SUMMARY PLAN DESCRIPTION

Effective January 1, 2024

A summary for *hourly employees* as set forth in supplemental agreements between General Motors LLC and the UAW, dated October 30, 2023

Contents:

WELCOME

Dear General Motors Hourly Employee:

This Summary Plan Description (SPD) 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 information 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,

Mike Perez
Vice President
GMNA Labor Relations
General Motors

Mike Booth
Vice President and Director
UAW General Motors Department

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PLAN ADMINISTRATION

GENERAL INFORMATION

The information in this Summary Plan Description (SPD) is based upon the benefit plan provisions in effect through termination of the 2023 UAW-GM Agreement. This SPD 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 SPD 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 SPD 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 language and this SPD, the Plan documents and negotiated Agreements always will govern. Your eligibility for any benefit described in this SPD 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.

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 2023 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.

Subject to the 2023 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 SPD. 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.

WHO TO CONTACT

CONTACT INFORMATION FOR GM BENEFITS	Website	Phone #
GM Benefits & Services Center P.O. Box 770003 Cincinnati, OH 45277	gmbenefits.com netbenefits.com	**800-489-4646** **Dial 711 for hearing/speech support**
HEALTH CARE PROGRAM - Eligibility and Enrollment - COBRA Continuation		
DEPENDENT CARE REIMBURSEMENT PLAN (***When calling the GM Benefits & Services Center, select "Pensions, Savings or Health Care"***) - Eligibility and Enrollment - Payroll Deduction Changes		
PERSONAL SAVINGS PLAN (PSP) - Eligibility and Enrollment - Account Transactions		
DISABILITY BENEFITS (***When calling the GM Benefits & Services Center, select "Disability" to be routed to Sedgwick***) - Sickness & Accident Benefits - Extended Disability Benefits		
LIFE INSURANCE ***(When calling the GM Benefits & Services Center, select "Life Insurance" to be routed to MetLife)*** - Eligibility and Enrollment - Beneficiary Designations - Basic Life & Extra Accident - Optional Life, Dependent Life & Personal Accident - Survivor Income Benefit Insurance		
SUPPLEMENTAL UNEMPLOYMENT BENEFIT (SUB) PLAN - Regular SUB Benefit - Transition Support Program (TSP) - Short Week Benefit - Separation Payment		
PENSION PLAN - Eligibility and Retirement Initiation - Credited Service - Beneficiary Information - Planning and Guidance		
OTHER SERVICES - Family Medical Leave (FMLA) - Qualified Domestic Relations Order (QDRO) - Reporting a Death/Survivor Services - Service Awards - Wage & Employment Verification - Workers' Compensation		

Benefit Plan / Program	Carrier / Plan Administrator	Contact Information
Benefit Enrollment	GM Benefits & Services Center	800-489-4646 netbenefits.com
LifeSteps Program	WebMD	888-383-8755 lifesteps.com
Traditional Care Network (TCN) Enrollees:		
- Medical - Physical/Occupational Therapy - Behavioral Health and Substance Use Disorder	Blue Cross Blue Shield of Michigan	800-482-2210 bcbsm.com
	Virtual Care / Urgent Care / Behavioral Health Visits	800-Teladoc bcbsm.com/virtualcare 877-264-6690 Blue Cross Behavioral Health
	Coordinated Care & 24/7 Nurseline	800-775-2583
- Hearing Aid	AudioNet America	586-239-0242 audionetamerica.com
- Prescription Drugs	CVS Caremark	844-379-1671 caremark.com
	CVS Specialty Pharmacy	800-237-2767 cvsspecialty.com
Health Maintenance Organization (HMO) Enrollees:		
- Medical, Behavioral Health and Substance Use Disorder, and Prescription Drugs	Blue Care Network HMO (BCN)	800-662-6667 bcbsm.com
	Health Alliance Plan of Michigan HMO (HAP)	800-422-4641 hap.org
	MercyCare Health Plan of Wisconsin	800-895-2421 mercycarehealthplans.com
Dental Plan	Delta Dental of Michigan	800-942-0667 deltadentalmi.com
Vision Plan	Davis Vision	888-672-8393 davisvision.com
Dependent Care Reimbursement Plan	Bank of America	866-567-3993 myhealth.bankofamerica.com/GM
Personal Savings Plan 401k	Fidelity	800-489-4646 netbenefits.com
Disability	Sedgwick	800-489-4646 877-347-5225 TTY claimlookup.com/generalmotors
Life Insurance	MetLife	800-489-4646 888-688-2860 TTY mybenefits.metlife.com

Benefit Plan / Program	Carrier / Plan Administrator	Contact Information
Parental Leave	Sedgwick	800-489-4646 877-347-5225 TTY claimlookup.com/generalmotors
Pension Plan	Fidelity	800-489-4646 netbenefits.com
UAW-GM Tuition Assistance Plan		TAPadmins@uawgmjp.com
UAW Legal Services Plan		800-482-7700 uawlegalservices.com
UAW Retiree Health Care Coverage	UAW Retiree Medical Benefits Trust	866-637-7555 uawtrust.org
College 529 Plan	Fidelity	800-544-1914 fidelity.com/529-plans/overview
GM Savings Marketplace	Beneplace	800-683-2886 gm.savings.beneplace.com
GM Vehicle Purchase Program	GM Family First	800-235-4646 gmfamilyfirst.com
Medicare Assistance	SSDC	800-374-9950 ssdcservices.com

Additional U.S. government resources:

Program / Services	Department	Contact Information
Medicare	Centers for Medicare & Medicaid Services (CMS)	medicare.gov
Medicare & Medicaid	Centers for Medicare & Medicaid Services (CMS)	cms.gov
Social Security	U.S. Social Security Administration	800-772-1213 800-325-0778 TTY ssa.gov

WHO IS ELIGIBLE

The benefits described in this SPD are generally offered to UAW-represented, hourly-rated employees, as summarized in the *BENEFITS SUMMARY* section below.

Additional employee and dependents eligibility information, along with effective dates for coverage, are outlined in each applicable benefit section.

BENEFITS SUMMARY

Traditional and In-Progression Employees

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
Medical	Comprehensive hospital, surgical, medical, behavioral health and prescription drug coverage, including routine physical exams.	▪ Traditional Care Network (TCN) ▪ Blue Care Network HMO (select areas) ▪ HAP HMO (select areas) ▪ MercyCare HMO (select areas) ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Traditional Care Network (TCN) option with self-only coverage, and any eligible dependents will not have coverage.
Dental	Preventive and restorative dental care, along with orthodontic care for enrolled dependents under age 19.	▪ Traditional Dental Plan ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Traditional Dental Plan for self-only coverage, and any eligible dependents will not have coverage.
Vision	One eye exam annually and eyeglasses or contacts every year	▪ Vision Plan ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Vision Plan with self-only coverage, and any eligible dependents will not have coverage.
Dependent Care Reimbursement Plan	May defer up to $5,000 pre-tax to pay for qualified dependent care expenses	▪ Dependent Care FSA ▪ No coverage	On the ninety-first (91st) day of employment	You will be automatically enrolled with no coverage.
Personal Savings Plan (PSP)	401(k) Employee & Employer Contributions	Employee deferral elections	On the ninety-first (91st) day of employment	Unless you opt out, you will be automatically enrolled to contribute to the PSP.

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election...
Sickness & Accident Benefits (S&A)	Company-provided short-term coverage to protect a portion of your income in the event of total disability.	Sickness & Accident Benefits (S&A)	For **Traditional employees:** You are eligible for *coverage* the first of the month following six (6) months of employment. For **In-Progression employees:** you are eligible for *coverage* the first day after acquiring one year of seniority	Once you are eligible, enrollment is automatic.
Extended Disability Benefits (EDB)	Company-provided long-term coverage to protect a portion of your income if you are totally disabled.	Extended Disability Benefits (EBB)	For **Traditional employees:** You are eligible for *coverage* the first of the month following six (6) months of employment. For **In-Progression employees:** you are eligible for *coverage* the first day after acquiring one year of seniority.	Once you are eligible, enrollment is automatic.
Company-Paid Life Insurance	Provides a benefit to you or your designated beneficiary if you were to die during employment	▪ Basic Life ▪ Extra Accident ▪ Survivor Income Benefit Insurance (SIBI)	On the first day of employment.	You will be automatically enrolled in employer-paid life insurance coverages.[1]
Employee (Self) Paid Life Insurance	Provides a benefit to your designated beneficiary if you were to die during employment	▪ Optional Life ▪ Dependent Life ▪ Personal Accident Insurance	Dependent on when you enroll in coverage; detailed information will be sent from MetLife.	If you want coverage, you must enroll.[1]

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
Supplemental Unemployment Benefit (SUB)	Provides an income replacement benefit intended to supplement your (weekly) state unemployment benefit if you are laid off consistent with the Plan terms	Supplemental Unemployment Benefit (SUB)	You are eligible for the benefit once you have attained 90 calendar days of employment as of your last day worked, prior to a qualifying layoff.	There is no enrollment. Once you're eligible, you may need to apply for each weekly benefit.
GM Hourly-Rate Employees Pension Plan	Defined benefit plan for employees: ▪ hired on or before October 15, 2007, or ▪ eligible to participate under the terms of a Memorandum of Understanding between the union and GM	Benefit paid post-employment to retired employees or those with a deferred vested benefit.	Eligible Employees begin accruing credited service on date of hire. Benefit retention based on vesting.	Enrollment action is not required by employee.

[1] *If you are not in active service on the day your coverages otherwise would begin, coverage will begin once you are in active service as defined by the Collective Bargaining Agreement.*

Full-Time Temporary Employees

The following is a summary of benefits offered to **Full-Time Temporary employees**.

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
Medical	Comprehensive hospital, surgical, medical, behavioral health and prescription drug coverage, including routine physical exams.	▪ Traditional Care Network (TCN) ▪ Blue Care Network HMO (select areas) ▪ HAP HMO (select areas) ▪ MercyCare HMO (select areas) ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Traditional Care Network (TCN) option with self-only coverage, and any eligible dependents will not have coverage.
Dental	Preventive and restorative dental care, along with orthodontic care for enrolled dependents under age 19.	▪ Traditional Dental Plan ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Traditional Dental Plan for self-only coverage, and any eligible dependents will not have coverage.
Vision	One eye exam annually and eyeglasses or contacts every year	▪ Vision Plan ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Vision Plan with self-only coverage, and any eligible dependents will not have coverage.
Dependent Care Reimbursement Plan	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Personal Savings Plan (PSP)	401(k) Employee Contributions	Employee deferral elections	On the ninety-first (91st) day of employment	Unless you opt out, you will be automatically enrolled to contribute to the PSP.
Sickness & Accident Benefits (S&A)	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Extended Disability Benefits (EDB)	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Company-Paid Life Insurance	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Employee (Self) Paid Life Insurance	Not Eligible	Not Applicable	Not Applicable	Not Applicable

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
Supplemental Unemployment Benefit (SUB)	Provides an income replacement benefit intended to supplement your (weekly) state unemployment benefit if you are laid off consistent with the Plan terms	Supplemental Unemployment Benefit (SUB)	You are eligible for the benefit once you have attained 90 calendar days of employment as of your last day worked, prior to a qualifying layoff.	There is no enrollment. Once you're eligible, you may need to apply for each weekly benefit.
GM Hourly-Rate Employees Pension Plan	Not Eligible	Not Applicable	Not Applicable	Not Applicable

Part-Time Temporary Employees

The following is a summary of benefits offered to **Part-Time Temporary employees.**

Plan	Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
Medical	Comprehensive hospital, surgical, medical, behavioral health and prescription drug coverage, including routine physical exams.	▪ Temporary Employee Health Care Plan ▪ No coverage	On the first (1st) day of employment	You will be automatically enrolled in the Temporary Employee Health Care Plan with self-only coverage, and any eligible dependents will not have coverage.
Dental	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Vision	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Dependent Care Reimbursement Plan	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Personal Savings Plan (PSP)	401(k) Employee Contributions	Employee deferral elections	On the ninety-first (91st) day of employment	Unless you opt out, you will be automatically enrolled to contribute to the PSP.
Sickness & Accident Benefits (S&A)	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Extended Disability Benefits (EDB)	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Company-Paid Life Insurance	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Employee (Self) Paid Life Insurance	Not Eligible	Not Applicable	Not Applicable	Not Applicable
Supplemental Unemployment Benefit (SUB)	Not Eligible	Not Applicable	Not Applicable	Not Applicable
GM Hourly-Rate Employees Pension Plan	Not Eligible	Not Applicable	Not Applicable	Not Applicable

COST FOR COVERAGE

Who Pays for Coverage

Health Care, Disability, Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance are provided by the Company at no cost to you while you are in active service. The Company funds the Pension Plan, SUB Plan and Profit Sharing Plan. The Company also contributes to the cost of legal services. Whereas, if you wish to enroll in Optional Life Insurance, Dependent Life Insurance, and/or Personal Accident Insurance, you pay the applicable premium costs.

In certain situations, you may be required to contribute to the cost of health care coverage on a self-pay basis, see *Situations Affecting Your Benefits* for more details.

The amount of any employee contributions to the Personal Savings Plan is determined by provisions set forth in the Plan.

What is the Cost of Coverage

- If you are required to contribute to the cost of health care coverage in certain situations, contribution amounts are determined actuarially and vary by plan and coverage level.
- The Company's contributions to the Health Care Program are based on the Plans' claim and administrative costs.
- The amount the Company contributes to the Pension Plan is determined actuarially.
- The Company's contributions to the SUB Plan are determined under Program provisions and paid subject to the SUB Maximum Financial Liability Cap.
- The amount the Company contributes 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 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.

WHEN COVERAGE BEGINS

Health Care Program
Eligibility for coverage in the Medical Plan will be effective on the first (1st) day of employment.

For **Traditional, In-Progression and Full-Time Temporary employees**, eligibility for coverage in the Dental and Vision Plans will be effective on the first (1st) day of employment.

Dependent Care Reimbursement Plan
For **Traditional and In-Progression employees**, eligibility for coverage will be effective on the ninety-first (91st) calendar day.[1] Participation, if elected, begins on the first day of the first pay period following the attainment of eligibility and remains in effect through December 31 of that same year.

Personal Savings Plan (PSP)
Employees are eligible to participate and accumulate savings under the Personal Savings Plan (PSP) following their completion of 90 days of employment with the Company.

A previously eligible Employee who resumes active employment following termination of employment will be eligible to participate immediately.

Disability Benefits
For **In-Progression employees** hired on or after October 16, 2007, Sickness and Accident and Extended Disability Benefits coverages are effective the day after an employee acquires one year of seniority.[1] Enrollment is automatic once eligible.

Life Insurance
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.[1]

Supplemental Unemployment Benefit (SUB) Plan
Supplemental Unemployment Benefit (SUB) is "income replacement" while you are on Layoff. It is provided in three (3) forms: (1) Regular SUB for full weeks of layoff, (2) Transition Support Program (TSP) payments for Indefinite layoffs and (3) Automatic Short Week Benefits (ASWB) for partial layoff periods. In all instances, employees must have attained 90 calendar days of employment, as of their last day worked prior to the layoff and be on a qualifying layoff.

Pension Plan
Traditional employees hired on or prior to October 15, 2007 are eligible to participate in the GM Hourly-Rate Employees Pension Plan (the Pension Plan or HPP). Certain other employees, who may be covered by other Union agreements resulting from divestitures, purchases or other disposition of specific operations, are also eligible to participate subject to the terms of those agreements.

[1] *If you are not in active service on the day your coverages otherwise would begin, coverage will begin once you are in active service as defined by the Collective Bargaining Agreement.*

WHEN COVERAGE ENDS

The following generally describes when your benefit coverage will end if your employment is terminated or a dependent is no longer eligible for coverage. Other situations affecting your benefit eligibility for are described in the *Situations Affecting Your Benefits* section.

Health Care Program
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 currently under *Consolidated Omnibus Budget Reconciliation Act (COBRA)*. *(**Note:** If you file a grievance contesting loss of seniority, health care coverage may be continued provided you pay the full month cost of coverage while the grievance is pending.)*

Dependent Care Reimbursement Plan
Your participation ceases when you are no longer receiving regular pay through payroll and your pre-tax contributions to your Dependent Care FSA end.

Disability Benefits, Basic Life Insurance, Extra Accident Insurance and Survivor Income Benefit Insurance
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, if you file 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 by making any required monthly contributions.

Optional Life Insurance, Dependent Life Insurance and Personal Accident Insurance
Coverage ceases 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 and Personal Accident Insurance for a dependent also cease 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.

HOW TO ENROLL, CANCEL OR MAKE CHANGES

When You Hire

Health Care Coverage: The GM Benefits & Services Center will send an enrollment packet to your home when you become eligible for health care coverage. You will need to make your benefit enrollment elections for you and your eligible dependents per the terms of the Program (see the Collective Bargaining Agreement)[2]. If you do not actively elect coverage when you have the opportunity to enroll, you will automatically be enrolled in coverage as follows:

Employee Classification	Benefit Coverage	Coverage Option	Coverage Level
Hourly-Rated, Traditional, In-Progression, and Full-Time Temporary Employee	Medical	Traditional Care Network Health Care Plan	Self-Only
	Dental	Traditional Dental Plan	Self-Only
	Vision	Vision Plan	Self-Only
Hourly-Rated, Part-Time Temporary Employee	Medical	GM Temporary Employee Health Care Plan	Self-Only
	Dental	Not Eligible	
	Vision	Not Eligible	

Dependent Care Reimbursement Plan: The GM Benefits & Services Center will send an enrollment packet to your home when you become eligible to participate in the Dependent Care Reimbursement Plan. You will need to make your benefit enrollment election per the terms of the Plan (see the Collective Bargaining Agreement)[2].

Personal Savings Plan (PSP): If you are a newly hired employee and you have not enrolled in the Plan, you will be automatically enrolled unless you opt out of Automatic Enrollment prior to the first contribution. You will be automatically enrolled at a 3% pre-tax contribution rate of eligible weekly earnings. This contribution will be made through payroll deductions. Your PSP employee contributions can be increased or decreased by accessing your account through **gmbenefits.com**.

Disability Benefits: You are automatically covered for Sickness and Accident (S&A) and Extended Disability Benefits (EDB) when eligible, no action is needed to enroll.

Life Insurance: MetLife will send enrollment information to your home. You will be automatically enrolled in employer-paid life insurance coverages, such as Basic Life Insurance. However, you must actively enroll in any employee-paid coverage, such as Optional Life, Dependent Life and Personal Accident Insurance. You must name beneficiaries for coverages you elect.

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

Rolling Enrollment

Health Care Coverage: After you complete your initial enrollment for health care coverage, you will be allowed to make changes to your health care elections only after waiting twelve (12) months from the effective date of your coverage. Once you have satisfied the 12-month period, you may elect to enroll in, decline or change your health care coverage any time thereafter. If you do make new elections for health care, you won't be able to change those elections for another 12-month period, unless you experience a *qualifying life event*.

In the event your change in coverage request 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.

Annual Enrollment

Dependent Care Reimbursement Plan: You have the opportunity to elect to participate in the Dependent Care Reimbursement Plan each year during annual enrollment in the fall. The election you make during annual enrollment is effective January 1 of the next Plan Year and remains in effect through December 31 of that same year, so long as you remain an eligible employee.

Qualifying Life Events

You may have the opportunity to make changes to your health care coverage and Dependent Care Reimbursement Plan election if you experience certain qualified life events. If you would like to make a change to your benefit elections, it is your responsibility to notify the *GM Benefits & Services Center* per the terms of the Plan (see the Collective Bargaining Agreement)[2] of any qualifying life event.

Your election changes become effective on the first of the month following your enrollment change request. In cases where you are adding a new dependent to coverage because of birth or adoption, coverage will be effective as of the date of the event.

Qualifying life events are those considered to be a major change in your family situation, including, but not limited to:

- A change in address.
- A change in your marital status (e.g., marriage, divorce, death of a spouse).
- Addition or loss of an eligible dependent (e.g., birth or adoption of a child, death of a child).
- Certain changes in employment status for you, your spouse or an eligible dependent (e.g., retirement, termination, spouse loses coverage due to termination of employment, etc.).

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

It is your responsibility to 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.

Where to Enroll in Your Benefits

The enrollment process to select the benefits you wish to participate in is paperless. You have two options to access the enrollment process:

1. **Online:**
   a. Log in via **gmbenefits.com** to enroll in health care benefits, the Dependent Care Reimbursement Plan, disability, and retirement benefits. You may also designate your beneficiary for your Personal Savings Plan (PSP); and
   b. Visit **MyBenefits.Metlife.com** to complete your life insurance and personal accident insurance enrollment, including designating your beneficiary.
2. **Telephonically:**

   Call the *GM Benefits & Services Center* to speak with a customer service representative who can assist you with enrolling in your benefits.

Notice of Special Enrollment Rights

If you have declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Health Care Program if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Health Care Program, including the option of changing your medical plan, if you are already participating. However, you must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after the marriage, birth, adoption, or placement for adoption.

APPEALING YOUR BENEFITS

Each health, welfare and retirement Program described in this SPD 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. The Plan Administrator will provide adequate notice, in writing, to any participant or beneficiary whose claim for benefits under the applicable Plan has been denied setting forth the specific reason for such denial. Provisions with respect to such discussion, and procedures for making appeals, are set forth by Plan, in the applicable section.

How to Receive Assistance

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 from a local Union Benefit Representative or the *GM Benefits & Services Center* to provide information about your questions or concerns.

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

SITUATIONS AFFECTING YOUR BENEFITS

For Employees on Disability Leave of Absence

Health Care Coverage (applicable to In-Progression Employees Only)

In most cases, GM contributions for health care coverages will be continued for the duration of an approved disability leave of absence. Your coverage for health care will cease at the end of the month in which the maximum Sickness and Accident Benefits or Extended Disability Benefits are payable.

Health Care Coverage (applicable to Traditional Employees Only)

In most cases, GM 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 equaled your length of 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.

For both Traditional and In-Progression employees, exceptions to the above include, but are not necessarily limited to, the following situations:

(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 on 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 or retirement program, health care coverages under the Health Care Program will cease upon retirement. In this circumstance, you may be eligible for health care coverage from the UAW Retiree Medical Benefits Trust (see the *Health Care Coverage* section under *For Employees Who Retire* for more information).

If you become "totally and permanently disabled" and 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 health care coverages on a self-paid basis. Your coverage may continue for the period of time you would have had coverage had you not taken the Separation Payment. Continuation of coverage is subject to periodic proof of continued disability.

Dependent Care Reimbursement Plan

If you are no longer receiving regular pay through payroll, your pre-tax contributions to your Dependent Care FSA will end. Please see the *Dependent Care Reimbursement Plan* > *When Pre-tax Contributions Cease or End* section for more information regarding eligible expenses and requesting reimbursement while on a disability leave of absence.

Life and Disability Coverage

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 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.

Pension Plan

You are eligible for credited service for each calendar week of sick leave 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 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 or Company approved sick leave.

Personal Savings Plan

Generally, your employee and GM contributions (if eligible) to the Personal Savings Plan (PSP) will continue while you are receiving eligible weekly earnings through payroll. If you are not receiving eligible weekly earnings, your employee and GM contributions (if eligible) will cease, with the exception of any Profit Sharing payment you elect to contribute to the PSP (if eligible).

You will remain eligible to make changes to your investment elections, rebalance your current investments, and apply for eligible loans and withdrawals (subject to PSP terms) while on a leave of absence.

If you are receiving eligible weekly earnings, loan repayments are made through after-tax payroll deductions. If, as the result of your leave status, you are not receiving eligible weekly earnings through payroll, you have the option to:

- Continue to make loan repayments directly to the GM Benefits & Services Center.
- Suspend loan repayments for the duration of your leave, not to extend beyond your loan terms or 12 months.

For Employees Who Become Totally and Permanently Disabled

Pension Plan

Pension benefits may be payable upon application and approval if you are a GM employee at the time of application. You must meet all of the following criteria prior to making application:

- You must be an active participant in the HPP;
- You must have been on a disability leave for at least five months;
- You must have at least 10 years of credited service;
- You must become totally and permanently disabled before age 65

The Total and Permanent Disability (T&PD) retirement requires GM Medical approval. 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) the Pension Plan, if you die while you are totally disabled and meet eligibility under the Plan. See the *Pension Survivor Benefits* section for details.

Personal Savings Plan

You may make a written request to the Plan Administrator to be considered permanently disabled under the Personal Savings Plan (PSP). The Plan Administrator will determine whether you are disabled solely for purposes of distribution under the PSP based on the following:

- Designation of a Total and Permanent Disability Retirement under the General Motors Hourly-Rate Employees Pension Plan; or
- Designation of disability by the U.S. Social Security Administration.

You will be required to provide a valid award letter from the U.S. Social Security Administration as evidence of such disability. Funds which are restricted from distribution prior to termination of employment, such as Company Contributions and Retirement Contributions, continue to be ineligible for distribution by employees (subject to PSP terms).

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*)

For Employees on Parental Leave

You continue to be eligible for health care coverage and life insurance while on an approved Parental Leave of Absence. Please contact *GM Benefits & Services Center* for more information.

For Employees on Other Non-Disability Leaves

If you are granted a non-disability leave of absence, you will be given a notice explaining your options to continue coverages under the Health Care Program and Life and Disability Benefits, including information on monthly contributions you may have to make.

Health Care Coverage

Your health care coverages as an active employee will continue through the end of the month in which you are last in active service. You will have the option to continue medical, dental and/or vision coverage for a period of time currently under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)*.

If you are granted a non-disability leave of absence in anticipation of a disability leave of absence at a future date, **and if you enroll in continuation of coverages under COBRA**, you will be eligible for reinstatement of GM contributions for coverages, and for continuation of such coverages during the period you are on a disability leave of absence.

Dependent Care Reimbursement Plan

If you are no longer receiving regular pay through payroll, your pre-tax contributions to your Dependent Care FSA will end. Please see the *Dependent Care Reimbursement Plan* > *When Pre-tax Contributions Cease or End* section for more information regarding eligible expenses and requesting reimbursement while on a non-disability leave of absence.

Life and Disability Coverage

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), 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. For 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 the Carrier 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 the Carrier 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.

Pension Plan

The type of leave and duration determines if you will accrue credited service under the Pension Plan while on leave.

Personal Savings Plan

Generally, your employee and GM contributions (if eligible) to the Personal Savings Plan (PSP) will continue while you are receiving eligible weekly earnings through payroll. If you are not receiving eligible weekly earnings, your employee and GM contributions (if eligible) will cease, with the exception of any Profit Sharing payment you elect to contribute to the PSP (if eligible).

You will remain eligible to make changes to your investment elections, rebalance your current investments, and apply for eligible loans and withdrawals (subject to PSP terms) while on leave of absence.

If you are receiving eligible weekly earnings, loan repayments are made through after-tax payroll deductions. If, as the result of your leave status, you are not receiving eligible weekly earnings through payroll , you have the option to:

- Continue to make loan payments directly to the GM Benefits & Services Center.
- Suspend loan for the duration of your leave, not to extend beyond your loan terms or a period of up to 12 months.

For Employees on Layoff

The following describes how your benefit coverage will be affected if you are placed on layoff. See the section titled *For Employees Returning from Layoff* for information on when your benefit coverage will be reinstated upon return-to-work.

Health Care Coverage

Traditional, In-Progression and Full-Time Temporary Employees

For Employees at work on or after November 20, 2023:

If you are laid off, your coverage as an active employee will cease at the end of the month in which you last are in active service, as defined under the Health Care Program. Thereafter, in any month in which you are continuously laid off, you will be eligible for continued coverages through and including the last day of the 24th month following the month in which you were laid off.

For Employees who last worked between October 29, 2019 and November 19, 2023:

If you were laid off on or after October 29, 2019 and prior to November 19, 2023, your coverage as an active employee ceased at the end of the month in which you were last in active service, as defined under the Health Care Program. Thereafter, generally you are entitled to a number of months of continued health care coverage (with GM contributions) based upon your seniority at the time of layoff, as shown in the following chart.

Years of Seniority as of Last Day Worked[3] Prior to Layoff	Maximum Number of Months of Health Care Coverage Continuation
Less than 1	1
1 but less than 2	4
2 but less than 3	6
3 but less than 4	8
4 but less than 5	10
5 but less than 10	13
10 and over	25

For Full-Time Temporary employees, the above table does not apply. Coverage shall automatically cease as of the last date of the month following the month in which you are placed on layoff.

For Employees who last worked on or before October 28, 2019:

If you were laid off on or before October 28, 2019, the provisions of the appropriate Collective Bargaining Agreement apply. If you have questions regarding your eligibility for health care coverage continuation, contact the *GM Benefits & Services Center* for assistance.

The information above 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. After the period of continuation of coverage described above, you will be given a notice explaining your health care continuation rights currently under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)*.

Health Care Coverage for Part-Time Temporary Employees

For Employees who last worked on or after August 25, 2023:

If you are laid off on or after August 25, 2023, coverage shall automatically cease as of the last date of the month following the month in which you are placed on layoff.

For Employees who last worked before August 25, 2023:

If you were laid off on or after August 25, 2023, coverage shall automatically cease as of the last date of the month in which you are placed on layoff.

Once coverage ceases, you will be given the opportunity to continue medical, dental and/or vision coverage (if applicable) under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)*.

[3] *If you are **placed on layoff while on a 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.*

Dependent Care Reimbursement Plan

If you are no longer receiving regular pay through payroll, your pre-tax contributions to your Dependent Care FSA will end. Please see the *Dependent Care Reimbursement Plan* > *When Pre-tax Contributions Cease or End* section for more information regarding eligible expenses and requesting reimbursement while on a layoff.

Disability Coverage

While on layoff, Sickness and Accident and Extended Disability Benefit coverages may be continued through the end of the month following the month in which you last worked prior to layoff at GM cost.

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 by calling the *GM Benefits & Services Center*;
- 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 fifty-two (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.

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.

Life Insurance

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 following chart.
- 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 benefits 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 in the following chart.

	Basic Life Insurance	Personal Accident Insurance
Years of Seniority as of Last Day Worked Prior to Layoff	Maximum Number of Months of Company-Paid Continuation	Maximum Number of Months for Which Personal Accident Insurance Can Be Continued
Less than 1	0	0
1 but less than 2	4	16
2 but less than 3	6	18
3 but less than 4	8	20
4 but less than 5	10	22
5 but less than 10	12	24
10 and over	24	36

Pension Plan

You are eligible for credited service for each calendar week of 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 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 or Company approved sick leave.

Personal Savings Plan

Generally, your employee and GM contributions (if eligible) to the Personal Savings Plan (PSP) will continue while you are receiving eligible weekly earnings through payroll. If you are not receiving eligible weekly earnings, your employee and GM contributions (if eligible) will cease, with the exception of any Profit Sharing payment you elect to contribute to the PSP (if eligible).

You will remain eligible to make changes to your investment elections, rebalance your current investments, and apply for eligible loans and withdrawals (subject to PSP terms) while on layoff.

If you are receiving eligible weekly earnings, loan repayments are made through after-tax payroll deductions. If, as the result of your layoff status, you are not receiving eligible weekly earnings through payroll , you have the option to:

- Continue to make loan payments directly to the GM Benefits & Services Center.
- Suspend loan for the duration of your leave, not to extend beyond your loan terms or a period of up to 12 months.

For Employees Returning from Permanent Layoff

Health Care Coverage

Upon return to active work from layoff, any health care coverage discontinued while on layoff with seniority will be reinstated the day you return to active work. GM contributions to coverage also will resume at that time.

Note: If you return to work from permanent layoff and are laid off again or become disabled, please refer to the *For Employees on Layoff* section for special information regarding health care continuation.

Dependent Care Reimbursement Plan

If you return from layoff during the Plan Year in which you have made an election to contribute to a Dependent Care FSA and your pre-tax contribution ceased while on layoff, your pre-tax contributions will be reinstated. The amount deducted per pay period will be adjusted to ensure your total annual contribution election is met by the end of the Plan Year.

Life and Disability Coverage

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.

Personal Savings Plan

If you have an outstanding PSP loan, you must contact the *GM Benefits & Services Center* upon your return from layoff or leave to reinstate your loan repayments through payroll.

For Employees Terminating Employment

Health Care Coverage

If you terminate your employment, your health care coverage will end on the last day of the month in which you are last in active service. Currently, you will have the option to continue medical, dental and/or vision coverage (if applicable) under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)*.

Dependent Care Reimbursement Plan

If you are no longer receiving regular pay through payroll, your pre-tax contributions to your Dependent Care FSA will end. Please see the *Dependent Care Reimbursement Plan* > *When Pre-tax Contributions Cease or End* section for more information regarding eligible expenses and requesting reimbursement after you have terminated from the Company.

Life Insurance

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.

Pension Plan

If you terminate your employment, to receive lifetime monthly benefits, you must meet vesting eligibility under the GM Hourly-Rate Employees Pension Plan. Vesting for employees hired on and after January 1, 1989, is five (5) years. If you are vested but not eligible to retire on your date of separation, you may commence your pension benefit on or after age 55.

For Employees Who Retire

Health Care Coverage

If you retire, your health care coverage will end of the last day of the month in which you are last in active service. You will have the option to continue medical, dental and/or vision coverage (if applicable) under the *Consolidated Omnibus Budget Reconciliation Act (COBRA)*.

Effective January 1, 2010, GM no longer offers company-sponsored health care coverage to UAW affiliated retirees or 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 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 coverage and eligibility directly to the Trust, see the *Who To Contact* section for details.

Dependent Care Reimbursement Plan

If you are no longer receiving regular pay through payroll, your pre-tax contributions to your Dependent Care FSA will end. Please see the *Dependent Care Reimbursement Plan* > *When Pre-tax Contributions Cease or End* section for more information regarding eligible expenses and requesting reimbursement after you have retired from the Company.

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** after attaining age 55 and 10 years of seniority 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 1½% 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:

$49,000 x 2% = $980

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

1½% x 30 = 45% x $49,000 = $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.

Pension Plan

See the *Pension Plan* section for your pension benefits.

In the Event of Your Death

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. Contact the *GM Benefits & Services Center* for additional information if required.

If you die *prior to attaining eligibility* for health care coverage, your surviving spouse may enroll, on a **self-paid basis**, in the Medical Plan (no dental or vision coverage) 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 coverage 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 continuation of coverage under COBRA.

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 does not offer company-sponsored health care coverage to a surviving spouse or eligible dependents of UAW affiliated retirees/survivors. 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 separate and independent from GM. The Trust is responsible for providing retirees/surviving spouses 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* (see "Who To Contact").

If you die because of an accidental injury caused solely by employment with GM, and your spouse was not retirement eligible, your surviving spouse will be eligible for health care coverages that were available to you, subject to all Program provisions until the earlier of the date when your spouse (1) dies, or (2) remarries. Your eligible dependent children will be provided continued coverage, subject to all Program provisions, through the end of the month in which they become age 26, unless your dependent child has been determined to be totally and permanently disabled under the provisions outlined in the Collective Bargaining Agreement.

If your spouse was retirement eligible, GM does not offer company-sponsored health care coverage to a surviving spouse or eligible dependents of UAW affiliated retirees/survivors. 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 separate and independent from GM. The Trust is responsible for providing retirees/surviving spouses 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* (see "Who To Contact").

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

YOUR RIGHTS UNDER THE UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment to undertake military service. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

The model U.S. Department of Labor USERRA notice may also be viewed on the Internet at dol.gov/vets/programs/userra/USERRA_private.pdf#Non-Federal.

Reemployment Rights
Under federal law, you have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five (5) years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation
Under federal law if you are a past or present member of the uniformed service; have applied for membership in the uniformed service; are obligated to serve in the uniformed service; then an employer may not deny you any of the following because of this status:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24-months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at dol.gov/vets. An interactive online USERRA Advisor can be viewed at webapps.dol.gov/elaws/vets/userra/. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

As a participant in one or more of GM's Hourly Benefit Programs, you are entitled to certain rights and protections under the Family and Medical Leave Act of 1993 (FMLA). Under FMLA, you have certain rights to take leave time and still retain certain coverages and benefits under various company benefit plans. You may continue benefit coverages during an approved family medical leave (FMLA), provided you continue to pay the required contributions or premiums for coverage when they are due.

If you are receiving continued pay while on FMLA, your standard deductions will continue for any contributory coverage you may be enrolled in (e.g., Optional Life, Dependent Life and/or Voluntary Accidental Death & Dismemberment). However, if you are on an approved FMLA without pay, you will be billed monthly for your contributions to your benefits. **Even if you do not receive a monthly benefits billing statement, however, it is still your responsibility to remit your monthly contribution payment by the first of the month for each month you are not receiving an active paycheck**. If you fail to make your required monthly premium payment(s) by the end of a 30-day grace period, your coverage will be canceled retroactively to the date of your last payroll deduction or plan contributions payment. If your coverage ends due to non-payment of plan contributions, you will be permitted to request reinstatement of benefit coverages effective the day you return to work. Other reinstatements of benefits will be per the terms of the applicable Plan.

For more information, please call the *GM Benefits & Services Center*.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

With the exception of the right to amend, modify, suspend, or terminate, this section applies only to benefit plans governed by ERISA.

Types of Plans
The GM Pension Plan is a defined benefit plan providing trusteed pension benefits to employees who retire, and/or to their eligible survivors. The GM Personal Savings Plan (PSP) 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 General Motors Health Care Program for Hourly Employees 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. 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 SPD.

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 SPD. 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 SPD. The administrator's address is Mail Code 482-C36-D48, 300 Renaissance Center, Detroit, MI 48265-3000.

Identification Numbers

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

Plan Name	Number
Pension	003
Personal Savings	014
Life & Disability	503
SUB	505
Health Care	525

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, Mail Code 482-C24-SOP, 300 Renaissance Center, Detroit, MI 48265-3000.

Participant Rights

As a participant in the GM benefit plans 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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plans, 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 plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. 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

- 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 SPD to learn more about your COBRA continuation coverage rights.

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.
- 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.

Pension Plan Benefit Guarantee
Your 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, **pbgc.gov** or call the PBGC toll free at 1-800-400-7242.

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

- In the case of benefits payable as an annuity:
  - 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
  - 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),
- 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,
- All other nonforfeitable benefits under the Plan, and
- 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, the Company's obligation to contribute to the Plan shall cease entirely, the parties shall negotiate for a period of 60 days with respect to the use of the money which the Company otherwise would be obligated to contribute under the Plan. If no agreement is reached, there shall be a general wage increase in the amount of the basic contribution rate then in effect, but not less than 22 cents per hour to all hourly-rate employees then covered by the Collective Bargaining Agreement which shall be applied to the basic and incentive rates, in the same manner that the general increase is made applicable under Paragraph 98(a) of the CBA, and effective as of the date of such termination.

Personal Savings Plan
Upon termination or partial termination of the Personal Savings Plan, no further contributions or savings will be made to accounts. Each Participant will maintain entitlement to vested benefits held in their account.

Trustees
Trustees of the Pension Plan, who accumulate assets through which pension benefits are provided, are as follows:

State Street Bank and Trust Company
One Lincoln Street
State Street Financial Center
Boston, MA 02111

The Trustee of the Personal Savings Plan, who accumulates assets through which Personal Savings Plan benefits are provided, is:

State Street Bank and Trust Company
One Lincoln Street
State Street Financial Center
Boston, MA 02111

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

INTERACTION OF STATE LAWS & ERISA

ERISA contains a broad preemption provision that supersedes many state laws that govern employee benefit plans (or that would govern such plans but for ERISA preemption). Nonetheless, in limited circumstances, ERISA-governed plans may need to comply with certain state laws. In addition, ERISA does not preempt the application of state laws to non-ERISA plans or benefit programs.

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. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the General Motors Health Care Program for Hourly Employees, referred to in this Notice as the "Plans," may use and disclose protected health information about you for purposes of payment of health care claims and health care operations. The Plans may also use and disclose protected health information for other purposes that are permitted or required by law as described below.

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 currently in effect.

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. If your PHI is stored in electronic form, you have a right to request that a copy be provided in electronic form if it is readily producible in that form. Generally, the Plans' records containing your PHI are claims payment records and associated documents.

Your request to review and/or obtain a copy of this PHI must be made in writing. The Plans may charge a fee for the costs of producing, copying, and mailing or sending electronically your requested information, but the Plans will tell you the cost in advance. If the Plans deny your request for access, the Plans will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review. 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, and the Plans have a right to rebut any such statement. The Plans will also notify you in writing if the Plans deny your amendment request.

(2) 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. The Plans are not required to agree to a requested restriction, except requests to restrict disclosures to a health plan where (a) the disclosure relates to Payment or Health Care Operations disclosures and is not required by law, and (b) the PHI pertains solely to a health care item or service for which you (or another person other than the Plans) has paid in full. If the Plans agree to a restriction request, the Plans will comply with your request unless the information is needed for an emergency.

Your request for a restriction must be made in writing. In your request, you must tell the Plans (a) what information you want to limit; (b) whether you want to limit how the Plans use or disclose your information, or both; and (c) to whom you want the restrictions to apply.

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. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. The Plans will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

(3) You have a right to an accounting of certain disclosures of your PHI. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than the six years prior to your request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, the Plans may charge for providing the accounting, but the Plans will tell you the cost in advance.

(4) 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 at the end of this form. 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 or Disclosed
Treatment: The Plans are permitted to use or disclose your PHI to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, the Plans may disclose your PHI to providers to provide information about alternative treatments.

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 may disclose your PHI to Business Associates that 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. 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, provided General Motors LLC has agreed to certain restrictions on how it will use or disclose the PHI (such as agreeing not to use the PHI for employment-related actions or decisions). For example, the Plans may disclose PHI to General Motors LLC in its capacity as plan sponsor for the purpose of considering plan enhancements.

Person(s) Involved in Your Care or Payment for Your Care: The Plans may disclose PHI to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. The Plans may disclose the relevant PHI to these persons if you do not object or the Plans can reasonably infer from the circumstances that you do not object to the disclosure.

Required by Law: The Plans may use or disclose PHI about you as required by state and federal law. 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.

Law Enforcement: The Plans may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Research: Under certain circumstances, the Plans may disclose PHI about you for research purposes, provided certain measures have been taken to protect your privacy.

Legal Proceedings: The Plans may disclose your PHI: (1) 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 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.

Underwriting: If applicable, the Plans may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plans use or disclose your PHI for underwriting purposes, the Plans are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Less Common Permitted Uses and Disclosures: The law permits the Plans to use and disclosure of your PHI in additional, less common situations, such as: to a health oversight agency (such as Medicare or Medicaid); for government functions (for reasons of national security, public health, or if required by military authorities); to avert a serious health or safety threat; to government agencies about abuse, neglect, or domestic violence; to coroners or funeral directors as necessary to allow them to carry out their duties; in connection with organ or tissue donation; or for post-mortem identification.

Other Uses and Disclosures: Any other uses and disclosures of your PHI not described in this Notice 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. Your authorization is required for the Plans to use or disclose your PHI to market to you (with limited exceptions). If you provide an authorization, you may revoke the authorization in writing at any time (except to the extent the Plans have already taken action in reliance on the authorization), and this revocation will be effective for future uses and disclosures of PHI requiring authorization.

Breach Notification
The Plan must notify you in the event that there is a breach involving your PHI.

Complaints and Inquiries
You may file a complaint with the Plans or the Secretary of 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 at any time, effective for PHI that the Plans already have about you as well as any PHI that the Plans receive in the future. The Plans will provide you with a copy of the new Notice whenever the Plans make a material change to the privacy practices described in this Notice. The revised Notice will be provided by mail or email.

Contact Information
For assistance, or to obtain a copy of this notice, you may call the GM Benefits & Services Center at 1-800-489-4646 or write to:

GM Health Care Privacy Office
Mail Code 482-C24-B81
300 Renaissance Center
Detroit, MI 48265-3000

LIFESTEPS PROGRAM

OVERVIEW

At GM, we know nothing is more important than your health. That's why we've teamed up with WebMD to bring you the LifeSteps Program. Now, it's easier than ever to take control of your well-being and achieve the goals that matter most to you.

The goal of the LifeSteps Program is to create a culture of wellness by educating, supporting, and empowering employees and their families to improve and maintain their overall well-being through healthy lifestyle choices.

The LifeSteps Program is a comprehensive program offering:

- **Health Assessment:** Answer a few questions about your health, well-being, and lifestyle. In just 15 minutes, you'll learn where your health stands and receive personalized recommendations to help you improve it.
- **Health coaching:** Get professional help achieving your wellness goals. Even better, coaching sessions are convenient, confidential, and completely free.
- **Wellness at Your Side mobile app and online tools:** Access LifeSteps anytime 24/7; access health tools, track your progress and work toward your wellness goals.
- And more!

ELIGIBILITY

The LifeSteps Program is offered to all U.S. hourly employees, their spouses, and dependent child(ren) age 18 and older. Your dependent children under the age of 18 are not eligible to access LifeSteps programs.

HOW TO ACCESS SERVICES

You have several options to connect with LifeSteps for services:

1. **Telephone:** Contact your local onsite LifeSteps Wellness Coach
2. **Email:** lifesteps@webmd.com
3. **Website:** lifesteps.com
4. **Mobile App:** Download the ***Wellness At Your Side*** mobile app on the App Store℠ or Google Play™

COST

GM pays for the cost of this service. You and your eligible family members may access this service at no cost to you.

HEALTH CARE PROGRAM

GENERAL INFORMATION

Overview

The General Motors Health Care Program for Hourly Employees (Health Care Program) provides comprehensive coverage for hospital, surgical, medical, behavioral health, prescription drug, dental and vision services received by eligible employees and dependents.

Services, supplies and prescribed medications necessary to treat medical and behavioral health conditions are covered under the Medical Plan. You will have the option to enroll in the Traditional Care Network (TCN) or in some regions, a Health Maintenance Organization (HMO) option. The TCN is offered nationwide regardless of where you live. Your choice of using an in-network provider (or network physician) or an out-of-network provider (or out-of-network physician) will normally determine how the Plan pays benefits. If you use a health care provider who participates in the TCN provider network, your share of the cost of medical care will generally be less than if you use an out-of-network provider. The TCN is administered by Blue Cross Blue Shield of Michigan.

Two HMO options are offered in Michigan (Blue Care Network HMO (BCN) and Health Alliance Plan HMO (HAP)) and one HMO option (MercyCare) is offered in certain zip codes in Wisconsin. HMOs are not offered outside of Michigan and Wisconsin. The HMO options require all care be provided or directed by your primary care physician (PCP) and you must use only those physicians and hospitals that participate in the HMO network or no benefits are payable, with the exception of emergency situations.

If you enroll in the Medical Plan, you will receive a GM health care ID card. When you receive medical services, always present your GM health care ID card to the provider. You may request additional cards at no cost by accessing your account through the *Carrier's* website or contacting the Carrier at the customer service number on the back of your GM health care ID card.

In addition to the Medical Plan, the Health Care Program gives you the option to enroll in coverage under the Dental and Vision Plans. You have the opportunity to elect benefit coverages that fit the needs of you and your family. You determine what value you will receive from your personal benefits package by choosing the Plans and coverage levels right for you.

Use this document as a guide to know what services are covered before you need to use them. Learn the meaning of common terms and become familiar with your coverage before a health care crisis occurs.

Eligibility

Employee

Traditional, In-Progression, and Full-Time Temporary employees are eligible for the Traditional Care Network and HMO medical plan options, along with dental and vision coverage on 1st day of employment.

Part-Time Temporary employees are eligible for coverage under the GM Temporary Employee Health Care Plan on 1st day of employment. **Part-Time Temporary employees** are not eligible for medical coverage under an HMO option, or dental and vision coverage.

Dependents

The following dependents are eligible to be enrolled in coverage.

Spouse
Your spouse who is legally married to you. Your spouse by common-law marriage is eligible for coverage if the laws of the state in which you reside recognize common-law relationships.

Dependent Children by Birth or Legal Adoption
Your dependent children, or your spouse's dependent children (i.e., your stepchildren), by birth or legal adoption are eligible for coverage through the end of the month in which they turn age 26, regardless of financial dependency, student status, employment, marital status, residency, or eligibility for other coverage.

Dependent Children by Legal Guardianship
If you are a legal guardian to a dependent child, they are eligible for coverage if **all** of the following criteria are met:

- Is a blood-relative to you or your spouse; and
- Has not reached the end of the month in which they turned age 26.

Dependent Children by Birth or Legal Adoption Who Are Totally and Permanently Disabled
Your biological or legally adopted child or stepchild is eligible for coverage beyond the end of the month in which they become age 26 if they are disabled and meet **all** of the following criteria:

- Became totally and permanently disabled **prior** to the end of the month in which the child turns age 26;
- Lives primarily with you or the other parent in a parent-child relationship; and
- Is unmarried.

Qualified Medical Child Support Order (QMCSO) or Medical Support Notice
Federal law requires the Plan to honor a Qualified Medical Child Support Order (QMCSO) and/or Medical Support Notice. In general, a QMCSO/Medical Support Notice is a state court order requiring an employee-parent to provide group health plan coverage (medical, prescription drug, dental and vision) to a dependent minor child, for example, in cases of legal separation or divorce. GM has no discretion and must comply with the terms of every duly authorized QMCSO/Medical Support Notice that it receives.

Information regarding enrollment pursuant to a Qualified Medical Child Support Order or Medical Support Notice can be obtained, without charge, by writing to the Plan Administrator at the, GM Benefits & Services Center, ATTN: QMCSO Processing, P.O. Box 770003, Cincinnati, OH 45277-0071, or by calling 1-800-489-4646.

No Double Coverage Permitted

You and your dependents cannot have double coverage under the GM Salaried and/or Hourly Health Care Programs. For example, if your spouse is also an eligible GM employee or retiree, you or your spouse may each be enrolled in coverage as an employee/retiree or one of you can be enrolled in coverage as the employee/retiree and the other as a dependent of the employee/retiree. You cannot be enrolled in coverage both as an employee or retiree, and as a dependent. Likewise, if you have an eligible dependent of two eligible employees/retirees (for example, both mother and father are employed and/or retired by GM; your eligible dependent can be covered by only one employee or retiree of GM.

Enrollment

Levels of Coverage

You may elect coverage for:

(1) Yourself only (single),

(2) Yourself plus your spouse,

(3) Yourself plus your child,

(4) Yourself and two or more children, or

(5) Yourself plus your spouse and your child(ren) (family).

Documentation Requirements for Enrolling Your Dependents to Your Coverage

As the primary enrollee, you will be asked to provide documentation necessary to substantiate the eligibility of enrolled dependents within thirty (30) days after receipt of the initial verification letter you receive, with a 15-day grace period. If documentation is not received by the designated deadline, the dependent will be removed from coverage on the first of the month following the end of the grace period (e.g., if the grace period ends on March 20, your dependents' coverage will end on April 1). 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.

For Spouse and Dependent Children: The documentation necessary for adding a spouse and dependent child(ren) and/or stepchildren must establish their relationship to you or your current spouse, such as a marriage certificate and birth certificates.

For Dependents by Legal Guardianship: The documentation necessary for adding a dependent by legal guardianship must establish blood relationship to you or your current spouse and legal documentation establishing the guardianship.

A note regarding dependents by legal guardianship: Health care coverage is effective the date guardianship becomes final as provided in the legal court documents, however a retroactive effective date is limited to twelve (12) months.

Ongoing Documentation Requirements: If you have dependents enrolled in coverage under the Program, you may be required to furnish documentation necessary to substantiate the continued eligibility of enrolled dependents (e.g., during a dependent verification audit).

If You are a New Employee or First Become Eligible

When you enroll in coverage, you may enroll in the Plans that best meet your family's needs. For example, enrollment in the Dental or Vision Plan is not dependent on your enrollment in the Medical Plan. You may elect to enroll in the:

- Medical Plan coverage alone,
- Medical Plan plus the Dental and/or Vision Plans for which you may be eligible,
- Dental and/or Vision Plan for which you are eligible only; or
- Waive all coverages.

When multiple medical plan options exist (e.g., TCN and HMOs), your enrollment option will apply to all enrolled dependents.

If you do not actively enroll in coverage when you first become eligible for coverage, you will automatically be enrolled in the TCN option with self-only (single) coverage.

Rolling Enrollment

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 permitted for the next twelve (12) months. Additional changes in coverage options are allowed, as exceptions to the 12-month waiting period, for *qualifying 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.

See the *When Enrollment Changes Are Effective* section for more information.

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 prospective option selections without regard to the normal 12-month waiting period.

Special Enrollment and Qualifying Life Events

If you have declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Health Care Program if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). You must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Health Care Program, including the option of changing your medical plan option (e.g., TCN or HMO), if you are already participating. However, you must request enrollment per the terms of the Plan (see the Collective Bargaining Agreement)[2] after the marriage, birth, adoption, or placement for adoption.

When Enrollment Changes Are Effective

Changes in enrollment will be prospective and generally effective on the first day of the month after the GM Benefits & Services Center receives your request for enrollment changes. For example, if your enrollment change request is received on February 15, your requested changes will become effective on March 1. In the event the change is delayed, you will be informed of the effective date.

When Coverage Ends

Assuming you do not waive coverage under the Program, your coverage ends on the last day of the month in which:

- You no longer meet the eligibility requirements under the Health Care Program.
- Your employment with the Company terminates (see *Consolidated Omnibus Budget Reconciliation Act (COBRA)* section for more information.)
- You fail to pay required self-pay rates in certain situations.

Assuming you do not waive coverage under the Program, your dependents' coverage ends on the last day of the month in which:

- Your coverage ends.
- Dependent coverage is terminated.
- The individual is no longer an eligible dependent under this Program.

Explanation of Benefits (EOB)

An *Explanation of Benefits* (EOB) will be sent to you after your claim is processed. The EOB shows you what services have been rendered, the status of the claim and any payment made by either you or the Plan. It is not a bill. Please check this form carefully to make sure you received the services listed. It is very important that you notify the Plan's administrator (the carrier) if you did not receive the services outlined or if there are any discrepancies.

[2] *When, as a result of oversight or error, an eligible primary or secondary enrollee entitled to coverage is not enrolled in a timely manner, coverage may be provided retroactive to the date of eligibility that would have been established if proper processing had occurred. However, in no event will the retroactivity exceed twelve (12) months from the month in which the error or omission is discovered. See Art. III, 9(a)(6) of Exhibit C-1.*

Health Care Tips

The cost of health care affects everyone. That's why it is important that each of us takes an active part in keeping health care affordable. Following these tips will help to reduce health care costs:

Use in-network providers: In-network providers have chosen to work closely with GM's *Carriers* to help hold down rising health care costs. When you choose to receive services and supplies from in-network providers, you can reduce your own out-of-pocket expenses and support the Program's efforts to keep health care affordable.

Select a primary care physician (PCP): It is important to have one physician that you see on a regular basis. Most people use either a family practitioner, an internist, or pediatrician as their personal physician or "family doctor." Let your physician get to know you, your medical history, and your lifestyle. Your PCP can then take care of you for regular check-ups, refer you to specialists when necessary, help you manage chronic conditions, and coordinate your hospital care. Be sure to select a physician who makes you feel comfortable and whose specialization meets most of your day-to-day health care needs.

Understand your health care benefits: Know what services are covered before you need to use them, and whether the provider you are receiving services from is in-network. Learn the meaning of terms such as deductible, copayment (copay), coinsurance and out-of-pocket maximums. Become familiar with your coverage before a health care crisis occurs and learn about the most appropriate places for care when you need it. Utilize the assistance of your local Union Benefit Representatives (UBRs) where appropriate.

Ask questions: Feel free to ask your provider questions. It is important to know how much office visits cost if recommended tests are necessary or if a prescribed medication has possible side effects. Always insist all your questions are answered and be sure to discuss all your treatment options with your provider so you can make informed decisions.

Use your benefits efficiently: The best health care isn't always the most expensive care. For example, you may want to see a doctor virtually or use an urgent care center or walk-in clinic, versus an emergency room when your symptoms are not life-threatening.

Stay healthy: The best way to protect your health is to live a healthy lifestyle. Use good sense in maintaining a balanced diet, exercising regularly, wearing your seat belt, and avoiding tobacco and alcohol misuse. Pay attention to the warning signs your body gives you. When you follow good health rules, you avoid habits and activities that put you at risk for disease and injury.

Look over your health care bills: Doctors' offices and hospitals can make mistakes, so it's smart to look at your bills closely. Make sure you aren't billed for services you didn't receive. If you find an error, inform your provider or hospital right away. Utilize the assistance of your local Union Benefit Representatives (UBRs) where appropriate.

Help prevent fraud: Each year, health care fraud costs employers and employees, so it is important to check your bills and explanation of benefits statements to make sure you received the services listed.

Common Terms

Ambulance Services – Medically necessary transportation and life support services provided to sick, injured, or incapacitated patients by a licensed ambulance provider, utilizing ambulance vehicles and personnel recognized as qualified to perform such services at the time and place where rendered.

Approved 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 network providers for covered services or the actual amount charged by the provider if less than the maximum. Other common terms used for *approved amount* may be "eligible expense," "payable allowance," "reasonable and customary amount," "allowed amount," "negotiated rate," or "payment allowance." *The Plan/Collective Bargaining Agreement refers to the Approved Amount as the Allowed Amount.*

Balance Billing – When a provider bills you the difference between the total charged for a health care service and the approved amount. For example, if the provider's charge is $100 and the approved amount is $70, the provider may bill you for the remaining $30, in addition to any cost-sharing (deductible and/or coinsurance) responsibilities. A preferred or in-network provider must accept approved charges as payment in full and may *not* bill you for covered services in excess of the approved amount.

Benefit Period – A period of time during which you or an enrolled dependent is entitled to receive certain covered services that are subject to Health Care Program maximums.

Carrier – Any entity by which the various health plans (medical, pharmacy, behavioral health, physical therapy, hearing aids, dental and vision) are administered or benefits paid. Examples of Carriers for purposes of this Program are Blue Cross Blue Shield of Michigan, CVS Caremark, AudioNet, Delta Dental of Michigan, Davis Vision, etc.

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 service, usually a percentage (for example, 10%) of the approved amount for the service. (For example, if the approved 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 remaining portion of the approved amount, or $90.)

Copayment (Copay) – A set dollar amount you pay for a health care service or prescription, usually when you receive it.

Core Coverage – Under the Health Care Program, benefits are paid for hospital, surgical, medical, prescription drug and hearing aid services as set forth in Appendix A, and behavioral health and substance use disorder treatments as set forth in Appendix B, of Exhibit C to the Supplemental Agreement (Exhibit C). Collectively, these coverages shall be referred to as the Medical Plan throughout this document.

Covered Expense – The approved amount 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 does not meet all the specifications to be eligible for coverage (e.g., medically necessary) is considered a non-covered service.

Custodial or Domiciliary Care or Services – Non-medical care or assistance to help an individual with activities of daily living (ADL), such as bathing, dressing, eating, etc. Care may be recommended by a licensed provider, but the provider of the care itself is not required to be a medical professional (for additional clarification, refer to App. A. 1.F. of the Supplemental Agreement (Exhibit C)).

Deductible – The amount you *could* owe during a coverage period (for the Health Care Program, January 1 – December 31) for covered health care services before your 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.

Diagnostic Services – Tests and evaluations ordered by a doctor or health care professional to determine the cause of symptoms related to a specific condition, illness or injury.

Durable Medical Equipment (DME) – Equipment that 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 delivered in the emergency department of a hospital 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 woman, the health of the woman 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.

Freestanding Ambulatory Surgical Center (ASC) – A modern health care facility focused on providing same-day surgical care on an outpatient basis, including diagnostic and preventive procedures. Such facilities must meet Health Care Program standards and be approved by the Carrier for services to be eligible for coverage.

GM Benefits & Services Center – A service center through which GM employees, retirees and surviving spouses may obtain services regarding their benefits. The GM Benefits & Services Center processes various benefit-related transactions, provides general benefit-related information and assists with problem resolution. They also provide services regarding account information and transactions under the Personal Savings Plan, and benefits under the Pension Plan. Their website is **gmbenefits.com**.

Health Maintenance Organization (HMO) – A type of plan where you need to get a referral from your primary care provider before seeing a specialist. If enrolled in an HMO, you must generally use HMO providers 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 Health Care Program standards and be approved by the Carrier for services to be eligible for coverage.

In-Network Provider – Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist, or other provider of health care services who meets Program standards and has entered into a contract or agreement with a Carrier to provide health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the approved amount for covered expenses, as determined by the Carrier, as payment in full (unless otherwise provided).

Inpatient Behavioral Health Care – Mental health or substance use disorder treatment received in a hospital, detoxification facility, or residential care facility.

Intermittent Care – Part-time care that 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.

Medical Emergency – 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 – Under the Health Care Program, benefits paid for dental (Appendix C) and vision (Appendix D) services as set forth in the Supplemental Agreement (Exhibit C). Collectively, these coverages shall be referred to as the Dental Plan and Vision Plan throughout this document.

Orthotic Appliance – An external device intended to correct any defect of form or function of the human body.

Out-of-Pocket Maximum – The most you'll have to pay during a Plan Year for covered health care services you receive. Your out-of-pocket maximum includes your deductible, copay, and coinsurance.

Outpatient Behavioral/Mental Health Facilities – Governmental, public, private, or independent unit facility or treatment centers providing outpatient behavioral health counseling/therapy/substance use disorder services in an ambulatory care setting to care for adults or children, such as a hospital unit, clinic or partial hospitalization treatment center.

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 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 a 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 coverage. 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 chiropractic spinal manipulation (CSM) and chiropractic manipulation (CM) as set forth in Appendix A, III, M. Under the 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 the Program when performed in response to a medical diagnosis and when Program standards are met.

Plan Year – A 12-month period of benefits coverage. For purposes of the Health Care Program, the Plan Year is January 1 through December 31.

Precertification – Approval required for a health care service before you receive it, so that the Program will pay benefits for treatment. Also sometimes referred to as *predetermination (as defined in the CBA)*, *prior authorization*, or *pre-approval*.

Preferred Provider Organization (PPO) – A type of plan where you don't need to get a referral from your primary care provider to see a specialist, and that may offer more flexibility in choosing providers, specialists and facilities. PPO enrollees must use PPO physicians and facilities in order to receive the maximum benefit under the Program.

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 Carrier.

Preventive Service – Tests or other health care services *(as defined in the CBA)* intended to prevent diseases or conditions at an early stage when treatment is likely to work best.

Primary Plan – Refers to the health care plan responsible to pay first when the covered person has coverage under more than one plan.

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 in-network 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 in-network providers whenever possible to limit the likelihood of personal liability for charges in excess of the Carrier's payment.

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.
- 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 network providers or similar organizations to reimburse participating or contracted providers for covered services.

Secondary Plan – Refers to the health care plan that has the secondary obligation to pay benefits when more than one 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 Carrier for services to be covered.

Spouse – An individual who is lawfully married to another individual, including by common-law marriage only to the extent such relationship is recognized by the laws of the state in which the individual resides (refer to Article III, 9(b) of the Supplemental Agreement (Exhibit C) for further clarification).

Subrogation – The process of recovering payment when another person, insurance company or organization may be legally obligated to pay for health care services that a carrier has already paid; for example, in the case of a court judgment.

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.

Utilization Review Organization – An organization retained to perform certain utilization review and utilization management functions, including predetermination, concurrent and retrospective utilization review.

MEDICAL PLAN (CORE COVERAGE)

Medical Plan Options

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

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

The options are designed to provide you and your eligible family members high-quality health care. 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.

Common Terms are defined in the *General Information* section.

GM Traditional Care Network and HMO Medical Plans and Cost-Sharing At-A-Glance (for Traditional, In-Progression and Full-Time Temporary Employees)

The chart below compares what you pay and what the Program pays depending on the medical plan option in which you enroll. Please note that prescription drug copayments may be adjusted on an annual basis.

	Traditional Care Network PPO	HMO (in select regions)
In-Network and Out-of-Network Deductible	None	None
In-Network Care (Coinsurance)[4]	Many services covered at 100%	Many services covered at 100%
Out-of-Network Care (Coinsurance)[5]	Many services covered at 90%, you pay 10%	Not covered (except in emergencies)
In-Network Annual Out-of-Pocket Maximum	None	HAP HMO: $8,150 single / $16,300 family MercyCare: $8,150 single / $16,300 family BCN HMO: $6,350 single / $12,700 family
Out-of-Network Annual Out-of-Pocket Maximum	$250 single / $500 family *(**Note:** Copays for office visits, emergency room, urgent care and prescription drugs are not applied to annual maximum)*	Not applicable
In-Network Office Visits[6]	$25 copay per visit (in-network only)	$25 copay per visit (in-network only) *HAP HMO and MercyCare: Referrals are not required by primary care physician for specialist care as long as the specialist is in-network* *BCN HMO: Referrals required by primary care physician for specialist care*

	Traditional Care Network PPO	HMO (in select regions)
Out-of-Network Office Visits[6]	$25 copay per visit; referral required for office visits to be covered for an out-of-network provider (otherwise not covered)	Not covered
Chiropractic Visits	$25 copay per visit; limited to a combined maximum of 24 manipulation visits per calendar year	HAP HMO: $25 copay per visit; limited to a combined maximum of 24 manipulation visits per calendar year MercyCare: $25 copay per visit; unlimited visits BCN HMO: $25 copay per visit; unlimited visits, when referred
Emergency Room Visits[6]	$100 copay per visit, waived if admitted	$100 copay per visit, waived if admitted
Telehealth Visits[6]	$12.50 copay per visit	HAP HMO: $12.50 copay per visit MercyCare: $12.50 copay per visit BCN HMO: $12.50 copay per visit
Urgent Care Visits[6]	$50 copay per visit	$50 copay per visit
Prescription Drugs[6] *(in-network retail pharmacies)*	$6 generic $12 brand name $17 erectile dysfunction	$6 generic $12 brand name $17 erectile dysfunction[7]
Prescription Drugs[6]	*Select participating retail pharmacies, or through Caremark Mail-Order Service* $12 generic $17 brand name $21 erectile dysfunction	*90-supply fill using the HMO mail-order pharmacy service:* $12 generic $17 brand name $21 erectile dysfunction[7]
Preventive Services and Drugs	Baby/child/adult routine exam annually covered at 100% when received in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives) require a prescription and must be dispensed by a participating pharmacy to be covered at 100%.	Baby/child/adult routine exam annually covered at 100% when received in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives, vitamin D supplementation) require a prescription and must be dispensed by a participating pharmacy to be covered at 100%.

	Traditional Care Network PPO	HMO (in select regions)
Inpatient Behavioral Health Services and Substance Use Disorder Treatment	**In-Network:** Covered 100% up to 365 days, renewable after 60 days of non-confinement. **Out-of-Network:** Covered 90% up to 365 days, renewable after 60 days of non-confinement. You pay 10% coinsurance up to the Out-of-Pocket Maximum (OOPM). Services subject to Plan cost-sharing provisions (deductibles and coinsurance).	**Inpatient Behavioral Health:** Covered 100% when authorized by HMO **Inpatient Substance Use Disorder:** Covered 100% when authorized by HMO
Outpatient Behavioral Health Services and Substance Use Disorder Treatment *received in a clinical setting*[9]	**In-Network Behavioral Health:** **Visits** **You Pay**[9] 1-20 $0 21-35 25% *(up to a maximum of* $25) 36+ $25 copay **In-Network Substance Use Disorder:** **Visits** **You Pay**[9] 1-35 $0 36+ $25 copay **Out-of-Network Behavioral Health:** Reimbursed at 50% for treatment received from an M.D. or D.O.[8] **Out-of-Network Substance Use Disorder:** No coverage, except in the case of an emergency, subject to certain conditions, in which case treatment is covered in full (see App. B, III. E. 2. b. (2)(b)).	**Outpatient Behavioral Health:** Covered 100% when authorized by HMO **Outpatient Substance Use Disorder:** Covered 100% when authorized by HMO

	Traditional Care Network PPO	HMO (in select regions)
Outpatient Behavioral Health Services and Substance Use Disorder Treatment ***received in a virtual setting***	**In-Network Behavioral Health:** **Visits** **You Pay** 1-20 $0 21-35 12% *(up to a max. of* **$12.00)** 36+ $12.00 copay **In-Network Substance Use Disorder:** **Visits** **You Pay** 1-35 $0 36+ $12.00 copay **Out-of-Network Behavioral Health:** No coverage **Out-of-Network Substance Use Disorder:** No coverage	**Outpatient Behavioral Health:** Covered 100% when authorized by HMO **Outpatient Substance Use Disorder:** Covered 100% when authorized by HMO

[4] *Covered services received in-network are paid at 100% of the amount the Plan allows for payment for the covered service. For the Traditional Care Network, if necessary, predetermination approvals for certain services are not obtained, services are payable at 80% of allowed charges after the first $100 of expense, up to a maximum out-of-pocket charge of $750 individual, $1,500 family.*

[5] *Covered services received from out-of-network providers are paid at 90% of the amount the Plan allows for payment of the covered service. Charges above the amount allowed by the Plan may be the responsibility of the enrollee.*

[6] *Not applied to out-of-pocket maximum accumulators.*

[7] *Not covered if enrolled in MercyCare HMO.*

[8] *If outpatient behavioral health services are rendered by an out-of-network physician, then the first visit will be covered. Any additional visits must be authorized by the CRO. Unauthorized visits to an out-of-network physician will be paid at 50% of the amount which would have been paid to an in-network provider. These payments will be made to you, not the provider. You are responsible for paying the provider. Behavioral health services rendered by out-of-network, non-physician providers, (psychologists, social workers, etc.) are not covered under the Program.*

[9] *Certain services, including but not limited to Applied Behavioral Analysis (ABA), will be paid at 100% of the allowed amount when provided by in-network providers, and paid at 90% of the allowed amount for services provided by out-of-network providers. (See App. B, III. E. 2. b. (2)(c)).*

GM Temporary Employee Health Care Plan and Cost-Sharing At-A-Glance (for Part-Time Temporary Employees)

The chart below shows what **Part-Time Temporary employees** pay and what the Program pays.

	Traditional Care Network PPO
In-Network Deductible	$300 single / $600 family
Out-of-Network Deductible	$1,200 single / $2,100 family
In-Network Care[4]	Many services covered at 90%, you pay 10%
Out-of-Network Care[5]	Many services covered at 65%, you pay 35%
In-Network Annual Out-of-Pocket Maximum	$1,000 single / $2,000 family
Out-of-Network Annual Out-of-Pocket Maximum	Not applicable (no maximum out-of-pocket maximum)
In-Network Office Visits[6]	You pay 100% coinsurance (in-network only; out-of-network not covered)
Chiropractic Visits[6]	$25 copay per visit after deductible; limited to a combined maximum of 24 manipulation visits per calendar year
Emergency Room Visits	Subject to deductible, coinsurance and out-of-pocket maximum
Telehealth Visits[6]	You pay 100% coinsurance
Urgent Care Visits	Subject to deductible, coinsurance and out-of-pocket maximum
Prescription Drugs[6] *(34-day supply at network retail pharmacies)*	$7.50 generic $15 brand name
Prescription Drugs[6] *90-day supply*	*Select participating retail pharmacies or through Caremark Mail-Order Service* $7.50 generic $15 brand name
Preventive Services and Drugs	Annual baby/child/adult routine exam covered at 100% when receive in-network. Certain prescription and OTC meds (aspirin, fluoride prep, smoking deterrents, folic acid preparations, prescription contraceptives) require a prescription and must be dispensed by a participating pharmacy covered at 100%.
Inpatient Behavioral Health Services and Substance Use Disorder Treatment	**In-Network and Out-of-Network:** Covered 100% up to 365 days, renewable after 60 days of non-confinement. Services subject to Plan cost-sharing provisions (deductibles and coinsurance).

	Traditional Care Network PPO
Outpatient Behavioral Health Services and Substance Use Disorder Treatment ***received in both a clinical and virtual setting***	**In-Network Behavioral Health:** **Visits** **You Pay*** 1-20 $0 21-35 25% *(up to a maximum of $25)* 36+ 100% coinsurance **In-Network Substance Use Disorder:** **Visits** **You Pay*** 1-35 $0 36+ 100% coinsurance[5] **Out-of-Network Behavioral Health:** Reimbursed at 50% for treatment received from an M.D. or D.O. **Out-of-Network Substance Use Disorder:** No coverage, except in the case of an emergency, subject to certain conditions, in which case treatment is covered in full (see App. B, III. E. 2. b. (2)(b) of the Supplemental Agreement, Exhibit C). **Certain services, including but not limited to Applied Behavioral Analysis (ABA), will be paid at 90% of the* ***allowed*** *amount after deductible when provided by in-network providers, and paid at 65% of* ***the allowed*** *amount after deductible for services provided by out-of-network providers. (See App. F, Sect. 5. 2. c).*

Traditional Care Network (TCN) Option

Financing of Coverage

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

Selecting A Health Care Provider

If you enroll in the TCN option, your benefits are provided through a Preferred Provider Organization, which is designed to limit your out-of-pocket costs when you use PPO providers. These providers are called network providers. You will receive the highest level of coverage when you receive services from these providers.

Although the TCN provider network through the Carrier is extensive, you have the flexibility of choosing providers other than network providers. However, before you select a health care provider, you should determine the provider's TCN participation status. The level of a provider's participation impacts the costs for which you will be responsible.

[4] *Covered services received in-network are paid at 100% of the amount the Plan allows for payment for the covered service. For the Traditional Care Network, if necessary, predetermination approvals for certain services are not obtained, services are payable at 80% of allowed charges after the first $100 of expense, up to a maximum out-of-pocket charge of $750 individual, $1,500 family.*

[5] *Covered services received from out-of-network providers are paid at 90% of the amount the Plan allows for payment of the covered service. Charges above the amount allowed by the Plan may be the responsibility of the enrollee.*

[6] *Not applied to out-of-pocket maximum accumulators.*

There are three levels of TCN participation through the Carrier (Blue Cross Blue Shield):

- PPO Network Providers
- Non-PPO Network Providers, but BCBS Participating Providers
- Nonparticipating BCBS Providers

You do not have to notify the Carrier when you select or change providers.

TCN (PPO) Network Providers: To receive the highest coverage level, you should use providers within the TCN (PPO) network. Network providers have signed agreements with the Carrier to accept the Plan's approved amount for covered services as payment in full. You will only pay for the Plan's in-network copayments, deductibles and/or coinsurances required by your coverage.

Ask your provider if they participate with your Carrier's PPO network. If you need help locating a network provider, call the Carrier's customer service number on the back of your GM health care ID card or visit the Carrier's website. The telephone number and website address are listed in the *Plan Administration* > *Who To Contact* section of this book.

When you receive services from network providers, you do not have to submit claim forms. Network providers submit claims to the Carrier for you and the providers are paid directly by the Carrier.

Non-PPO Network Providers, but Carrier Participating Providers: Although many providers are a part of the Carrier's PPO network, you have the freedom to visit an out-of-network provider and still receive coverage for covered services. Providers who are not part of the Carrier's PPO network are called out-of-network providers.

When using an out-of-network provider, try to use a Carrier approved provider. Out-of-network, but approved providers have been credentialed by the Carrier and have signed agreements to accept the Carrier's approved amount as payment in full for covered services. However, because these providers are not a part of the Carrier PPO network, you may pay a higher (out-of-network) deductible and/or coinsurance for your care. Additionally, in some cases, the services you receive from an out-of-network provider may not be covered.

When you receive services from out-of-network, but participating providers, you do not have to submit claim forms. These providers submit claims to the Carrier for you and the providers are paid directly by Carrier.

Nonparticipating Providers: Nonparticipating providers do not have signed agreements with the Carrier. This means they may or may not choose to accept the approved amount as payment in full. If your provider does not participate with the Carrier, ask if they will accept the approved amount as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services on the claim.

You may pay a higher (out-of-network) deductible and/or coinsurance for your care. Additionally, if a nonparticipating provider will not accept the approved amount as payment in full for covered services, you will be responsible for the difference between the approved amount and the provider's charges.

You are usually required to pay nonparticipating providers directly and then submit a claim to the Carrier for reimbursement. As a reminder, the amount the Plan reimburses you may be less than the amount your provider charged. The responsibility for paying this difference is between you and the provider.

Emergency and Referral Services: You are not required to pay a higher deductible and/or coinsurance when you receive services outside the TCN (PPO) network in certain situations. These situations include:

- If you receive treatment from an out-of-network provider for a medical emergency. **The treatment received must be for a true emergency as determined by the Carrier, pursuant to the terms of the Plan.**
- There may be a circumstance when your provider will refer you to another provider, such as a specialist. If you are referred to an out-of-network provider, you must have a Carrier PPO Referral Form completed and signed by your network physician and pre-approval from the Carrier to have the claim paid at the same level as in-network services for **each visit, pursuant to the terms of the Plan.**

In the above circumstances, you will not be required to pay the higher, out-of-network deductible and/or coinsurance.

Payment Terms

If you are enrolled in the TCN, the following payment terms, defined above in the *Common Terms*, are important for you to understand:

- *Copayment or Copay*
- *Annual Deductible*
- *Coinsurance*
- *Annual Out-of-Pocket Maximum*
- *Approved Amount*

Prior Authorization

The TCN option requires precertification (also sometimes referred to as prior authorization or predetermination *(as defined in the CBA)*) 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 prior authorization process, the coverage 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 approved 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 GM health care ID 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** by calling the toll-free telephone number printed on your GM health care ID card.

Health Maintenance Organization (HMO) Options

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.

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.

Financing of Coverage

GM pays the HMO premiums and each HMO handles administration and claims processing.

Selecting a Health Care Provider

Primary Care Physicians: If you enroll in HMO coverage, you and your enrolled dependents must select a primary care physician (PCP). Your PCP can be an internist, general practitioner, family practitioner or pediatrician. To receive coverage under an HMO Plan, your PCP must coordinate all of your health care, including:

- Making specialist referrals to a preferred care provider in the HMO network
- Coordinating hospital stays
- Handling paperwork and claims for you

Exceptions where you do not require referral assistance from your PCP include emergency services and an annual routine gynecological examination with direct access to network OB/GYNs. You must receive a referral from your PCP, however, for follow-up visits or treatment.

If you need help locating a network provider, call the HMO's member service center or visit their website. The telephone number and website address are listed in the *Plan Administration* > *Who To Contact* section.

Emergency Services: When you follow the proper procedures, emergency care is generally covered by the HMO after the applicable copayment. If you use an emergency facility that is not participating with the HMO's network, you may be required to pay for the emergency treatment at the time of service and request reimbursement from the HMO later. In this case, it is very important that you obtain a detailed bill from the provider to submit to your HMO. You or a family member should also call the HMO or your PCP as soon as possible, but no later than two business days after receiving emergency treatment.

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

Certificate of Insurance

If you are enrolled in (or considering enrolling in) an HMO, the HMO will 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 SPD 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 HMO's Certificate of Insurance will 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.

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 coverage for prescription drugs, behavioral health and substance use disorder treatment and other services. 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.

Your Medical and Hospitalization Benefits – Covered Services

This section generally describes the types of medical, surgical and hospitalization services covered.

Office Visit Coverage

Office visits with in-network providers are covered subject to the cost-sharing provisions outlined in the section titled *Medical Plan Options*. Office visits with an out-of-network provider are not covered, unless an enrollee lives outside of the defined service area and the service is pre-approved by the Carrier.

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. If services are provided by an out-of-network provider, 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.

- Mammograms: One routine mammography screening per calendar year, starting at age 40
    - The maximum benefit payable for digital mammography is the Carrier approved amount for the alternative film mammography
- Pap smear: Laboratory and pathological service for one (1) test per calendar year
- BRCA Testing, one (1) per lifetime
- 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 Care: Up to eight (8) visits for babies under one (1) year of age; up to six (6) well visits from age 13 months through age 23 months; up to six (6) well visits from age 24 months through age 35 months, two (2) well visits from age 36 months through age 47 months; and one (1) health maintenance exam per year from 48 months through adulthood.
- 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 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 Immunochemical Test: One (1) test per year, beginning at age 50
- Flexible Sigmoidoscopy, Barium Enema and Colonoscopy: Coverage for barium enema is provided for one (1) every 5 years when no colonoscopy within 10 years or no sigmoidoscopy within 5 years. Coverage is provided for one (1) flexible sigmoidoscopy **or** one (1) fecal occult blood test or one (1) colonoscopy every year

- One (1) ColoGuard Oncology Screening covered every three (3) years
- Infectious Disease Screenings
    - Chlamydia: one (1) per year for men and women through age 21 (women over age 21 if risks factors present)
    - Gonorrhea: one (1) per year for men and women through age 21 (women over age 21 if risk factors present)
    - Syphilis: one (1) per year for men and women at any age
    - HIV: one (1) per year for men and women of any age
    - Hepatitis B: one (1) per year for men and women of any age with risk factors
    - High-risk Human Papillomavirus (HPV): DNA testing for women of any age, one (1) 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).

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

- Gender affirming services when ordered by a licensed physician with prior authorization from the medical plan Carrier for services including, but not limited to:
  - Psychotherapy
  - Puberty suppression in adolescents
  - Hormone therapy (for masculinization/feminization)
  - Electrolysis (specific to genital reconstruction)
  - Gender affirming surgery/ies, including genitalia reconstruction *(as defined in the CBA)*
- In the case of an enrollee who undergoes a mastectomy and 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
  - 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).

Hospital Coverage

In-Network

Inpatient hospital coverage is provided for up to 365 days of covered care in a semiprivate room in a network hospital for general conditions, including maternity care. Precertification (*pre-determination, as defined in the CBA)* is required for non-emergency, non-maternity hospitalizations to be eligible for coverage. Precertification must be obtained within 24 hours for emergency admissions. If precertification is not obtained, payment (of benefits) is reduced by 20% after the $100 deductible.

Plans and insurers may not, under federal law, require that a provider obtain prior 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 (MRI), 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 (see *Physical, Occupational and Speech Therapy Coverage* section)
- 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 (MRI), and magnetic resonance angiography (MRA)

Out-of-Network (Excluding Psychiatric Hospitals)

Emergency room services received at an out-of-network hospital are covered in full, with the applicable cost-sharing (see *Medical Plan Options*). If you are admitted to an out-of-network hospital for a medical emergency, including treatment for an accidental injury, the first five (5) days of hospitalization are eligible for full coverage.

Coverage for **inpatient care** received at an out-of-network hospital is limited to $500 per day for room and board and $50 per day for ancillary charges.

If you receive **outpatient services** at an out-of-network hospital, coverage is limited to $50 for each outpatient visit.

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

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 an in-network hospital, Freestanding Outpatient Therapy Facility, Home Health Care Agency, *Skilled Nursing Facility*, physician or licensed therapist under the following circumstances:

- 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.

If you are enrolled in the Traditional Care Network (TCN), your benefits for physical, occupational, and speech therapy services are administered by Blue Cross Blue Shield of Michigan. You can find an in-network provider by logging into your member portal or calling BCBSM customer service on the back of your GM health care ID card.

Fertility Services

Diagnostic testing to identify causes of infertility, and procedures to correct underlying fertility-related medical conditions are covered benefits.

You and your spouse (if enrolled) each have access to a maximum of $5,000 annually towards expenses associated with services to treat infertility. Covered fertility services include, but are not limited to:

- Artificial insemination (IUI)
- Assisted reproductive technologies (ART)
- Prescription drugs as part of fertility treatments including, but not limited to, medications related to IVF, IUI, or ovarian stimulation, and oocyte (egg) induction

Fertility services are covered when furnished and billed by an eligible provider and approved by the Carrier. A diagnosis of infertility is required to receive covered fertility services.

Skilled Nursing Facility Coverage

Medically necessary admissions to an in-network 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 functional occupational therapy when medically necessary (see App. A, III. C. of the Supplemental Agreement, Exhibit C)
- Oxygen and other gas therapy

- Drugs, biologicals and solutions used during the facility stay
- Gauze, cotton, fabrics, solutions, plaster, splints and other materials used in dressings and casts
- *Durable medical equipment*

WHAT IS NOT COVERED

- 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
- If you have reached your maximum level of recovery possible for your particular condition and no longer require treatment other than routine supportive care

Home Health Care

Coverage, up to the approved 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.

Coverage for home health care services is limited to up to three (3) visits for each remaining unused day of inpatient hospitalization during a benefit period. The maximum number of home health care visits eligible for coverage per benefit period is 1,095 (which is 365 hospital care days times three). For specific details regarding coverage for home health care, please refer to Appendix A, III. C of the Supplemental Agreement (Exhibit C).

Pre-Hospice and Hospice Coverage

You are eligible for pre-hospice care of up to twenty-eight visits (28) when certified by a physician and have been diagnosed with a terminal illness. Pre-hospice services must consist of evaluation, consultation and education, and support services. Coverage is available for up to 365 days of hospice services if you are terminally ill 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.

Ambulance Coverage

Ambulance services for medically necessary ground, air, or boat transportation to the closest available facility are covered 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. You 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 your physician prescribes such equipment, and the Carrier approves it. The Carrier administrating benefits for coverage of durable medical equipment and prosthetic and orthotic appliances is Blue Cross Blue Shield of Michigan.

You, your physician, or your provider may contact the Carrier for prior authorization, 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)
- Continual Glucose Monitors, and insulin pumps, including the OmniPod, are covered for diabetics who meet Control Plan 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 (1) 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 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 hearing aid benefits 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 approved amount for the following services and product, up to maximum of $2,200, once every 3 years:

- Audiometric examination
- Hearing aid evaluation test
- Hearing aid and covered ear molds

Hearing aid benefits are administered by AudioNet America. To find an in-network provider, you should contact *AudioNet America*.

HMOs also provide coverage for hearing aids. 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.

How Prescription Drug Coverage Works

Important Terms

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

- A **Brand Name Drug** is 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.
- A **Generic Drug** is a drug that is chemically equivalent to a brand name drug.
- An **Erectile Dysfunction (ED) Drug** is a drug prescribed primarily for the treatment of erectile dysfunction.

Cost-Sharing Provisions

The copays you are responsible for when filling a prescription at an in-network retail pharmacy and through mail-order services are outlined in the *Medical Plan Options* section above.

Preventive Prescription Drugs Not Subject to Cost-Sharing

Certain preventive medications are covered at 100% and not subject to copay if you have a written prescription order from a licensed provider and the medication is dispensed at a network retail pharmacy or through the mail-order pharmacy, subject to the Carrier's standards.

A list of the preventive medications can be found at *CVS Caremark*.

What's Covered

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.

What's Not Covered

The following medications are not covered under the Program:

- 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) or appliances (e.g., orthotics)

- Any charge for a vaccine administered for prevention of infectious diseases
- Antineoplastic (e.g., chemotherapy) agents except those that can be self-administered through subcutaneous or intramuscular injection or oral dosage form and are not covered under another subsection of the Plan (Appendix A or Appendix B of the Exhibit C-1 of the CBA)
- Any charge for the administration of covered drugs
- Any charge for a covered drug in excess of the amount specified by the physician or a refill dispensed more than one year from the physician's order
- Any charge for more than a thirty-four (34) day supply at retail
- Any charge for medications furnished on an inpatient or outpatient basis covered under another subsection of the Plan (Appendix A or Appendix B of the Exhibit C of the CBA)
- Dapoxetine
- Non-sedating antihistamines
- Any charge for compounded medications unless a request for medical exception is evaluated and authorized by the carrier

Pharmacy Network

Locating a Network Pharmacy

There are thousands of network pharmacies nationwide, including chain pharmacies, independent pharmacies and CVS Pharmacy locations including those inside Target stores. You may contact CVS Caremark at the number on the back of your GM health care ID card or visit **caremark.com** to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, the customer service representative on the toll-free line will assist you in locating the nearest network pharmacy.

Using an Out-of-Network Pharmacy

If you have a prescription filled at an out-of-network pharmacy, you will pay the full cost of the prescription. If you submit a claim form to CVS Caremark afterwards, you will be reimbursed for 75% of the Carrier approved amount less the applicable copayment. You are responsible for the 25% difference. Claim forms may be obtained online at **caremark.com** or by calling CVS Caremark at the number on the back of your GM health care ID card.

In the case of an emergency, out-of-network claims for covered prescriptions will be covered at 100% of the Carrier approved amount less the applicable copayment when obtained from providers located outside the area, or from in-area out-of-network providers.

Maximum Supply Per Prescription Filled

When you fill a prescription at:

- Any network retail pharmacy, a 34-day supply is the maximum you can receive for one copayment.
- Select participating retail pharmacies or through the CVS Mail-Order Service, you may receive a 90-day supply 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.

90-Day Prescription Drug Supply Options

If you are taking any medications on a regular basis, you may be able to save money by purchasing your prescription in a 90-day supply. You have two options for filling a 90-day supply prescription.

- Select Participating Retail Pharmacies: You may obtain a 90-day supply prescription at select participating retail pharmacies by bringing your prescription to a select participating retail pharmacy location or having your doctor submit your prescription to the select participating pharmacy of your choice.
- Mail-Order Pharmacy: Mail-order is a convenient way to have 90-day supplies of your long-term medications delivered to your home, postage-paid. Your prescription will be delivered within 10 days from the date that CVS Caremark receives your prescription order. Filling a prescription through the mail-order service can save you both time and money. You don't have to make trips to the pharmacy every 34 days and a 90-day supply typically costs less than three 34-day prescription fills.

How to Use the Mail-Order Service

Once your doctor has determined that you require medication on an ongoing basis, they may prescribe up to a 90-day supply, plus refills, for dispensing through mail order. If you are now taking medication on a long-term basis, and are not currently using the mail-order option, ask your doctor for a new prescription written for a 90-day supply. A year's worth of medication would include three refills covering up to 90 days each.

To begin filling your prescription through Mail-Order Service, you can contact CVS Caremark through one of the following:

(1) **Phone:** Call CVS Customer Care toll-free at 1-844-379-1671.

(2) **Online:** Visit **caremark.com/mailservice** and sign in. Follow the guided steps to request a prescription.

(3) **Fax:** Your doctor can return a mail service order form via fax at 1-800-378-0323.

(4) **Mail:** Fill out and return a mail service order form. You can download one at **caremark.com**, or you can obtain one from CVS Customer Care toll-free at 1-844-379-1671.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 10 days from the date that CVS Caremark receives your prescription order.

Prescription Drug Management Programs

Your prescription drug benefits include some programs that provide both safe and cost-effective measures toward your prescribed treatments. These programs are described more fully below.

Mandatory Generic Drug Policy

Generic drugs are effective yet significantly less expensive than brand name drugs. Whether you fill a prescription at a retail or mail-order pharmacy, if a brand-name drug is dispensed instead of its generic version, you must pay the applicable 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 a retail pharmacy, 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 with CVS Caremark 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 once a paper claim is submitted and CVS Caremark 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.

90-Day Supply for Maintenance Medications

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 or select participating retail pharmacies. You will be advised by CVS Caremark 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.

To avoid paying a 100% copayment at retail, you will need a 90-day prescription that can be filled at a select participating retail pharmacy or through the CVS Mail-Order Service. Filling a prescription at a select participating retail pharmacy or through the CVS Mail-Order Service allows you to obtain an up to 90-day supply for one copayment.

Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. CVS Specialty Pharmacy is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

A separate pharmacy network is in place for specialty drugs. Before filling your specialty drug prescription, please contact *CVS Specialty Pharmacy* to find a network specialty pharmacy. Not all retail pharmacies can fill a specialty drug prescription.

Prior Authorization

Criteria for coverage approval is predefined for certain drug classes. If your medication falls within this list, it is necessary to have your physician contact CVS Prior Authorization to provide information that ensures you are meeting the clinical recommended criteria for the prescription. After receiving this information, CVS determines whether or not coverage under the plan is approved. Contact *CVS Caremark* to learn what drug classes are subject to prior authorization.

Step Therapy

When many different drugs are available for treating a medical condition, it is often useful to follow a step-wise process for finding the best treatment for an individual. This process, known as step therapy, provides an effective approach to reducing the cost of drugs for you and the health plan. In step therapy, specific high-cost, second-line, and/or non-preferred drugs are covered by the Plan only after first-line, clinically appropriate, proven and/or cost-effective drugs are tried.

In partnership with both pharmacists and physicians, CVS Caremark has developed an automated Step Therapy program as a drug use management tool. This program is geared to ensure that you are receiving the best medication recommended for your condition. Here is a quick overview of how it works:

- When a prescription for a second-line (lower cost) drug is being processed at your pharmacy, the online system will scan your recent prescription records.
- If the system finds a record for a first-line alternative, the Step Therapy program will not interrupt the dispensing process.
- If the system does not find a prescription for a first-line alternative to your prescription, it will alert the pharmacist and they may contact your prescribing physician to recommend a more cost-effective first-line drug.

Contact *CVS Caremark* to learn what drug classes are subject to step therapy.

Utilization Management

To promote safety and clinically appropriate care while maintaining the costs of prescription drug coverage, the Carrier may administer additional utilization review processes such as dose and quantity edits, dose duration edits and dose optimization edits related to select drugs or drug classes.

Behavioral Health and Substance Use Disorder Treatment Coverages

If you are enrolled in the TCN option, coverage for behavioral health and substance use disorder treatment is administered by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan has a network of qualified providers and promotes the delivery of care in appropriate settings.

Important Terms

The following terms are used to describe certain elements of the Behavioral Health and Substance Use Disorder benefit:

Network providers are behavioral health or substance use disorder providers who participate in, and make up the Carrier's network. The Plan uses the term Panel Providers.

Out-of-network providers are behavioral health or substance use disorder providers that are not part of the Carrier's network. The Plan uses the term Non-Panel Providers.

If you have any questions regarding your coverage for behavioral health/substance use disorder treatment or need services, contact *Blue Cross Blue Shield of Michigan* Remember, you must use in-network providers to receive full amount of available coverage.

How to Receive Care

Blue Cross Blue Shield of Michigan uses an integrated behavioral health and substance use disorder treatment delivery system which includes:

(1) A national Central Review Organization (CRO) designated to: (1) confirm the eligibility of the patient for coverage under the Program; (2) authorize and approve all inpatient and outpatient behavioral health treatment, certain courses of outpatient substance use disorder treatment and outpatient psychological testing; and (3) evaluate in-network providers.

(2) A network of Central Diagnostic and Referral assessment coordinators (CDRs) located in most communities, responsible for making assessments required under the Program for the development of substance use disorder continuing care treatment plans. In addition, CDR assessment coordinators make determinations regarding whether the patient's condition requires behavioral health and/or substance use disorder treatment. The CDR assessment coordinators also make referrals to in-network providers, provide short-term counseling (up to two visits) and perform aftercare planning and follow-up. In addition, CDR assessment coordinators may provide up to three short-term counseling sessions for enrollees. The CDR assessment coordinator may communicate with Work/Family program representatives about assessment and referral activities related to an enrollee, where appropriate, and when authorized by the enrollee.

(3) An extensive nationwide network of inpatient and outpatient behavioral health and substance use disorder professionals and facilities including:

- Psychiatrists
- Ph.D. psychologists
- Licensed social workers with a master's 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

Cost-Sharing Provisions

The combined coverage for behavioral health and substance use disorder treatment is outlined in the *Medical Plan Options* section above.

What's Not Covered

Coverage is not available for treatment of behavioral 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 cognitive disability/impairment.

The coverage is structured in such a way that every enrollee will have easy access to care through a network of providers. **If substance use disorder services are rendered by an out-of-network provider, the services are not covered unless an out-of-network authorization is secured from the CRO prior to treatment.**

Travel Expense Reimbursement for Covered Health Care Services

Certain travel and lodging expenses primarily for, and essential to, receiving covered health care services under the Program are eligible for reimbursement if a network provider is not available within 150 miles of your primary residence and virtual care is not an option. To qualify for reimbursement:

- Travel and lodging expenses must be incurred to receive covered health care services from the nearest network provider in a location where the services are available and permitted under applicable state and local law; and
- Costs associated must be for U.S. domestic travel and lodging for you or your covered family member, and one companion to travel from your home address; and
- Travel expenses eligible for reimbursement are limited to those defined as medical expenses under Internal Revenue Code Section 213(d) and its implementing regulations and sub-regulatory guidance (see **IRS Publication 502** for details); and
- Total maximum travel and lodging benefit is not to exceed $2,000 annually per person enrolled in the Medical Plan.

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 Health Care Program, may be found in the appropriate Program language, or similar documents provided by GM or the Carriers.

The following are examples of additional services excluded from coverage:

- Programs and/or surgical procedures that are considered to be research, investigational or experimental in nature
- 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
- 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.

Claims

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 an enrolled 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, Surgical and Behavioral Health/Substance Use Disorder Claims

If your Carrier is Blue Cross Blue Shield, show your GM health care ID card when you go to the hospital, outpatient treatment facility, physician, or other provider of covered services anywhere in the country. In-network providers will be 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. You may call customer service on the back of your GM health care ID card for assistance.

If you utilize an out-of-network provider, you may be required to file a claim. Instructions and forms can be obtained by calling your Carrier, see the *Who To Contact* section for telephone numbers or the customer service number on the back of your GM health care ID card.

Hearing Aid Claims

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

Prescription Drug Claims

When you fill prescriptions at a network pharmacy, the appropriate charges will be filed electronically by the pharmacy. If you fill a prescription at an out-of-network provider, you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling *CVS Caremark*. 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.

DENTAL PLAN (NON-CORE COVERAGE)

Understanding Your Benefits

(Traditional) Dental Plan At-A-Glance

Service / Treatment	Preferred PPO Plan Pays	Premier Plan Pays	Non-Participating[10] Plan Pays
Class I (includes diagnostic and preventive services such as exams, routine cleanings, fluoride treatments and emergency palliative treatments)	100%	100%	100%
Class II (includes X-rays; relines and repairs to crowns, bridges and dentures; minor restorative services (e.g., fillings); periodontic services; endodontic services)	100%	90%	90%
Oral Surgery	90%	90%	90%
Major Restorative Services (e.g., crowns and implants)	90%	90%	90%
Prosthodontic Services (e.g., bridges and dentures)	70%	50%	50%
Orthodontia	60%	50%	50%
Annual Maximum Benefit per Enrollee	$2,000	$2,000	$2,000
Lifetime Orthodontia Maximum per Enrollee (up to age 19)[11]	$2,200	$2,200	$2,200

Important Reminder: **Traditional, In-Progression, and Full-Time Temporary employees** are eligible for coverage in the Dental Plan. **Part-Time Temporary employees** are not eligible for the coverage under the Dental Plan.

The Dental Plan is administered by Delta Dental Plan of Michigan (Delta Dental). Benefits are payable based on Delta Dental's established fee schedule of allowed amounts. As the Dental Plan Administrator, Delta Dental provides access to two provider networks: Delta Dental Premier and Delta Dental PPO. **You can increase your benefits, while lowering your costs, when you receive services from a dentist in the PPO network.** This means that your out-of-pocket costs will be lower, and your annual and lifetime maximum benefits will go further. The PPO network operates within Delta Dental and does not require special enrollment. Use of a PPO or Premier network dentist is voluntary, yet there will be greater savings to both you and GM if you seek treatment from a PPO dentist. If you choose to utilize a non-participating dentist, in addition to your applicable copayment, you may be responsible for the difference between the amount charged by the dentist and Delta Dental's established fee schedule of allowed amounts.

[10] *When you receive services from a non-participating dentist, the percentages in this column indicate the portion of the Carrier's non-participating dentist fee that will be paid for those services. This amount may be less than what the dentist charges or the amount the Carrier approves and you will be responsible for that difference.*

[11] *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.*

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, and
- Accident must be documented, e.g., police report, and
- Services received must be a direct result of the accident and are provided within one year of the accident.

How the Plan Works

The following information is applicable when you receive dental services from a *Delta Dental Premier provider.*

What Is Covered

- Benefits are payable at 100%, based on Delta Dental's established fee schedule of allowed amounts: 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 age 14 and under, unless a specific dental condition makes such treatment necessary;
- Space maintainers that replace prematurely lost teeth for persons under 19 years of age;
- 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 its interpretation.

BENEFITS ARE PAYABLE AT 90%, BASED ON DELTA DENTAL'S ESTABLISHED FEE SCHEDULE OF ALLOWED AMOUNTS:

- 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.
- 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.

You are responsible for the remaining 10% of the fee schedule of allowed amounts.

BENEFITS ARE PAYABLE AT 50%, BASED ON DELTA DENTAL'S ESTABLISHED FEE SCHEDULE OF ALLOWED AMOUNTS:

- 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.

You are responsible for the remaining 50% of the fee schedule of allowed amounts.

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 coverage;
- 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 eight 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.

Plan Exclusions and 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 copays. 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.

Claims

Dentist 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 are available from Delta Dental's website at **deltadentalmi.com**, by selecting the "member" tab, then accessing Delta Dental's Member's Portal or by going directly to the **memberportal.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 prior to the commencement of treatment. Delta Dental will notify the dentist of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results. By submitting a predetermination prior to receiving treatment you will have a clear understanding of your financial responsibility, and whether a different course of treatment should be considered. The predetermination process is not necessary for courses of treatment with an expected cost under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes and fluoride treatments. Failure to file a description and estimate of your course of treatment prior to treatment could result in your being faced with higher than anticipated out-of-pocket expenses.

VISION PLAN (NON-CORE COVERAGE)

Understanding Your Benefits

(Traditional) Vision Plan At-A-Glance[12]

Benefit	Frequency	In-Network	Out-of-Network	Out-of-Area *(No network provider within 25 miles of residence)*
Vision Exam	Once each calendar year	Covered in full for Optometrist or Ophthalmologist after $7 copay	Enrollee reimbursement as follows: **Optometrist:** Scheduled amount after $7 copay **Ophthalmologist:** based on Reasonable and Customary fee after $7 copay	Enrollee reimbursement based on Reasonable & Customary fee after $7 copay, for Optometrist or Ophthalmologist
Frames	Once each calendar year	Covered in full for frames with retail value of up to $80 allowance[13] after $10 copay[14]	Enrollee reimbursement of $24 after $10 copay[14]	Enrollee reimbursement of $24 after $10 copay[14]
Eyeglass Lenses	Once each calendar year	Covered in full after $10 copay[14]	Enrollee reimbursed the carrier scheduled amount after $10 copay[14] ***Enrollee may be responsible for balance billing***	Enrollee reimbursement based on Reasonable & Customary fee after $10 copay[14]
Contact Lenses	Once each calendar year in place of regular lenses	Covered in full when medically necessary due to certain conditions after $10 copay[14], otherwise covered at scheduled amount of $80 after $10 copay[14]	Enrollee reimbursed the Reasonable and Customary fee when medically necessary due to certain conditions after $10 copay[14], otherwise reimbursed at scheduled amount after $10 copay[14] ***Enrollee may be responsible for balance billing***	Enrollee reimbursement based on Reasonable & Customary fee after $10 copay[14]
Corrective Eye Surgery	Once every four years	Enrollee reimbursement up to $350[15]		

[12] *Services include the following but are not necessarily limited to this list. Excluded services are not necessarily limited to the list provided herein.*

[13] *If eyeglass frames with a retail value greater than $80 is selected, you will be responsible for network retailers discounted price over $104.*

[14] *There is a combined annual copayment of $10 for lenses and frames.*

[15] *An enrollee receiving benefits for corrective eye surgery will be ineligible for material benefits (frames, lenses and contact lenses) for 12 subsequent months. A corrective eye surgery claim form is necessary for reimbursement.*

Traditional, In-Progression, and Full-Time Temporary employees are eligible for benefits available under the Vision Plan. **Part-Time 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.

How the Plan Works

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;
    - Frame allowance up to $80 once per calendar year.
    - 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.

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 $350 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 twelve (12) subsequent months. 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.

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. 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. If you choose to upgrade your frame selection by choosing a more expensive frame, the retail price of the frame will be discounted. Additionally, there are many popular non-covered lens features whose prices are discounted under the participating provider agreement.

Participating (in-network) 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 contacting *Davis Vision*.

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 copay.

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.

Plan Exclusions and Limitations

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.

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.

SITUATIONS AFFECTING YOUR BENEFITS

Plan Limitations

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

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 are described in the *Plan Administration* > *Situations Affecting Your Benefits section.*

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 approved amount (see *Common Terms* for more information).

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.

Effect of Medicare

If You Are Actively Working

Medicare Part A (Hospital Insurance) provides coverage for inpatient care, skilled nursing facilities, hospice and home health care. Generally, if you have paid FICA taxes to earn 40 quarters (typically 10 years) and are a U.S. citizen or have met the legal residency requirements, you are eligible for premium-free Medicare Part A, which can supplement the GM Program. Medicare Part B (Medical Insurance) provides coverage for doctor's services and outpatient care. You are required to pay a monthly premium for Part B. If you are actively working, you can delay enrollment in Part B until retirement, regardless of age, without incurring a late enrollment penalty fee.

When you become eligible for Medicare at age 65 and 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 if you remain actively working. It is important to note, 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 your local Social Security Administration office to apply for Medicare. It is recommended you do so prior to terminating your employment with GM.

You have resources to help you avoid any unnecessary costs or if you need help signing up for Medicare Part B:

- Centers for Medicare & Medicaid Services: **www.cms.gov**
- Medicare: **www.medicare.gov** (1-800-633-4227)
- SSDC Services Corporation: **www.ssdcservices.com** (1-800-374-9950; TTY users call 711)

If You Become Disabled

If you are on a disability-related leave of absence, your health care coverage will change how the Program pays for your health care services. For the first six months while you're on disability, the GM Health Care Program will be the primary payer of your health care services. Once that six-month period ends and you and/or your covered dependents are eligible or become eligible for Medicare, Medicare becomes the primary payer of health care services, and GM becomes the secondary payer.

If you do not return to work, and you and/or your covered dependents are eligible for Medicare, the GM Health Care Program's provisions require your Plan's carrier to adjust claims and pay as if you are enrolled in Medicare Part A and Part B. The GM Health Care Program will make limited or no payment of claims once you are eligible for Medicare, even if you are not enrolled. If you and/or your covered dependents don't enroll, or disenroll in Medicare Part A and Part B, you could have high out-of-pocket expenses (up to 80%).

If you are on a disability leave of absence and are eligible to enroll in Medicare, Medicare may become the primary payer of your medical claims during such leave.

Most people sign up for Medicare when they're first eligible. Generally, there are risks to signing up later, like a gap in your coverage or having to pay a penalty. If you miss your 7-month Initial Enrollment Period (IEP), you may have to wait to sign up and pay a monthly late enrollment penalty for as long as you have Part B coverage. The penalty goes up the longer you wait.

Here are some online government resources to help you learn about Medicare:

- Centers for Medicare & Medicaid Services: **www.cms.gov**
- Medicare: **www.medicare.gov** **(1-800-633-4227)**

When you become eligible for Medicare, signing up only takes a couple steps:

1. Contact your local Social Security Administration office to apply for Medicare Part A and Part B coverage. You can find the office closest to you at **www.ssa.gov/locator/**.
2. When you receive your Medicare card, call the GM Benefits & Services Center immediately at **1-800-489-4646** from 7:30 a.m. to 6:00 p.m. Eastern Time, Monday through Friday, to update your status. TTY users call **711**. They'll ask you for the coverage effective date, which you'll find on your Medicare card.

General Motors has partnered with SSDC Services to assist you with determining if you're eligible for enrollment in Medicare Part B if on a disability leave of absence. They can also provide required documentation for enrollment, when applicable. There is no cost to you for this service. SSDC Services can be reached at **1-800-374-9950**, option 5; TTY users call 711 or you can visit their website at **www.ssdcservices.com**.

If You Have End-Stage Renal Disease (ESRD)

If you or one of your dependents have end-stage renal disease (ESRD), or undergo a kidney transplant, you (or your dependent) may be eligible for Medicare coverage prior to age 65. For the first 30 months after being diagnosed with ESRD, also referred to as the "coordination period," your GM health care plan is the primary payer for your health care services. After the 30-month coordination period has ended, Medicare will become the primary payer of your health care services. If you (or your dependent) don't enroll in Medicare Part A and Part B by the end of the ESRD coordination period, the provisions of the Program require the Carrier to adjust claims and pay as if you're enrolled in Medicare coverage. This can result in limited payment or no payment by the GM Health Care Program and the possibility of high out-of-pocket expenses.

It is important to consider enrolling in Medicare even if you've received a transplant. Please be advised that governmental guidelines state that a transplant isn't (considered) successful for 36 months from the date of the transplant. Medicare remains the primary payer until the transplant is deemed successful.

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 Health Care Program is secondary, the following provision apply:

- 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);

- 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 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 ½ 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.

Recovery of Benefit (Claim) Overpayments

If any benefit paid to you or on your behalf (or to one of your dependents or on their 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.

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. Should you or your dependent receive a letter of inquiry from GM's subrogation vendor, 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.

APPEALS

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. 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 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 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 coverage 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.

ADDITIONAL INFORMATION

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

This notice applies to you if you are covered under the General Motors Health Care Program for Hourly Employees. 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 their 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 their 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 becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child 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 their employment terminates, COBRA continuation coverage for their 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 **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, to speak with a Customer Service Associate.

Conversion Privilege

If you choose to not continue your coverage under COBRA, or if your continuation of coverage under COBRA ends, you may have the option of converting your current health care coverage to an individual policy. To determine the availability of a conversion policy, you must contact your current carrier within 30 days of your coverage end date.

Newborns' and Mothers' Health Protection Act of 1996

Under federal law, medical plans may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery without complications, or less than 96 hours following a caesarean section, or require that a provider (e.g., a doctor or hospital) obtain authorization from the plan or the insurance issuer (including an HMO or PPO) for prescribing a length of stay which is not more than the above periods. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above respective periods.

Women's Health and Cancer Rights Act of 1998

Under federal law, GM is required to notify plan participants of the Women's Health and Cancer Rights Act of 1998, which requires group health care plans to provide certain benefits for breast reconstructive surgery following a mastectomy.

Under federal law, participants and eligible dependents who receive benefits in connection with a mastectomy, and who elect breast reconstruction, will be provided coverage under the plan, in a manner determined by consultation with the attending doctor and the patient for:

- All stages of 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 at all stages of the mastectomy, including lymph edemas.

Coverage and benefits are subject to the plan's applicable copayments, coinsurance, deductibles and other limitations and exclusions, including limitations for reasonable and customary charges. For a complete description of benefits, limitations and exclusions, please see the *Medical Plan* section.

Patient Protection and Affordable Care Act (PPACA)

The Plan Administrator believes that the medical plan offered to Temporary employees under the General Motors 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-C36-D48, 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.

No Surprises Act of the 2021 Consolidated Appropriations Act

Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Provider for any covered service is higher than the maximum approved amount determined by the Plan, participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion. Continuity or Transition of Care In the event you are a continuing care/transition of care patient receiving a course of treatment from a Provider that has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, you shall have the following rights to continuation/transition of care.

The Plan shall notify you in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that you have rights to elect continued transitional care from the Provider. If you elect in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when you cease to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who: 1. is undergoing a course of treatment for a serious and complex condition from a specific Provider, 2. is undergoing a course of institutional or inpatient care from a specific Provider, 3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery, 4. is pregnant and undergoing a course of treatment for the pregnancy from a specific Provider, or 5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider. Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the participant for any amounts above the Plan's benefit amount.

No Surprises Act – Emergency Services and Surprise Bills

For non-contracted Provider claims subject to the No Surprises Act ("NSA"), participant cost-sharing will be the same amount as would be applied if the claim was provided by a contracted Provider and will be calculated as if the Plan's Approved Amount was the recognized amount, regardless of the Plan's actual maximum approved amount. The NSA prohibits Providers from pursuing participants for the difference between the maximum approved amount and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost sharing amounts will accrue toward deductibles and out-of-pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider. Claims subject to the NSA are those which are submitted for: Emergency Services; Non-emergency services rendered by a non-contracted Provider at a contracted Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and Covered non-contracted air ambulance services.

DEPENDENT CARE REIMBURSEMENT PLAN

GENERAL INFORMATION

Overview

The Dependent Care Reimbursement Plan, also known as a Dependent Care Flexible Spending Account (DCFSA), is a flexible spending account that offers a cost-effective way for you to pay for eligible childcare and/or eldercare, such as licensed daycare, summer day camp, adult or senior daycare and other dependent care-related expenses, that allows you and your spouse (if married) to go to work, look for work or attend school full-time.

Your contributions to the DCFSA are automatically deducted from your pay before tax, meaning you save tax dollars on eligible dependent care expenses. If you are currently paying for daycare expenses outside of the Dependent Care FSA, you are paying in taxable dollars and may be taking the federal tax credit on your personal tax return at the end of the year. Using the Dependent Care FSA may result in greater tax savings compared to the federal tax credit.

Benefit Coverage	Options	Coverage Start Date	If you don't make an election…
May defer up to $5,000 pre-tax to help pay for eligible dependent care expenses	▪ Dependent Care FSA ▪ No coverage	On the ninety-first (91st) day of employment	You will automatically be enrolled with no coverage.

Eligibility

Traditional and In-Progression employees are eligible to participate in the Dependent Care FSA on the ninety-first (91st) day of employment.

Full-Time and Part-Time Temporary employees are not eligible to participate in the Dependent Care FSA.

Your Options

Your contributions to the Dependent Care FSA are deducted from your pay before federal, state and Social Security (FICA) taxes are withheld. That means eligible dependent care expenses actually cost you less because you can pay for them with pre-tax dollars. You have the options to determine how much of your pay is deferred, with minimum and maximum requirements.

- **Annual minimum** is $104 ($2 per pay period if participating January 1-December 31)
- **Annual maximum** is $5,000 if single or married, filing jointly ($96.16 per pay period if participating January 1-December 31). **Note:** If you are married, filing separately, the annual maximum is $2,500.

Is the Dependent Care FSA good for me?

It's easy to determine if the Dependent Care FSA can save you money. Before you make your annual election, you should estimate the expenses you will incur during the Plan Year (January 1–December 31) and then determine if you're better off paying for such items on an after-tax basis outside of the Plan versus a pre-tax bases in the Plan.

How does the Dependent Care FSA work?

After you have determined your estimated annual expenses and have arrived at an annual Dependent Care FSA contribution dollar amount with which you are comfortable, divide this amount by the number of pay periods for the Plan Year (at the beginning of the year, divide by 52). This amount will be deducted in even amounts from each of your paychecks and contributed to your DCFSA. You will need to plan carefully as the IRS requires that you forfeit any money you contributed during the Plan Year for which you did not incur expenses by March 15 of the following year. Additionally, these expenses must be submitted for reimbursement by April 30 following the end of the Plan Year. Therefore, you should use conservative estimates to avoid the IRS "*Use It or Lose It*" rule.

Tax Savings Using a Flexible Spending Account

The following is an example of a married employee (filing jointly) earning $60,000 per year who expects to defer $5,000 to a Dependent Care FSA.

	Pre-Tax (Using FSA)	**Post-Tax (Not Using FSA)**
Annual Base Salary	$60,000	$60,000
Less: FSA Election	$5,000	$0
Taxable Salary	$55,000	$60,000
Less:		
Estimated Taxes	$8,800	$9,600
After Tax Expenses	$0	$5,000
Net Pay	**$46,200**	**$45,400**

Estimated, annual increase in spendable income by using a pre-tax Flexible Spending Account in this example is $800. The above illustration is an approximation only, and is not an indication of exact amounts saved.

Effect of the FSA Plans on Social Security Benefits

When you contribute to the Dependent Care FSA, your taxable income is reduced by the amount of your contribution. This affects the amount of Social Security taxes you pay. In addition, because your taxable income is reduced, your Social Security benefits at retirement or disability may be slightly reduced. Research suggests, however, that your tax savings over time will generally outweigh your Social Security benefit reduction.

Planning Carefully

Each participant must decide how much, if any, to set aside for their Dependent Care FSA. This can be done by carefully reviewing expenses from the prior year and estimating predictable expenses for the current/upcoming Plan Year. All eligible expenses must be incurred during the Plan Year or by March 15 of the following year, and all deductions are taken during the Plan Year.

To help you determine the amount you wish to contribute to your Dependent Care FSA for the Plan Year, Bank of America provides a helpful calculator online (healthaccounts.bankofamerica.com/dcfsa-calculator-individual.shtml) that can help you estimate your dependent care expenses and find out how much you could save by participating.

Use It or Lose It

Because of the tax advantages provided by using a Dependent Care FSA, the Internal Revenue Service has established guidelines for its use. One of these guidelines is commonly known as the "Use It or Lose It" rule. The rule is this: If you deposit pre-tax dollars into an FSA account and then do not use all of the dollars you deposit by the stated deadline; you will lose the remaining balance in the account. For this reason, it is essential that you plan your contributions carefully. Only allocate those dollars that you are confident you will spend during the Plan Year:

- The deadline for **incurring** qualified expenses is **March 15** following the end of the Plan Year
- The deadline for **submitting claims for reimbursement** is **April 30** following the end of the Plan Year

Claim Administrator

Bank of America has been selected as the claim administrator for the Dependent Care FSA Plan. Bank of America's website (healthaccounts.bankofamerica.com/gm) provides you with account information including real-time status on your spending account. You may submit reimbursement claims online, confirm the receipt of a faxed or mailed claim, check claim status, view your account balance and review your annual contribution.

HOW THE DEPENDENT CARE FSA WORKS

Contribution Amounts

The Dependent Care FSA allows you to defer from $104 to $5,000 if married, filing jointly ($2,500 if married, filing separately) to your dependent care account. You are responsible for determining the amount that best meets your needs based on your expected eligible expenses.

When Pre-Tax Contributions Cease or End

Upon the cessation or stoppage of pre-tax contributions (e.g., due to retirement, termination of employment, unpaid leave of absence, etc.), you may continue to submit claims for reimbursement of eligible dependent care expenses, up to the available balance in your account, through April 30 following the end of the Plan Year.

Important: When pre-tax contributions cease, it is your responsibility to determine eligibility of such claims based on criteria established by the Internal Revenue Service (IRS) in Publication 503: Child and Dependent Care Expenses (irs.gov/pub/irs-pdf/p503.pdf).

Who is a Qualified Dependent?

Your child or adult care expenses are eligible for reimbursement if your eligible dependent is:

- A child under thirteen (13) years of age for whom you are allowed a personal exemption on your annual federal income tax return.
- An adult, such as a spouse or relative, who is physically or cognitively incapable of self-care, who has the same principal residence as you for more than one-half (½) of the calendar year, and for whom you claim a personal exemption on your annual federal income tax return.

Who is a Qualified Dependent Care Provider?

You may use any care provider you choose. The care provider must meet the business and licensing requirements of your state. The services may be as informal as care provided by your neighbor, as long as the provider claims the money received for services as income when determining their taxes at the end of the year. You will also need to obtain the provider's federal identification/Social Security number (if the provider is an individual) for inclusion on your own tax filing return.

A qualified dependent care provider is **not**:

- A person for whom you (or your spouse, if filing jointly) can claim as a dependent;
- Your child (including stepchild or foster child) who was under age 19 at the end of the year, even if they were not claimed as your dependent;
- A person who was your spouse any time during the year; or
- The parent of your qualifying dependent if your qualifying dependent is your child and under age 13.

Eligible Dependent Care Expenses

Generally, eligible expenses include costs for daycare for your tax-qualified dependents. For a list of eligible expenses, refer to **What Expenses Are Covered?** From Bank of America's Learn Site and **IRS Publication 503**.

Some of the costs you can use your Dependent Care FSA funds include:

- Daycare facility fees (excluding transportation, lunches, educational services)
- Before-school and after-school care
- Local day camp (for the purpose of childcare)
- In-home baby-sitting fees (income must be claimed by your care provider)
- Nursery school and preschool
- Adult daycare

Your dependent care costs can only be covered if you must pay these expenses so that you, and your spouse (if married), can work, look for work, or attend school full-time.

Ineligible Dependent Care Expenses

Expenses that are not eligible for payment or reimbursement include, but are not limited to:

- Dependent care obtained for non-work/school-related reasons
- Dependent care that could be provided by your employed spouse whose work hours differ from yours
- Dependent care expenses incurred if your spouse does not work or attend school on a full-time basis, unless they are disabled
- Expenses paid by another organization or provided without cost
- Care that is provided by your child
- Care provided for a dependent age 13 or older in a full-time residential institution such as a nursing home or home for the mentally disabled
- Care provided in a group care center that does not meet state and local laws
- Charges for referrals to daycare providers
- Cost of food, clothing, or entertainment
- Tuition or educational expenses
- Overnight camps
- Payments for services not yet provided
- Registration fees (required for eligible care, *prior* to actual services being received)
- Transportation to and from eligible care that is *not* provided by your care provider
- Any expenses you claim for the dependent care tax credit on your federal income tax return

Dependent Care FSA vs. Federal Tax Credit

Remember that you may be able to take a federal tax credit for eligible dependent care expenses and that any amounts deposited into a Dependent Care FSA will reduce dollar-for-dollar, the amount you can take under the tax credit. Only you and your tax advisor can determine whether the Dependent Care FSA or the federal tax credit is more beneficial to you. If you wish to learn more about the federal tax credit and how it compares to the Dependent Care FSA, refer to Publication 503: Child and Dependent Care Expenses (**irs.gov/pub/irs-pdf/p503.pdf**).

Participation in the Dependent Care FSA will reduce or eliminate the ability to use the federal tax credit for dependent care. However, for most taxpayers, the Dependent Care FSA results in a greater tax savings. If you participate in the Dependent Care FSA, **IRS Form 2441** must be completed as part of your annual tax filing.

CLAIMING YOUR BENEFITS

Requests for Reimbursement

With the Dependent Care FSA, you are reimbursed only for eligible dependent care expenses up to the available balance in your account. You may receive reimbursement for any claim in excess of your balance as your accounts grows through subsequent contributions. When you elect to participate in the Dependent Care FSA, Bank of America will process eligible claims for reimbursement and issue payment to you or your provider.

There are three (3) ways to pay for eligible expenses with your Dependent Care FSA:

- Use your Bank of America *Health and Benefit Accounts Visa* debit card
- Pay out-of-pocket, then file a claim to reimburse yourself from the Bank of America member website or the *MyHealth BofA* mobile app
- Submit a manual claim for reimbursement or payment by filling out the Bank of America Reimbursement Request Form

Note: Payment from your Dependent Care FSA cannot be made until the expense has been incurred. For example, if you pay for childcare for the entire month of January on January 1, you will not be able to be reimbursed until after January 31. Funds can only be used for expenses incurred during the current Plan Year.

Correcting Mistakes in Payment

If you are mistakenly paid more of a reimbursement than you are entitled, the claim administrator will:

- Require you to return the overpayment, or
- Reduce future payment by the amount of the overpayment

APPEALS

If a request for reimbursement is denied, in whole or in part, you will receive notice of the denial from the claim administrator. You will receive the denial within sixty (60) days from the date the claim administrator received your request for reimbursement. Your denial notice from the claim administrator will include:

- Reason(s) for the denial
- Denial explanation as related to Plan provisions
- Required actions to correct the denial

You may appeal the denied reimbursement request by submitting the claim administrator's Claim Appeal Form within 180 days after you receive the denial notice. The Claim Appeal Form can be found online at myhealth.bankofamerica.com. When submitting the Claim Appeal Form, you must include your reason for requesting the review, and any additional information and/or documentation that support the claim. The Claim Appeal Form and additional documentation must be mailed to Bank of America, c/o Health Account Services, PO Box 2203, Fargo, ND 58108, or faxed to 1-844-590-0919.

Your appeal will be reviewed, and ordinarily you will be notified of the final decision within sixty (60) days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the sixty (60) days following receipt of your request.

You must exhaust all of the administrative appeal remedies provided prior to filing suit in a state or federal court, as provided for by ERISA.

ADDITIONAL INFORMATION

- Find tools and resources to help you manage your Dependent Care FSA by visiting the Bank of America Learn Center (**healthaccounts.bankofamerica.com/gm**)
- Get the *MyHealth BofA* mobile app directly from the App Store℠ or Google Play™[6]
- If you have questions or need assistance, contact Bank of America by calling the number on the back of your debit card or see the *Plan Administration* > *Who To Contact* section

PERSONAL SAVINGS PLAN (PSP)

GENERAL INFORMATION

Overview

The Personal Savings Plan ("PSP") is a defined contribution plan that provides a 401(k) account to help you accumulate retirement savings.

For complete information regarding the PSP, please refer to the plan document, which can be requested from the PSP Plan Administrator at Mail Code 482-C36-D48, 300 Renaissance Center, Detroit, MI 48265-3000. Investment options related to the PSP can be found in the GM Savings Plans Investment Guide at **netbenefits.com.**

Common Terms

After-Tax Savings – Amounts deducted from an employee's eligible weekly earnings, after federal income taxes and other applicable taxes are withheld, to be contributed to the PSP as elected by the employee.

Beneficiary – The person, persons, or entity named by an employee to receive the benefits of the PSP account in the event of the employee's death.

Business Day – Any day the New York Stock Exchange is open for business.

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.

Deferred Savings (pre-tax) – Amounts deducted from an employee's eligible weekly earnings before federal income taxes and other applicable taxes are withheld, to be contributed to the PSP as elected by the employee.

ERISA – The Employee Retirement Income Security Act of 1974 is a federal law that sets standards of protection for individuals who are 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.

Participant – An employee, former employee, or surviving spouse who has a PSP account.

Plan Recordkeeper – The party designated by GM to maintain a participant's PSP account and perform other PSP account services. For this purpose, Fidelity is the plan recordkeeper. You may contact Fidelity by calling the GM Benefits & Services Center at 1-800-489-4646.

Prospectus – A thorough, written description of a new security issue or mutual fund.

Rollover – A transfer of cash attributable to the taxable amount of a PSP distribution that would be taxable to you if not moved directly from one qualified retirement plan to another qualified plan or Individual Retirement Account (IRA).

Roth Savings – Amounts deducted from an employee's eligible weekly earnings, after federal income taxes and other applicable taxes are withheld, to be contributed to the PSP as elected by the

employee. Under current tax law, at the time of withdrawal, the participant will owe no taxes as long as the withdrawal occurs at or after age 59½, or upon disability or death, and as long as it has been at least a 5-taxable-years since the first Roth contribution was made.

Spouse – Includes the parties to a marriage of two persons, regardless of gender, provided the marriage was lawful in the jurisdiction in which it occurred.

Temporary Employee – For purposes of the PSP only, a Temporary Employee is an employee classified by the Company as temporary. This includes Full-Time Temporary and Part-Time Temporary employees.

Trustee – The entity responsible for holding, investing, and distributing the benefits or assets of the PSP. GM's current Trustees are listed under *Plan Administration* > *Employee Retirement Income Security Act of 1974*.

Vested – To be vested means a participant owns the assets in their PSP account. All employee contributions to the PSP are immediately vested (including gains and losses), and all GM contributions to the PSP are vested once the employee has reached three years of employment on an elapsed-time basis.

UNDERSTANDING YOUR BENEFITS

Eligibility

Traditional, In-Progression, and Temporary employees are eligible to participate in the PSP following their completion of 90 days of employment with the Company. Making employee contributions to the PSP is voluntary. Employees may discontinue or change their contributions at any time. For eligibility to receive Company Contributions and Retirement Contributions to the PSP, see *GM Contributions*.

Enrollment

Employees may enroll in the PSP or change their contribution election at any time by logging in to their account via **gmbenefits.com** or by contacting the *GM Benefits & Services Center*.

Automatic Enrollment

Newly hired employees who have not made a PSP contribution election will be automatically enrolled at a contribution rate of 3% (pre-tax) unless they actively opt out of the automatic enrollment process prior to their first contribution. Such contributions will be made through payroll deductions and will be invested based on the investment option(s) the employee has elected. If the employee has not made an investment election, such contributions will be invested in the State Street Target Retirement Fund (referred to as the Qualified Default Investment Alternative or "QDIA") with a target retirement date closest to the year in which the employee turns age 65, or the State Street Target Retirement Income Fund. Employees may change their contribution amount or investment election by logging in to their account via **gmbenefits.com**. or by contacting the *GM Benefits & Services Center*.

Employees who are automatically enrolled may request to have such contributions refunded if requested within 90 days of their first contribution. The refund will be adjusted for gains and losses, which may result in a refund that is greater or less than the total contributions.

Employer-Directed Automatic Increase Program

Effective January 1, 2020, an employer-directed automatic increase feature was added to the PSP. Eligible employees contributing between 1% and 9% to the PSP were automatically enrolled into the Automatic Increase Program (AIP). Under the AIP, the contribution election of eligible employees will be automatically increased by 1% each April, until the employee's contribution percentage reaches 10%, or the employee actively changes their election by contacting the *GM Benefits & Services Center.*

Eligible employees will be notified at least 45 days in advance of being enrolled in AIP. Such notification will provide directions to opt out of AIP in advance of the first 1% increase. Employees who do not actively opt out of AIP will be automatically enrolled and will receive confirmation statements each year after the annual 1% increase takes effect.

Employees will remain enrolled in the AIP until their contribution election reaches 10% or until they actively increase or decrease their contribution election.

Employee-Directed Automatic Increase

Employees may choose to enroll in the PSP's automatic increase feature. Employees who enroll are not eligible to have such contributions refunded but may change their annual increase election at any time.

If you do not otherwise make an investment election, Automatic Enrollment contributions will be invested automatically in the State Street Target Retirement Fund with a target retirement date (as specified in the fund's name) closest to the year that you will attain age 65, or the State Street Target Retirement Income Fund. The State Street Target Retirement Funds are the Qualified Default Investment Alternative (QDIA) for the PSP. You may select an alternative investment option at any time.

Access to Your Account

When you participate in the PSP, you must establish a confidential username and password to access your account via **gmbenefits.com**. You may only access your personal account information and initiate transactions online or by phone using your username and password. *You should not give anyone your username and password.*

Account Security

In addition to using your confidential username and password to access account information and initiate transactions, you may establish a voiceprint using Fidelity MyVoice®. Fidelity MyVoice® is voice verification technology that provides a secure way for Fidelity to authenticate your identity.

Trusted Contact Feature

This voluntary feature allows you the opportunity to authorize someone you trust to be contacted by Fidelity or the Plan Administrator regarding your PSP account. Your trusted contact is utilized if there are concerns related to your behavior during an interaction with the GM Benefits & Services Center, such as suspicion of potential diminished capacity, elder abuse, or fraud. While your trusted contact is alerted to check on your well-being, they do not have access to your account or any information related to your account, nor do they have the authority to provide any account direction. A trusted contact does not have any powers or authorities provided under a Power of Attorney document. You may contact the *GM Benefits & Services Center* to add a trusted contact.

HOW THE PLAN WORKS

Employee Contributions

Traditional, **In-Progression**, and **Temporary employees** are eligible to make employee contributions to the PSP following their completion of 90 days of employment with the Company.

You have the option to contribute up to 100% of your eligible weekly earnings, after all legally required deductions, to the PSP through payroll deductions. Such contributions are referred to as "employee contributions" and may be made on a pre-tax basis (*Deferred Savings*), Roth basis (*Roth Savings*), or after-tax basis (*After-Tax Savings*), or any combination of pre-tax, Roth, or after-tax. Your total contributions may not exceed 100% of your eligible weekly earnings or the annual contribution limits established each year by the Internal Revenue Service (IRS). For 2024, the limit on employee contributions (which includes pre-tax and Roth contributions only) is $23,000, and the limit on all contributions (employee plus GM contributions combined) is $69,000, and thereafter indexed for inflation as provided by the IRS. Catch-Up Contributions, which are described in the following section, are not subject to these limits.

If you are eligible to receive a payment under the General Motors Profit Sharing Plan for Hourly-Rate Employees in the United States, you may elect to contribute up to 100% of such payment as a percentage or dollar amount (subject to IRS limits) to the PSP, less any required payroll deductions. Such contribution can be made on a pre-tax basis only. To the extent all or a portion of the payment, if contributed to the PSP, would exceed the IRS limit on pre-tax employee contributions, the excess amount will be paid to you in your paycheck as taxable income on the same date profit sharing is paid.

You may change the amount of your contributions at any time. The amount you elect to contribute may be limited by federal tax law. Upon allocation to your PSP account, all employee contributions (including catch-up contributions described in the following section), are immediately vested.

Catch-Up Contributions

If you are age 50 or older or will turn age 50 by the end of the calendar year, you may be eligible to make additional "Catch-Up Contributions" to the PSP, to the extent allowed by federal tax law. Catch-up contributions are made in addition to your regular PSP payroll contributions. You may elect to contribute up to 100% of your eligible weekly earnings, after all legally required deductions, as catch-up contributions. If eligible to make catch-up contributions, the limit for 2024 is $7,500, and thereafter indexed for inflation as provided by the Internal Revenue Code (IRC). Catch-up contributions may only be made on a pre-tax or Roth basis but are not subject to the $23,000 employee contribution limit.

You may elect to have catch-up contributions deducted at the same time as your regular pre-tax and/or Roth payroll deductions (up to the IRS limit), however, your catch-up contributions will only be counted as "catch-up contributions" after you reach the $23,000 employee contribution limit.

Investment of Employee Contributions

Your employee contributions will be invested based on the investment option(s) you have elected. If you have not made an investment election, your employee contributions will be invested in the State Street Target Retirement Fund (referred to as the Qualified Default Investment Alternative or "QDIA") with a target retirement date closest to the year in which you turn age 65, or the State Street Target Retirement Income Fund. You may change your investment election at any time.

GM Contributions

Company Contributions

Traditional, Temporary employees are ineligible to receive Company Contributions to the PSP.

In-Progression employees hired on or after October 15, 2007, as well as certain employees who may be covered by other Union agreements, are eligible to receive Company Contributions to the PSP following their completion of 90 days of employment with the Company. GM will automatically contribute such contributions on a pre-tax basis to an employee's PSP account each pay period. The amount of Company Contributions will be equal to $1 per hour of straight time (up to 40 compensated hours in any one work week), including hours compensated for certain eligible time not worked (e.g., vacation and holiday). Company Contributions will be made regardless of an eligible employee's election to make their own contributions to the PSP, and will be made in addition to *Retirement Contributions* described in the following section.

Retirement Contributions

Traditional and Temporary employees are ineligible to receive Retirement Contributions to the PSP.

In-Progression employees hired on or after October 16, 2007, as well as certain employees who may be covered by other Union agreements, are eligible to receive Retirement Contributions to the PSP following their completion of 90 days of employment with the Company. GM will automatically contribute such contributions on a pre-tax basis to an employee's PSP account each pay period. The amount of Retirement Contributions will be equal to 10% of your base hourly straight time pay received (up to 40 compensated hours in any one work week), including hours compensated for any cost-of-living allowance on such hours worked (if applicable). Retirement Contributions will be made of an eligible employee's election to make their own contributions to the PSP, and will be made in addition to *Company Contributions* described in the preceding section.

Investment of GM Contributions

Company Contributions and Retirement Contributions made by GM will be invested based on the investment option(s) you have elected for your employee contributions. If you have not made an investment election, Company and Retirement Contributions will be invested in the State Street Target Retirement Fund (referred to as the Qualified Default Investment Alternative or "QDIA") with a target retirement date closest to the year in which you turn age 65, or the State Street Target Retirement Income Fund. You may change your investment election at any time.

Vesting of GM Contributions

Company Contributions and Retirement Contributions made by GM shall vest upon the attainment of three years of vesting service. If you terminate employment from the Company prior to attaining three years of vesting service, all Company Contributions and Retirement Contributions (and related earnings) will be forfeited.

Restoration of Forfeited GM Contributions

If you terminate employment from GM and are rehired prior to incurring five consecutive one-year breaks-in-service following your termination, any previously forfeited Company Contributions and Retirement Contributions (and related earnings) will be automatically restored. Note: Restored GM contributions are not adjusted for gains or losses. You should contact the *GM Benefits & Services Center* for additional information.

Rollover Contributions from Other Eligible Retirement Plans

Once you are eligible to participate in the PSP, you may elect to make a rollover contribution to the PSP of taxable and/or nontaxable cash proceeds from other eligible retirement plans. For rollovers from a traditional Individual Retirement Account (IRA), the rollover amount may not exceed the taxable portion of cash proceeds received. Additionally, you may rollover cash proceeds received under a Qualified Domestic Relations Order (QDRO) from another eligible retirement plan into the PSP. 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, or at such other times as may be provided by the PSP Administrator in accordance with applicable law.

Roth In-Plan Conversion

The "Roth In-Plan Conversion" option allows you to convert all or a portion of your non-Roth assets to Roth assets within the PSP. The amount eligible for such conversion includes all vested assets, including your pre-tax savings, after-tax savings, Company Contributions, and Retirement Contributions, and earnings (if applicable). The benefit of converting such assets to Roth is that they may qualify to be distributed tax-free (including earnings), similar to distributions of qualified Roth IRA assets.

Special tax rules apply to Roth in-plan conversions and are an important consideration in deciding whether to do such conversion. Generally, the taxable amount of a conversion is determined as if the converted assets were distributed to you from the PSP as a taxable distribution, however, the assets will only be transferred to the Roth portion of your account; no amount is actually distributed to you, therefore no penalty would apply for a Roth in-plan conversion prior to age 59½. 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 potential tax consequences of a conversion, it is recommended you consult with your personal tax. To process a Roth in-plan conversion, please contact the *GM Benefits & Services Center*.

Investment of Contributions

You may elect to invest 100% of your contributions, in 1% increments, in any of the PSP's investment options. Your investment elections will remain in effect until you change them, subject to PSP provisions. The PSP provides you with flexibility to change your investment election on any business day, subject to any limitations on exchanges (including frequency) applicable to the different investment options in the PSP.

Before You Invest

The PSP provides a broad range of investment options, each with different risk and return characteristics. GM encourages you to familiarize yourself with the PSP's investment features. You should carefully read the Plan materials, including the GM Savings Plans Investment Guide that may be obtained by logging in to your account via **gmbenefits.com** or by calling the *GM Benefits & Services Center*. Familiarization with the PSP's investment features, coupled with the flexibility to change your investment options, will help you to make informed investment decisions as you seek to meet your financial goals.

As a PSP 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, General Motors Investment Management Corporation (GMIMCo), and any other appointed fiduciary are not empowered to advise you regarding the amount of your contributions, the manner in which your investments should be made, or any allocation or reallocation of those investments. The fact that an investment option is available under the Plan should not be construed by you as a recommendation by GM or GMIMCo, or anyone else, for investment in that option.

The market value and rate of return on each investment option may fluctuate over time and in varying degrees. Accordingly, any proceeds you may 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 any of the investment options will achieve their objectives or your objectives. Additionally, past performance of any investment option is not predictive of its future performance.

Each investment option is subject to varying degrees of risk, which are discussed in the GM Savings Plans Investment Guide, in prospectuses for any mutual funds in the lineup, and in other fund documents made available by investment managers and trustees of the funds. A listing and description of the investment options, including mutual funds available under the Plan, can be found in the GM Savings Plans Investment Guide that may be obtained by logging in to your account via **gmbenefits.com** or by calling the *GM Benefits & Services Center*. You should carefully review these materials, including information regarding risk factors, before making any investment decisions.

Investment Pathways

The PSP's investment options are organized into two "pathways." Although the two pathways contain different groups of investment options, all investment options in the PSP are generally available to you at any time. You can mix options from either of the two pathways. *Like any investment, it is possible to lose money by investing in these funds.*

Pathway One: "Leave the Driving to Someone Else"

This pathway includes target date funds which are designed to make investments easy for you, providing an age-specific investment strategy that is 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 mix of stocks, bonds, and other investments that automatically change over time, gradually becoming more conservative as the target retirement date 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: "Take the Wheel"

This pathway offers a more hands on approach and may be right for you if you have knowledge of investing and asset allocation, you wish 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's investment options include a selection of investments across major asset classes that can help create a diversified portfolio that meets your personal level of risk tolerance. The investment options are segmented into "actively managed" and "passively managed" funds.

Actively managed funds use portfolio managers to select investments in an attempt to outperform the market and produce better returns than passively managed funds. They tend to have higher operating costs due to the research and analysis entailed in selecting those investments. By relying on a fund manager's knowledge to interpret and act on market trends, actively managed funds may have the potential to outperform the market as a whole.

Passively managed funds are made up of investments that mirror a market index. They tend to have lower expenses, because index fund managers do not rely on a research staff, nor do they buy and sell securities as frequently. Historically, index fund returns have been "in line with" the index they are designed to track.

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, including exchanges between the investment options under the two pathway options outlined above. Certain funds may impose a redemption fee on your exchange if you hold that investment for less than a stated period (this fee is paid by you 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.

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 Conservative Income Fund. Except with respect to the Conservative Income Fund, a "roundtrip transaction" occurs when you exchange into and then out of a fund within a 30-day period. Please note that systematic contributions and withdrawals (e.g., payroll contributions, loan repayments, 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 $10,000 per investment option are counted for the 2024 calendar year. Refer to the GM Savings Plans Investment Guide for the most current excessive trading policy information, including current limits.

Restrictions on Excessive Withdrawals from, or Inflows into, a Fund

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, advisors, 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 (e.g., brokerage commissions, fees, expenses, stamp taxes, and trading costs). In certain instances, there could be interest charges associated with these types of 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, canceled, reversed, and/or reprocessed. In certain instances, additional direction from the participant could be required to resubmit 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.

None of GM, GMIMCo, the investment managers, investment funds, investment advisors, fund providers, or trustees are responsible for any economic impact (including change in market value) resulting from any delay, limitation, suspension, rejection, or other restriction described above.

Loans

You may borrow from the assets in your account one time each calendar year and may have up to five loans outstanding at any one time. Assets available for loan include all employee contributions. Note: Company Contributions and Retirement Contributions (and related earnings) are not available for loan until they are (1) 100% vested, and (2) the employee has terminated employment from the Company. If you are a former employee or a surviving spouse of an employee and you have assets in the PSP, you

may initiate a loan from your account. A loan may be initiated for any reason, and no credit check 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 and the maximum loan amount (when added to the outstanding balance of all loans under the PSP) is $50,000. You may apply for a loan for an amount that is the lesser of:

- $50,000 less the highest amount of loans you had outstanding during the previous 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 and accrued interest of any loan that has been defaulted and deemed to be a distribution to you after December 31, 2001. 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 applied to your loan will be the prime rate 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.

A loan may be granted with a minimum term of twelve months to a maximum term of five years, or ten years if the loan is to purchase or build your principal residence. The loan will be fully due and payable in accordance with the terms of the loan agreement.

Cash for your loan will be 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 and are invested based on the current investment options you have elected for your employee contributions.

Repayments

Loan repayments are made through after-tax payroll deductions. Generally, the repayment period of a loan ranges from twelve months to five years, or ten years if the loan is to purchase or build your principal residence. The minimum repayment amount is $10 per pay period. 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.

Generally, if you are not receiving pay through payroll and are not otherwise permitted to suspend loan repayments, repayment must be made directly to the GM Benefits & Services Center in accordance with the terms and conditions of the loan agreement, but no less than on a quarterly basis to prevent default. Additionally, if you are seeking to make a partial loan repayment, repay a loan in full, or repay a defaulted loan after it has been declared a deemed distribution, such repayments may be made directly to the GM Benefits & Services Center. There are no penalties if you repay a loan in full, earlier than scheduled. Until paid in full, any loan repayments made in excess of the repayment amount specified in your loan agreement will be applied to the principal balance of the loan. Such repayments may be made electronically by linking your personal banking account directly to your PSP account (known as ACH). To take advantage of this convenient repayment method, log in to your PSP

account via **gmbenefits.com**, then select "Bank/Tax Information" from the PSP Quick Links dropdown. If you require assistance, contact the *GM Benefits & Services Center*.

If you fail to make a required loan repayment and such failure to make repayment continues beyond the last day of the calendar quarter following the calendar quarter in which your required loan repayment was due, your loan will be defaulted and you will be irrevocably deemed to have received a distribution of assets in an amount equal to the outstanding principal balance and accrued interest of the loan as of the date the loan was deemed a distribution. Prior to defaulting on an outstanding loan, a notice will be sent to you providing you with a repayment opportunity. Please note that defaulting on an outstanding loan may result in tax consequences. Repayments for any subsequent loan(s) taken will be made through after-tax payroll deductions.

Withdrawals and Distributions

A withdrawal or distribution of assets is permitted, subject to certain limitations to comply with federal regulations. Withdrawals or distributions may be subject to tax penalties, therefore it is recommended you review the *Important Tax Considerations* and consult with a tax professional before taking a withdrawal or distribution.

Generally, while you remain actively employed at GM, you may withdraw from your account part, or all, of your:

- After-Tax Savings (and related earnings) at any time, without restrictions;
- Deferred Savings (pre-tax) and related earnings for any reason at or after age 59½;
- Roth Savings and related earnings for any reason at or after age 59½, provided it has been at least 5 years since your first Roth contribution to the PSP. Under current tax law, your Roth Savings are contributed to your PSP account after income taxes are deducted, therefore you will owe no taxes if you choose to withdraw your Roth Savings at or after age 59½, or upon disability or death. Note: Roth Savings may be withdrawn separately from other savings (i.e., you may withdraw Roth Savings without withdrawing your After-Tax or Deferred Savings).

Company Contributions and Retirement Contributions (and related earnings) are not available for withdrawal until fully vested, and you have reached Normal Retirement Age (age 65) or have terminated employment from the Company, whichever comes first.

Important Tax Considerations

Under current tax law, an additional 10% early distribution tax will be imposed on any taxable or Roth Savings withdrawn or distributed to you from the PSP before you turn 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, to an Individual Retirement Account (IRA) or another eligible retirement plan.

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

- made to you after you terminate employment by retirement during or after the calendar year in which you turn 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 termination of employment and continue for five years or until age 59½, whichever is later;
- Roth distributions that are made to you after age 59½, provided it has been at least 5 years since your first Roth contribution to the PSP; 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 your PSP distribution into an IRA or other eligible retirement plan. If you do this, under current tax law, you will pay no tax on the amount rolled over at the time of distribution. However, if you choose to have such 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 rollover 100% of the taxable amount of such distribution into an IRA or other 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, or at such times as may be permitted by the Plan Administrator in accordance with applicable law. Any amount rolled over will not be taxed under current tax law until you withdraw it from the IRA or other 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: Financial 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 assets.

Financial Hardship

You may be permitted to withdraw your Deferred Savings (pre-tax) and Roth Savings prior to age 59 ½ only in the event of an approved "financial hardship" as defined by the IRS. Such withdrawal may occur if 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 dependent;
- pay tuition, related educational fees, and room and board expenses for the next 12 months of post-secondary education for you, your spouse, or dependent;
- pay funeral expenses for your deceased parents, spouse, or dependent;
- pay for repairs to your principal residence due to casualty loss (determined without regard to section 165(h)(5) of the Code and whether the loss exceeds 10% of adjusted gross income);
- pay for expenses and losses (including loss of income) incurred on account of a disaster declared by the Federal Emergency Management Agency (FEMA), provided your principal

residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster; or

- any other reason permitted under IRS rulings and notices.

Any withdrawal of Deferred Savings or Roth Savings for a hardship will be limited to the amount of your contributions. Earnings on Deferred Savings 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 Savings or Roth Savings can be withdrawn for a hardship, you must take all available asset distributions, withdrawals, and loans under all applicable plans maintained by GM, and you must represent, in writing, by an electronic medium (or in such other form as may be prescribed by the Internal Revenue Service), that you have insufficient cash or other liquid assets to meet the financial hardship.

Upon Termination of Employment or Retirement from GM

Generally, in the event of your termination of employment from GM, including retirement under the GM Hourly-Rate Employees Pension Plan, you will be entitled to receive a full distribution of all assets in your PSP account, including all vested GM contributions (including your vested Company Contributions and Retirement Contributions), regardless of the reason for termination. If your GM contributions are not vested at the time of termination (i.e., you have less than three years of vesting service), you will be entitled to receive a full distribution of all vested assets attributable to your employee contributions and related earnings. Any GM contributions and related earnings not vested will be forfeited.

If you terminate employment for any reason and the value of your vested account assets are:

- **$1,000 or less**, you will receive a distribution of the entire amount of your account, less any required federal and state tax withholdings, no later than 60 days following the month in which the termination occurred.
- **Greater than $1,000 but is less than $5,000** and you do not elect to have such distribution paid directly to you or to an eligible retirement plan as a direct rollover, such distribution will be paid as a direct rollover to an Individual Retirement Account (IRA) designated by the Plan Administrator.
- **$5,000 or more**, you may keep your account assets in the PSP (until *Required Minimum Distributions* must commence), and you may elect to receive a distribution of assets at any time.

During the period your assets remain in the PSP, you may continue to exchange assets among the various investment funds, initiate a new loan as permitted by the Plan and described under *Loans*, elect partial distributions at any time, and/or request to receive periodic installment payments. Note: If you have any outstanding loans at the time of termination, or if you initiate any new loans thereafter, you must make repayments directly to the GM Benefits & Services Center, as described under *Repayments*. Partial distributions may be elected with or without an election to receive installment payments. Installment payments must be in whole dollar amounts and may be paid to you on a monthly, quarterly, semi-annual, or annual basis. You may, at any time, discontinue or revise the amount and frequency of such installment payments. For more information, contact the *GM Benefits & Services Center* or log in to your account via **gmbenefits.com**.

Required Minimum Distributions

Following your termination of employment from GM, if you have assets remaining in the PSP upon your attainment of age 72, the IRS requires you to begin receiving an annual Required Minimum Distribution (RMD) from your PSP account. Effective January 1, 2024, legislation excludes Roth assets from pre-death RMDs required for tax years after this date. Your first RMD will be paid to you no later than April 1 following the year in which you turn age 72, and all subsequent RMDs will be paid to you in December each year (unless you elect a different payment date). You will be notified, in writing, prior to receipt of your first RMD.

Effective January 1, 2023, legislation increased the RMD starting age to 73, therefore if you attain age 72 after December 31, 2022, you will begin to receive an annual RMD from your PSP account no later than April 1 following the year in which you turn age 73.

Your annual RMD amount will be determined each year in accordance with IRS regulations and is generally based on (1) your account balance, and (2) the remaining life expectancy of you and/or your spouse (if your spouse is sole beneficiary). Additionally, the cumulative amount of any voluntary installment payment(s) and/or partial distribution(s) taken in the given calendar year will be used first to satisfy your RMD amount.

In the Event of Death

In the event of your death and upon receipt of documentation satisfactory to the administrator, assets in your PSP account (including all GM contributions and earnings) will be transferred to the beneficiary(ies) designated by you.

If you are not married and have not designated a beneficiary(ies), or such designation is invalid, assets in your account will be distributed in the following order:

1. Participant's surviving children, equally; or
2. Participant's mother or father or both, equally; or
3. Participant's estate.

Payment to Spousal Beneficiary

If you are married and have designated your spouse as sole beneficiary, assets will be transferred to a separate account in your spouse's name (unless your spouse had agreed earlier, in writing and on forms satisfactory to the administrator, to the designation of some other person(s) as beneficiary(ies) to receive your PSP assets) and they will be permitted to maintain assets in the PSP after your death. Your spouse may request to receive the assets as a lump sum at any time. While the assets remain in the PSP, your spouse may initiate fund exchanges and new loans, elect partial distributions, and/or request to receive installment payments. Your surviving spouse is not permitted to contribute to the PSP, and must continue to make loan repayments (if applicable) to the GM Benefits & Services Center as described under *Repayments*.

In the event your spouse does not withdraw all assets by their attainment of age 72 (age 73 after December 31, 2022), they will begin receiving a *Required Minimum Distribution* from their account. Effective January 1, 2024, a surviving spouse who is the sole beneficiary of the PSP account may elect to have the initial RMD delayed to the year in which you would have attained age 73.

Payment to Non-Spousal Beneficiary

If you have designated a non-spousal beneficiary, assets will be transferred to a separate account in your beneficiary's name; however, your beneficiary is not permitted to maintain assets in the Plan. If your beneficiary does not request a distribution (such as a tax-free rollover distribution to an inherited IRA) within 180 days of the transfer, the entire account balance will be irrevocably paid in cash, less required tax withholdings and penalties (if applicable). Non-spousal beneficiaries must contact the *GM Benefits & Services Center* within 180 days of asset transfer to request a tax-free rollover distribution to an inherited IRA. Important: If the 180th day falls on a non-business day, such distribution will occur the previous business day.

Contribution Limits and Tax Considerations

The defined contribution limits for 2024 are reflected in the chart below. These amounts are adjusted periodically by the Internal Revenue Service (IRS).

Defined Contribution Limits:	Description:	2024:
Employee Contributions	The maximum you may contribute, pre-tax and Roth combined.	**$23,000**
Catch-Up Contributions	Individuals age 50 or over (or who will turn age 50 by year-end) may contribute additional employee contributions, pre-tax and Roth combined. ***Important:*** *This requires you to make a separate "catch-up contribution" election in NetBenefits.*	**$7,500**
Defined Contribution Limit (Employee + GM)	The maximum amount of employee and GM contributions (combined).	**$69,000**
Highly Compensated Employee Limit	The amount of income to define a highly compensated employee.	**$345,000**

Under current IRS limits, GM is required to limit the combined amount of your pre-tax and Roth contributions. This limit is $23,000 for 2024 and thereafter indexed for inflation. 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 through the end of the calendar year may be (1) recategorized from pre-tax to after-tax, or (2) reduced or refunded to you.

Your PSP contributions are subject to Social Security (FICA) taxes. 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 elect such 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 into an Individual Retirement Account (IRA) or other eligible retirement plan.

GM may not give tax advice to you and recommends you consult with a tax professional.

In the event the PSP should be disqualified, or GM makes a decision to terminate the Plan, 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. Such disqualification or termination may result in tax consequences to you.

Failure to comply with eligibility rules will result in your ineligibility to contribute to the PSP.

APPEALS

The Plan Administrator will provide an adequate determination notice, in writing, to any participant or beneficiary whose claim for benefits under the Plan has been denied, including the specific reason(s) for such denial.

The participant or beneficiary will be given 60 days from the date of the determination notice to request a full and fair review by the Personal Savings Plan Board of Administration (the "Board") by utilizing the following appeal procedure:

- With respect to a participant's Personal Savings Plan, any participant who disputes a determination from the Plan Administrator may file, with the GM Benefits & Services Center, a written claim on form SA-1, "Participant Claim to Personal Savings Plan Board of Administration." Such claim must be filed within 60 days of receipt of the determination notice from the Plan Administrator.
- In all cases where a participant files a claim on form SA-1, the Board will thoroughly review the claim and return a decision within 60 days of the participant's appeal. The written signed statement will include one copy of form SA-1, and will provide all facts and circumstances of the case, including any material pertinent to the claim. If special circumstances arise, as determined by the Board, in its sole discretion, such decision will 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 SA-1 for each appeal must be requested from the Secretary, Personal Savings Plan Board of Administration, Mail Code 482-C36-D48, 300 Renaissance Center, Detroit, MI 48265-3000.

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 10 years by logging into your PSP account via **gmbenefits.com**.

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

Qualified Domestic Relations Order (QDRO)

In an event of a divorce, you may submit a Domestic Relations Order (DRO) for review to: GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0066.

A DRO is a court order issued under a state's domestic relations law that recognizes the right of an alternate payee (who must be either a spouse, former spouse, child, or other dependent of a participant in an employee benefit plan) to receive all or part of the participant's retirement plan benefits. DROs are permitted for three reasons: to divide marital assets in a divorce or separation, to pay alimony, or to provide child support.

The GM Benefits & Services Center will review your DRO and determine if it meets the requirements under section 414(p) of the Code, corresponding regulations and the provisions of the GM Personal Savings Plan and/or GM Hourly-Rate Employees Pension Plan to be "qualified." Once the DRO is qualified, it becomes a Qualified Domestic Relations Order (QDRO). When you and your legal representative are drafting a DRO, you may consult the QDRO website at **qdro.fidelity.com**, which contains the Plan's QDRO Approval Guidelines and Procedures. The information on the QDRO website is designed to assist you in the preparation of a DRO that meets the legal requirements and the provisions of the GM Personal Savings Plan and/or GM Hourly-Rate Employees Pension Plan.

Typically, the GM Benefits & Services Center determines the qualification or non-qualification of a DRO within 15 business days for orders generated from the QDRO website, and within 30 business days for orders not generated from the QDRO website.

If a DRO is qualified, the GM Benefits & Services Center adjusts the participant's benefit by the offset of the alternate payee's benefit and sends correspondence describing the benefits payable to the participant, proposed alternate payee, and their attorneys.

If a DRO is not qualified, the GM Benefits & Services Center notifies the participant, proposed alternate payee, and their attorneys. As part of the notification, the Center includes a non-qualification letter to all the parties with reasons for the non-qualification and requests the parties to submit an amended DRO. The participant's retirement account is frozen for 18 months after the non-qualification letter is sent if no amended DRO is submitted. The freeze is lifted if no amended order is received after 18 months. If a DRO is determined to be "qualified" after the 18-month period, such QDRO shall be applied on a prospective basis only.

DISABILITY BENEFITS

GENERAL INFORMATION

GM offers you Sickness and Accident (S&A) benefits (short term) and Extended Disability Benefits (EDB) (long-term) to protect a portion of your income in the event that you are unable to work due to illness or injury. Once you are eligible, you will be automatically enrolled for coverage under the disability benefit programs.

UNDERSTANDING YOUR BENEFITS

If you are unable to work because of sickness or injury, weekly S&A benefits can provide you with income for up to 52 weeks. Certification of disability must be provided during the first seven days of disability by a physician legally licensed to practice medicine, a physician assistant, nurse practitioner, or a midwife (for birth of a child only). Certification by a psychiatrist is required under certain claim situations. Treatment must be provided by a legally licensed physician, physician assistant, nurse practitioner or psychologist.

S&A benefits may also 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 S&A benefits, you may be eligible for monthly EDB.

Eligibility

Traditional employees - S&A and EDB 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 S&A and EDB coverages otherwise would begin, these coverages begin the day you return to work. Enrollment is automatic once eligible.

In-Progression employees - If you were hired on or after October 16, 2007 as an In-Progression employee, S&A and EDB coverages are effective the day after you acquire one year of seniority. Enrollment is automatic once eligible.

Full-Time and Part-Time Temporary employees are not eligible.

HOW THE BENEFITS WORK

Application for Disability Benefits

To file a claim for disability benefits, you must call the GM Benefits & Services Center at 1-800-489-4646 and select “Disability” to be transferred to a Sedgwick Customer Service Associate; for hearing and/or speech support, call Sedgwick directly at 1-877-347-5225. You may also file a claim online. You and your attending physician must complete the claim forms and return them to the GM Benefits & Services Center as soon as possible.

Duration of Benefits

Traditional Employees

Sickness and Accident (S&A) 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.

Extended Disability Benefits (EDB)

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.

In-Progression Employees

Sickness and Accident (S&A) Benefits

S&A 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 Benefits (EDB)

EDB duration is as follows:

- 1 year seniority or more, the lesser of recovery, death, 10 years or age 65

All other disability plan provisions as described in this SPD apply.

If your employment terminates for any reason while receiving S&A benefits, you will not be eligible to receive EDB.

General Information

Sickness and Accident (S&A) Benefits

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.

Extended Disability Benefits (EDB)

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.

Commencement of Benefits

Sickness and Accident (S&A) Benefits

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 Health Care Program. 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 S&A 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 S&A benefits for 20 weeks, returned to work and then became disabled again 8 weeks later from the same or similar condition, you would be eligible for 32 additional weeks of benefits, without a new waiting period. If your second absence results from a different condition, the first absence does not affect the benefits or waiting period, if any, for the second absence.

Reductions in Benefits

Sickness and Accident (S&A) Benefits

S&A 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 S&A Benefits. You may be required to apply for SSDIB if your disability is expected to continue for 52 weeks, or longer.

Extended Disability Benefits (EDB)

EDB 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 EDB 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 EDB 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.

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 S&A or EDB. 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.

Schedule of Disability Benefits

SCHEDULE OF DISABILITY BENEFITS FOR EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Weekly Sickness and Accident Benefit (Maximum 52 Weeks)[17]	Monthly Extended Disability Benefit	
Base Hourly Rate[16]		Schedule I	Schedule II[18]
$	$	$	$
Under - 21.29	505	1,865	2,050
21.30 - 21.64	515	1,900	2,085
21.65 - 21.99	525	1,930	2,120
22.00 - 22.34	530	1,960	2,150
22.35 - 22.69	540	1,990	2,185
22.70 - 23.04	550	2,020	2,220
23.05 - 23.39	555	2,055	2,255
23.40 - 23.74	565	2,085	2,290

SCHEDULE OF DISABILITY BENEFITS FOR EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
Base Hourly Rate[16]	Weekly Sickness and Accident Benefit (Maximum 52 Weeks)[17]	Monthly Extended Disability Benefit	
		Schedule I	Schedule II[18]
$	$	$	$
23.75 - 24.09	575	2,115	2,320
24.10 - 24.44	585	2,145	2,355
24.45 - 24.79	590	2,175	2,390
24.80 - 25.14	600	2,205	2,425
25.15 - 25.49	610	2,240	2,460
25.50 - 25.84	615	2,270	2,490
25.85 - 26.19	625	2,300	2,525
26.20 - 26.54	635	2,330	2,560
26.55 - 26.89	640	2,360	2,595
26.90 - 27.24	650	2,395	2,630
27.25 - 27.59	660	2,425	2,660
27.60 - 27.94	665	2,455	2,695
27.95 - 28.29	675	2,485	2,730
28.30 - 28.64	685	2,515	2,765
28.65 - 28.99	690	2,550	2,795
29.00 - 29.34	700	2,580	2,830
29.35 - 29.69	710	2,610	2,865
29.70 - 30.04	715	2,640	2,900
30.05 - 30.39	725	2,670	2,935
30.40 - 30.74	735	2,700	2,965
30.75 - 31.09	740	2,735	3,000
31.10 - 31.44	750	2,765	3,035
31.45 - 31.79	760	2,795	3,070
31.80 - 32.14	765	2,825	3,105
32.15 - 32.49	775	2,855	3,135
32.50 - 32.84	785	2,890	3,170
32.85 - 33.19	795	2,920	3,205
33.20 - 33.54	800	2,950	3,240
33.55 - 33.89	810	2,980	3,275
33.90 - 34.24	820	3,010	3,305
34.25 - 34.59	825	3,045	3,340
34.60 - 34.94	835	3,075	3,375
34.95 - 35.29	845	3,105	3,410
35.30 - 35.64	850	3,135	3,445
35.65 - 35.99	860	3,165	3,475
36.00 - 36.34	870	3,195	3,510
36.35 - 36.69	875	3,230	3,545
36.70 - 37.04	885	3,260	3,580
37.05 - 37.39	895	3,290	3,615

SCHEDULE OF DISABILITY BENEFITS FOR EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Weekly Sickness and Accident Benefit (Maximum 52 Weeks)[17]	Monthly Extended Disability Benefit	
Base Hourly Rate[16]		Schedule I	Schedule II[18]
$	$	$	$
37.40 - 37.74	900	3,320	3,645
37.75 - 38.09	910	3,350	3,680
38.10 - 38.44	920	3,385	3,715
38.45 - 38.79	925	3,415	3,750
38.80 - 39.14	935	3,445	3,785
39.15 - 39.49	945	3,475	3,815
39.50 - 39.84	950	3,505	3,850
39.85 - 40.19	960	3,540	3,885
40.20 - 40.54	970	3,570	3,920
40.55 - 40.89	975	3,600	3,955
40.90 - 41.24	985	3,630	3,985
41.25 - 41.59	995	3,660	4,020
41.60 - 41.94	1,000	3,690	4,055
41.95 - 42.29	1,010	3,725	4,090
42.30 - 42.64	1,020	3,755	4,120
42.65 - 42.99	1,030	3,785	4,155
43.00 - 43.34	1,035	3,815	4,190
43.35 - 43.69	1,045	3,845	4,225
43.70 - 44.04	1,055	3,880	4,260
44.05 - 44.39	1,060	3,910	4,290
44.40 - 44.74	1,070	3,940	4,325
44.75 - 45.09	1,080	3,970	4,360
45.10 - 45.44	1,085	4,000	4,395
45.45 - 45.79	1,095	4,035	4,430
45.80 - 46.14	1,105	4,065	4,460
46.15 - 46.49	1,110	4,095	4,495
46.50 - 46.84	1,120	4,125	4,530
46.85 - 47.19	1,130	4,155	4,565
47.20 - 47.54	1,135	4,190	4,600
47.55 - 47.89	1,145	4,220	4,630
47.90 - 48.24	1,155	4,250	4,665
48.25 - 48.59	1,160	4,280	4,700
48.60 - 48.94	1,170	4,310	4,735
48.95 - 49.29	1,180	4,340	4,770
49.30 - 49.64	1,185	4,375	4,800
49.65 - 49.99	1,195	4,405	4,835
50.00 - 50.34	1,205	4,435	4,870
50.35 - 50.69	1,210	4,465	4,905
50.70 - 51.04	1,220	4,495	4,940

SCHEDULE OF DISABILITY BENEFITS FOR EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Weekly Sickness and Accident Benefit (Maximum 52 Weeks)[17]	Monthly Extended Disability Benefit	
Base Hourly Rate[16]		Schedule I	Schedule II[18]
$	$	$	$
51.05 - 51.39	1,230	4,530	4,970
51.40 - 51.74	1,240	4,560	5,005
51.75 - 52.09	1,245	4,590	5,040
52.10 - 52.44	1,255	4,620	5,075
52.45 - 52.79	1,265	4,650	5,110
52.80 - 53.14	1,270	4,685	5,140
53.15 - 53.49	1,280	4,715	5,140
53.50 & Over	1,290	4,745	5,210

PLAN LIMITATIONS

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

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.

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 S&A benefits during disability are explained below.

[16] *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.*

[17] *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)].*

[18] *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. Eligible In-Progression employees will receive Extended Disability Benefits based on the amount provided for in Schedule II and the years of Participation restrictions stated in such Schedule II shall be disregarded for such eligible employees.*

If any federal or state legislation is in effect or is enacted or amended to provide disability benefits similar to those described in this SPD, 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 S&A benefits may be payable under 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.

APPEALS

Appeal of a Denied Disability Claim

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.

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 GM 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, GM 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 GM, the Union if applicable, the Carrier and you. Pursuant to ERISA, you may seek court review subject to the above.

Voluntary Review of Denied Disability Claims

To afford yourself a means by which you can seek review and possible reconsideration of a denied claim for disability benefits, internal procedures of GM 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 are advised of the reasons for the denial of your disability claim, you 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 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 GM. A copy of such appeal form shall be presented to the management representative. The case should be referred to the International Union for review within 90 days after receipt of the appeal form as provided by the management representative. An extension of time will be allowed if needed.

Step 4: The International Union will notify GM within 60 days of its intent to review a case on a Step 4 appeal form provided for such purpose. An extension of time will be allowed if needed. GM will request a review by the Carrier and a peer to peer opinion review in the case of a disability appeal. GM 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 GM and the International Union are unable to resolve their differences, GM, upon written request of the International Union, will request a review within 60 days by the Carrier. Such request to the Carrier will be in writing and will incorporate the Union's position. An extension of time will be allowed if needed. 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, GM and the Carrier to discuss the claim under consideration.

Step 6: The Carrier will report to the International Union and to GM 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 S&A 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.

ADDITIONAL INFORMATION

Social Security Disability Insurance Benefits (SSDIB)

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. 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.

It is important for you to apply for 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 SSDIB. Medicare can provide additional coverage (office visits for TCN option enrollees for example).
- If you are receiving SSDIB 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 S&A or EDB, 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 SSDIB. If you fail to complete this authorization, your S&A or EDB 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.

LIFE INSURANCE

GENERAL INFORMATION

Overview

Whether you are single or married, own a home, have children or a family who rely on you for financial support, life insurance can provide income replacement upon your death. Over time, you will need to periodically review your life insurance needs and make adjustments as your life changes, including keeping your desired beneficiary designations current. You should review your life insurance needs as you face significant life events, such as a change in marital status or birth of a child.

Common Terms

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.

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.

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.

Total Control Account Program® – The MetLife Total Control Account® (TCA) is an insurance settlement option, which is a method for paying insurance or annuity benefits in full.

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.
- **For service subsequent to September 1, 1950 and prior to October 1, 1975**, Years of Participation shall be the total duration of all periods after September 1, 1950 during which you are insured for Life Insurance whether or not your service is continuous for such periods, plus any time spent on military leave, plus any period during which you received Total and Permanent Disability Benefits under the Program. After September 1, 1950 and prior to October 1, 1975, any employee who is not insured for Life Insurance under the Program for the whole of a period in excess of 24 consecutive months shall lose Years of Participation for any period prior to a subsequent resumption of coverage, except that there shall be no loss of Years of Participation while your seniority remains unbroken.

- Notwithstanding the definition of Years of Participation prior to October 1, 1975, in the case of any employee under age 65 whose years of credited service accrued prior to the end of the month in which such employee attains age 65 under the General Motors Hourly-Rate Employees Pension Plan exceed the employee's Years of Participation under the Program, such credited service shall be used in lieu of Years of Participation.
- **On and after October 1, 1975**, Years of Participation shall be the sum of: (1) the greater of your Years of Participation or credited service accrued under the General Motors Hourly-Rate Employees Pension Plan as of September 30, 1975, plus (2) your credited service accrued under such Plan on and after October 1, 1975.

UNDERSTANDING YOUR BENEFITS

Eligibility

Traditional and In-Progression employees are eligible for Basic Life Insurance on their hire date assuming they are actively at work. Eligibility for self-paid coverage varies upon election and other plan rules.

Full-Time and Part-Time Temporary employees are not eligible.

Benefits At-A-Glance

	Employer Provided Coverage	Employee Paid Coverage
Life Insurance	▪ Basic Life ▪ Extra Accident ▪ Survivor Income Benefit Insurance (SIBI)	▪ Optional Life ▪ Dependent Life ▪ Personal Accident Insurance

Basic Life Insurance

Basic Life Insurance is employer-paid coverage on your life and is payable upon your death to your designated beneficiary(ies).

Extra Accident Insurance

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.

BASIC LIFE INSURANCE AND EXTRA ACCIDENT INSURANCE FOR TRADITIONAL EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023

	Active Amount		
Base Hourly Rate[19]	Basic Life Insurance	Extra Accident Insurance[20]	Total Basic Life and Extra Accident Insurance
$	$	$	$
Under - 21.29	48,500	24,250	72,750
21.30 - 21.64	49,000	24,500	73,500
21.65 - 21.99	50,000	25,000	75,000
22.00 - 22.34	50,500	25,250	75,750
22.35 - 22.69	51,500	25,750	77,250
22.70 - 23.04	52,500	26,250	78,750
23.05 - 23.39	53,000	26,500	79,500
23.40 - 23.74	54,000	27,000	81,000
23.75 - 24.09	54,500	27,250	81,750
24.10 - 24.44	55,500	27,750	83,250
24.45 - 24.79	56,500	28,250	84,750
24.80 - 25.14	57,000	28,500	85,500
25.15 - 25.49	58,000	29,000	87,000
25.50 - 25.84	58,500	29,250	87,750

BASIC LIFE INSURANCE AND EXTRA ACCIDENT INSURANCE FOR TRADITIONAL EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Active Amount		
Base Hourly Rate[19]	Basic Life Insurance	Extra Accident Insurance[20]	Total Basic Life and Extra Accident Insurance
$	$	$	$
25.85 - 26.19	59,500	29,750	89,250
26.20 - 26.54	60,500	30,250	90,750
26.55 - 26.89	61,000	30,500	91,500
26.90 - 27.24	62,000	31,000	93,000
27.25 - 27.59	62,500	31,250	93,750
27.60 - 27.94	63,500	31,750	95,250
27.95 - 28.29	64,500	32,250	96,750
28.30 - 28.64	65,000	32,500	97,500
28.65 - 28.99	66,000	33,000	99,000
29.00 - 29.34	67,500	33,750	101,250
29.35 - 29.69	68,000	34,000	102,000
29.70 - 30.04	69,000	34,500	103,500
30.05 - 30.39	70,000	35,000	105,000
30.40 - 30.74	70,500	35,250	105,750
30.75 - 31.09	71,500	35,750	107,250
31.10 - 31.44	72,000	36,000	108,000
31.45 - 31.79	73,000	36,500	109,500
31.80 - 32.14	74,000	37,000	111,000
32.15 - 32.49	74,500	37,250	111,750
32.50 - 32.84	75,500	37,750	113,250
32.85 - 33.19	76,000	38,000	114,000
33.20 - 33.54	77,000	38,500	115,500
33.55 - 33.89	78,000	39,000	117,000
33.90 - 34.24	78,500	39,250	117,750
34.25 - 34.59	79,500	39,750	119,250
34.60 - 34.94	80,500	40,250	120,750
34.95 - 35.29	81,000	40,500	121,500
35.30 - 35.64	82,000	41,000	123,000
35.65 - 35.99	82,500	41,250	123,750
36.00 - 36.34	83,500	41,750	125,250
36.35 - 36.69	84,500	42,250	126,750
36.70 - 37.04	85,000	42,500	127,500
37.05 - 37.39	86,000	43,000	129,000
37.40 - 37.74	86,500	43,250	129,750
37.75 - 38.09	87,500	43,750	131,250
38.10 - 38.44	88,500	44,250	132,750
38.45 - 38.79	89,000	44,500	133,500
38.80 - 39.14	90,000	45,000	135,000

BASIC LIFE INSURANCE AND EXTRA ACCIDENT INSURANCE FOR TRADITIONAL EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Active Amount		
Base Hourly Rate[19]	Basic Life Insurance	Extra Accident Insurance[20]	Total Basic Life and Extra Accident Insurance
$	$	$	$
39.15 - 39.49	91,000	45,500	136,500
39.50 - 39.84	91,500	45,750	137,250
39.85 - 40.19	92,500	46,250	138,750
40.20 - 40.54	93,000	46,500	139,500
40.55 - 40.89	94,000	47,000	141,000
40.90 - 41.24	95,000	47,500	142,500
41.25 - 41.59	95,500	47,750	143,250
41.60 - 41.94	96,500	48,250	144,750
41.95 - 42.29	97,000	48,500	145,500
42.30 - 42.64	98,000	49,000	147,000
42.65 - 42.99	99,000	49,500	148,500
43.00 - 43.34	99,500	49,750	149,250
43.35 - 43.69	100,500	50,250	150,750
43.70 - 44.04	101,500	50,750	152,250
44.05 - 44.39	102,000	51,000	153,000
44.40 - 44.74	103,000	51,500	154,500
44.75 - 45.09	103,500	51,750	155,250
45.10 - 45.44	104,500	52,250	156,750
45.45 - 45.79	105,500	52,750	158,250
45.80 - 46.14	106,000	53,000	159,000
46.15 - 46.49	107,000	53,500	160,500
46.50 - 46.84	108,000	54,000	162,000
46.85 - 47.19	108,500	54,250	162,750
47.20 - 47.54	109,500	54,750	164,250
47.55 - 47.89	110,000	55,000	165,000
47.90 - 48.24	111,000	55,500	166,500
48.25 - 48.59	112,000	56,000	168,000
48.60 - 48.94	112,500	56,250	168,750
48.95 - 49.29	113,500	56,750	170,250
49.30 - 49.64	114,000	57,000	171,000
49.65 - 49.99	115,000	57,500	172,500
50.00 - 50.34	116,000	58,000	174,000
50.35 - 50.69	116,500	58,250	174,750
50.70 - 51.04	117,500	58,750	176,250
51.05 - 51.39	118,500	59,250	177,750
51.40 - 51.74	119,000	59,500	178,500
51.75 - 52.09	120,000	60,000	180,000
52.10 - 52.44	120,500	60,250	180,750

BASIC LIFE INSURANCE AND EXTRA ACCIDENT INSURANCE FOR TRADITIONAL EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Active Amount		
Base Hourly Rate[19]	Basic Life Insurance	Extra Accident Insurance[20]	Total Basic Life and Extra Accident Insurance
$	$	$	$
52.45 - 52.79	121,500	60,750	182,250
52.80 - 53.14	122,500	61,250	183,750
53.15 - 53.49	123,000	61,500	184,500
53.50 & Over	124,000	62,000	186,000

BASIC LIFE INSURANCE AND EXTRA ACCIDENT INSURANCE FOR IN-PROGRESSION EMPLOYEES AT WORK ON OR AFTER NOVEMBER 20, 2023			
	Active Amount		
Base Hourly Rate	Basic Life Insurance	Extra Accident Insurance[20]	Total Basic Life and Extra Accident Insurance
$	$	$	$
N/A	45,000	22,500	67,500

Survivor Income Benefit Insurance

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.

[19] *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.*

[20] *Three times the scheduled amount may be payable for an occupation-related death.*

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.

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.

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.

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, $400,000 and $450,000.

Eligibility

You are eligible for Optional Life Insurance on the first day of your employment with GM, 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.

Dependent Life Insurance

You may enroll for Dependent Life Insurance covering your spouse and each eligible dependent child. You can choose from one of the following schedules:

Amounts of Life Insurance	Spouse	Child
Schedule I	$5,000	$2,000
Schedule II	$10,000	$4,000
Schedule III	$15,000	$6,000
Schedule IV	$20,000	$8,000
Schedule V	$25,000	$10,000
Schedule VI	$30,000	$12,000
Schedule VII	$35,000	$14,000
Schedule VIII	$40,000	$16,000
Schedule IX	$45,000	$18,000
Schedule X	$50,000	$20,000
Schedule XI	$60,000	$24,000
Schedule XII	$75,000	$30,000
Schedule XIII	$100,000	$40,000
Schedule XIV	$125,000	$50,000
Schedule XV	$150,000	$50,000

Eligibility

You are eligible for Dependent Life Insurance on the first day of your employment with GM, 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.

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 child
    1. of yours from the moment of live birth, legal adoption, or legal guardianship. "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,
    3. who is related by blood or marriage to you and 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.
- A child as defined in (1), (2), or (3), is included until the end of the month in which the child attains age 26, or regardless of age if totally and permanently disabled, provided such child became totally and permanently disabled prior to attaining age 26. A totally and permanently disabled child who is 26 years of age or older at the time of a newly eligible employee's enrollment also is included, provided such child became totally and permanently disabled prior to attaining age 26. "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 calling the *GM Benefits & Services Center*. 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.

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.

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 GM, 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 calling the *GM Benefits & Services Center*.

HOW LIFE INSURANCE WORKS

Contributions

Optional Life Insurance

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*, who administers all of your life insurance coverages, can inform you of the current monthly contribution rate for your age group. Rates are guaranteed by the insurance company during the term of the 2023 Agreement.

Dependent Life Insurance

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*, who administers all of your life insurance coverages, can inform you of the current monthly contribution rate for your age group. Rates are guaranteed by the insurance company during the term of the 2023 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 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*, who administers all of your life insurance coverages, can inform you of the current monthly contribution rate for Personal Accident Insurance (personal or family coverage). Rates are guaranteed by the insurance company during the term of the 2023 Agreement.

Application for all Life Insurance Benefits

A beneficiary needs to make a claim on a form. A form may be obtained by calling the GM Benefits & Services Center at 1-800-489-4646 and selecting "Life Insurance" to be transferred to a MetLife Customer Service Associate; for hearing and/or speech support, call MetLife directly at 1-888-688-2860.

Beneficiaries

You may change or view your beneficiary designations at any time via gmbenefits.com > *Life Insurance*. You may also call the GM Benefits & Services Center at 1-800-489-4646 and select "Life Insurance" to be transferred to a MetLife Customer Service Associate; for hearing and/or speech support, call MetLife directly at 1-888-688-2860.

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. 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 especially critical to review your beneficiary in the event of a divorce, as a divorce decree does not change your beneficiary record.

Basic Life Insurance

You may name anyone you wish as your beneficiary or beneficiaries. Your beneficiary will receive the Basic Life Insurance benefit (less any Accelerated Benefits Option payment). Your Basic Life Insurance beneficiary will receive the Extra Accident Insurance benefit.

Optional Life Insurance

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.

Dependent Life Insurance

You are the beneficiary for Dependent Life Insurance.

Personal Accident Insurance

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 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 below.

Schedule of Losses

Loss	Amount Payable
Loss of life	The full amount
Presumption of death benefit for loss of life[21]	The full amount
Loss of both hands or both feet	The full amount
Loss of one hand and one foot	The full amount
Loss of the entire sight of both eyes	The full amount
Loss of speech and hearing	The full amount[22]
Loss of the entire sight of one eye and one hand or foot	The full amount
Loss of one hand or one foot	½ the full amount
Loss of the entire sight of one eye	½ the full amount
Loss of speech or hearing	½ the full amount[22]
Loss of thumb and index finger (of the same hand)	¼ the full amount[22]
Paralysis	
Quadriplegia	The full amount
Paraplegia	¾ the full amount
Hemiplegia	½ the full amount

[21] *"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.*

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

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, or participation in a felonious enterprise

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.

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 *Beneficiaries > Personal Accident Insurance* 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 *Beneficiaries > Personal Accident Insurance* 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.

Payment of Life Insurance Benefits

MetLife Total Control Account®

The MetLife Total Control Account® (TCA) is an insurance settlement option, which is a method of 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 provides additional information regarding their account. The beneficiary can draw on their TCA for a minimum of $250 up to the entire amount at any time.

The Total Control Account® (TCA) begins to earn interest the day the account is established. The account provides a minimum guaranteed interest rate of 0.50%. There are no monthly maintenance fees, service charges or transaction charges and there are no charges for withdrawals, drafts, or for reordering drafts. Fees may be charged for special services or for an overdrawn TCA. Accountholders have the ability to link the TCA to all popular mobile payment apps and services. Also, accountholders can set up automatic debits that are deducted directly from the account. Beneficiaries receive quarterly 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 TCA is not available to beneficiaries residing outside of the United States. Details regarding the TCA will be provided to the beneficiary when a claim is filed.

PLAN LIMITATIONS

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

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.

APPEALS

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 calling the *GM Benefits & Services Center*.

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.

Appeal of Denied Life Insurance Claim

To afford yourself a means by which you can seek review and possible reconsideration of a denied claim for life insurance, internal procedures of GM 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 GM. A copy of such appeal form shall be presented to the management representative. The case should be referred to the International Union for review within 90 days after receipt of the appeal form as provided by the management representative. An extension of time will be allowed if needed.

Step 4: The International Union will notify GM within 60 days of its intent to review a case on a Step 4 appeal form provided for such purpose. An extension of time will be allowed if needed. GM 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 GM and the International Union are unable to resolve their differences, GM upon written request of the International Union, will request a review within 60 days by the Carrier. Such request to the Carrier will be in writing and will incorporate the Union's position. An extension of time will be allowed if needed. 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, GM and the Carrier to discuss the claim under consideration.

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

Information regarding any delay in the release of a determination by the Carrier, 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 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.

ADDITIONAL INFORMATION

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, 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 by calling the *GM Benefits & Services Center*.

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 call the *GM Benefits & Services Center* immediately. 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.

Life Insurance Certificates

Certificates containing all the detailed provisions of insured benefit coverages you have under the group policies issued to GM by its insurance Carriers will be made available to you by calling the *GM Benefits & Services Center.*

Recovery of Benefit Overpayments

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.

SUPPLEMENTAL UNEMPLOYMENT BENEFIT (SUB) PLAN

GENERAL INFORMATION

Overview

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

- ***Regular SUBenefit*** for a full week of layoff from GM;
- ***Transition Support Program (TSP) Benefit*** for a full week of layoff from GM during extended periods;
- ***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.

UNDERSTANDING YOUR BENEFITS

Eligibility

Traditional employees are eligible for the Regular SUB Benefit, the Transition Support Program (TSP) Benefit, and the Short Work Week Benefit after 90 calendar days of employment and the Separation Payment Benefit after one year of seniority.

In-Progression employees are eligible for the Regular SUB Benefit, the Transition Support Program (TSP) Benefit, and the Short Work Week Benefit after 90 calendar days of employment and the Separation Payment Benefit after one year of seniority.

Full-Time Temporary employees are eligible for the Regular SUB Benefit during Temporary Layoffs and the Short Work Week Benefit after 90 calendar days of employment. **Full-Time Temporary employees** are not eligible for Regular SUB and TSP Benefits during Indefinite Layoffs nor the Separation Payment Benefit.

Part-Time Temporary employees are not eligible for any SUB Benefits.

Regular SUBenefit – For a Full Week of Layoff From GM

You may be eligible for a regular SUBenefit for a full week of layoff if you have ninety (90) calendar days of employment under the SUB Plan and are laid off due to

- reduction in force
- discontinuance of a plant or operation
- temporary layoff
- 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 or federal system benefit such as state Unemployment Compensation (UC) or Unemployment Insurance (UI), federal additional compensation 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
- sabotage (including arson) or insurrection

Generally, if you refuse a GM employment interview or job offer within your Area Hire area, your SUBenefit eligibility will be terminated until you return to work for GM. However, if such refusal is allowable under the Agreement and does not disqualify the employee and results in denial of state Unemployment Compensation (UC) benefits for one or more weeks of layoff thereafter, you may either (1) be denied SUB for such weeks, or (2) have your payment limited to the maximum amount of $200 per week.

Transition Support Program (TSP) Benefit – For a Full Week of Layoff From GM During Indefinite Layoffs

After exhausting your entitlement for Regular SUBenefit, you may become eligible for TSP benefits. In general, eligibility requirements are the same as for Regular SUBenefit.

Prior to becoming eligible for TSP benefits, you may elect to opt out of TSP benefits and receive a lump sum cash payment; in doing so, you 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 you would otherwise be eligible (i.e., 50% of your gross weekly wages, based on a 40-hour week, multiplied by 52). If you elect to opt out of the TSP, you will continue to receive health care coverage for the remainder of the months of extended coverage for which you would have been eligible, based on years of seniority at the time of layoff, had you not elected to opt out of the TSP.

Short Week Benefit – When Laid Off from GM for Part of a Week

You may be eligible for an Automatic Short Week Benefit for a week if

- you had less than 40 hours of Compensated or Available hours 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 SUBenefit 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 ninety (90) calendar days of employment 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)
- 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 2023 National Agreement on overtime or additional hours will be taken into consideration.

Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability

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
- 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.

HOW THE PLAN WORKS

Application Requirements

Regular SUBenefit and Transition Support Program (TSP) Benefits– For a Full Week of Layoff From GM

If a written application is required, you may contact a GM Benefits & Services Center benefit analyst and an application form will be provided to you. Applications are also available online via gmbenefits.com.

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.

Short Week Benefit – When Laid Off from GM for Part of a Week

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 by calling the *GM Benefits & Services Center*. The address to submit your application is: GM Benefits & Services Center, P.O. Box 5078, Southfield, MI 48086-5078.

Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability

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).

Duration of Benefits

Regular SUBenefit – For a Full Week of Layoff from GM During Indefinite Layoffs

If you are laid off with at least ninety (90) calendar days of employment as of your last day worked prior to a qualifying layoff, and are otherwise eligible, you may receive SUB based on 90 days of employment as of your last day worked. Benefit durations are applicable for periods of "indefinite layoff" as follows:

Traditional, In-Progression, and all Skilled Trades Employees:	**52 weeks**

Transition Support Program (TSP) Benefit – For a Full Week of Layoff from GM During Indefinite Layoffs

If you are on a qualifying layoff and exhaust your maximum regular SUB duration (52 weeks), you may receive TSP benefits based on 90 days of employment as of your last day worked. Benefit durations are as follows:

Traditional, In-Progression, and all Skilled Trades Employees:	**52 weeks**

Amount of Benefits

Regular SUBenefit – For a Full Week of Layoff From GM

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 or federal 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 $35.88.

40 hours' gross pay	$ 1,435.20
Total income level for week (74%)	$ 1,062.05

The total income level for the week, of $1,062.05 consists of a $362 state (MI) UC benefits and a $700.05 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.

Transition Support Program (TSP) Benefit – For a Full Week of Layoff from GM During Indefinite Layoffs

The amount of your weekly TSP benefit payment is calculated as 50% of your gross weekly wages, based on a 40 hour work week.

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

Short Week Benefit – When Laid Off from GM for Part of a Week

Automatic Short Week Benefits are payable at 80% of your straight-time pay for each tenth of an hour less than 40 Compensated or Available hours for which you (1) were not offered work, or (2) did not receive pay.

Example

An employee earning $35.88 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:

Monday	8	hours worked
Tuesday	6	hours worked (laid off for 2 hours, machine breakdown)
Wednesday	9	hours worked (1 hour additional - scheduled Monday)
Thursday	0	hours worked (laid off because of parts shortage)
Friday	0	hours worked (holiday–no work but received 8 hours holiday pay)
TOTAL	**31**	

Therefore, the employee is entitled to an automatic Short Week Benefit of 80% of 9 hours pay $258.34 ($35.88 an hour x 9 hours x 80%).

Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability

The amount of your Separation Payment is determined by multiplying your base hourly rate by the number of hours of pay, according to your years of seniority, as shown in the table below, less any SUBenefit paid to you for weeks following your last day worked.

SEPARATION PAYMENT TABLE			
Years of Seniority on Last Day on the Active Employment Roll	**Number of Hours of Pay**	**Years of Seniority on Last Day on the Active Employment Roll**	**Number of Hours of Pay**
1 but less than 2	50	16 but less than 17	770
2 but less than 3	70	17 but less than 18	840
3 but less than 4	100	18 but less than 19	920
4 but less than 5	135	19 but less than 20	1000
5 but less than 6	170	20 but less than 21	1085
6 but less than 7	210	21 but less than 22	1170
7 but less than 8	255	22 but less than 23	1260
8 but less than 9	300	23 but less than 24	1355
9 but less than 10	350	24 but less than 25	1455
10 but less than 11	400	25 but less than 26	1560
11 but less than 12	455	26 but less than 27	1665
12 but less than 13	510	27 but less than 28	1770
13 but less than 14	570	28 but less than 29	1875
14 but less than 15	630	29 but less than 30	1980
15 but less than 16	700	30 and over	2080

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.

PLAN LIMITATIONS

Separation Payment – Upon Termination of Employment Due to Layoff or Total and Permanent Disability

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.

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 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.

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

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.

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 ½ of your weekly SUBenefit or paycheck, will be deducted from your future SUBenefit or paychecks until the overpayment is recovered in full. No overpayment recovery limits apply in cases of fraud or willful misrepresentation.

APPEALS

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.

PENSION PLAN

GENERAL INFORMATION

Overview

The Pension Plan section is for employees hired (1) on or prior to October 15, 2007 and/or (2) under the terms of a Memorandum of Understanding between the union and GM. This section provides you with information as it relates to the GM Hourly-Rate Employees Pension Plan, referred to as "the Plan." Information covered in this area includes contact information, eligibility, vesting, credited service, survivor coverages, calculation of the monthly benefit and commencement of your retirement benefit. This section represents a summary of information that may be helpful and is not a replacement for the terms and conditions agreed to by the parties under the Agreement.

For all others who are not covered under the Plan, please refer to the *Personal Savings Plan* section.

Note: All retirements are voluntary under the Plan and provide post-employment, lifetime monthly benefits. In the event of death of the employee or retiree, it may provide eligible survivors with lifetime pension survivor benefits.

Common Terms

Basic Benefit – The monthly benefit payable under the Plan for the lifetime of a retired or separated employee, including a benefit reduced by a percentage because of early retirement.

Benefit Class Code – Based on the table in Appendix A of the Plan, the Benefit Class Code is determined on the basis of the maximum base hourly rate for the job classification you held for the greatest number of calendar days during the 24 consecutive months immediately preceding your last day worked.

Basic Benefit Rate – The negotiated rate tied to your Benefit Class Code on your last day of employment.

Benefit Commencement Date (BCD) – The date you commence your monthly pension benefits.

Credited Service (CS) – Credited service shall be computed for each calendar year for each employee participating in the Plan based on total hours compensated by any plant or division of General Motors LLC during such calendar year while the employee has unbroken seniority. Any calendar year in which the employee has 1700 or more compensated hours shall be counted as a full calendar year. Where the employee's compensated hours are less than 1,700 hours, a proportionate credit shall be given to the nearest 1/10 of a year.

Contingent Annuitant Option (CA) – Provides a lifetime survivor benefit to any person (spouse or non-spouse) you designate.

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 employment.

ERISA – The **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974, is a federal law that sets standards of protection for individuals provided private-sector health care, defined contribution and defined benefit plans.

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 – The normal form of payment under the Plan for married participants. If you have been married for twelve months or more on your elected BCD, this form of payment is automatic and provides an ongoing lifetime benefit to your eligible spouse in the event of your death.

Total and Permanent Disability Retirement (T&PD) – Disability form of retirement under the Plan for employees prior to age 65.

UNDERSTANDING YOUR BENEFITS

Eligibility for Participation in the Plan

Traditional and In-Progression employees – If you were hired (1) on or before October 15, 2007 and/or (2) under the terms of a Memorandum of Understanding between the union and GM, you are eligible to participate in the Pension Plan. If you were hired after October 15, 2007, please refer to the *Personal Savings Plan*.

Full-Time and Part-Time Temporary employees are not eligible for the Pension Plan; please refer to the *Personal Savings Plan*.

Eligibility for Retirement

The Pension Plan provides certain monthly pension benefits when you retire with five (5) or more years of credited service. All retirements are voluntary under the Plan and provide eligible employees or their eligible survivors with lifetime monthly benefits.

Normal Retirement – At age 65, you may elect to retire with any amount of credited service.

Early voluntary retirement – You may also elect to retire prior to age 65 as follows:

- as early as age 60 and prior to age 65 with 10 or more years of credited service, or
- as early as age 55 and prior to age 60, if your years of credited service and age total 85 or more, or
- at any age if you have 30 or more years of credited service.

Mutually satisfactory retirement – You may also elect to retire under the mutually satisfactory provisions of the Plan 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 (T&PD) retirement – You may be eligible to apply for a Total and Permanent Disability Retirement at any age prior to age 65 with 10 or more years of credited service if you become totally and permanently disabled. You must be an active employee of GM to apply. This type of retirement requires an application and GM medical approval. It provides lifetime monthly Pension benefits in accordance with the Plan. In addition, you are required to report to the GM Benefits & Services Center your eligibility for Social Security Disability Insurance (SSDIB) Benefits to avoid a pension overpayment.

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. An employee is limited to earning a maximum of one year of credited service for each calendar year, with the exception being eligible Foundry service. When service is coordinated with another pension plan resulting from a special agreement, an employee may accrue no more than one year of service between the plans in a given calendar year. No service can be earned after retirement.

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.

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 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.

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, upon making proper application. If you have prior credited service, which has not been reinstated, you should contact the *GM Benefits & Services Center*.

Credited Service Information
Credited service information may be obtained at any time by accessing your records online via **gmbenefits.com** or by calling the *GM Benefits & Services Center*. If you believe your credited service information is incorrect you may request a credited service audit. Audits are restricted to a maximum of one per year.

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 of "service," the 5 years "service" would provide you with 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 due to pregnancy, birth of a child, 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.

HOW THE PLAN WORKS

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 is based on your benefit class code and your retirement date. Your benefit class code is determined by the maximum base hourly rate for the job classification you held for the greatest number of calendar days during the 24 consecutive months immediately preceding your last day worked (per the following table).

	For Job Classification Having a Maximum Base Hourly Rate of	Benefit Class Code
On or after October 1, 2023 but prior to October 1, 2024	Less than $35.21 $35.21 but less than $35.55 $35.55 but less than $37.00 $37.00 and over	A B C D
On or after October 1, 2024 but prior to October 1, 2025	Less than $36.27 $36.27 but less than $36.62 $36.62 but less than $38.11 $38.11 and over	A B C D
On or after October 1, 2025 but prior to October 1, 2026	Less than $37.35 $37.35 but less than $37.72 $37.72 but less than $39.25 $39.25 and over	A B C D
On or after October 1, 2026 but prior to October 1, 2027	Less than $38.47 $38.47 but less than $38.85 $38.85 but less than $40.43 $40.43 and over	A B C D
On or after October 1, 2027	Less than $40.40 $40.40 but less than $40.79 $40.79 but less than $42.45 $42.45 and over	A B C D

Basic Benefit Rates – Based on your Benefit Class Code, your Basic Benefit Rate is taken from the table below.

Retirement With Benefits Payable Commencing	Benefit Class Code	10/01/23 and After
		$
October 1, 2023 and After	A	58.55
	B	58.80
	C	59.05
	D	59.30

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

Basic Benefit Rate	$59.05
Years of Credited Service	X 30
Monthly Basic Benefit	$1,771.50

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 (ERS) Prior to Age 62 and One Month	
October 1, 2023 or After	$3,465

Continuing the previous example, if the employee retired at age 55 with 30 years of service and a benefit class code of C, their pension calculation would be made up of the following basic benefit and ERS:

Monthly Unreduced Basic Benefit (total benefit after age 62 and one month)		$ 1,771.50
(times) Age Reduction Percentage		X 57.9%
(equals) Reduced Monthly Benefit		$ 1,025.69
Early Retirement Supplement Max Rate (total benefit prior to age 62 and one month)		$ 3,465.00
(minus) Reduced Monthly Benefit	-	$ 1,025.69
(equals) Early Retirement Supplement		$ 2,439.31

At 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.

Therefore, under the example above you will receive an unreduced basic benefit of $1,771.50 at age 62 and one month.

If You Retire with 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:

	Monthly Amount[23] and Effective Date of Interim Supplement Payable Prior to Age 62 and One Month for Each Year of Credited Service
Age at Retirement	October 1, 2023 or After
	$
55	24.70
56	29.20
57	35.25
58	41.30
59	46.15
60/61	53.40

At age 62 and one month, the interim supplement will cease, and you will continue to receive a monthly basic benefit. Your monthly basic benefit will continue to be reduced for age if your age and credited service at retirement total less than 85 points. However, if your age and credited service at retirement total 85 points or more then beginning at age 62 and one month, your monthly basic benefit is unreduced for age.

"Early Retirement" and "Interim" Supplements — Limitations

If you retire voluntarily and become eligible for a Social Security Disability Insurance Benefit (SSDIB), your monthly ERS and Interim Supplements will be reduced by the temporary benefit amount in effect at the time of your SSDIB award. This temporary benefit amount will be calculated in the same manner as described in the section titled *Mutually Satisfactory Retirement*.

Mutually Satisfactory Retirement (MSR) and Total & Permanent Disability (T&PD) Retirement

Mutually Satisfactory Retirement

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.

[23] *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.*

In addition to the monthly basic benefit, 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 below.

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.

	Monthly Temporary Benefit	
Retirement Date	Per Year of Credited Service	Maximum
October 1, 2023 or After	$56.20	$1,686.00

Total and Permanent Disability (T&PD) Retirement

You may be eligible, upon application and GM Medical approval, 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 be under the age of 65, and (3) must have been on a disability leave for at least five months (except in the case of an occupational injury or disease or in the case of a terminal condition).

If you are approved and voluntarily elect to retire under the T&PD provisions, this type of retirement will be reclassified as a Normal retirement upon your attainment of age 65.

Your T&PD benefit will cease, if you either (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 under a T&PD retirement is equal to your basic benefit rate multiplied by your credited service and is unreduced for age. In addition, if Social Security determines that you are not eligible for disability benefits under the Social Security Act, you may receive a monthly temporary benefit until you reach age 62 and one month.

This monthly temporary benefit will be calculated in the same way as for retirement under mutually satisfactory conditions, as described previously. The temporary benefit is payable to the earlier of (1) age 62 and one month or (2) upon your receipt of a SSDIB benefit. You are required to notify the GM Benefits & Services Center if you are awarded SSDIB as it impacts the payment of your Temporary Benefit and Early Retirement Supplement.

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. The Early Retirement Supplement (ERS) will be reduced by any temporary benefit you may be eligible to receive.

Providing Benefits for Surviving Spouse in the Event of Your Death After Retirement

Surviving Spouse Coverage
Under ERISA, if you are married when you retire (and have passed the one-year anniversary of your marriage), you are required to provide a pension survivor benefit to your spouse, unless your spouse waives the benefit by providing a signed notarized form acceptable to the Plan administrator. Under the GM Pension Plan, the 65% Surviving Spouse Annuity is the normal form for a married retiree. It is a monthly benefit payable to you which is reduced for the cost of providing an ongoing monthly benefit to your spouse if your spouse is still living when you die. In addition, an employee separated with deferred vested benefits has automatic surviving spouse protection at commencement of vested benefits. If this coverage is waived, it will not be available in the future, and, if you predecease your spouse, your spouse will not receive any surviving spouse benefits.

You may also elect the Surviving Spouse Coverage if you are married less than one year at your retirement. If you make this election, the Surviving Spouse Coverage will become effective on the one-year anniversary date of your marriage. Survivor benefits will not 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.

If you elect the Surviving Spouse Coverage (including automatically electing the option), your monthly benefit will be reduced for the cost of the coverage. The cost is based upon the difference between your age and that of your spouse, as follows:

- The cost of the coverage is 5%, if yours and your spouse's dates of birth are within five years of each other.
- The cost increases by one-half (½) percent for each 12 months in excess of five years that your age exceeds your spouse's age.
- The cost decreases by one-half (½) percent for each 12 months in excess of five years that your spouse's age exceeds your age. The minimum cost is zero.
- The cost is calculated against the basic benefit you are otherwise eligible to receive at redetermination (age 62 and one month).

Contingent Annuitant Option
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. The Contingent Annuitant Option provides a survivor benefit to any person (spouse or non-spouse) that you designate and is available in lieu of the surviving spouse coverage (if applicable). If you are married at the time of your retirement, written notarized consent of your spouse, on a form acceptable to the Plan administration, must be obtained.

50% Joint and Survivor Coverage
If you retire due to total and permanent disability before age 55 with less than 30 years of credited service, your spouse will be covered under the 50% Joint and Survivor coverage. It is automatic unless rejected and payable to the spouse when the deceased employee would have turned age 55. Coverage cost is calculated actuarially.

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 rejected and you predecease your spouse prior to obtaining age 55, your spouse will not receive any surviving spouse benefits.

If living, upon obtaining the age of 55, the survivor coverage as described above is automatic unless rejected.

Marriage/Remarriage
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 the surviving spouse coverage with respect to your new spouse. To elect the coverage, you must contact the *GM Benefits & Services Center* prior to the date you have been married 18 months. Provided eligibility is met, the applicable reduction in your monthly basic benefit will commence effective with the one-year anniversary of your marriage or remarriage. In all cases, the Surviving Spouse Coverage will provide benefits under the terms and conditions of the Plan which are in effect at the time that you retire.

In no event shall such coverage be effective if you previously rejected survivor coverage. If you terminate employment with a deferred vested benefit (not retirement eligible), you are not eligible to elect surviving spouse coverage for a marriage that occurred after you had commenced your pension benefit.

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 Coverages 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 GM 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 GM Hourly-Rate Employees Pension Plan.

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, any supplement and temporary benefit is reduced, or eliminated, when you become eligible for Social Security Disability Benefits. You are responsible for contacting the Social Security Administration to learn more regarding applying for Social Security benefits.

MAKING APPLICATION

You may apply for pension benefits by contacting the *GM Benefits & Services Center*. You should contact the GM Benefits & Services Center at least 30 days but no more than 180 days prior to your benefit commencement date.

PLAN LIMITATIONS

Disqualification, Ineligibility, Denial, Loss, Forfeiture, Suspension, Offset, Reduction or Recovery of Benefits

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 Supplement 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 GM.
- 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 on or 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.

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.

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.

If you are eligible for only deferred vested pension benefits, you are not eligible to elect surviving spouse coverage for a marriage that occurs after you have commenced your pension benefit.

Upon separation from the Company, it is important to ensure that the GM Benefits & Services Center is promptly informed of any changes to your address of record. This is necessary to receive Plan notices regarding your vested pension benefit.

APPEALS

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.
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' 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 of Administration.
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.
8. 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.

Please send all materials and requests in writing to, either the Secretary, Pension Board of Administration or to the Plan Administrator at: General Motors LLC Global Headquarters, Mail Code 482-C36-D48, 300 Renaissance Center, Detroit, MI 48265-3000.

Appeal of Initial/Voluntary Determination of Total and Permanent Disability (T&PD) Retirement

Initial T&PD Appeal

If the employee is denied a T&PD retirement during any stage of the application or appeal process, including during the Impartial Medical Examination, due to medical disqualification as defined in Article II, Section 3(b) of the Plan, the employee will be notified of the denial. The denial notice will:

(a) provide the specific reason(s) for the denial,

(b) make specific reference to the pertinent Plan provision(s) upon which the denial is based,

(c) describe any additional material or information necessary and why such material or information is needed,

(d) describe the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the employees right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal,

(e) include a statement that the employee is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits,

(f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, (A) either describe the specific rule, guideline, protocol, or other similar criterion or include a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request, or (B) include a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist,

(g) if the adverse determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the employees medical circumstances or a statement that such explanation will be provided free of charge upon request, and

(h) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) the views presented by the employee to the Plan of health care professionals who treated the employee and vocational professionals who evaluated the employee;

(ii) the identity and views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) a disability determination made on the employee's behalf by the Social Security Administration, presented by the employee to the Plan.

The notification provided under the foregoing paragraph will be provided in a culturally and linguistically appropriate manner, as stated under Department of Labor regulation 29 CFR Section 2560.503-1(o).

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, provided they were neither the individual who made the initial claim denial that is subject to the appeal, nor the subordinate of such individual. 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 will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit denial whether or not such advice was relied upon in making the benefit determination.

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.

Voluntary Appeal Process (Must go through the Initial Appeal first)

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) or identify an impartial medical specialist 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.

Mileage reimbursement
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 LLC employing unit is more than 30 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, for miles actually driven from the employee's residence to such clinic and back, using the most direct route available. Such rate will be based on the Internal Revenue Service (IRS) mileage rate.

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.

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.

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.

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.

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 an employee 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.

If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, it will provide the employee with such new or additional evidence, without request, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow the employee time to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the Plan Administrator must provide the employee with a copy of the rationale at no cost. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the employee time to respond.

ADDITIONAL INFORMATION

Qualified Domestic Relations Order (QDRO)

Qualified Domestic Relations Order (QDRO), as defined in section 414(p) of the Code, shall mean any judgment, decree, or order (including approval of a property settlement agreement) which: (i) relates to the provisions of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant's; and (ii) is made pursuant to a state domestic relations law (including a community property law).

In an event of a divorce, you may submit a Domestic Relations Order (DRO) for review to: GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0066. The GM Benefits & Services Center will review your DRO and determine if it meets the requirements to be Qualified.

When you and your legal representative are drafting a DRO, you may consult the QDRO website (**qdro.fidelity.com/**), which contains the Plan's QDRO Approval Guidelines and Procedures, a glossary of terms, frequently asked questions and QDRO examples.

The submission of DROs for qualification to the Plan during the retirement process might result in a delay in receiving pension payments during the segregation and review period. Payments to a plan participant and/or alternate payee could be postponed for up to 18 months (after the Plan receives the order), pending the determination of the segregation of benefits.

Pension Survivor Benefits

Death Prior to Retirement – If Eligible to Retire

The surviving spouse of an employee who dies before retirement may be eligible for a lifetime monthly benefit 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 prior to death would have been either immediately eligible to retire voluntarily (reference below) or approved to retire under the total and permanent disability retirement provisions under the Pension Plan.

To retire under the Hourly Pension Plan's voluntary provisions, the deceased employee must have met one of the following retirement criteria prior to their death:

- Age 65 or older, or
- Age 60 or older with 10 or more years of credited service, or
- Age 55 or older with years of age and credited service totaling 85 or more, or
- Any age 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.

Retirement Equity Act (REA) of 1984-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 survivor 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.

The amount payable to an eligible surviving spouse is equal to 50% of the deferred vested benefit amount. The pre-retirement survivor benefit can be commenced, unreduced for age, when the deceased employee would have attained age 65 or reduced for age, any month after the deceased employee would have attained age 55.

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 (QDRO) 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. You must contact the *GM Benefits & Services Center* if you wish to revoke the survivor coverage.

If you have a *Qualified Domestic Relations Order*, you should send it to: GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0066

If You Marry After Retirement

If you marry or remarry after retirement and you had not previously rejected the surviving spouse coverage when it was available to you, you may elect the surviving spouse coverage with respect to your new spouse. To elect the coverage, you must contact the GM Benefit Services Center prior to the date you have been married 18 months. Provided eligibility is met, the applicable reduction in your monthly basic benefit will commence effective with the one-year anniversary of your marriage or remarriage. In no event shall such coverage be effective if you previously rejected survivor coverage.

Note: Adding your spouse to your UAW retiree health care coverage through the URMBT will not provide them with surviving spouse coverage under your pension plan benefit.

Note: If there is a former spouse who has a pension benefit entitlement from your pension, there may be restrictions to adding a new spouse or limiting the new spouse's entitlement. It is advisable to review the terms of the qualified domestic order with your legal advisor.

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

QUESTIONS	ANSWERS
PRE-RETIREMENT	
Is the pre-retirement survivor benefit the same as the regular surviving spouse benefit?	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.
How do I elect the pre-retirement survivor coverage?	The pre-retirement survivor coverage is automatic. You do not need to elect it.
How long is the pre-retirement survivor coverage in effect?	The pre-retirement survivor coverage is in effect until you become eligible for the regular survivor coverage. The regular survivor coverage is available, unreduced for age when you would have attained age 65 or is available, reduced for age, after the date you would have attained age 55, the earliest age at which you would be eligible to retire voluntarily.
POST-EMPLOYMENT	
When does 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.
What information must I supply to GM?	Proof of your marriage, proof of your spouse's age and your spouse's Social Security number.
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?	5% of your age 62 basic pension benefit.
What would be the reduction if my spouse is more or less than five years younger than I am?	The 5% reduction would increase or decrease by ½% for each 12 months of age difference in excess of five years.
What monthly benefit would be payable to my surviving spouse after my death?	The regular survivor benefit is 65% of your reduced age 62 basic benefit.
Can I revoke the regular survivor coverage after I retire if (1) my spouse dies, or (2) we are divorced?	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.
If I remarry after I retire, may I elect the regular survivor coverage for my new spouse?	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.

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 surviving spouse 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 instead a Contingent Annuitant Option. The Contingent Annuitant Option provides a survivor benefit to any person (spouse or non-spouse) that you designate and is available in lieu of the surviving spouse coverage (if applicable). If you are married at the time of your retirement, written notarized consent of your spouse on a form acceptable to the Plan administration must be obtained.

If you retire under normal or early retirement provisions, 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, only a 75% Contingent 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 effective, the Contingent Annuitant Option can only be rescinded in the case where you were unmarried at the time of retirement and subsequently marry. You may rescind your designated contingent annuitant in order to elect surviving spouse coverage for your new spouse upon submission of evidence, satisfactory to the Company, of the good health of your contingent annuitant and yourself. Designation of a contingent annuitant under the Pension Plan does not create eligibility for any other benefit Plan or Program.

3.GM-H-425C.109