care Carrier.

**Balance Billing** – When a non-participating or out-of-network provider bills you for the difference between the provider’s charges and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30, in addition to any cost-sharing responsibilities. A preferred or in-network provider must accept allowed charges as payment in full and may not bill a plan participant for covered services in excess of the allowed amount.

**Beneficiary** – The person, persons, or entity named by you, a plan participant, to receive the plan’s benefits when you die – or if you die prior to receiving a benefit due you.

**Benefit Period** – A period of time during which an enrollee is entitled to receive certain covered services which are subject to Health Care Program maximums.

**Business Day** – Any day the New York Stock Exchange is open for business.

**Carrier** – Any entity by which the various benefit program coverages are administered or benefits paid. The term includes, but is not limited to, the following:
- General Motors Company;
- An insurance company; and/or
- Non-governmental administrative services organizations.

**Carrier Allowed Amount** – The maximum amount of payment by carriers and preferred providers or similar organizations to reimburse participating or contracted providers for covered services or the actual amount charged by the provider if less than the maximum. Also referred to as “payable allowance,” “reasonable and customary amount,” and “allowable amount.”

**COBRA** – Consolidated Omnibus Budget Reconciliation Act of 1985 – Federal legislation providing continuation rights to certain employees or dependents whose coverage under company-sponsored Programs is lost due to certain “qualifying events.”

**Coinsurance** – Your share of the costs of a covered health care services, calculated as a percentage (for example, 10%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, in the plan’s allowed amount for a covered service is $100 and you have met your deductible, your coinsurance payment of 10% would be $10. The plan pays the rest of the allowed amount, or $90.)

**Copayment (Copay)** – A fixed amount (for example, $25) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Conversion** – An opportunity to obtain other available individual coverage on a self-paid basis, from the Carrier with which the employee was enrolled at the time eligibility terminated.
**Core Coverage** – Hospital, surgical, medical, prescription drug, hearing aid, mental health/substance abuse, and durable medical equipment, including prosthetics and orthotics.

**Covered Expenses** – The reasonable and customary, pre-established, or contracted charges incurred for covered materials and services provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of the Health Care Program.

**Covered Service** – A service that is included within the range of services identified in the Program, and that meets all Health Care Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Health Care Program (e.g., a diagnostic radiology service) but which does not meet all of the specifications to be eligible for benefit payment (e.g., medically necessary) is considered a non-covered service.

**Current Market Value** – The value of your assets invested in the PSP investment options, as may be applicable, based on the unit values as determined each business day by the Trustee.

**Custodial or Domiciliary Care or Services** – The type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical, or psychiatric care, or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services).

Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons without special skills or training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toileting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes, and routine skin care.

The determination as to the nature of the care is not a function of the setting (i.e., hospital, skilled nursing facility, nursing home, another institutional setting, or the patient’s home) or of the professional status of the person (i.e., physician, nurse, therapist, or aide) rendering the service, but of the severity of the patient’s illness and the intensity of services being performed. The Carriers shall have discretionary authority to interpret, apply, and construe this provision of the Health Care Program. The Carrier’s determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

**Deductible** – The amount you could owe during a coverage period (for the GM Health Care Program for Hourly Employees, January 1 – December 31) for health care services your health insurer or Plan covers before your health insurer or Plan begins to pay. For example, if your deductible is $250, your Plan will not pay for covered expenses until you have met your $250 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Deferred Savings** – PSP contributions deducted from an employee’s eligible wage before federal income taxes and other taxes (if applicable) are determined (i.e., pre-tax employee contributions).

**Deferred Vested Benefits** – Pension Plan vested benefits that are payable at a future date to eligible former employees who were not retirement eligible at the time they separated.
GLOSSARY OF TERMS

Durable Medical Equipment – Equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

Emergency Room Services and Observation Care – Services in the emergency room of a hospital that are covered for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant women, the health of the women or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

ERISA – The Employee Retirement Income Security Act of 1974, is a Federal law that sets standards of protection for individuals provided private-sector health care, defined contribution and defined benefit plans.

Exchange – An exchange is a transfer of PSP assets from one investment fund to another.

Freestanding Ambulatory Surgical Center – A facility, separate from a hospital, in which outpatient surgical services are provided. Such facilities must meet Health Care Program standards and be approved by the local Carrier.

GM Benefits & Services Center – A service center through which GM employees, retirees, and surviving spouses may obtain services regarding their benefits. The Center processes various benefit-related transactions, provides general benefit-related information, and assists with problem resolution. The Center also provides services regarding account information and transactions under the Personal Savings Plan, and benefits under the Pension Plan. The Center maintains an Internet website at www.gmbenefits.com.

www.gmbenefits.com – The GM Benefits & Services Center Internet website which provides information and online services regarding benefits for GM employees.

Health Maintenance Organization (HMO) – An organization that provides health care services on a pre-paid basis for Participants in a designated geographic area. Enrollees generally must use HMO physicians and facilities in order to receive benefits.

HIPAA – Health Insurance Portability and Accountability Act of 1996 — Federal legislation intended to improve the availability and portability of health care coverage, which requires employers to provide a certificate of prior health care coverage when an enrollee loses coverage.

Home Health Care (HHC) – Care or services provided in the home for a patient who is essentially homebound, but whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/service is generally skilled, part-time and intermittent in nature.

Hospice Program, including Pre-Hospice Programs – Medical and non-medical services provided for terminally ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet GM Salaried Health Care Program standards and be approved by the local Carrier.
**Intermittent Care** – Part-time care which is provided on less than a daily basis or up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, but for a temporary period not to exceed one month.

**Live Birth** – A child born with spontaneous respiration or a heartbeat. Live birth does not include a stillbirth, miscarriage, spontaneous abortion or induced abortion.

**Medical Emergency** – A medical emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- Acute symptoms must occur suddenly and unexpectedly.
- Care must be secured within 72 hours of the onset of the condition.
- The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the enrollee’s health, or place such enrollee’s life in jeopardy.
- The signs and symptoms demonstrated by the patient at the time of treatment, as verified by the physician, and not the final diagnosis must confirm the existence of a threat to life or bodily functions.

**Non-Core Coverages** – Dental and Vision coverage.

**Non-Physician Practitioners** – An individual who meets Program Standards for the given profession and is approved by the Carrier for reimbursement for certain professional services in accordance with their training and licensure and which would be covered under the Program when performed by a physician. Program standards for non-physician practitioners shall include, but not be limited to, the requirements that the individuals be registered, certified and/or licensed as applicable under state law in the jurisdiction where services are provided, be legally entitled to practice their specialties at the time and place services are performed, that they render specified services which they are legally qualified to perform and that they be approved for enrollees who have Medicare as their primary coverage.

The categories of non-physician practitioners, and the services that may be covered when performed by them, include:

- “Advance Practice Nurses” means health care professionals including, but not limited to, certified nurse practitioners, clinical nurse specialists, certified nurse midwives and certified nurse anesthetists.
- "Physical Therapist" means an individual trained in the evaluation and rehabilitation of injured or disabled enrollees through non-medical and non-surgical measures.
- "Functional Occupational Therapist" means an individual trained in the restoration of a specified level of function of injured or disabled enrollees through non-medical and non-surgical measures.
- "Speech Therapist" means an individual trained in the correction of speech and language disorders through non-medical and non-surgical measures.
- “Physician Assistants” means health care professionals licensed to practice medicine with physician supervision.
GLOSSARY OF TERMS

- “Audiologist” means a health care professional who possesses a master’s or doctorate degree in audiology or speech pathology from an accredited university, possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association, and meets state licensure requirements. Certain services of an audiologist may be covered under this Appendix when performed in response to a medical diagnosis. Additionally, services performed by an audiologist may also be covered under hearing aid coverage.

- “Pharmacist” means a health care professional licensed to prepare, compound, and dispense drugs upon a prescription from a licensed practitioner such as a physician, dentist, or advanced practice nurse. A pharmacist at an approved pharmacy can administer vaccinations for influenza, herpes zoster (shingles), and pneumococcus bacterium infection (pneumonia) based on local Carrier Program criteria. In addition, services may also be covered under prescription drug coverage.

Orthotic Appliance – An external device intended to correct any defect of form or function of the human body.

Out-of-Pocket Maximum – The most enrollees in a health care plan will pay in deductibles and most copayments for covered expenses during a calendar year.

Part A (Basic Benefit) – A non-contributory part of the Hourly Pension Plan for employees hired prior to October 15, 2007.

Participating or Approved Provider – Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist, or other provider of health care services which, at the time an enrollee receives services included under the Health Care Program, meets program standards and has entered into a contract or agreement with a Carrier to provide those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expenses, as determined by the Carrier, as payment in full (unless otherwise provided). Providers who are not participating providers may or may not participate for individual claims and accept the amount determined by the Carrier as payment in full. Use of a non-participating hospital for non-emergency inpatient or outpatient treatment may result in the application of benefit payment maximums which could leave an enrollee with responsibility for a substantial portion of the reimbursement required by the non-participating provider for such treatment.

Part-Time Care – Up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or up to 35 hours per week for less than eight hours per day, subject to individual review and approval by the Carrier.

Physical Therapy and/or Functional Occupational Therapy – Therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, the development of new function attainable following surgery, or, if for a chronic or congenital condition, significantly improving the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

Physician – A doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally
GLOSSARY OF TERMS

qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services they are legally qualified to perform:

- “Dentist” means doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention, and treatment of disease of the teeth and related structures.
- “Podiatrist” means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages. A podiatrist also may prescribe medications that may be covered under the prescription drug coverage.
- “Chiropractor” means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxation or misalignments of the spinal column and related bones and tissues that produce nerve interference. Services of chiropractors that may be covered are limited to diagnostic radiological services and emergency first-aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues. Under the GM Salaried Health Care Program, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.
- “Optometrist” means a doctor of optometry (O.D.) whose scope of practice is the examination, diagnoses, treatment, and management of diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as to identify related systemic conditions affecting the eye. Services of optometrists which may be covered per local plan policies are limited to routine eye examinations, any other services performed by an optometrist are not covered.
- “Psychologist” means a health care professional with a clinical or counseling doctoral degree of psychology (Ph.D.). Certain services of a psychologist may be covered under this Appendix when performed in response to a medical diagnosis and when Program standards are met. Services may also be covered under mental health and substance abuse coverage (see App. B of this Program).

Predetermination – A review process performed by a Carrier or Utilization Review Organization prior to treatment to determine if proposed treatments, services, or facilities may be appropriate.

Preferred Provider Organization (PPO) – An arrangement with selected doctors, hospitals and other providers within a geographic area to provide care on a fee-for-service basis. PPO enrollees must use PPO physicians and facilities in order to receive the maximum benefit under the plan.

Pre-hospice – Refers to an initial level of hospice care consisting of evaluation, consultation and education, and support services that may be used prior to a terminally ill enrollee’s election of hospice coverage. A pre-hospice program must meet Health Care Program standards and be approved by the local Carrier.

Primary Plan – Refers to the health care plan responsible to pay first when the covered person has coverage under more than one plan.

Private Duty Nursing – Care or services provided by a nurse pursuant to a contract with a patient and/or a patient’s family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by
an institution (such as a hospital or skilled nursing facility) or the part time/intermittent/skilled care provided by a home health care agency.

**Prospectus** – A thorough, written description of a new security issue or mutual fund.

**Prosthetic Appliance** – An artificial device that replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

**Provider** – A person (such as a doctor) or a facility (such as a hospital) that provides health care services. Providers are considered to be “participating” when they have signed an agreement with the Carrier to accept as “payment in full” the amount which the Carrier determines to be an appropriate charge for services rendered. You should use participating providers whenever possible to limit the likelihood of personal liability for charges in excess of the Carrier’s payment.

You may be uncertain about the participating status, or whether there is any need for participation, by any health care provider in your area. If in doubt, contact the appropriate Carrier or the GM Benefits & Services Center.

**Reasonable and Customary Charge** – As it relates to covered health care expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the Carrier, taking into consideration, among other factors, the following:

- The usual amount that the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;
- The prevailing range of charges made in the same geographic area by providers with similar training and experience for the service rendered or materials furnished; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

The Carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service, or material. The Carrier shall have discretionary authority to interpret, apply, and construe this provision of the Health Care Program. The determination by the Carrier as to the reasonable and customary charge shall be final and conclusive, and shall be given full force and effect unless it is determined by the Program Administrator to have been contrary to the Health Care Program provisions or it is proven that the determination was arbitrary and capricious.

As used in the Health Care Program, reasonable and customary also refers to the forms and/or amount of payment used by Carriers and preferred provider or similar organizations to reimburse participating or contracted providers for covered services.

**Regular Savings** – Contributions made by a Participant to the PSP after federal income taxes and other taxes (if applicable) are deducted from an employee’s eligible wages (i.e., after-tax employee contributions).

**Rollover** – A transfer of cash attributable to the taxable amount of a PSP distribution that would be taxable to the Participant if not moved directly from one qualified retirement plan to another qualified plan or to an Individual Retirement Account (IRA).
**Roth After-Tax Savings** – Contributions made by a Participant to the PSP after federal income taxes and other taxes (if applicable) are deducted from an employee’s eligible wages. Under current tax law, at the time of withdrawal, the Participant will owe no taxes as long as the withdrawal from the Roth account is made on or after age 59 ½, or upon disability or death, and as long as the account existed for at least a 5-taxable-year period beginning with the year that the first Roth contribution is made.

**Secondary Plan** – Refers to the health care plan that has the secondary obligation to pay benefits when more than one health care plan covers an individual.

**Skilled Nursing Care** – Care or services that are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury that requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient’s medical condition, determines whether the service is skilled.

**Skilled Nursing Facility (SNF)** – A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet Health Care Program standards and be approved by the local Carrier.

**Spouse** – Includes the parties to a marriage of two persons of the opposite sex or of two persons of the same sex provided the marriage was lawful in the jurisdiction in which it occurred. If a marriage was lawful in the jurisdiction in which it occurred, it will be deemed lawful for plan administration purposes thereafter regardless of whether the Participant or spouse later establish residence or become domiciled in a jurisdiction in which such marriage is not recognized or is otherwise deemed unlawful.

**Surviving Spouse Coverage** – Where applicable, provides benefits for your eligible spouse in the event that you die before your spouse.

**Therapeutic Care** – Specific and definitive surgical, medical, psychiatric, or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient’s level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient’s condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance care in nature.

**Total and Permanent Disability Retirement (T&PD)** – Based on medical evidence satisfactory to General Motors, the eligible employee is found to be wholly and permanently prevented from engaging in regular employment at the location last employed.

**Total Control Account Program®** – Provides a beneficiary with control of the proceeds from GM life insurances, including ready access to the money and earnings/interest on money remaining in their account.
Trustee – The entity responsible for holding the benefits or assets of a program or plan. GM’s current Trustees are listed under the General Information section.

Unit – The measure of a Participant’s interests in the investment funds offered under the PSP.

Utilization Review Organization – An organization retained to perform certain utilization review and utilization management functions, including predetermination, concurrent and retrospective utilization review.

Work Life Plus – A resource which provides employees and dependents with trained counselors who assist in resolving personal problems through counseling and/or referral to community services. Education and consultation services are also provided to management to assist in helping troubled employees or resolving problematic situations.

Years of Participation – under the Life and Disability Benefits Program is defined as follows:

- **Prior to September 1, 1950**, years of participation, in general, equal your recognized length of service as of September 1, 1950.
- **From September 1, 1950 through December 31, 1973**, you receive credit while insured for Life Insurance, plus any period while (1) on military leave or (2) receiving your Life Insurance in installments because of total and permanent disability. If you are not insured for a period in excess of 24 consecutive months and your recognized length of service is broken, you lose credit for prior years of participation. If your credited service under the Retirement Program is greater than your years of participation, credited service may be used instead of years of participation.
- **On and After January 1, 1974**, for Life and Disability Benefits Program purposes, your credited service accrued on and after January 1, 1974, under the Retirement Program will be added to your years of participation under the Life and Disability Benefits Program (or credited service, if greater) as of December 31, 1973.
- **On and After January 1, 2007**, years of participation and credited service shall be defined as Eligibility Service under the Retirement Program. Eligibility Service is equal to Part A credited service plus service earned after December 31, 2006.

Years of Seniority – the period of time from your date of hire to your last day worked.
SECTION 11: A LIST OF IMPORTANT ITEMS TO REMEMBER

- **INFORM** the GM Benefits & Services Center if:
  - You change your address
  - Your marital status changes
  - Your dependents change
  - You become disabled
  - Your spouse dies
  - Your beneficiary dies
  - You desire to change your beneficiary
  - You are laid off and secure other employment
  - You become eligible for Social Security Disability Insurance Benefits
  - You want survivor coverage and are eligible for it

- **YOU** may be asked for your Social Security Number for identification purposes when calling to make changes to your benefits. If you are communicating via a letter, please include the last 4 digits of your Social Security Number.

- **CONTACT** your local Social Security office if you have any questions about Social Security or Medicare.

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