

*For Pre-Age 65 Retirees, Certain Inactive Employees
and Dependents Eligible for Coverage*

Your Benefits Handbook

GE Health Care Benefits

Effective January 1, 2012

This Handbook is valid only if you receive it directly from US Employee Services
with a cover letter indicating that it applies to you.



IMPORTANT INFORMATION ABOUT THIS HANDBOOK

This handbook provides a summary of certain GE benefits. It is intended for plan participants who are no longer on the active payroll of the Company. While every attempt has been made to make this handbook as accurate as possible, full details of all provisions are not included. Full details of each program or plan are contained in the official plan documents, which are available to you as described in Section 8.0, "Administrative Information." If a provision described in this handbook differs from the provisions of the applicable plan document, the plan document prevails. Similarly, any oral or written representations by a Company employee or agent, or any benefit estimates that you may receive, cannot override, reverse or supplement the provisions of the plan documents.

You should understand the meaning of certain important terms, such as "employee," which are used throughout this handbook and which appear in the "Key Terms" section.

This handbook does not create a contract of employment between the Company and any individual.

For participants whose benefits arose under a collective bargaining agreement, participation in plans incorporated by reference into such agreement is only to the extent provided through the incorporation. For certain benefits whose specific terms and conditions are derived from a collective bargaining agreement, the terms and conditions of such collective bargaining agreement will govern should a conflict arise between this handbook or any programs or plans and the terms and conditions of such agreement.

The Board of Directors of General Electric Company reserves the right to terminate, amend, eliminate or replace any program, plan or benefit at its discretion and at any time to the extent permitted by law.

Your participation in any program or plan described in this handbook means that you have authorized your benefits-related data to be processed and transmitted by the Company, its affiliates and any authorized suppliers anywhere in the world, in accordance with the GE Employment Data Protection Standards.

ABOUT THIS HANDBOOK

Your Benefits Handbook is designed to help you understand how to make the most of the GE benefits for which you are eligible.



Health Care Benefits

- 1.0 WHO IS ELIGIBLE FOR GE BENEFITS?9**
 - 1.1 How can I tell if I am eligible?9
 - 1.2 Who is not eligible for benefits?9
 - 1.3 Who qualifies as an eligible dependent?9
 - 1.4 Who qualifies as a child?11
- 2.0 MEDICAL CARE OPTIONS11**
 - 2.1 Medical Care Options12
 - 2.1.1 Key Things to Know13
 - 2.1.2 Key Things to Do14
 - 2.1.3 Medical Participation14
 - 2.1.3.1 What are my GE Medical Care Options?14
 - 2.1.3.2 Who is eligible?17
 - 2.1.3.3 How do I enroll when I first become eligible?18
 - 2.1.3.4 When can I make changes to my coverage?19
 - 2.1.3.5 How much does coverage cost?20
 - 2.1.3.6 What if my spouse or same-sex domestic partner's employer offers coverage? ..21
 - 2.1.3.7 What if there is other coverage?21
 - 2.1.3.8 What if I receive a qualified medical child support order (QMCSO)?23
 - 2.1.3.9 When does coverage end?24
 - 2.1.3.10 What other provisions may apply?25
 - 2.2 GE Health Care Preferred27
 - 2.2.1 Key Things to Know27
 - 2.2.2 Key Things to Do28
 - 2.2.3 How GE Health Care Preferred Works29
 - 2.2.3.1 How do I access network care?29
 - 2.2.3.2 What do I do in an emergency?30
 - 2.2.3.3 What if I need care while away from home?31
 - 2.2.3.4 What if I go out-of-network?31

2.2.4	What GE Health Care Preferred Covers	35
2.2.4.1	Preventive screenings	35
2.2.4.2	Doctors and other providers	37
2.2.4.3	Surgery, tests and other services	39
2.2.4.4	Hospitals, special facilities and programs	45
2.2.4.5	Behavioral health and substance abuse treatment	49
2.2.4.6	Accident-related dental services	51
2.2.4.7	Special coverage for clinical trials	51
2.3	GE Medical Benefits	52
2.3.1	Key Things to Know	53
2.3.2	Key Things to Do	54
2.3.3	How GE Medical Benefits Works	55
2.3.3.1	How can I save by using preferred providers?	56
2.3.3.2	When must I call the benefits administrator?	56
2.3.3.3	What's my deductible?	57
2.3.3.4	What's my out-of-pocket maximum?	58
2.3.3.5	How does reasonable, necessary and customary work?	59
2.3.3.6	How do I claim benefits?	59
2.3.4	What GE Medical Benefits Covers	60
2.3.4.1	Preventive health screenings	61
2.3.4.2	Doctors, medical services and supplies	63
2.3.4.3	Surgery, tests and other services	66
2.3.4.4	Hospitals, special facilities and programs	67
2.3.4.5	Behavioral health and substance abuse treatment	71
2.3.4.6	Accident-related dental services	73
2.3.4.7	Special coverage for clinical trials	73
2.4	What's Not Covered?	74
2.5	Alternative Health Plans	75
2.6	When Your GE Health Coverage Ends	76
2.6.1	Key Things to Know	76
2.6.2	Key Things to Do	77
2.6.3	How COBRA Health Coverage Works	78
2.6.3.1	What does COBRA health coverage provide?	78
2.6.3.2	How much does COBRA cost?	78
2.6.3.3	Are there other types of funding for COBRA health coverage?	79
2.6.3.4	How do I elect COBRA?	79
2.6.3.5	How long does COBRA health coverage continue?	80
2.6.3.6	What happens if I die?	81
2.6.3.7	When does COBRA health coverage end?	81

2.7	Subrogation	82
3.0	PRESCRIPTION DRUG BENEFITS	83
3.1	Key Things to Know	84
3.2	Key Things to Do	84
3.3	Prescription Drug Participation	85
3.3.1	Who is eligible?	85
3.3.2	What if there is other coverage?	85
3.4	Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits	85
3.5	When Your GE Prescription Drug Coverage Ends	90
4.0	DENTAL CARE OPTIONS	91
4.1	Key Things to Know	91
4.2	Key Things to Do	93
4.3	Dental Participation	94
4.3.1	What are my GE Dental Care Options?	94
4.3.2	Who is eligible?	95
4.3.3	How do I enroll when I first become eligible?	96
4.3.4	When can I make changes to my coverage?	98
4.3.5	How much does coverage cost?	99
4.3.6	What if there is other coverage?	100
4.3.7	What if I receive a qualified medical child support order (QMCSO)?	101
4.3.8	When does coverage end?	102
4.4	GE Dental Care Options Basics	103
4.4.1	How can I save by using network dentists?	104
4.4.2	How does reasonable, necessary and customary work?	104
4.4.3	How does predetermination of benefits work?	105
4.4.4	What if an alternative treatment is appropriate?	106
4.4.5	How do I claim benefits?	106
4.4.6	What if I change dental options?	107
4.5	GE Dental Schedule Option	108
4.5.1	How does the GE Dental Schedule Option work?	108
4.5.2	What does the GE Dental Schedule Option cover?	108
4.5.3	How does the schedule of benefits work?	111
4.5.4	Which schedule applies?	112
4.5.5	Schedule of benefits	115
4.6	GE Dental Premium Option	119
4.6.1	How does the GE Dental Premium Option work?	119
4.6.2	What does the GE Dental Premium Option cover?	119

4.7	What's Not Covered?	122
4.8	Subrogation	123

5.0 VISION CARE BENEFITS124

5.1	Key Things to Know	124
5.2	Key Things to Do	125
5.3	Vision Participation	125
5.3.1	Who is eligible?	125
5.3.2	What if there is other coverage?	126
5.4	How the Plan Works	126
5.4.1	What does the plan cover?	126
5.4.2	About network providers	130
5.4.3	What if I go out-of-network?	130
5.4.4	How can I save on contact lenses?	131
5.4.5	What's not covered?	131
5.5	GE Vision Value Option	132
5.5.1	How much can I save?	133
5.6	When Your GE Vision Care Coverage Ends	134

6.0 CONTINUING COVERAGE IN SPECIAL CASES134

6.1	After You Retire	134
6.1.1	Who is eligible?	135
6.1.2	Your GE Medical Care Options before age 65	136
6.1.3	GE Dental Care Options	138
6.1.4	GE Vision Care	139
6.1.5	Your GE Pensioner Health Plans at age 65	139
6.2	In Case of Disability	141
6.2.1	GE medical, dental and vision coverage	141
6.2.2	GE Health Care Flexible Spending Account (FSA)	142
6.3	In Case of Your Death	142
6.3.1	GE medical, dental and vision coverage	142
6.3.2	Medical and vision coverage beyond one year	142
6.4	In Case of Layoff or Work Transfer	145
6.4.1	GE Medical Care Options (including GE Vision Care)	145
6.4.2	GE Dental Care Options	146
6.4.3	Medical, dental and vision coverage under COBRA	146
6.4.4	Protection for long-service employees	146
6.5	In Case of Plant Closing	146
6.5.1	GE Medical Care Options (including GE Vision Care)	147
6.5.2	GE Dental Care Options	147

6.5.3	Medical, dental and vision coverage under COBRA	147
6.5.4	Expanded eligibility for continuing health coverage	147
7.0	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	148
7.1	Key Things to Know	148
7.2	Key Things to Do	149
7.3	GE Health Care FSA Participation	149
7.3.1	Who is eligible?	149
7.3.2	How do I enroll?	150
7.3.3	When can I change my participation?	150
7.3.4	When does participation end?	151
7.4	How the Account Works	153
7.4.1	How much can I contribute to my account?	153
7.4.2	How can an FSA help me save?	154
7.4.3	How do I file for reimbursement?	154
7.4.4	What if there is money left in my account?	155
7.4.5	How will an FSA affect my taxes?	156
7.4.6	Can participation in an FSA affect my other benefits?	156
7.4.7	What expenses are eligible?	156
7.4.8	What's not eligible?	158
8.0	ADMINISTRATIVE INFORMATION	159
8.1	Plan Basics	159
8.1.1	What's GE's employer identification number?	159
8.1.2	Who is the plan administrator?	159
8.1.3	How can I access official plan documents?	159
8.1.4	What are the claims and appeals procedures?	160
8.1.5	Can the plans be changed, replaced or terminated?	166
8.1.6	How do I pay for coverage when not on the payroll?	166
8.1.7	How are the plans funded?	167
8.1.8	What are my rights under ERISA?	167
8.1.9	What are my rights under the HIPAA privacy regulations?	169
8.1.10	Which GE affiliates are participating companies?	174
8.2	Additional Plan Information as of January 1, 2012	174
8.3	GE Health Care Preferred Benefits Administrators	176
KEY TERMS	177
INDEX	181



1.0 WHO IS ELIGIBLE FOR GE BENEFITS?

GE provides health care benefit plans for eligible Company employees, retirees, and their families. This Section describes the requirements that determine your eligibility and affect your participation in these benefits.

1.1 HOW CAN I TELL IF I AM ELIGIBLE?

Each Section of this handbook that describes a GE health care benefit includes information on who is eligible to participate in that benefit — typically under the heading "Who is eligible?" See those Sections to determine whether or not you are eligible. The benefit descriptions will also discuss any special provisions (such as different contributions) that may apply to certain eligible groups.

You must be a Company employee (or eligible retiree) to become eligible for any GE benefits. A Company employee is an individual on the active payroll (as defined in "Key Terms") of:

- General Electric Company; or
- An affiliate that participates in the applicable plan or program. See Section 6.1.9, "Which GE affiliates are participating companies?"

This Section of the handbook provides information on many key requirements that affect your eligibility, such as your service — how long you've worked for the Company. It also includes information that is common to more than one GE benefit, such as information on dependent eligibility and who is not eligible for GE benefits.

1.2 WHO IS NOT ELIGIBLE FOR BENEFITS?

In all cases, you are not eligible for the benefits described in this handbook if you are:

- Covered by a collective bargaining agreement that does not provide for participation in the applicable plan or program;
- Employed by an affiliate that does not participate in the applicable plan or program. See Section 8.1.10, "Which GE affiliates are participating companies?";
- An individual classified by the Company as a leased employee, contingent worker or as an independent contractor;
- An individual engaged under an agreement that states that you are not eligible to participate in the applicable plan or program;
- Any other individual who provides services to the Company but is not on the active payroll of the Company; or
- In any other special classification of employees that is not eligible, as determined by the Company.

In the event you are denied eligibility because you are not treated as an employee, your reclassification as an employee will not entitle you to participate in the applicable plan or program.

1.3 WHO QUALIFIES AS AN ELIGIBLE DEPENDENT?

If you are eligible, certain members of your family also may be eligible for coverage as your dependents under the following GE benefits:

- GE Medical Care Options (including GE Vision Care); and
- GE Dental Care Options.

Information on dependent eligibility is included in the description of each benefit plan or program. For the GE benefits listed above, your eligible dependents include:

- Your spouse;
- Your same-sex domestic partner (see "Key Terms" for definition). In order for your same-sex domestic partner to be eligible, you will need to provide a signed affidavit affirming the following criteria:
 - The employee and same-sex domestic partner may not be related by blood to a degree of kinship that would prevent marriage under the applicable law of the state of residence;
 - The relationship must be exclusive and the parties must have lived together in the same household for a minimum of 12 consecutive months prior to enrollment and continue to live together for the duration of coverage;

- Both parties must be 18 years of age or older; and
- Both parties must be jointly responsible for each other's welfare and financial obligations, or the same-sex domestic partner is chiefly dependent on the employee for care and financial support.

A signed affidavit is not required in states that permit a form of legal union, but proof of such legal union must be provided. In the event that the employee's state of residence enacts legislation recognizing civil unions or another legal union after the employee has submitted an affidavit for coverage, the employee and same-sex domestic partner must enter into a civil union agreement or other legal union within one year of its availability in order to retain coverage. Note that a same-sex domestic partner may not be added to your coverage if you are retired.

If your same-sex domestic partnership ends or subsequently fails to meet any of the criteria listed above, you must provide an affidavit of termination **within 63 days**. Coverage for the same-sex domestic partner and any covered children of the same-sex domestic partner will end as of the date the relationship ends or no longer meets all of the criteria above.

DEPENDENT CHILDREN

For the purposes of GE medical care benefits, a child (up to age 26) includes:

- Your children by birth;
- Your adopted children (or children placed for adoption);
- Your stepchildren;
- Your foster children;
- The children of a same-sex domestic partner; or
- Any other children that depend solely on you for support and for whom you or your spouse is the court-appointed permanent guardian.

In the case of a child who, prior to his or her 26th birthday, is incapable of self-sustaining employment due to mental or physical disability, coverage will continue up to the earlier of the date of recovery or age 65. In order to qualify for this continued coverage, the child must be covered by the plan as of his or her 26th birthday, and application for continued coverage must be made within 31 days of coverage otherwise ending. No retroactive disability determinations will be accepted.

For GE Dental Care Option

- Your unmarried children (as defined in Section 1.5, "Who qualifies as a child?"):
 - Up to age 19;
 - Up to age 21 who are not working full-time and who principally depend on you for financial support; and
 - Up to age 25 who are full-time students and who principally depend on you for financial support.

In the case of a child who, prior to his or her 25th birthday, is incapable of self-sustaining employment due to mental or physical disability, GE dental and life insurance coverage will continue up to the earlier of the date of recovery or age 65. In order to qualify for this continued coverage, the child must be covered by the plan as of his or her 25th birthday, and application for continued coverage must be made within 31 days of coverage otherwise ending. No retroactive disability determinations will be accepted.

Once a dependent child's coverage stops after age 25, it cannot begin again. However, your child may be eligible to continue health care coverage at his or her own expense through COBRA. For the child to be eligible for this COBRA coverage, the parent must have been working for the Company and covering that dependent child before he or she turns 25 (age 26 for medical coverage). See Section 2.1.6, "What are my rights when my health coverage ends?" for more information.

You will be asked periodically for information about a child's continuing eligibility (employment, education or disability status). To qualify for coverage under the GE welfare benefits listed above, your dependents must:

- Be permanent residents of the United States or Canada;
- Not be in the armed services of any country. However, any of these eligible dependents who are serving in the armed forces of the United States may be eligible for coverage under GE Dependent Life Insurance and GE Personal Accident Insurance; and

- Not be covered under any other GE group medical plan.

A dependent may not be covered by two employees and/or retirees.

Please Note — Dependent coverage is not available for:

- Dependents covered under any of the plans as an eligible Company retiree; or
- Same-sex domestic partners acquired subsequent to your retirement.

FOR OTHER BENEFITS

Different eligibility rules apply for some GE benefits other than the health care and insurance plans listed previously. Internal Revenue Service (IRS) rules determine who is an eligible dependent under the GE Health Care Flexible Spending Account. The definition of eligible dependents for the flexible spending account is included in Section 7.0, "Health Care Flexible Spending Account (FSA)."

1.4 WHO QUALIFIES AS A CHILD?

For GE dependent eligibility purposes, your children are:

- Your children by birth;
- Your adopted children as of the earliest of the following dates:
 - When the adoption is final;
 - When the child is placed in your home; or
 - When you begin to provide financial support for the child;
- Your stepchildren who live with you;
- Children of your same-sex domestic partner who live with you (you must submit an affidavit for same-sex domestic partnership benefits — see Section 1.3 — in order to cover children of a same-sex domestic partner, even if you do not elect medical care and/or dental care coverage for your same-sex domestic partner) and;
- Other children who live with you permanently, depend solely on you for support and for whom you or your spouse is the court-appointed permanent guardian.

2.0 MEDICAL CARE OPTIONS

The Company provides you with a range of medical, dental and vision coverage options. It's up to you to choose the coverage that makes the best sense for you and your family.

In addition, if you are actively employed, you have the opportunity to use a GE Health Care Flexible Spending Account (FSA) to pay your share of out-of-pocket medical, dental and vision expenses with pre-tax dollars.

FAST ANSWERS

You also can use these handbook features to help you find answers quickly and easily:

- Index; and
- "Key Terms"

YOUR ROLE IN YOUR HEALTH CARE

It's up to you to:

- Understand your coverage;
- Take advantage of the health screenings and preventive care services your plan covers; and
- Use the tools and information the Company provides to help identify and control any risk factors or problems.

YOUR GE MEDICAL CARE OPTIONS

GE Medical Care Options

Your GE Medical Care Options offer broad coverage, within certain limits. In general, you can choose from two health plans: GE Health Care Preferred and GE Medical Benefits. These plans represent different types of health care coverage:

- **GE Health Care Preferred:** Like all managed care plans, this plan provides access to care through a network of providers in your area. Costs are lower and coverage is greater if you stay within the network. You may also receive care out-of-network, but at a higher cost. When you use network providers, there are no claim forms or deductibles; and
- **GE Medical Benefits:** This is a traditional indemnity-type health plan. You are free to see any doctor or provider, and you file claim forms for reimbursement of covered expenses. The plan pays benefits based on a percentage of charges for covered services; some services are subject to an annual deductible or co-pay.

In some regions, you may have alternative health plan options, such as a Health Maintenance Organization (HMO). More information about your specific options is available at benefits.ge.com or by calling the GE Benefits Center at 1-800-252-5259.

GE DENTAL CARE OPTIONS

Both GE Dental Care Options — the GE Dental Schedule Option and the GE Dental Premium Option — are designed to encourage good preventive care and help you pay for a broad range of dental care services and supplies. In many areas, you can also reduce your out-of-pocket costs by using dentists and other providers who participate in the plans' network. For details, see Section 4.0, "Dental Care Options."

GE VISION CARE

GE Vision Care helps you pay for covered eye exams, lenses and eyeglass frames. You can save on the cost of vision care by using providers who participate in the plan's network (available in most areas) and by ordering contact lenses by mail. And, through a program called the GE Vision Value Option, you can save on the cost of additional vision care if you've already used your GE Vision Care benefits. For details, see Section 5.0, "Vision Care Benefits."

GE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

If you're actively employed, a GE Health Care Flexible Spending Account (FSA) helps you save by letting you set aside money from your paycheck on a pre-tax basis to pay for your share of eligible medical, dental and vision care expenses. This reduces your taxable income, which means that you'll have more money available to cover these out-of-pocket expenses. If you are not actively employed, you may continue your FSA coverage through COBRA on an after-tax basis. For details, see Section 7.0, "Health Care Flexible Spending Accounts (FSA)."

2.1 MEDICAL CARE OPTIONS

Your medical care options provide a package of coverage for medical, prescription drug, behavioral health and substance abuse treatment, and vision care benefits. Offering a choice of medical care options allows you to select the coverage that's right for you and your family.

WHAT'S COVERED

For a description of services and supplies covered by your GE Medical Care Option:

- See Section 2.2.4, "What GE Health Care Preferred Covers," or
- See Section 2.3.4, "What GE Medical Benefits Covers."

If you're enrolled in GE Health Care Select or a Health Maintenance Organization (HMO), see Section 2.5, "Alternative Health Plans."

2.1.1 KEY THINGS TO KNOW

GE Medical Care Options are designed to help you stay healthy through good preventive care, and to protect you from the high costs of illness and injury.

If you're an eligible full-time employee, the Company pays the major share of the cost of medical coverage for you and your eligible dependents; eligible part-time employees pay different rates.

You choose the option that best meets your needs and the needs of your family:

- GE Health Care Preferred — available in most locations;
- GE Medical Benefits — available in all locations; or
- An alternative health plan option, such as a health maintenance organization — available in certain locations.

You have the opportunity to change your medical option once each year during Annual Enrollment, if you experience a qualifying event (such as birth or marriage) or if you should relocate into or out of a network service area.

If there is other coverage, benefits are coordinated to prevent duplication of payments — a feature called maintenance of benefits.

If another plan provides your primary coverage, the Company pays any difference between what you receive from your primary plan and what you would have received if your Company plan was your only coverage. You will never pay more than if the Company plan had been your only coverage. **If your spouse or same-sex domestic partner is also a Company employee, you may choose to:**

-
- Enroll only one of you as a Company employee. The spouse or same-sex domestic partner with the lower salary must be covered as a dependent of the higher-paid employee; or
 - Enroll both yourself and your spouse or same-sex domestic partner as Company employees.

If your spouse's or same-sex domestic partner's employer (other than the Company) offers medical coverage, your spouse or same-sex domestic partner can choose to:

- Be covered by his or her employer and receive no Company coverage;
- Be covered by his or her employer and also be covered by the Company as your dependent; or
- Waive his or her employer's coverage and instead be covered by the Company as your dependent. In this case, you'll pay an additional contribution for your dependent coverage.

HEALTH COACH FROM GE

A family of resources for your health and wellness. Health Coach helps GE employees and families choose high quality doctors and hospitals, prepare for office visits, and gain a better understanding of their diagnoses and treatment options. Health Coach also offers lifestyle coaching and after-hours services.

Health Coach has expanded its scope and now includes additional support. For questions about medical claims, your first call should always be to the Claims Administrator. But if your issue is not resolved, you can turn to Health Coach for assistance. Call Health Coach from GE at 1-866-272-6007, 24 hours a day, 7 days a week.

2.1.2 KEY THINGS TO DO

If you or your dependents lose coverage under another medical plan — You can enroll yourself and/or your eligible dependents in a GE Medical Care Option **within 63 days** without proof of good health. See "If you lose other coverage" in Section 2.1.3.4, "When can I make changes to my coverage?"

WHEN COVERAGE ENDS

- **Elect COBRA health coverage** — You and your dependents may be eligible for continued health coverage under COBRA if you enroll **within 60 days**. See Section 2.6, "When Your GE Health Coverage Ends"; or
- **Convert coverage** — You may apply to convert your coverage to a different individual policy **within 31 days** after your COBRA health coverage ends. See "Conversion" in Section 2.6.3.7, "When does COBRA health coverage end?"

2.1.3 MEDICAL PARTICIPATION

The following sections describe the plan provisions common to all GE Medical Care Options, such as eligibility, enrollment and other important features that affect your coverage.

ADDITIONAL HEALTH CARE COVERAGE

The Company also provides dental and vision care coverage to help you meet your health care needs. See Section 4.0, "Dental Care Options" and Section 5.0, "Vision Care Benefits" for information.

2.1.3.1 WHAT ARE MY GE MEDICAL CARE OPTIONS?

Your GE Medical Care Options are:

- **GE Health Care Preferred** (available in most locations). Like all managed care plans, this plan provides access to care through a network of providers in your area. Costs are lower and coverage is greater if you stay within the network. You may also receive care out-of-network, but at a higher cost. When you use network providers, there are no claim forms or deductibles. GE Health Care Preferred is administered regionally by benefits administrators selected by the Company, and the Company will designate the regions in which GE Health Care Preferred is available and the benefits administrators available in each of those regions at its sole discretion;
- **GE Medical Benefits** (available in all locations). This is a traditional indemnity-type health plan. You are free to see any doctor or provider, and you file claim forms for reimbursement of covered expenses. The plan pays benefits based on a percentage of charges for covered services, with some services subject to an annual deductible; and
- **Alternative health plan options, such as Health Maintenance Organizations (HMOs)** and consumer-directed health plans (available in certain locations). For more information, see Section 2.5, "Alternative Health Plans."

YOUR GE MEDICAL CARE OPTIONS AT A GLANCE — PLAN BASICS*

	GE HEALTH CARE PREFERRED		GE MEDICAL BENEFITS
	In-Network	Out-of-Network	
Annual deductible (based on salary level)	None.	\$250 to \$850 per person. \$500 to \$1,700 per family.	\$150 to \$600 per person. \$300 to \$1,200 per family.
Annual out-of-pocket limit** (based on salary level)	None.	\$1,250 to \$2,750 per person. \$2,500 to \$5,500 per family.	\$1,100 to \$2,350 per family.
Annual prescription drug co-pay maximum	\$2,500 per person. \$5,000 per family.	N/A	\$2,500 per person; \$5,000 per family. (Does not apply to non-network pharmacies.)

* Alternative health plan options may be available in certain locations. See Section 2.5, "Alternative Health Plans."

** Excluding expenses for prescription drugs.

YOUR GE MEDICAL CARE OPTIONS AT A GLANCE — COVERED SERVICES*

	GE HEALTH CARE PREFERRED		GE MEDICAL BENEFITS
	In-Network	Out-of-Network	
Primary Care Physician charges — office visits	100%, after \$15 co-pay.	80%, after your deductible.	80%, after your deductible.
Specialist charges — office visits	100%, after \$30 co-pay.	80%, after your deductible.	80%, after your deductible.
Physical, occupational, speech or cardiac rehabilitation therapy, chiropractic care and non-routine obstetrical and gynecological care.	100%, after \$25 co-pay.	80%, after your deductible.	80%, after your deductible.
Physician charges — surgery	100%.	80%, after your deductible.	80% coverage.
Outpatient services — lab tests	100%.	80%, after your deductible.	80%, after your deductible.
Outpatient radiology — MRI, CAT and PET	100%, after \$100 co-pay (maximum of 2 co-pays per family per year).	80%, after your deductible.	80% coverage.
Hospital stays	100%, after \$300 co-pay (maximum of 2 co-pays per family per year**).	80%, after your deductible.	100%, after \$300 co-pay for preferred facilities; \$400 co-pay for non-preferred facilities (maximum of 2 co-pays per family per year**).

YOUR GE MEDICAL CARE OPTIONS AT A GLANCE — COVERED SERVICES* CONTINUED...

GE HEALTH CARE PREFERRED			GE MEDICAL BENEFITS
	In-Network	Out-of-Network	
Outpatient hospital and ambulatory surgical facilities	100%, after \$100 co-pay for each procedure (not to exceed 2 such co-pays per family per year).	80%, after your deductible.	100% coverage.
Hospital emergency care	100% coverage, after \$50 co-pay. Special provisions may apply in some cases.	100% coverage, after \$50 co-pay. Special provisions may apply in some cases.	100% coverage, after \$50 co-pay. Special provisions may apply in some cases.
Preventive screenings	100% coverage.	Not covered.	100% coverage.
Well-child care	100% coverage.	Not covered.	100% coverage.
Prescription drugs — retail	\$12 per 21-day supply — generic. \$30 per 21-day supply — brand. \$30 per 21-day supply — specialty.	Not covered.	\$12 per 21-day supply — generic. \$30 per 21-day supply — brand. \$30 per 21-day supply — specialty.
Prescription drugs — mail order	\$20 for up to a 90-day supply — generic. \$65 for up to a 90-day supply — brand and specialty.	N/A	\$20 for up to a 90-day supply — generic. \$65 for up to a 90-day supply — brand and specialty.
Behavioral health treatment — outpatient	100% coverage, after \$15 co-pay.	80% coverage, after your deductible.	80% coverage, after your deductible.
Behavioral health treatment — inpatient	100% coverage, after \$300 co-pay (maximum of 2 co-pays, per family, per year**).	80% coverage, after your deductible.	In-Network: 100% coverage, after \$300 co-pay. Out-of-network: 80% coverage, after \$400 co-pay (maximum of 2 co-pays per family per year**).

* Alternative health plan options may be available in certain locations. See Section 2.5, "Alternative Health Plans."

** Combined for medical-surgical and behavioral health inpatient hospital stays.

GE MEDICAL CARE OPTION OVERVIEW

These charts provide an overview of your GE Medical Care Options. Each option is described in detail in Section 2.2, "GE Health Care Preferred" and Section 2.3, "GE Medical Benefits." For a comparison of the costs of each option, see Section 2.1.3.5, "How much does coverage cost?"

2.1.3.2 WHO IS ELIGIBLE?

You are eligible to continue coverage in a GE Medical Care Option if you meet the criteria for pre-65 retiree coverage, as provided in Section 6.1 "After You Retire". Certain active employees may also be eligible; you will be notified if you are eligible.

You're not eligible if you are in one of the excluded groups listed in Section 1.2, "Who is not eligible for benefits?"

YOUR DEPENDENTS

If you're eligible to enroll in a GE Medical Care Option, you also may enroll your eligible dependents. Eligible dependents are described under Section 1.3, "Who qualifies as an eligible dependent?" Note that for your eligible dependents to be covered under a GE Medical Care Option, you must be covered yourself, and they must be covered under the same option in which you are enrolled.

Special dependent eligibility requirements may apply if you enroll in a Health Maintenance Organization (HMO). Contact the HMO for information.

WHEN YOUR DEPENDENTS LIVE AWAY FROM HOME

Special provisions may apply under GE Health Care Preferred or another network option (for example, an alternative health plan option) when one or more of your dependents live outside of your network area.

In this situation, you enroll the whole family in the home network of the Company employee who is providing the primary health coverage or you may decide that GE Medical Benefits is a better option.

Some GE Health Care Preferred benefits administrators have networks in multiple areas of the country and allow reciprocal arrangements. Please contact your benefits administrator to determine if such arrangements are available.

For more information about the options available to you and the provisions that apply, call your benefits administrator.

IF YOUR SPOUSE OR SAME-SEX DOMESTIC PARTNER IS A COMPANY EMPLOYEE

If both you and your spouse or same-sex domestic partner are eligible Company employees, you may choose to either:

- **Enroll only one of you as a Company employee** — The spouse or same-sex domestic partner with the lower salary must be covered as a dependent of the higher-paid employee; **or**
- **Enroll both yourself and your spouse or same-sex domestic partner as Company employees** — In this case, either of you — but not both of you — may cover your children. The employee who covers the children must enroll them in the same GE Medical Care Option in which he or she is enrolled. In most cases, it will make financial sense for the spouse or same-sex domestic partner who earns less to cover the children.

You should consider the contributions, annual deductibles and annual out-of-pocket maximums for each alternative when making your decision.

IF YOU WORK AFTER REACHING AGE 65

If you continue working for the Company after you reach age 65, you may choose either to continue being covered by a GE Medical Care Option or to begin using Medicare as your only source of coverage at age 65. Your Company coverage will continue automatically unless you notify the GE Benefits Center that you want to choose Medicare as your only coverage.

If your spouse or same-sex domestic partner is eligible for Medicare but wishes to be covered as your dependent under your GE Medical Care Option instead, be sure to call the Social Security Administration for information on the provisions that will apply in that situation **before you make any enrollment decisions**.

Please Note —

- If you choose Company coverage, Medicare will provide secondary coverage if you're enrolled; or
- If you choose Medicare, the Company will not provide further coverage.

ELIGIBILITY

For more information about eligibility requirements for you and your dependents, see Section 1.0, "Who is Eligible for GE Benefits?"

Medicare-eligible employees/dependents

For more information, see "When you or your dependent is covered by Medicare" in Section 2.1.3.6, "What if there is other coverage?"

DEPENDENTS LIVING AWAY FROM HOME?

With a network-based plan like GE Health Care Preferred, the rules for out-of-area coverage for dependents (such as college students) can be complicated, especially for nonemergency care. If you want to make coverage for out-of-area covered family members as simple as possible, consider enrolling in GE Medical Benefits.

2.1.3.3 HOW DO I ENROLL WHEN I FIRST BECOME ELIGIBLE?

When you first become eligible, you'll receive information about your GE Medical Care Options, including enrollment instructions. If you have questions, you can call the GE Benefits Center at 1-800-252-5259.

Here's a general description of how to enroll yourself and your eligible dependents:

- Decide which GE Medical Care Option you wish to enroll in — the options available to you depend on where you live;
- Decide which level of coverage you want — coverage for yourself only, or for yourself and your eligible dependents;
- You will be instructed on how to make your medical coverage election — for GE Health Care Preferred, you'll also need to select a primary care physician from within the network for yourself and for each covered dependent.

Please Note —

- If you elect to cover dependents, you must provide each eligible dependent's name, birth date and Social Security number; and
- Remember that all covered dependents must participate in the same GE Medical Care Option in which you participate.

Special provisions apply to spouses or same-sex domestic partners who also work for the Company. See "If your spouse or same-sex domestic partner is a Company employee" in Section 2.1.3.2, "Who is eligible?"

You can enroll for coverage under a GE Medical Care Option **within 63 days** after you become eligible. If you make no election — to enroll or waive coverage — by the end of the **63-day deadline**, you will automatically be enrolled in GE Medical Benefits at the "Three or More" coverage level. However, you will have the opportunity to adjust your coverage to accurately reflect your coverage needs. Coverage and contributions will be retroactive to the later of your date of hire or January 1 of the current calendar year. In both cases, coverage is effective as of the date you become eligible, as long as you are actively at work (or on vacation) on that day.

HOW TO WAIVE COVERAGE

If you don't want any medical coverage from the Company, you can waive coverage. If you choose to waive coverage, be sure to notify the GE Benefits Center. Waiving medical coverage will also waive prescription drug, behavioral health and substance abuse treatment, and vision coverage, but not dental coverage.

2.1.3.4 WHEN CAN I MAKE CHANGES TO MY COVERAGE?

When you first become eligible for coverage, you have a 63-day enrollment opportunity to specify the coverage you want. After this **63-day deadline** passes, you will have the following opportunities to change your coverage:

- **Once each year, during Annual Enrollment.** You can enroll or make changes for yourself or your eligible dependents during the Annual Enrollment period, generally held in the fall of each year. Annual Enrollment is your only opportunity to change your GE Medical Care and GE Vision Care options. Any elections or changes you make during the Annual Enrollment period will be effective the following January 1, or the date announced during the Annual Enrollment period; or
- **After certain events**, such as adding a new dependent, losing coverage under another medical plan, transfer to a new work location or other qualified status changes, as described in this section. You can enroll or make changes **within 63 days** of such events. Please note that you cannot change your GE Medical Care or Vision Care options as a result of these events. Please refer to Section 3.3.4, "Qualified Status Changes."

ADDING DEPENDENTS TO YOUR COVERAGE

You may add a dependent after your initial enrollment at benefits.ge.com, or by calling the GE Benefits Center at 1-800-252-5259. Be prepared to provide your date of marriage (if applicable) and each eligible dependent's name, birth date and Social Security number. No benefits will be paid until this information is provided.

If you are not enrolled when you add a new dependent to your family, for example, by marriage, birth or adoption, you may enroll yourself, or yourself and any other eligible dependents not already covered under the Plan. When you add a new dependent, you may also enroll eligible dependents not previously enrolled. However, except for newborn children, you must do so **within 63 days** of adding a new dependent. Coverage will become effective retroactive to the date of the addition of the new dependent.

In the case of a newborn child, you will have **90 days** from the birth of the child to add coverage, unless you are already enrolled at the "Three or More" coverage level, in which case coverage will be effective upon notice to the Company. You may be required to show proof of eligibility.

DISCONTINUING COVERAGE

You may discontinue coverage for yourself or your eligible dependents once a year during Annual Enrollment or as a result of a qualified status change. In accordance with IRS rules, if you wish to discontinue coverage outside of these events, your contributions for coverage will not be reduced until the next calendar year. See Section 3.3.4, "Qualified Status Changes" for more information.

IF YOU LOSE OTHER COVERAGE

If you or your dependents lose coverage under another medical plan (such as a spouse's plan at work) and you are not covered under a GE Medical Care Option, you may enroll yourself and your eligible dependents in a GE Medical Care Option without proof of good health **within 63 days** of losing your other coverage. Coverage is effective on the date the prior coverage ends.

If you do not enroll **within 63 days** after losing coverage, you will not have another opportunity to enroll until the next annual enrollment period, unless you experience another qualified status change.

WHAT IS A QUALIFIED STATUS CHANGE?

Qualified changes in status are:

- Your marriage, divorce or legal separation;
- Birth, adoption or marriage of a dependent;
- Death of your spouse;
- Start or end of your spouse's employment;
- Your spouse's involuntary loss of health coverage;
- Your removal from the active payroll, for example, because of disability, layoff, leave of absence or strike, including leaves under the Family and Medical Leave Act of 1993 (FMLA);
- Your transfer to a new work location requiring a change in your Company-sponsored health coverage; and
- Your or your spouse's entitlement to Medicare.

2.1.3.5 HOW MUCH DOES COVERAGE COST?

The Company pays the major share of the cost to provide you with medical coverage. To participate, you contribute through payroll deductions or in some cases direct billing.

RETIREES

Please see Section 6.1.2, "Your GE Medical Care Options before age 65" for the rules used to determine your contributions.

COBRA BENEFICIARIES

Please see Section 2.6.3.2, "How much does COBRA cost?" to determine your contributions.

OTHER PARTICIPANTS

Your contribution is determined by your status. To obtain the contributions applicable to you, please call the GE Insurance Continuation Center at 1-800-242-7419 (1-609-734-9470).

For information about the cost to participate in a Health Maintenance Organization (HMO) or other alternative health plan option, see Section 2.5, "Alternative Health Plans."

TAX IMPLICATIONS FOR SAME-SEX DOMESTIC PARTNER COVERAGE

It's important that you understand the Internal Revenue Service (IRS) rules regarding the tax implications of enrolling a same-sex domestic partner or children that are not qualified tax dependents in health care and/or dental care option benefits. For any year, "qualified tax dependents" are individuals who are claimed on the employee's federal income tax return as a dependent. Please see IRS Publication 501 for the rules regarding who can be claimed as a dependent. If a same-sex domestic partner or child of a same-sex domestic partner is not a qualified tax dependent as defined above, the value of the health care and dental coverage provided will be added to your income and taxed accordingly.

LAWS AFFECTING BENEFITS

If an applicable federal, state or local government law mandates coverage or benefits in excess of what your GE Medical Care Option pays, the plan will provide the additional coverage or benefits. If you are subject to such a law, your contributions will be increased to pay the full cost of the additional coverage or benefits.

If a federal, state or local government applies a tax or surcharge on health care services, benefits or enrollment, the tax or surcharge will be considered a covered expense, subject to the applicable benefit payment provisions. Contributions for participants affected by the tax or surcharge will be increased to pay for half of the added cost to the plan or the Company resulting from the tax or surcharge. The Company pays the other half.

WHAT PAY COUNTS?

Certain features of the GE Medical Care Options — such as contributions, deductibles and out-of-pocket maximums — are based on annual pay. For purposes of the plan, pay is the employee's normal straight-time annual earnings, including your regular base pay. It also may include a portion of commissions and other variable compensation. It does not include overtime or night-shift bonus.

WEIGHING THE COST

In general, employee contributions reflect the Company's cost associated with each GE Medical Care Option. That's why you pay more for coverage under GE Medical Benefits, while coverage under GE Health Care Preferred costs less — for both you and the Company.

2.1.3.6 WHAT IF MY SPOUSE'S OR SAME-SEX DOMESTIC PARTNER'S EMPLOYER OFFERS COVERAGE?

If you enroll for dependent coverage through the Company and your working spouse or same-sex domestic partner does not enroll in medical coverage offered by his or her employer (that is, an employer other than the Company), you'll need to pay an additional contribution each week. The additional contribution amount is based on your annual pay. Rates may be found at benefits.ge.com.

You'll be asked to certify periodically that your working spouse or same-sex domestic partner has coverage, and to provide information about that coverage, or to certify that his or her employer does not offer medical coverage, to avoid the additional payroll deduction. If you don't respond, the additional payroll deduction is applied automatically.

Your additional weekly contribution is subject to change on the effective date of any change in your pay or in your spouse's or same-sex domestic partner's employment or medical coverage status. In the event that your spouse no longer has coverage available through his or her employer, you must give notice of the change to the Company **within 63 days** of the event in order to have the working spouse contribution ended.

Company employees who are not on the active payroll and retirees are not required to pay this additional contribution.

2.1.3.7 WHAT IF THERE IS OTHER COVERAGE?

Your GE Medical Care Option, like many employer-sponsored plans, has a maintenance of benefits feature. This feature is designed to prevent duplication of payments when you or your dependents are covered by another group medical plan, such as a spouse's plan at work or Medicare.

Under maintenance of benefits, the plan that is primarily responsible for a person's expenses — the plan that pays benefits first — is considered the primary coverage for that person. If another plan is primary, the Company pays the difference, if any, between what you receive from the other plan and what you would have received if your Company plan were your only coverage, according to plan provisions. You will never pay more than if the Company plan had been your only coverage.

The out-of-pocket cost calculations used to determine maintenance of benefit payments are based only on covered expenses under your GE Medical Care Option. This is the same way your annual out-of-pocket maximum is determined.

To receive payment on a claim when your GE Medical Care Option coverage is secondary, you must submit a claim form, including a copy of the Explanation of Benefits from the primary insurance plan, to your benefits administrator.

You'll be required to provide information that the benefits administrator needs to prevent duplication of benefits.

WHEN YOUR SPOUSE OR SAME-SEX DOMESTIC PARTNER HAS COVERAGE AT WORK

Here's how maintenance of benefits works when your spouse or same-sex domestic partner has employer-sponsored medical coverage:

- **For you** — Your GE Medical Care Option is your primary coverage, if you're enrolled. Submit your medical bills to the Company plan first, then to your spouse's or same-sex domestic partner's plan;
- **For your spouse** — Your spouse's or same-sex domestic partner's employer-sponsored plan is primary, if he or she is enrolled. Submit his or her medical bills to the other employer's plan first, then to the Company plan; or
- **For your children** — If your children are covered under both your GE Medical Care Option and your spouse's or same-sex domestic partner's plan, the "birthday rule" determines which plan is primary. The plan covering the spouse or same-sex domestic partner whose birth date (month and day) falls earlier in the year is primary for the children. Submit your children's medical bills to the primary plan first, then to the other plan. If both of you have the same birth date, the plan covering you or your spouse or same-sex domestic partner for the longer period of time will pay first. The "birthday rule" also applies to your new spouse if you are remarried.

HOW MAINTENANCE OF BENEFITS WORKS

FOR EXAMPLE

Jorge, the spouse of a Company employee, has medical insurance through his own employer. This employer-provided coverage is his "primary" coverage. Jorge's wife also enrolls him for coverage under GE Health Care Preferred (HCP), as her dependent. Jorge's HCP coverage is his "secondary" coverage.

Jorge visits his primary care doctor and is charged \$60. Jorge's primary plan covers him at 80%, with no deductible for this visit. Jorge's out-of-pocket cost before submitting his claim to the HCP Benefits Administrator is \$12 (20% of \$60).

Because Jorge's primary care doctor participates in the GE Health Care Preferred network, his coverage is at the network level. If there were no primary coverage, the HCP benefit would be 100% of \$60 less a \$15 co-pay, for a total benefit of \$45. Since the \$45 that HCP would pay is less than the \$48 that Jorge's primary plan has already paid, he would not receive any additional benefit for this claim.

Now, Jorge is hospitalized and incurs \$900 in charges. For this hospital care, Jorge must meet a \$400 deductible before his primary plan pays benefits. His plan's coverage pays 80% of the \$500 left after the deductible, for a benefit of \$400.

Jorge then submits his claim to GE Health Care Preferred. Because Jorge's primary care doctor and the hospital are both part of the GE Health Care Preferred network, the coverage is at the network level — 100% of the \$900 in covered charges. However, since Jorge's primary plan has already paid him \$400, he will be reimbursed for the difference minus the \$300 co-pay he would have paid if GE HCP was primary — \$200.

WHEN THE COMPANY IS THE SECONDARY PAYER...

When the Company coverage is the secondary payer, the benefits it pays depend on:

- Whether the care is covered by your primary plan; and
- What charges are considered eligible expenses under your primary plan and/or the Company plan, as described below.

For example:

- If you receive care that your primary plan does not cover but which the Company plan does, the Company plan's benefits will effectively be the same as if the Company plan were primary, provided that you follow the rules of the Company plan. This is because the Company's secondary coverage is not being offset by any primary plan benefits, since none were paid;
- If you receive care that your primary plan covers, but the coverage is affected by limits, such as reasonable, necessary and customary limits, then the Company's secondary benefits will be limited to the amounts considered eligible expenses under the Company plan, even if the Company plan's limits are lower; and
- If you receive care that your primary plan covers, but the coverage is affected by discounts, such as reduced rates offered by a preferred provider network, then the Company's secondary benefits will be limited to the amounts considered eligible under the primary plan.

In all cases, the Company's secondary coverage will be subject to the Company plan's exclusions, limits and maximums. This includes the exclusion for expenses that you would not be required to pay. This means, for example, that if your primary plan includes discounts that allow you to pay less than the provider's usual fee, the Company plan will not pay benefits on a claim to pay the provider the amount by which his or her usual fee exceeds the discounted fee.

COORDINATION OF BENEFITS — NO-FAULT AUTO INSURANCE

Your GE Medical Care Option also coordinates with no-fault auto insurance plans. If you incur medical expenses that are reimbursed by a no-fault auto insurance plan, those payments will be considered primary and your GE Medical Care Option secondary. The Company will reimburse 100% of reasonable, necessary and customary expenses, less the benefits paid by the no-fault auto insurance policy.

WHEN YOU OR YOUR DEPENDENT IS COVERED BY MEDICARE

If you or a covered dependent is covered by Medicare and is not working, Medicare is the primary coverage for most expenses. Submit your medical bills to Medicare first, then to your benefits administrator.

If you or a covered dependent is eligible for Medicare as a result of End Stage Renal Disease (ESRD) and receive primary Medicare ESRD benefits (after the 30th month of Medicare eligibility), the Company will reimburse your Medicare Part B premium.

THE "BIRTHDAY RULE"

When children are covered by more than one parent's employer-sponsored medical plan, the parent whose birth date (month and day) falls first in the year provides primary coverage.

2.1.3.8 WHAT IF I RECEIVE A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)?

An individual who is a child of a covered employee shall be enrolled for coverage under the medical and/or dental plan, as applicable, in accordance with the direction of a qualified medical child support order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement, that:

- Provides for support of a dependent child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);

- Relates to benefits under the appropriate plan; and
- Is "qualified" in that it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act Section 1908 (as amended by the Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage for a dependent child of a noncustodial parent who is (or will become) covered by a domestic relations order that provides for health care coverage.

If you receive one of these orders and have questions, or would like a copy of the QMCSO procedures at no cost to you, contact the GE QDRO Administration, PO Box 534277, St. Petersburg, FL 33747 (1-727-866-5907).

2.1.3.9 WHEN DOES COVERAGE END?

Your coverage under a GE Medical Care Option ends on the earliest of the following dates:

- When your employment stops for any reason (such as resignation or termination) and your continuous service ends. Coverage may continue if you meet certain qualifications;
- The end of the period for which any required contributions have been paid, if you fail to make further contributions or you cancel your payroll deduction authorization;
- When you transfer to a classification of employees not eligible for medical coverage; or
- For represented employees, the day before the day you go on strike unless the Company makes arrangements for coverage to continue.

Coverage for your dependent ends on the earlier of the following dates:

- When your dependent no longer meets eligibility requirements — for example, when your dependent child reaches the plan's age limit. See Section 1.3, "Who qualifies as an eligible dependent?"; or
- The end of the period for which any required contributions have been paid, if you fail to make further contributions or you cancel your payroll deduction authorization for dependent coverage.

If a covered dependent is totally disabled when coverage would otherwise end, his or her coverage can continue as long as the disability continues, up to the end of the following calendar year.

CERTIFICATION OF COVERAGE

When coverage under your GE Medical Care Option ends, you will receive a certificate of coverage stating how long you were covered. Prior coverage may reduce the length of time you are subject to any pre-existing medical condition limits under a new plan. You also may request a certificate of coverage from the COBRA administrator within 24 months after coverage ends. See Section 2.6.3.7, "When does COBRA health coverage end?"

COBRA HEALTH COVERAGE

When coverage under your GE Medical Care Option ends, you and/or your covered dependents may be eligible to purchase continued health coverage under a federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended). In some cases, the Company may pay for some or all of your COBRA health coverage. See Section 2.6, "When Your GE Health Coverage Ends."

CONVERTING COVERAGE

If coverage under your GE Medical Care Option ends for any reason, you may change your coverage to a different individual policy directly with the company that administers your plan — a process called conversion. You or your dependents must apply for conversion **within 31 days** after your GE coverage ends. You pay the full premium cost. For details about the conversion coverages that are available, call the benefits administrator.

2.1.3.10 WHAT OTHER PROVISIONS MAY APPLY?

FEDERALLY MANDATED BENEFITS

Under federal law, group health plans generally may not limit benefits for any hospital stay for childbirth to less than 48 hours following a normal delivery (96 hours following a Cesarean Section) for the mother or baby, or require a provider to obtain plan approval for prescribing a length of stay within those timeframes. However, you don't have to stay in the hospital for the full federally mandated length if you and your doctor feel that it is not necessary.

If you're enrolled in GE Medical Benefits, you'll need to call your benefits administrator at the toll-free number on your medical ID card for advance approval of a maternity stay beyond 48 or 96 hours. For GE Health Care Preferred, your primary care physician or benefits administrator will help coordinate your care.

Federal law also requires that plans that cover mastectomies also cover certain reconstructive surgery and treatment following a mastectomy, including:

- Expenses for surgery for all stages of reconstruction on the breast on which the mastectomy was performed;
- The cost of prostheses;
- Expenses for surgery on the other breast to achieve symmetry; and
- The costs for treatment of physical complications at any stage of the mastectomy, including lymphedemas.

Normal plan deductibles and co-pays apply.

Under the federal Patient Protection Affordable Care Act, health plans are now prohibited from retroactively terminating your coverage, except in cases of failure to pay premiums, fraud or intentional misrepresentation of material facts. Otherwise, you must be notified at least 30 days in advance if your coverage will be terminated.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Under the federal Patient Protection and Affordable Care Act, health plans are prohibited from retroactively terminating your coverage, except in cases of failure to pay premiums, fraud or intentional misrepresentation of material facts. Otherwise, you must be notified at least 30 days in advance if your coverage will be terminated.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits health coverage discrimination and employment discrimination against former employees based on their (or their family members') genetic information. Genetic information includes:

- You or your family member's genetic tests;
- The request for, or receipt of, genetic counseling or other genetic services by you or your family members; and
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and results of any genetic testing you undergo will be treated as confidential, as required by HIPAA and GINA. Likewise, genetic information collected about family history, such as through a health risk assessment, will be treated as confidential, as required by HIPAA and GINA.

The plan will not discriminate on the basis of genetic information, including changing contributions for any individuals or groups on the basis of genetic information.

The plan will not request or require you or your family member to undergo a genetic test. However, your Physician may obtain and use information about the results of a genetic test. The plan may also obtain such information to the extent required in making a determination regarding payment (e.g., where payment is made only as to medically necessary treatment and the results of a genetic test are necessary to determine the medical necessity of the services provided).

In some circumstances the plan may obtain or request genetic information for research purposes (if required by a state for the protection of individuals) or as part of your or your dependent's voluntary participation in a research study.

The plan will not collect genetic information for underwriting purposes, which includes:

- Determination of eligibility for benefits or coverage (including changes in cost-sharing in return for activities such as completing a health risk assessment or participating in a wellness program);
- Computation of contributions (including discounts in return for activities such as completing a health risk assessment or participating in a wellness program); or
- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. However, if the plan conditions a benefit based on its medical appropriateness, which depends on genetic information, the plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness.

The plan will not collect genetic information with respect to any individual prior to that individual's effective date of coverage, nor in connection with the rules for eligibility that apply to that individual.

EARLY RETIREE REINSURANCE PROGRAM (ERRP) NOTICE

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a federal program that was established under the Act. Under the ERRP, the federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014. Under the ERRP, the Company, as plan sponsor, may elect to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the plan sponsor uses the reimbursements for this purpose. The reimbursements may also be used to reduce or offset increases in the plan sponsor's costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and their families.

NETWORK PROVISIONS

Depending on your GE Medical Care Option, some or all of your covered benefits may be delivered by physicians, hospitals or other health care providers that participate in a network. The health care organizations that manage these networks may establish certain rules and provisions that determine how care is provided to participants. They may also include special payment arrangements and incentives for network physicians. For example, the network may have "capitation" provisions, under which a network physician is paid based on the number of patients to whom the physician provides care, rather than being paid for each instance of service. Providers may also receive additional reimbursement based on the quality of service provided.

For information about any such provisions, you should call your local health care benefits administrator, who manages these networks, at the toll-free number listed on your medical ID card. If you participate in GE Health Care Preferred, you can see a list of the benefits administrators in Section 8.3, "GE Health Care Preferred Benefits Administrators."

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse or same-sex domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents for coverage under a GE Medical Care Option, provided that you request enrollment **within 63 days** after your other coverage ends. 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, provided that you request enrollment **within 63 days** after the marriage, birth, adoption or placement for adoption.

YOUR RIGHT TO PRIVACY

The Department of Health and Human Services issued comprehensive federal regulations effective April 14, 2003 that give individuals broad protections over the privacy of their personal health information. These regulations, which are part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Provision, standardize and safeguard the transmission of protected health information, protect the confidentiality of your personal health information, and allow you access to your medical records. See Section 8.1.9, "What are my rights under the HIPAA privacy regulations?" for more information.

2.2 GE HEALTH CARE PREFERRED

GE Health Care Preferred provides access to care through a network of providers in your area. Costs are lower if you stay within the network for covered services. You may also receive care out-of-network, but at a higher cost. When you use network providers, there are no claim forms or deductibles.

2.2.1 KEY THINGS TO KNOW

GE Health Care Preferred offers broad medical coverage, including:

- Preventive screenings;
- Doctor office visits;
- Surgery, tests and other services;
- Hospitalizations;
- Prescription drugs;
- Behavioral health and substance abuse treatment; and
- Clinical trials.

You can receive care either through a network of health care providers or outside the network.

You choose a primary care physician within the network — your key to coordinated care and maximum benefits.

Network care performed, or in regions where referrals are required, authorized by your primary care physician, is covered at 100%; for certain services, you pay a co-pay — a fixed-dollar fee.

In most cases, out-of-network care is subject to a deductible and then is covered at 80%, up to your annual out-of-pocket maximum.

If you need urgent care while you're away from home (outside of the network area)...

You receive network-level coverage, provided you call the benefits administrator (or your primary care physician) for advance approval.

If you go out-of-network, the plan pays 80% of reasonable, necessary and customary charges, after you meet an annual deductible.

Other provisions apply that affect what you need to do and how much you pay (such as advance approvals for certain services). See Section 2.2.3.4, "What if I go out-of-network?"

For important information about the administration of GE Health Care Preferred, see Section 8.0, "Administrative Information."

2.2.2 KEY THINGS TO DO

Choose a primary care physician — to coordinate your overall care.

Schedule preventive care — Assess your risk for certain diseases and illnesses through periodic physicals, screenings.

For behavioral health or substance abuse treatment — Call the behavioral health administrator for advance approval. See Section 2.2.4.5, "Behavioral health and substance abuse treatment."

For prescription drugs — Use a network pharmacy or Mail Order Pharmacy Service to purchase prescription drugs.

- **Use a network pharmacy** — for short-term prescriptions. See "Network pharmacies" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits"; or
- **Use Mail Order Pharmacy Service** — for medicines you need regularly. See "Mail Order Pharmacy Service" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

IN SPECIAL CASES

In an emergency — Get help immediately if you have an injury or illness that, if not treated immediately, would, in the judgment of a reasonable person, jeopardize your life or seriously impair your health. If you're admitted to the hospital, call the benefits administrator by the end of the next business day. See Section 2.2.3.2, "What do I do in an emergency?"

If you need urgent care while away from home — For network-level benefits, call the benefits administrator for approval before obtaining medical services outside the network area. See Section 2.2.3.3, "What if I need care while away from home?"

If you go out-of-network — the plan covers out-of-network care, although at a higher cost to you. You'll need to file claim forms to be reimbursed for covered services. Be aware of certain additional provisions, such as required approvals; reasonable, necessary and customary guidelines; deductibles; and out-of-pocket limits. See Section 2.2.3.4, "What if I go out-of-network?"

If you've been told that you need a transplant — make sure that your physician knows that you have access to Centers of Excellence at network-level benefits. See "Centers of Excellence" in Section 2.2.4.4, "Hospitals, special facilities and programs."

FOR MORE INFORMATION

Look to benefits.ge.com — Through benefits.ge.com, you can check on your current enrollment status, locate network providers, get answers to frequently asked questions and more. To obtain similar information by phone, call the GE Benefits Center at 1-800-252-5259.

2.2.3 HOW GE HEALTH CARE PREFERRED WORKS

GE Health Care Preferred is a managed care option that is administered locally by a health plan (your benefits administrator) selected by GE. Typically, here is how GE Health Care Preferred works:

- **In the network, the plan pays 100%** — Medically necessary network care performed in accordance with the policies of your benefits administrator is covered at 100%, after any applicable co-pay. In general, your co-pay is:
 - \$15 for each primary care physician office visit;
 - \$30 for each specialist office visit;
 - \$100 for each outpatient surgical procedure;
 - \$100 for certain diagnostic imaging procedures (MRI, PET, CT);
 - \$300 for inpatient hospital care and treatment facility admissions;
 - \$50 for a hospital emergency care visit.
- **You choose a primary care physician** — your primary care physician is your key to coordinated care and maximum benefits.
- **For specialist or hospital care** — you should understand your benefits administrator's policies when seeking specialist or hospital care.

There are no deductibles to meet or claim forms to file. Your network physician handles required approvals for you. See the definition of "medically necessary" in "Key Terms"; and

- **You can choose to go out-of-network**, at a higher cost to you — You can go to an out-of-network provider at any time. In general, out-of-network care is covered at 80% of reasonable, necessary and customary charges, after you meet an annual deductible. See the definition of "reasonable, necessary and customary" in "Key Terms." In addition, approvals are required for certain services, and you'll need to file claim forms to be reimbursed.

For additional information about how GE Health Care Preferred works in your area, call your benefits administrator. Benefits administrators are listed in Section 8.3, "GE Health Care Preferred Benefits Administrators" or, if you are already enrolled, you can call the toll-free number listed on your medical ID card.

2.2.3.1 HOW DO I ACCESS NETWORK CARE?

In general, you receive maximum plan benefits when you access your benefits administrator's network. This includes medical care performed by a network provider referred by your primary care physician. Coverage will also be provided at a network level of benefits under the following circumstances:

- If the participant receives any radiology, anesthesiology, pathology, or surgical assistant services from an out-of-network Provider but only to the extent that the underlying surgical services are provided by a network Provider;
- If no network Provider is reasonably available because the participant lives outside a network service area; or
- If the participant lives inside a network service area and receives covered services from an out-of-network Provider because there is no network Provider of the same type reasonably available.

Be sure to contact your primary care physician (or benefits administrator) for nonemergency medical care first, even after hours and on weekends. **If you don't obtain authorization before seeking nonemergency medical care, your benefits may be reimbursed at the out-of-network level — even if you use a network provider.**

Please Note — If the benefits administrator in your region does not require referrals, you may see any **network** physician you like and receive network-level benefits for covered services.

ABOUT NETWORK PROVIDERS

A typical network includes physicians, hospitals and other health care providers. Network providers are selected by the benefits administrator and must meet specific standards for education, experience and credentials. They also undergo regular reviews for patient satisfaction, office management and effective delivery of care.

A directory of providers in your network will be made available to you without charge; you may access this information through *benefits.ge.com* or by calling your benefits administrator at the toll-free number on your medical ID card.

NETWORK CARE: STEP-BY-STEP

1. See your primary care physician or a referred (as required) specialist, hospital or other provider.
2. Show your medical ID card and pay any required co-pay; your provider bills the GE Health Care Preferred benefits administrator directly for the rest.
3. Questions? Call the benefits administrator and speak to a member services representative (or ask your provider to call). The toll-free number is shown on your medical ID card.

2.2.3.2 WHAT DO I DO IN AN EMERGENCY?

In an emergency, seek help immediately. An emergency is a serious medical condition or symptom resulting from injury, illness or mental illness that arises suddenly and, in the judgment of a reasonable person, requires immediate treatment (generally within 24 hours of onset) to avoid jeopardizing your life or seriously impairing your health — such as excessive bleeding, loss of consciousness or severe chest pain.

If you're admitted to the hospital in an emergency, you must call the benefits administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances). If you don't call, your benefits will be reduced by half, up to a maximum of \$1,000.

If it's not an emergency, but a condition that needs urgent attention on a weekend or at night, contact your primary care physician or the benefits administrator. Conditions that do not require immediate treatment are not considered emergencies. **If the benefits administrator determines that your condition doesn't qualify as an emergency and emergency treatment was not authorized, services will be covered at 80%, after the out-of-network deductible, whether you used a network or an out-of-network emergency room.**

For emergency coverage see "Hospital emergency care" in Section 2.2.4.4, "Hospitals, special facilities and programs." Be sure to coordinate any follow-up care with your primary care physician.

IN AN EMERGENCY

In case of an injury or illness that would, in the judgment of a reasonable person, jeopardize your life or seriously impair your health if not treated right away, get help immediately. If you're admitted to the hospital, call the benefits administrator by the end of the next business day.

If it's not an emergency, but a situation that needs urgent attention on a weekend or at night, contact your primary care physician or the benefits administrator.

2.2.3.3 WHAT IF I NEED CARE WHILE AWAY FROM HOME?

If you're vacationing or temporarily living outside the network service area, you still may receive network-level benefits for urgent, medically necessary treatment, including prescription drugs. This also applies to students living away at school. Contact your benefits administrator for more details.

Before obtaining urgent medical services out of your area, call the benefits administrator for approval. Your benefits administrator also may help you find a local doctor. Then, file a claim form for reimbursement at the network level.

CHILDREN AWAY AT SCHOOL

While your child is away at school, he or she cannot receive routine care, unless he or she is covered under a reciprocal arrangement. See "When your dependents live away from home" in Section 2.1.3.2, "Who is eligible?"

However, in all cases, your child may continue to receive network-level benefits:

- **For minor testing or treatment** — In cases where travel is unduly burdensome or the test or treatment may be readily performed locally, such services may be covered locally. Examples may include routine procedures, such as pre-operative bloodwork or allergy shots.
- **In an emergency** — your child should get help immediately from the nearest source. If your child is admitted to the hospital, call the benefits administrator by the end of the next business day.
- **For urgent care** (such as a severe case of the flu) — call the benefits administrator for approval in advance.

2.2.3.4 WHAT IF I GO OUT-OF-NETWORK?

When you go to an out-of-network doctor or other provider (or when your care is otherwise considered to be "out-of-network"), GE Health Care Preferred covers most services at 80% of reasonable, necessary and customary charges, after you meet an annual deductible. (Once you meet an annual out-of-pocket maximum, the plan pays 100% of covered charges.)

The benefits administrator determines what is reasonable, necessary and customary. See the definition of "reasonable, necessary and customary" in "Key Terms." When you receive out-of-network care, you're responsible for paying any charges in excess of reasonable, necessary and customary amounts.

Additional provisions apply out-of-network that affect what you need to do and how much you pay:

- Advance approvals, such as for care in a hospital, special facility or other program;
- Deductibles; and
- Out-of-pocket limits.

You also need to file claim forms for reimbursement of covered out-of-network expenses.

OUT-OF-NETWORK APPROVALS

Nonemergency care in a hospital, special facility or other program must be reviewed and approved in advance to help ensure that your treatment is appropriate and reasonable, and to keep health care costs — yours and the Company's — under control. For out-of-network care, you are responsible for obtaining approval by calling the benefits administrator.

If you don't obtain approval when required, most out-of-network benefits will be reduced by half, up to a maximum of \$1,000. Certain services will not be covered without advance approval.

Before you're admitted — To receive maximum benefits, you or your doctor must call the benefits administrator in advance of out-of-network nonemergency care in a hospital, special facility or other program. In some cases, the benefits administrator may require that you obtain a second opinion before your treatment is approved. If a second opinion is required, you'll be asked to see a doctor recommended by the benefits administrator. If you see the recommended doctor, costs associated with the required second opinion will be paid at 100%. If you don't see the recommended doctor, benefits for an out-of-network hospital stay will be reduced by half, up to a maximum of \$1,000.

While you're there — The benefits administrator will review your care to make sure that your length of stay is medically appropriate. For you to receive maximum benefits, the benefits administrator must approve your care.

Before you go home — The benefits administrator will work with your doctor to help arrange any treatment you need after your hospitalization. Your doctor will discuss discharge plans with you.

OUT-OF-NETWORK DEDUCTIBLE

When you obtain care outside the benefit administrator's network or, in regions where referrals are required, you obtain network care that isn't authorized by the benefits administrator, you pay an initial amount in covered out-of-network medical expenses each year before GE Health Care Preferred begins to pay out-of-network benefits. This amount is called your annual deductible. An individual deductible applies separately to you and to each of your covered dependents. A new deductible applies each calendar year (January 1 to December 31).

To help limit the number of individual deductibles a family must meet each year, the plan also has a family deductible. A family deductible is the total amount you and your covered dependents have to meet in deductibles each calendar year, regardless of how large your family is. When the combined amount you pay for your family's covered out-of-network expenses in a calendar year reaches your family deductible, the plan begins to pay benefits for you and all your covered dependents.

Your deductible amount is based on your annual pay on October 31 of the prior year (or, for new employees hired after October 31, your annual pay on your date of hire). If you're absent on October 31, your deductible is based on your annual pay when you were last at work. For the definition of pay, see "What pay counts" in Section 2.1.3.5, "How much does coverage cost?"

IF YOUR ANNUAL PAY IS...	YOUR ANNUAL OUT-OF-NETWORK DEDUCTIBLE IS...	
	Individual	Family
Up to \$24,999	\$250	\$500
\$25,000 - \$37,499	\$350	\$700
\$37,500 - \$49,999	\$450	\$900
\$50,000 - \$74,999	\$550	\$1,100
\$75,000 - \$99,999	\$650	\$1,300
\$100,000 - \$149,999	\$750	\$1,500
\$150,000 or more	\$850	\$1,700

Your deductible amount does not change throughout the calendar year, regardless of any change in your pay or employment status, unless you change coverage tier, for example, moving from two-person to three or more coverage.

OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM

When you obtain care outside the benefit administrator's network or, in regions where referrals are required, you obtain network care that isn't authorized by your primary care physician or benefits administrator, you pay a portion of the expense — usually the deductible plus 20% — up to an amount called your out-of-pocket maximum. Once your share of covered out-of-network expenses in a calendar year reaches your out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for the year. Note that covered expenses are based on reasonable, necessary and customary charges.

To help limit a family's annual out-of-pocket medical costs, the plan also has a family out-of-pocket maximum. A family out-of-pocket maximum is the most you and your covered dependents have to pay in covered out-of-network medical expenses each calendar year, regardless of how large your family is. When the combined amount you pay for your family's covered out-of-network expenses in a calendar year reaches your family out-of-pocket maximum, the plan pays the full cost of remaining covered expenses for the entire family for the year.

Just like your deductible, your out-of-pocket maximum amount is based on your annual pay on October 31 of the prior year (or, for new employees hired after October 31, your annual pay on your date of hire). If you're absent on October 31, your out-of-pocket maximum is based on your annual pay when you were last at work. For the definition of pay, see "What pay counts" in Section 2.1.3.5, "How much does coverage cost?"

IF YOUR ANNUAL PAY IS...	YOUR ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING THE ANNUAL DEDUCTIBLE) IS...	
	Individual	Family
Up to \$24,999	\$1,250	\$2,500
\$25,000 - \$37,499	\$1,500	\$3,000
\$37,500 - \$49,999	\$1,750	\$3,500
\$50,000 - \$74,999	\$2,000	\$4,000
\$75,000 - \$99,999	\$2,250	\$4,500
\$100,000 - \$149,999	\$2,500	\$5,000
\$150,000 or more	\$2,750	\$5,500

Your out-of-pocket maximum amount does not change throughout the calendar year, regardless of any change in your pay or employment status, unless you change coverage tier, for example, moving from two-person to three or more coverage.

Exceptions — Some expenses do not count toward your out-of-pocket maximum. These include amounts you pay:

- As co-pays for network services;
- For prescription drugs; however, a separate co-pay maximum applies (see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits");
- Above plan benefits for vision care;
- When you do not follow required approval procedures or recommendations for certain out-of-network benefits;
- Above reasonable, necessary and customary amounts for out-of-network expenses; and
- For any expenses not covered by the plan.

INITIATING CLAIMS FOR OUT-OF-NETWORK BENEFITS

Here's how to initiate a claim for out-of-network benefits:

1. **Present your GE medical ID card to your provider** — He or she may be willing to bill the insurance company directly. If you are admitted to the hospital, confirm that your stay has been approved.
2. **If direct billing isn't possible, obtain a claim form** — at *benefits.ge.com* or from your benefits administrator.
3. **Complete and sign the claim form** — and attach a copy of the bill. Be sure that the bill includes your name and Social Security number, the patient's name, Social Security number and address, the diagnosis and procedure code for the service, the date of the service and the charge. Mail the form and bill to the benefits administrator at the address shown on the form.
4. **You'll be notified** — by the benefits administrator of the amount you are responsible for paying.

Additional claims information —

- The benefits administrator has the right to require a medical examination of any person for whom a claim is made; and
- **You must submit your claims by June 30** for expenses that were incurred during the previous calendar year, unless you can show that it was not reasonably possible to do so.

Claims questions? If you have a question or problem with a claim:

1. **Gather basic information:**
 - Your Social Security number (and patient's name, if applicable);
 - Provider name, date of service and amount of bill, if applicable; and
 - Copies of any correspondence.
2. **Call the toll-free number on your medical ID card.**
3. **Discuss the question with a member services representative** — If you still have a question, ask for a supervisor.

If you need more help, contact the GE Benefits Center at 1-800-252-5259.

OUT-OF-NETWORK "TO DO'S"

- Get advance approval, when required.
- Be aware of reasonable, necessary and customary guidelines and other provisions.
- File claim forms for reimbursement of covered expenses.

TIMELY FILING

You must submit your medical claims **by June 30** for expenses that were incurred during the previous calendar year.

2.2.4 WHAT GE HEALTH CARE PREFERRED COVERS

GE Health Care Preferred covers a range of services, including preventive care and health screenings, doctors' services, surgery, diagnostic imaging, lab tests, prescription drugs, hospital services, and behavioral health and substance abuse treatment, as described in the following Sections. (For a description of your vision coverage as part of your GE Medical Care Option, see Section 5.0, "Vision Care Benefits.")

2.2.4.1 PREVENTIVE SCREENINGS

The Plan pays for preventive screenings provided on an outpatient basis at a Physician's office, an alternate facility or a Hospital when received from a Network Provider. Please note that preventive screenings are not covered out-of-Network.

In general, the Plan pays preventive screenings based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive screenings may be covered as well. Your Physician may recommend more frequent screenings based on your family or medical history. Examples of preventive screenings are listed below and provide a guide of what is considered an Eligible Expense. Please check with your Claims Administrator to verify coverage. Age, gender and condition restrictions may apply.

Examples of Eligible Expenses for Preventive Screenings include:

Cancer Screenings

- Breast Cancer: Mammography
- Cervical Cancer: Laboratory Testing
- Colon Cancer: Colonoscopy, Sigmoidoscopy and associated laboratory tests, e.g. biopsy

Blood/urine and other laboratory tests to screen for the following:

- Rh Incompatibility
- Lipid Disorder — Cholesterol, lipoprotein, and triglycerides
- Bacteriuria (For pregnant women only)
- Chlamydial Infection
- Gonorrhea
- HIV
- Syphilis Infection
- HPV Detection
- Diabetes Type II
- Iron Deficiency Anemia
- Sickle Cell
- Lead

Annual Adult Wellness Physicals and Annual Routine Gynecological Care

- Physical Wellness Examination
- Annual Gynecologic Examination
- Primary Preventive Counseling
- Electrocardiogram (Annual screening)
- Obesity Screening
- Osteoporosis Screening
- Abdominal Aortic Aneurysm Screening

Immunizations

- Influenza (i.e. H1N1)
- DTaP (Diphtheria, tetanus, pertussis)
- Hepatitis A
- Hepatitis B
- Hib (haemophilus influenzae type b)
- Human Papilloma-virus (HPV)
- Meningoccal Conjugate (MCV) or Polysaccharide (MPSV)
- MMR (Measles, mumps and rubella)
- Pneumococcal polysaccharide (PPSV)
- Polio
- Rotavirus (RV)
- Tetanus
- Varicella (Chickenpox)
- Zoster (Shingles)

Pediatric Prevention through age 21

- Well child care visits
- Screening tests
- Newborn hearing
- Annual vision
- Developmental Screening (condition restrictions apply)

2.2.4.2 DOCTORS AND OTHER PROVIDERS

For information on coverage for preventive care services and health screenings, see Section 2.2.4.1, "Preventive care and health screenings."

GE HEALTH CARE PREFERRED

Covered services include:	Network <i>Care must be performed or authorized by your primary care physician or benefits administrator, as required.</i>	Out-of-Network <i>Benefits are paid up to reasonable, necessary and customary amounts.</i>
Doctors' services/Primary Care — when provided in a doctor's office or elsewhere. For psychiatrists' and psychologists' services, see Section 2.2.4.5, "Behavioral health and substance abuse treatment."	100% coverage, after you pay a \$15 co-pay for each office visit, including: <ul style="list-style-type: none"> • Visits to your primary care physician; and • For women, routine visits to your obstetrician/gynecologist. Doctors' visits during hospitalization are covered at 100%, with no co-pay.	80% coverage, after your deductible.
Specialists' services — when provided in a doctor's office or elsewhere.	100% coverage, after you pay a \$30 co-pay for each office visit, when you're referred by your primary care physician. Referrals are not required for visits to network obstetricians/gynecologists and, in some regions, for visits to any network specialist.	80% coverage, after your deductible.
Obstetrical services — when performed by a doctor or a licensed midwife who is a licensed registered nurse certified by the American College of Nurse Midwives. Referrals are not required.	100% coverage, after you pay an initial \$25 office visit co-pay for all services related to the pregnancy and performed by the same provider.	80% coverage, after your deductible.
Gynecological services — for non-routine services.	100% coverage, after you pay a \$25 office visit co-pay for all services.	80% coverage, after your deductible.
Physical, occupational, speech or cardiac rehabilitation therapy — to correct impairments caused by illness or injury, including congenital anomalies, as long as the therapy continues to produce improvement in the level of functioning within a reasonable period of time. Educational services are not covered.	100% coverage, after you pay a \$25 co-pay for each visit. For physical therapy conditions that require treatment in excess of 30 visits will require medical necessity review.	80% coverage, after your deductible.

Chiropractic care — up to 15 visits in a calendar year (network and out-of-network combined), when necessary to treat a medical condition, and when performed by a licensed chiropractor. Maintenance care is not covered.	100% coverage, after you pay a \$25 co-pay for each office visit/treatment session.	80% coverage, after your deductible.
Nutritional consultations — up to three visits in a calendar year (network and out-of-network combined), when recommended by a doctor and provided by a registered dietitian. These consultations are covered only for medical conditions that would appropriately include this service as part of the normal course of treatment (for example, diabetes).	100% coverage, after you pay a \$30 co-pay for each office visit.	80% coverage, after your deductible.
Other specialists <ul style="list-style-type: none"> • Podiatrists' services — when required for specialized foot care. • Audiologists — when required for rehabilitative testing or therapy. 	100% coverage, after you pay a \$30 co-pay for each office visit.	80% coverage, after your deductible.
Christian Science practitioners' services — for healing purposes, provided the practitioner is accredited by the Mother Church in Boston, Massachusetts and is in your presence when the treatment is performed.	100% coverage, after you pay a \$30 co-pay for each office visit.	80% coverage, after your deductible.

2.2.4.3 SURGERY, TESTS AND OTHER SERVICES

GE HEALTH CARE PREFERRED

Covered services include:	Network <i>Care must be performed or authorized by your primary care physician or benefits administrator, as required.</i>	Out-of-Network <i>Benefits are paid up to reasonable, necessary and customary amounts.</i>
Surgery	100% coverage.	80% coverage, after your deductible.
Anesthesia — and its administration.	100% coverage.	80% coverage, after your deductible.
Diagnostic imaging procedures — used to diagnose an illness or injury. <ul style="list-style-type: none"> • MRI, CAT, and PET outpatient radiology procedures. • X-rays, EKGs, ultrasound and other imaging procedures. 	100% coverage, after \$100 co-pay for each procedure, not to exceed 2 such co-pays per family, per year 100% coverage.	80% coverage, after your deductible. 80% coverage, after your deductible.
Diagnostic laboratory procedures — such as blood and urine tests used to diagnose an illness or injury.	100% coverage.	80% coverage, after your deductible.
Other medical services and supplies — Expenses incurred for medical supplies prescribed by a licensed physician for therapeutic use in the treatment of an illness or injury including: <ul style="list-style-type: none"> • Oxygen and its administration; • Blood transfusions, including blood and blood plasma; and • Implants may be covered to treat a severe condition for which there are no alternative treatments, i.e., dentures or bridges. <p>Items that are non-medical in nature, or "over-the-counter" items are not covered.</p>	100% coverage.	80% coverage, after your deductible.

Second opinions and related tests — that you request before a hospital admission, outpatient surgery or any other service. In some cases, a second opinion may be required by the benefits administrator.	100% coverage, when provided by a doctor recommended by the benefits administrator or an in-network physician. Specialized second opinion services may also be made available by the Company.	80% coverage, after your deductible, for an opinion at your request. 100% coverage when the opinion is required by the benefits administrator and provided by a doctor recommended by the benefits administrator. If you don't obtain a second opinion as required, your benefits for an out-of-network hospital stay will be reduced by half, up to a maximum of \$1,000.
Chemotherapy and radiation therapy.	100% coverage.	80% coverage, after your deductible.
Injections — for medical conditions, such as allergies.	100% coverage. If a doctor's exam is performed, you may pay either a \$15 co-pay when performed in a primary care physician office visit or \$30 when performed in a specialist office visit.	80% coverage, after your deductible.
Professional ambulance service — when medically necessary to transport the patient to the nearest hospital or facility where appropriate treatment is available. To be covered, ambulance transportation, including air ambulance, must be medically necessary. Medical necessity is established when the patient's clinical condition is such that the use of any other method of transportation would endanger the patient's medical condition.	100% coverage.	80% coverage, after your deductible.

<p>Durable medical equipment — The rental or the purchase of durable medical equipment, including for therapeutic uses, when prescribed by a provider and approved by the benefits administrator. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Examples include but are not limited to:</p> <ul style="list-style-type: none">• Braces that stabilize injuries, or treat curvature of the spine• C-pap machines for treatment of sleep apnea• Circulators for post-surgical treatment• Crutches• Gait trainers• Hospital beds• Insulin pumps• Oxygen equipment• Pacemaker monitors• Prone standers• Portable EKG devices• Surgical sleeves/burn compression sleeves/surgical support hose• Wheelchairs/custom fitted strollers <p>Non-covered items include, but are not limited to: air conditioners; humidifiers; dehumidifiers; special lighting or other environmental modifiers; surgical supports, except as otherwise provided under durable medical equipment; or articles of clothing.</p>	<p>100% coverage.</p>	<p>80% coverage, after your deductible.</p>
--	-----------------------	---

Prosthetic appliances — Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered medical services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part. Examples include:

- Aids and supports for defective parts of the body, such as pacemakers, cochlear implants, intraocular lenses and electronic speech aids.
 - Breast prostheses, whether internal or external, following a mastectomy, and two surgical bras per year, as required by the Women's Health and Cancer Rights Act; and wigs, the first one following cancer treatment, not to exceed one per year thereafter.
 - Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
-

100% coverage.

80% coverage, after your deductible.

Orthotic devices and supplies — includes the initial purchase, fitting, and repair of such devices and supplies. The cost of casting, molding, fittings and adjustments are included.	100% coverage.	80% coverage, after your deductible.
Orthopedic shoes covered for the following indications:		
<ul style="list-style-type: none">• Specially constructed shoes that are an integral part of a leg brace or prosthesis.• Cast boots or shoes requested by the surgeon following a surgical procedure or treatment of a fracture.• Custom made or custom fitted shoes for members with diabetes mellitus or complications involving the foot related to ulceration, peripheral neuropathy with evidence of callus, deformities, amputation or restricted circulation		
Orthotic shoe inserts will be covered if custom molded and prescribed by a physician.		
Orthotic appliances may be replaced once per year if required, except that additional replacements will be allowed for children due to growth, or for damaged, unrepairable appliances.		
Corrective prescription or contact lenses used to treat a medical condition — an initial pair. For example, lenticular lenses for people who have had cataracts surgically removed, or contact lenses used as a bandage for treatment of keratoconus or similar conditions.	100% coverage.	80% coverage, after your deductible.
Hearing aids — including hearing exams for the purchase of two hearing aids (every three years), fittings and repairs. Replacement parts (except for batteries) are covered.	100% coverage, subject to reasonable, necessary and customary limits.	100% coverage, subject to reasonable, necessary and customary limits.

Sterilization procedures — for tubal ligation, vasectomy or other sterilization procedures. Reverse sterilizations are not covered.	100% coverage.	80% coverage, after your deductible.
--	----------------	--------------------------------------

Family planning supplies and services — in general, medical expenses related to the diagnosis and treatment of the condition of infertility are covered, but assisted reproductive services are not. In addition, the following are covered when provided in a doctor's office: <ul style="list-style-type: none">• Intrauterine devices (IUDs);• Diaphragms; and• Depo-Provera injections.	100% coverage, after a \$15 co-pay when performed during a primary care physician visit or during a gynecologist visit or \$25 when performed during a non-routine specialist office visit.	80% coverage, after your deductible.
--	---	--------------------------------------

For information on coverage for oral contraceptives and diaphragms under GE Prescription Drug Benefits, see "Family planning benefits" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

2.2.4.4 HOSPITALS, SPECIAL FACILITIES AND PROGRAMS

GE HEALTH CARE PREFERRED

Covered services include:	Network <i>Care must be performed or authorized by your primary care physician or benefits administrator, as required.</i>	Out-of-Network <i>Benefits are paid up to reasonable, necessary and customary amounts.</i>
Hospital stays — semiprivate room and board. Private room and board is covered only when a private room is medically necessary because of contagious disease. Otherwise, if you choose a private room, the semiprivate room rate will be paid.	100% coverage, after \$300 admission co-pay (maximum of two co-pays per family per year).	80% coverage, after your deductible. Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.
Special hospital services — including the use of an operating room, medicines and dressings, blood transfusions (blood and blood plasma), oxygen and its administration and other necessary services received during a hospital stay. Also includes doctors' visits during hospitalization.	100% coverage.	80% coverage, after your deductible. Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.
Pre- and post-admission testing — when the tests are related to a hospital admission or surgery in an ambulatory surgical facility.	100% coverage.	80% coverage, after your deductible.
Hospital emergency care — use of an emergency room and associated hospital services (network or out-of-network) when emergency treatment is required for an injury or illness that, if not treated immediately, would, in the judgment of a reasonable person, jeopardize your life or seriously impair your health — such as excessive bleeding, loss of consciousness or severe chest pain. Includes doctors' visits while you're in the emergency room. Follow-up care must be performed or authorized by your primary care physician.	100% coverage, after you pay a \$50 co-pay. If the benefits administrator determines that your condition doesn't qualify as an emergency, services will be covered at 80%, after the out-of-network deductible, whether you used a network or an out-of-network emergency room. If you're admitted to the hospital in an emergency, you don't have to pay the \$50 co-pay. However, you must call the benefits administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances). If you don't call, your benefits will be reduced by half, up to a maximum of \$1,000.	

Urgent care facilities — physician and facility charges and associated medical services/supplies. A referral may be required by some plan administrators.	100% coverage, after you pay a \$30 co-pay.	80% coverage, after your deductible.
Outpatient ambulatory surgical facilities — operating room and related special services in a facility that has met criteria established by the benefits administrator for handling surgical cases on a same-day basis. Co-pay not applicable to routine colonoscopies and sigmoidoscopies.	100% coverage, after \$100 co-pay for each procedure, not to exceed 2 such co-pays per family per year. Only one co-pay will be charged if multiple procedures are performed in a single visit.	80% coverage, after your deductible.
Birth centers — Note that these facilities may not be available in all areas.	100% coverage.	80% coverage, after your deductible, up to the local area average charge for a one-day hospital stay for a normal delivery. The facility must be approved by the benefits administrator.
Extended care facilities — semiprivate room and board, special services, prescription drugs and medical supplies in a facility that provides 24-hour skilled nursing care, for up to 120 days, per stay, per diagnosis or related diagnosis, when the stay is for convalescent care that requires medical supervision and skilled nursing services and when ordered by a physician.	100% coverage.	80% coverage, after your deductible. Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.
Hospice care — for treatment of a terminally ill person who is expected to live six months or less. Services may be provided at home or in a hospice facility, and may include family counseling.	100% coverage.	80% coverage, after your deductible, when the treatment program is approved in advance by the benefits administrator. Advance approval is required; otherwise, benefits will not be paid.

Home health care — when services are performed by a home health care agency and the treatment program is approved in advance by the benefits administrator, including: <ul style="list-style-type: none">• Nursing care by a registered graduate nurse or under RN supervision;• Care by a home health aide (custodial care is not covered);• Physical, occupational, speech and cardiac rehabilitation therapy;• Medical supplies, prescription drugs and lab services; and• Medical social services by a qualified social worker under a doctor's supervision.	100% coverage.	80% coverage, after your deductible, when: <ul style="list-style-type: none">• Services begin within seven days after discharge from the hospital or the extended care facility; and• Services are for the same or a related condition for which you were confined. Advance approval is required; otherwise, benefits will not be paid.
Home infusion therapy — infusion treatment (including intravenous, subcutaneous or epidural) administered in your home.	100% coverage.	80% coverage, after your deductible. Advance approval is required; otherwise, benefits will not be paid.
Dialysis — services provided for end-stage renal dialysis (hemodialysis or peritoneal dialysis) in your home or at a facility.	100% coverage.	80% coverage, after your deductible. Advance approval is required; otherwise, benefits will not be paid.
Home therapy for hemophilia — when your treatment program is accredited by the National Hemophiliac Foundation.	100% coverage.	80% coverage, after your deductible. Advance approval is required; otherwise, benefits will not be paid.

Centers of Excellence — For procedures such as organ transplants, you may be offered an opportunity to use a Center of Excellence — a nationally-recognized medical institution known for quality care and experience in performing certain types of high-technology medical procedures.

100% coverage.

Not applicable (see "Hospital stays" on page 44).

If you accept treatment at a recommended Center of Excellence, the plan covers eligible hospital expenses. It also covers reasonable expenses for lodging, transportation and meals for the patient and one member of the patient's immediate family, provided the travel is approved in advance by the benefits administrator. Donor expenses will be covered if the donor's insurance does not provide such coverage, or if specifically required by facility contract.

2.2.4.5 BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT

GE Health Care Preferred offers two ways to access quality behavioral health and substance abuse treatment at a reduced cost — through your local Employee Assistance Program (EAP) and through the behavioral health and substance abuse treatment network.

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

Personal and confidential assessment, counseling and referral services, known as Employee Assistance Programs (EAPs), are available in many locations to help Company employees and their families cope with a wide variety of concerns, such as stress, marital and family conflicts, substance abuse and depression.

If you or your dependents need any type of behavioral health or substance abuse treatment, you or your dependents should contact your local EAP first. Through the EAP, you may be eligible for certain services, including short-term behavioral health treatment, at no cost to you. If you need additional treatment, the EAP will work with the behavioral health and substance abuse benefits administrator to refer you to providers within the treatment network.

Call 1-866-272-6007 to be referred to the EAP in your area. EAP is not available to former employees or retirees.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT NETWORK

A network of psychiatrists, psychologists, certified addiction counselors, social workers, hospitals and treatment centers has been set up to provide behavioral health and substance abuse treatment to Company employees and their families.

To be covered, all treatment must be medically necessary and approved in advance by the behavioral health benefits administrator. Advance approval is required for out-of-network care; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

When you obtain care from a network provider and your care is approved in advance by the behavioral health administrator, you receive maximum benefits. In areas where network providers are not available, the behavioral health administrator will work with you to find a provider, so that maximum benefits can be paid.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
GE Health Care Preferred		
Care must be approved in advance by the behavioral health benefits administrator. Limits apply to behavioral health and substance abuse treatment combined.		
Covered services include:	Network	Out-of-Network <i>Benefits are paid up to reasonable, necessary and customary amounts.</i>
Outpatient visits	100% coverage, after you pay a \$15 co-pay for each office visit. Advance approval is required.	80% coverage, not subject to an annual deductible. Advance notification is required.

Hospital stays — Services performed by behavioral health or substance abuse treatment providers, such as psychiatrists or psychologists, during an inpatient hospital stay are covered as outpatient visits, but may be subject to a co-pay. See "Outpatient visits" on page 48.

100% coverage, after a \$300 co-pay (maximum of two co-pays per family per year*). **Advance approval is required.**

80% coverage, after your deductible.

Advance notification is required.

Halfway house — A halfway house is a supervised accredited or licensed residential facility or program as determined by the behavioral health administrator. You must be actively involved in onsite or community based outpatient individual, group and/or family treatment.

100% coverage.

Advance approval is required.

80% coverage, not subject to an annual deductible.

Advance notification is required.

Substance Abuse Centers of Excellence — For the treatment of substance abuse, you may be offered an opportunity to use a Center of Excellence — a nationally recognized medical facility known for quality care and experience in treating substance abuse.

100% coverage, after a \$300 co-pay (maximum of two co-pays per family per year*).

Advance approval is required.

Not applicable (see "Hospital stays" on page 49).

If you accept treatment at a recommended Center of Excellence, treatment for relapse within one year is covered at 100%.

** Combined for medical-surgical and behavioral health inpatient hospital stays.*

DIAGNOSIS OF BEHAVIORAL HEALTH CONDITIONS

Diagnostic procedures and services used to determine a psychiatric condition, such as neuro-psychological testing, will be reimbursed based on the type of provider rendering the service (i.e., by the behavioral health administrator if provided by a psychiatric specialist, or otherwise by the medical benefits administrator).

MAXIMIZING BEHAVIORAL HEALTH BENEFITS

Please note that EAP is not available to former employees or retirees. To make the most of your behavioral health and substance abuse benefits:

1. **Contact your local Employee Assistance Program (EAP) first** — for confidential assessment, counseling, short-term treatment and referrals — at no cost to you.
2. **For further treatment, call your behavioral health benefits administrator** — for advance approval; otherwise, your benefits will be reduced. See the back of your medical ID card for the phone number.

2.2.4.6 ACCIDENT-RELATED DENTAL SERVICES

Services for dental work and oral surgery are covered under GE Health Care Preferred if they are for the initial repair of an injury to the jaw, sound teeth or dental appliances, mouth or face which are required as a result of an accident. Injury as a result of chewing or biting is not considered an accidental injury unless due to a foreign object. "Initial repair" means services performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. Longer periods may be appropriate for children.

Covered services include, but are not limited to:

- Oral examinations;
- Diagnostic x-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/maxillary reconstruction;
- Anesthesia; and
- Emergency care

Benefits will be payable in accordance with the type of service performed.

Necessary orthodontic treatment for adults and children, required as a result of an injury will also be covered under the dental plan, except for orthodontic treatment that would have been necessary in the absence of the injury.

2.2.4.7 SPECIAL COVERAGE FOR CLINICAL TRIALS

To provide Company employees with access to the latest medical research and clinical developments on cancer, heart disease, arthritis, asthma and many other serious or chronic illnesses, GE Health Care Preferred covers expenses for investigational or experimental treatments.

GOVERNMENT-SPONSORED CLINICAL TRIALS

To be eligible for this coverage, you must qualify for and participate in a clinical research trial approved by the National Institutes of Health, the Food and Drug Administration, Centers for Disease Control, the Agency for Health Care Research and Quality, and the Department of Defense.

OTHER CLINICAL TRIALS

In addition, clinical trials sponsored by other entities may also be covered if approved by the benefits administrator, provided that the clinical trial has passed independent scientific review and has also been approved by an Institutional Review Board that will oversee the trial; and the clinical trial must be conducted in a setting and by personnel who maintain a high level of expertise because of their training, experience, and volume of patients. An institutional review board is an independent ethics committee usually associated with a university or physician accrediting organization that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the aim to protect the rights and welfare of the subjects.

For the purposes of this provision, "independent scientific review" includes, but is not limited to:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
- Peer-reviewed literature or biomedical compendia from such sources as the National Institute of Health's National Library of Medicine.

Expenses associated with all other investigational or experimental treatments are not covered under the plan. See Section 2.4, "What's Not Covered."

For information about clinical trials, talk with your physician. Information on government-sponsored clinical trials is also available online, at www.clinicaltrials.gov.

YOUR COSTS FOR CLINICAL TRIALS

The benefits available for clinical trials are covered at 100%, not subject to deductible.

Please Note —

- If you choose to participate in a clinical trial, you must notify your benefits administrator before treatment begins. Benefits will be determined and paid, subject to plan provisions, only for those expenses that would not be eligible for reimbursement under research grants funded by government or other sources, and which you would otherwise be obligated to pay if you were not covered under the plan. Certain nonmedical expenses related to clinical trials, such as travel to and from a facility and living accommodations for the patient and family members, are not covered by the plan.

2.3 GE MEDICAL BENEFITS

Under GE Medical Benefits, a traditional indemnity-type health plan, you can see any provider and use any hospital. Most benefits are based on a percentage of charges for covered services subject to an annual deductible. To be reimbursed for covered services, you will need to file a claim form. You can reduce your out-of-pocket costs by using preferred providers and other network options, where available.

2.3.1 KEY THINGS TO KNOW

GE Medical Benefits offers broad medical coverage for:

- Preventive screenings;
- Doctors, medical services and supplies;
- Surgery, tests and other services;
- Hospitals, special facilities and programs;
- Prescription drugs;
- Behavioral health and substance abuse treatment; and
- Clinical trials.

In general, the plan pays benefits based on a percentage of reasonable, necessary and customary charges.

The plan pays a percentage of covered charges. Some services are subject to a deductible or are subject to a co-pay.

Once you reach your annual out-of-pocket maximum, the plan pays 100%.

Advance approval is required for certain services.

For care in a hospital, special facility or other program, call your benefits administrator at the toll-free number on your medical ID card.

For behavioral health or substance abuse treatment, you'll need to call the number on the back of your medical ID card.

If you don't call when required, your benefits will be reduced. See Section 2.3.3, "How GE Medical Benefits Works" and Section 2.3.4.5, "Behavioral health and substance abuse treatment."

You can reduce your out-of-pocket medical costs by using preferred providers and other network options, where available.

Preferred hospitals — The plan pays 100% after a \$300 co-pay at a preferred hospital (maximum two co-pays per family per year*), or after a \$400 co-pay at a nonpreferred hospital; advance approval is required.

Preferred doctors and labs — You pay less because providers charge reduced rates; there are no claim forms to file in most cases.

Network pharmacies — You pay your co-pay directly to the network pharmacist; there are no claim forms to file. See Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

Mail Order Pharmacy Service — You can order medications you need regularly through the mail for added savings. See Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

Behavioral health and substance abuse treatment network — You receive maximum benefits when you use network providers; advance approval is required.

* Combined for medical-surgical and behavioral health inpatient hospital stays.

For important information about the administration of GE Medical Benefits, see Section 8.0, "Administrative Information."

2.3.2 KEY THINGS TO DO

Obtain advance approvals, when required:

- **Call your benefits administrator** (at the toll-free number on your medical ID card) — before care in a hospital, special facility or other program; otherwise, your benefits will be reduced. See Section 2.3.3.2, "When must I call the benefits administrator?"
-

In an emergency — get help immediately if you have an injury or illness that, if not treated immediately, would, in the judgment of a reasonable person, jeopardize your life or seriously impair your health. If you're admitted to the hospital, call your benefits administrator at the toll-free number on your medical ID card by the end of the next business day, or your benefits will be reduced. See Section 2.3.3.2, "When must I call the benefits administrator?"

Schedule preventive screenings — assess your risk for certain diseases and illnesses through periodic physicals, screenings and other preventive care services that are available; see Section 2.3.4.1, "Preventive screenings." Then work with your physician to create a plan to keep your health risks low or decrease them. Also, ask your human resources representative about any additional services that may be offered where you work.

Save by using preferred providers, where available — when you use a preferred hospital, your co-pay is \$300. At nonpreferred hospitals, your co-pay is \$400. Other preferred providers may be available in your area. See Section 2.3.3.1, "How can I save by using preferred providers?"

Save on prescription drug costs:

- At network pharmacies — for prescription drugs at reduced rates. See "Network pharmacies" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits"; or
 - Through Mail Order Pharmacy Service — for medicines you need regularly. See "Mail Order Pharmacy Service" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."
-

Follow reasonable, necessary and customary guidelines — to avoid paying more than you should. See Section 2.3.3.5, "How does reasonable, necessary and customary work?"

File claims by June 30 — for expenses that were incurred during the previous calendar year. See Section 2.3.3.6, "How do I claim benefits?"

2.3.3 HOW GE MEDICAL BENEFITS WORKS

GE Medical Benefits offers broad medical coverage for you and your family, including coverage for certain preventive screenings. You can see any physician or other provider and go to any hospital. Advance approval is required for certain services. In general, the plan pays benefits based on a percentage of reasonable, necessary and customary expenses; some services are subject to a deductible. You can reduce your out-of-pocket costs by using preferred providers and other network options, where available.

Here's an overview of how GE Medical Benefits works:

- **You go to any provider** — you go to the doctor or other provider of your choice and show your medical ID card. The provider charges a fee for each medical service. You can reduce your out-of-pocket medical costs by using preferred providers and other network options, such as the Mail Order Pharmacy Service.
- **The plan pays benefits based on a percentage of reasonable, necessary and customary charges for covered services** — however, some services are subject to an annual deductible or co-pay.
- **Once you reach your out-of-pocket maximum, the plan pays 100%** — in most cases, once your share of covered expenses reaches your annual out-of-pocket maximum, the plan pays the full cost of your covered expenses for the rest of the calendar year. Note that a separate co-pay maximum applies to prescription drug expenses.
- **Advance approval is required, in some cases:**
 - For care in a hospital, special facility or other program — you must call your benefits administrator to obtain advance approval; otherwise, your benefits will be reduced. If you're admitted to the hospital in an emergency, you have until the end of the next business day to call.
 - For behavioral health and substance abuse treatment — you must call the benefits administrator for advance approval; otherwise, your benefits will be reduced.
- **You file claims** — for reimbursement of covered expenses. Some doctors and hospitals will file claims for you.

REASONABLE, NECESSARY AND CUSTOMARY CHARGES

To make sure you aren't charged more than is customary for the supplies or services you receive, the benefits administrator will review all charges to ensure they are reasonable, necessary and customary.

Services and supplies are determined by the benefits administrator to be reasonable, necessary and customary if they are:

- Appropriate and consistent with the diagnosis or symptoms;
- Consistent with accepted medical standards;
- Not experimental or investigational;
- Not provided solely on a convenience or personal basis; and
- Employed appropriately, effectively and safely with respect to the type and level of care.

In addition, the amounts paid for such services or supplies must be customary for your area, taking into account the nature and complexity of the service, the amounts paid for other individuals with similar conditions and the type of provider.

For more information about how reasonable, necessary and customary works, see Section 2.3.3.5, "How does reasonable, necessary and customary work?"

2.3.3.1 HOW CAN I SAVE BY USING PREFERRED PROVIDERS?

In certain parts of the country, hospitals and other providers, such as doctors and labs, offer services at reduced costs through preferred provider networks. When you use these preferred providers, the costs — to you and to the Company — are lower because the providers charge less. In addition, there are no claim forms to file, in most cases. A directory of preferred providers in your network will be made available to you at no charge; you may access this information through *benefits.ge.com* or by calling your benefits administrator at the toll-free number on your medical ID card.

2.3.3.2 WHEN MUST I CALL THE BENEFITS ADMINISTRATOR?

Nonemergency care in a hospital, special facility or other program must be reviewed and approved **in advance** to help ensure that your treatment is appropriate and reasonable. This service is performed by your medical benefits administrator. If you're admitted to the hospital in an emergency, you'll need to call for approval **by the end of the next business day**.

To obtain approval, call your benefits administrator at the toll-free number on your medical ID card. **If you don't obtain approval when required, most benefits for care in a hospital, special facility or other program will be reduced by half, up to a maximum of \$1,000. Certain services will not be covered without advance approval.**

You also can call your benefits administrator for referrals to preferred providers and for help in arranging a second opinion.

NONEMERGENCY CARE IN A HOSPITAL, SPECIAL FACILITY OR OTHER PROGRAM

Before you're admitted — to receive maximum benefits, you must call for approval **in advance** of nonemergency care in a hospital, special facility or other program. In some cases, the benefits administrator may require that you obtain a second opinion before your treatment is approved. If a second opinion is required, you'll be asked to see a doctor recommended by the benefits administrator. If you see the recommended doctor, costs associated with the required second opinion are paid at 100%. If you don't see the recommended doctor, benefits for a hospital stay will be reduced by half, up to a maximum of \$1,000.

While you're there — The benefits administrator will review your care to make sure you aren't kept in the hospital longer than you need to be. During your stay, you may be required to call the benefits administrator to authorize additional days. The benefits administrator will work with your doctor to help arrange any treatment you need during and after hospitalization. You and your doctor should discuss your initial length of stay, any changes to your length of stay and discharge plans.

If you stay in the hospital beyond the length of stay approved by the benefits administrator, benefits for covered hospital expenses during such period will be reduced by half, up to a maximum of \$1,000.

If you don't obtain advance approval when required, your benefits will be reduced or, in some cases, will not be paid.

IN AN EMERGENCY

In an emergency, seek help immediately. An emergency is a serious medical condition or symptom resulting from injury, illness or mental illness that arises suddenly and, in the judgment of a reasonable person, requires immediate treatment (generally within 24 hours of onset) to avoid jeopardizing your life or seriously impairing your health — such as excessive bleeding, loss of consciousness or severe chest pain. Conditions that do not require immediate treatment are not considered emergencies.

If you're admitted to the hospital in an emergency, you must call your benefits administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances); otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

EMERGENCY COVERAGE

For emergency coverage, see "Hospital emergency care" in Section 2.3.4.4, "Hospitals, special facilities and programs."

BE SURE TO CALL YOUR BENEFITS ADMINISTRATOR AT THE TOLL-FREE NUMBER ON YOUR MEDICAL ID CARD:

- For nonemergency care in a hospital, special facility or other program — in advance;
- In an emergency — by the end of the next business day if you're admitted to the hospital;
- For referrals to preferred providers and for help arranging second opinions; and
- For maternity stays — special provisions apply. See Section 2.1.3.9, "What other provisions may apply?"

IN AN EMERGENCY

If you're admitted to the hospital in an emergency, call your benefits administrator at the toll-free number on your medical ID card by the end of the next business day; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

2.3.3.3 WHAT'S MY DEDUCTIBLE?

For most outpatient services, you pay an initial amount in covered medical expenses each year before GE Medical Benefits begins to pay benefits. This amount is called your annual deductible. An individual deductible applies separately to you and to each of your covered dependents. A new deductible applies each calendar year (January 1 to December 31).

To help limit the number of individual deductibles a family must meet each year, the plan also has a family deductible. A family deductible is the total amount you and your covered dependents have to meet in deductibles each calendar year, regardless of how large your family is. When the combined amount you pay for your family's covered expenses in a calendar year reaches your family deductible, the plan begins to pay benefits for you and all your covered dependents.

Your deductible amount is based on your annual pay on October 31 of the prior year (or, for new employees hired after October 31, your annual pay on your date of hire). If you're absent on October 31, your deductible is based on your annual pay when you were last at work.

For the definition of pay, see "What pay counts" in Section 2.1.3.5, "How much does coverage cost?"

IF YOUR ANNUAL PAY IS...	YOUR ANNUAL DEDUCTIBLE IS...	
	Individual	Family
Up to \$24,999	\$150	\$300
\$25,000 - \$49,999	\$225	\$450
\$50,000 - \$74,999	\$375	\$750
\$75,000 - \$99,999	\$450	\$900
\$100,000 - \$149,999	\$525	\$1,050
\$150,000 or more	\$600	\$1,200

Your deductible amount does not change throughout the calendar year, regardless of any change in your pay or employment status.

Two additional features help limit the number of deductibles you must meet:

- **Yearly carryover** — Any covered expenses incurred during the last three months of one calendar year used to meet that year's deductible are carried over to help satisfy the next year's individual and family deductibles, as well; and
- **Family accident limit** — If two or more covered members of your family are injured in the same accident, you must meet only one deductible for their combined covered expenses related to the accident for that calendar year.

Please Note — Amounts you pay for prescription drugs do not count toward your annual deductible.

2.3.3.4 WHAT'S MY OUT-OF-POCKET MAXIMUM?

Once your share of covered expenses in a calendar year (your deductible, your hospital stay and hospital emergency room co-pays, plus your percentage portion) reaches your annual out-of-pocket maximum, the plan pays the full cost of your remaining covered expenses for that year. The annual out-of-pocket maximum is the most your family has to pay in covered medical expenses each calendar year.

Just like your deductible, your out-of-pocket maximum amount is based on your annual pay on October 31 of the prior year (or, for new employees hired after October 31, your annual pay on your date of hire). If you're absent on October 31, your out-of-pocket maximum is based on your annual pay when you were last at work. For the definition of pay, see "What pay counts" in Section 2.1.3.5, "How much does coverage cost?"

IF YOUR ANNUAL PAY IS...	YOUR ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING THE ANNUAL DEDUCTIBLE) IS...
Up to \$24,999	\$1,100
\$25,000 - \$49,999	\$1,350
\$50,000 - \$74,999	\$1,600
\$75,000 - \$99,999	\$1,850
\$100,000 - \$149,999	\$2,100
\$150,000 or more	\$2,350

Your out-of-pocket maximum amount does not change throughout the calendar year, regardless of any change in your pay or employment status.

Exceptions — Some expenses do not count toward your out-of-pocket maximum. These include amounts you pay:

- For prescription drugs; however, a separate co-pay maximum applies (see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits");
- When you do not follow required approval procedures or recommendations;
- Above plan benefits for preventive screenings;
- Above plan benefits for vision care;
- Above reasonable, necessary and customary limits; and
- For any expenses not covered by the plan.

OUT-OF-POCKET PROTECTION

Your annual out-of-pocket maximum protects you and your family by limiting the total amount you have to pay in medical bills each year.

2.3.3.5 HOW DOES REASONABLE, NECESSARY AND CUSTOMARY WORK?

Like most traditional medical plans, GE Medical Benefits pays benefits based on reasonable, necessary and customary amounts, as determined by the benefits administrator. See the definition of "reasonable, necessary and customary" in "Key Terms."

However, some health care providers who are not part of a preferred provider network may charge fees in excess of what's reasonable, necessary and customary. To help the benefits administrator resolve these situations, be sure to follow these steps:

1. **Talk to your doctor** — Be sure your doctor or other health care provider knows that your Company provides benefits based on what's considered reasonable, necessary and customary. Most doctors are familiar with this concept. Refer your doctor directly to the benefits administrator if he or she has any questions. Also, discuss with your doctor and your benefits administrator the potential cost for services.
2. **Read before signing** — Don't agree in advance to pay your doctor or other provider a specific amount. If you're asked to sign a statement before receiving medical services, read it carefully to make sure it doesn't obligate you to a certain level of payment.
3. **Authorize direct payment, if possible** — If your provider agrees, you can authorize payment of benefits directly to your provider. Simply sign the "Payment of Benefits" Section of your claim form and ask your provider to file the claim. This allows the benefits administrator to work out payment directly with your provider if the charges are above reasonable, necessary and customary amounts.

If you've followed these steps and your provider insists that you pay additional amounts, contact the benefits administrator as soon as possible. The benefits administrator will work with the provider on your behalf. Please note, however, that the provider may continue to bill you while the situation remains unresolved.

AVOID BILLING DISPUTES

When you use preferred providers, benefits are based on negotiated fees that are within reasonable, necessary and customary limits.

2.3.3.6 HOW DO I CLAIM BENEFITS?

1. **Present your medical ID card to your provider** — When you use a preferred provider — such as a preferred hospital, doctor or lab — there are no claim forms to file, in most cases. Be sure to ask your provider whether he or she is willing to bill the insurance company directly. If you are admitted to the hospital, confirm that the benefits administrator has approved your stay.
2. **If direct billing isn't possible, obtain a claim form** — from benefits.ge.com or from your benefits administrator.
3. **Complete and sign the form** — and attach a copy of the bill. Be sure that the bill includes your name, the patient's name, address, the diagnosis and procedure code for the service, the date of the service and the charge. Mail the form and bill to your benefits administrator at the address shown on the form.
4. **Receive notification** — You'll be notified of the amount you are responsible for paying.

Additional claims information —

- The benefits administrator has the right to require a medical examination of any person for whom a claim is made; and
- **You must submit your claims by June 30** for expenses that were incurred during the previous calendar year, unless you can show that it was not reasonably possible to do so.

For out-of-network prescription drug claims, see "Out-of-network pharmacies" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

Claims questions? If you have a question or problem with a claim:

1. **Gather basic information:**

- Your medical ID card and patient's name, if applicable;
- Provider name, date of service and amount of bill, if applicable; and
- Copies of any correspondence.

2. **Call the GE Medical Benefits Claims Center** — The toll-free number is on your medical ID card.

3. **Discuss the question with a customer service representative** — If you still have a question, ask for a supervisor.

If you need more help, call the GE Benefits Center at 1-800-252-5259.

TIMELY FILING

You must submit your medical claims **by June 30** for expenses that were incurred during the previous calendar year.

2.3.4 WHAT GE MEDICAL BENEFITS COVERS

GE Medical Benefits covers a range of services, including preventive health screenings, doctors' services, surgery, diagnostic imaging, laboratory tests, prescription drugs, hospital services, and behavioral health and substance abuse treatment, as described in the following Sections.

2.3.4.1 PREVENTIVE SCREENINGS

The Plan pays for preventive screenings provided on an outpatient basis at a Physician's office, an alternate facility or a Hospital when received from a Network Provider. Please note that preventive screenings provided out-of-Network are covered at reasonable and customary rates.

In general, the Plan pays preventive screenings based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive screenings may be covered as well. Your Physician may recommend more frequent screenings based on your family or medical history. Examples of preventive screenings are listed below and provide a guide of what is considered an Eligible Expense. Please check with your Claims Administrator to verify coverage. Age, gender, frequency and condition restrictions may apply.

Examples of Eligible Expenses for Preventive Screenings include:

Cancer Screenings

- Breast Cancer: Mammography
- Cervical Cancer: Laboratory Testing
- Colon Cancer: Colonoscopy, Sigmoidoscopy and associated laboratory tests, e.g. biopsy

Blood/urine and other laboratory tests to screen for the following:

- Rh Incompatibility
- Lipid Disorder — Cholesterol, lipoprotein, and triglycerides
- Bacteriuria (For pregnant women only)
- Chlamydial Infection
- Gonorrhea
- HIV
- Syphilis Infection
- HPV Detection
- Diabetes Type II
- Iron Deficiency Anemia
- Sickle Cell
- Lead

Annual Adult Wellness Physicals and Annual Routine Gynecological Care

- Physical Wellness Examination
- Annual Gynecologic Examination
- Primary Preventive Counseling
- Electrocardiogram (Annual screening)
- Obesity Screening
- Osteoporosis Screening
- Abdominal Aortic Aneurysm Screening

Immunizations

- Influenza (i.e. H1N1)
- DTaP (Diphtheria, tetanus, pertussis)
- Hepatitis A
- Hepatitis B
- Hib (haemophilus influenzae type b)
- Human Papilloma-virus (HPV)
- Meningococcal Conjugate (MCV) or Polysaccharide (MPSV)
- MMR (Measles, mumps and rubella)
- Pneumococcal polysaccharide (PPSV)
- Polio
- Rotavirus (RV)
- Tetanus
- Varicella (Chickenpox)
- Zoster (Shingles)

Pediatric Prevention through age 21

- Well child care visits
- Screening tests
- Newborn hearing
- Annual vision
- Developmental Screening (condition restrictions apply)

2.3.4.2 DOCTORS, MEDICAL SERVICES AND SUPPLIES

GE MEDICAL BENEFITS

Benefits are paid up to reasonable, necessary and customary amounts.

Covered services include:

Doctors' services — when provided in a doctor's office, a hospital or elsewhere. 80% coverage, after your deductible.

For psychiatrists' and psychologists' services, see Section 2.3.4.5, "Behavioral health and substance abuse treatment."

Physical, occupational, speech or cardiac rehabilitation therapy — to correct impairments caused by illness or injury, including congenital anomalies, as long as the therapy continues to produce improvement in the level of functioning within a reasonable period of time. Educational services are not covered. 80% coverage, after your deductible.

Chiropractic care — up to 15 visits in a calendar year, when necessary to treat a medical condition and when performed by a licensed chiropractor. Maintenance care is not covered. 80% coverage, after your deductible.

Nutritional consultations — up to three visits in a calendar year, when recommended by a doctor and provided by a licensed provider. These consultations are covered only for medical conditions that would appropriately include this service as part of the normal course of treatment (for example, diabetes). 80% coverage, after your deductible.

Diagnostic laboratory procedures — such as blood and urine tests used to diagnose an illness or injury. 80% coverage, after your deductible.

Other medical services and supplies — Expenses incurred for medical supplies prescribed by a licensed physician for therapeutic use in the treatment of an illness or injury including:

- Oxygen and its administration;
- Blood transfusions, including blood and blood plasma; and
- Implants may be covered to treat a severe condition for which there are no alternative treatments, i.e., dentures or bridges.

Items that are non-medical in nature, or "over-the-counter" items are not covered.

Injections — for medical conditions, such as allergies.

80% coverage, after your deductible.

Durable medical equipment — The rental or the purchase of durable medical equipment, including for therapeutic uses, when prescribed by a provider and approved by the benefits administrator. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Examples include but are not limited to:

80% coverage, after your deductible.

- Braces that stabilize injuries, or treat curvature of the spine
- C-pap machines for treatment of sleep apnea
- Circulators for post-surgical treatment
- Crutches
- Gait trainers
- Hospital beds
- Insulin pumps and related supplies
- Oxygen equipment
- Pacemaker monitors
- Prone standers
- Portable EKG devices
- Surgical sleeves/burn compression sleeves/surgical support hose
- Wheelchairs/custom fitted strollers

Non-covered items include, but are not limited to: air conditioners; humidifiers; dehumidifiers; special lighting or other environmental modifiers; surgical supports, except as otherwise provided under durable medical equipment; or articles of clothing.

Prosthetic appliances — Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered medical services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body part. Examples include:

80% coverage, after your deductible.

- Aids and supports for defective parts of the body, such as pacemakers, cochlear implants, intraocular lenses and electronic speech aids.
 - Breast prostheses whether internal or external, following a mastectomy, and two surgical bras per year, as required by the Women's Health and Cancer Rights Act; and wigs, the first one following cancer treatment, not to exceed one per year thereafter.
 - Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
-

Orthotic devices and supplies — includes the initial purchase, fitting, and repair of such devices and supplies. The cost of casting, molding, fittings and adjustments are included.	80% coverage, after your deductible.
--	--------------------------------------

Orthopedic shoes are covered for the following indications:

- Specially constructed shoes that are an integral part of a leg brace or prosthesis.
- Cast boots or shoes requested by the surgeon following a surgical procedure or treatment of a fracture.
- Custom made or custom fitted shoes for members with diabetes mellitus or complications involving the foot related to ulceration, peripheral neuropathy with evidence of callus, deformities, amputation or restricted circulation

Orthotic shoe inserts will be covered if custom molded and prescribed by a physician.

Orthotic appliances may be replaced once per year if required, except that additional replacements will be allowed for children due to growth, or for damaged, unrepairable appliances.

Corrective prescription or contact lenses used to treat a medical condition — an initial pair. For example, lenticular lenses for people who have had cataracts surgically removed, or contact lenses used as a bandage for treatment of keratoconus or similar conditions.	80% coverage, after your deductible.
--	--------------------------------------

Hearing aids — including hearing exams for the purchase of two hearing aids (every three years), fittings and repairs. Replacement parts (except for batteries) are covered.	100% coverage, subject to reasonable, necessary and customary limits.
---	---

Other specialists <ul style="list-style-type: none">• Podiatrists' services — when required for specialized foot care.• Audiologists — when required for rehabilitative testing or therapy.	80% coverage, after your deductible.
---	--------------------------------------

Christian Science practitioners' services — for healing purposes, provided the practitioner is accredited by the Mother Church in Boston, Massachusetts and is in your presence when the treatment is performed.	80% coverage, after your deductible.
---	--------------------------------------

Family planning supplies and services — In general, medical expenses related to the diagnosis and treatment of the condition of infertility are covered, but assisted reproductive services are not. In addition, the following are covered when provided in a doctor's office: <ul style="list-style-type: none">• Intrauterine devices (IUDs);• Diaphragms; and• Depo-Provera injections.	80% coverage, after your deductible.
--	--------------------------------------

For information on coverage for oral contraceptives and diaphragms under GE Prescription Drug Benefits, see "Family planning benefits" in Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits."

For information on coverage for sterilization procedures, see Section 2.3.4.3, "Surgery, tests and other services."

2.3.4.3 SURGERY, TESTS AND OTHER SERVICES

GE MEDICAL BENEFITS

Benefits are paid up to reasonable, necessary and customary amounts.

Covered services include:

Surgery.	80% coverage.
Anesthesia — and its administration.	80% coverage.
Diagnostic imaging procedures — such as x-rays, EKGs and other imaging procedures used to diagnose an illness or injury.	80% coverage.
Obstetrical services — when performed by a doctor or a licensed midwife who is a licensed registered nurse certified by the American College of Nurse Midwives. Services may be performed in a hospital, a birth center or your home.	80% coverage.
Chemotherapy and radiation therapy.	80% coverage.
Sterilization procedures — for tubal ligation, vasectomy or other sterilization procedures. Reverse sterilizations are not covered.	80% coverage.
Professional ambulance service — when medically necessary to transport the patient to the nearest hospital or facility where appropriate treatment is available. To be covered, ambulance transportation, including air ambulance, must be medically necessary. Medical necessity is established when the patient's clinical condition is such that the use of any other method of transportation would endanger the patient's medical condition.	80% coverage.

2.3.4.4 HOSPITALS, SPECIAL FACILITIES AND PROGRAMS

GE MEDICAL BENEFITS

Benefits are paid up to reasonable, necessary and customary amounts.

Covered services include:

Hospital stays — semiprivate room and board. Private room and board is covered only when a private room is medically necessary because of contagious disease. Otherwise, if you choose a private room the semiprivate room rate will be paid.

In some cases, a second opinion may be required by the benefits administrator.

If you use a preferred hospital, coverage is at 100% after a \$300 admission co-pay (maximum of two co-pays per family per year).

If you use a nonpreferred hospital, coverage is at 100%, after you pay a \$400 co-pay for each stay. If there is no preferred hospital near your home (either within the same three-digit zip code area or within 25 miles), your co-pay will be \$300. There is no limit on the number of co-pays for nonpreferred hospitals.

Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

If you stay in the hospital beyond the length of stay approved by the benefits administrator, benefits for covered hospital expenses during such period will be reduced by half, up to a maximum of \$1,000.

If you don't obtain a second opinion from a doctor recommended by the benefits administrator when required, your benefits for a hospital stay will be reduced by half, up to a maximum of \$1,000.

Special hospital services — including the use of an operating room, medicines and dressings, blood transfusions (blood and blood plasma), oxygen and its administration and other necessary services received during a hospital stay of at least 18 hours.

100% coverage.

Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

Doctors' visits during hospitalization are covered at 80%, after your deductible.

Pre- and post-admission testing — when testing is on an outpatient basis within 14 days:

- Before a hospital admission;
- Before surgery in an outpatient ambulatory surgical facility; or
- After discharge when the tests are related to a hospital admission or to surgery in an ambulatory surgical facility.

100% coverage.

Second opinions and related tests — that you request before a hospital admission or outpatient surgery. In some cases, a second opinion may be required by the benefits administrator.

100% coverage, when the opinion is provided by a doctor recommended by the benefits administrator.

If you don't obtain a second opinion from a doctor recommended by the benefits administrator when required, benefits for a hospital stay will be reduced by half, up to a maximum of \$1,000.

If you don't use a doctor recommended by the benefits administrator, benefits for the second opinion will not be paid.

Hospital emergency care — use of an emergency room and associated hospital services.	<p>100% coverage, after you pay a \$50 co-pay, when emergency treatment is for an injury within 24 hours after an accident or includes surgery. If the benefits administrator determines that your treatment does not meet these conditions, services will be covered at 80%, after your deductible.</p> <p>If you're admitted to the hospital in an emergency, you don't have to pay the \$50 co-pay, but the applicable co-pay for a hospital stay will apply. However, you must call the benefits administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances). If you don't call, your benefits will be reduced by half, up to a maximum of \$1,000.</p>
Urgent care facilities — physician and facility charges and associated medical services/supplies.	80% coverage, after your deductible.
Outpatient ambulatory surgical facilities — operating room and related special services in a facility that has met criteria established by the benefits administrator for handling surgical cases on a same-day basis.	100% coverage.
Birth centers — when the facility is approved by the benefits administrator.	<p>100% coverage, up to the local area average charge for a one-day hospital stay for a normal delivery.</p> <p>Charges for doctors and licensed midwives, and other professional fees, are covered at 80%.</p>
Extended care facilities — semiprivate room and board, special services, prescription drugs and medical supplies in a facility that provides 24-hour skilled nursing care, for up to 120 days, per stay, per diagnosis or related diagnosis, when the stay is for convalescent care that requires medical supervision and skilled nursing services and when ordered by a physician.	<p>100% coverage.</p> <p>Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.</p>

<p>Hospice care — for treatment of a terminally ill person who is expected to live six months or less. Services may be provided at home or in a hospice facility, and may include family counseling.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, benefits will not be paid.</p>
<p>Home health care — when services are performed by an approved home health care agency and the treatment program is approved in advance by the benefits administrator. The services must begin within seven days after discharge from the hospital or the extended care facility and be for the same or a related condition for which you were confined.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, benefits will not be paid.</p>
<p>Services include:</p> <ul style="list-style-type: none"> • Nursing care by a registered graduate nurse or under RN supervision; • Care by a home health aide (custodial care is not covered); • Physical, occupational, speech and cardiac rehabilitation therapy; • Medical supplies, prescription drugs and lab services; and • Medical social services by a qualified social worker under a doctor's supervision. 	
<p>Home infusion therapy — infusion treatment (including intravenous, subcutaneous or epidural) administered in your home.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, benefits will not be paid.</p>
<p>Dialysis — services provided for end-stage renal dialysis in your home or at a facility.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, benefits will not be paid.</p>
<p>Home therapy for hemophilia — when your treatment program is accredited by the National Hemophiliac Foundation.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, benefits will not be paid.</p>
<p>Centers of Excellence — For procedures such as organ transplants, you may be offered an opportunity to use a Center of Excellence — a nationally recognized medical institution known for quality care and experience in performing certain types of high-technology medical procedures.</p> <p>If you accept treatment at a recommended Center of Excellence, the plan covers eligible hospital expenses. It also covers reasonable expenses for lodging, transportation and meals for the patient and one member of the patient's immediate family, provided the travel is approved in advance by the benefits administrator. Donor expenses will be covered if the donor's insurance does not provide such coverage, or if specifically required by facility contract.</p>	<p>100% coverage.</p> <p>Advance approval is required; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.</p>

2.3.4.5 BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT

GE Medical Benefits offers two ways to access quality behavioral health and substance abuse treatment at a reduced cost — through your local Employee Assistance Program (EAP) and through the behavioral health and substance abuse treatment network.

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

Personal and confidential assessment, counseling and referral services, known as Employee Assistance Programs (EAPs), are available in many locations to help Company employees and their families cope with a wide variety of concerns, such as stress, marital and family conflicts, substance abuse and depression.

If you or your dependents need any type of behavioral health or substance abuse treatment, you or your dependents should contact your local EAP first. Through the EAP, you may be eligible for certain services, including short-term behavioral health treatment, at no cost to you. If you need additional treatment, the EAP will work with the behavioral health and substance abuse benefits administrator to refer you to providers within the treatment network.

Call 1-800-442-4227 to be referred to the EAP in your area. Please note that EAP services are not available to former employees and retirees.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT NETWORK

A network of psychiatrists, psychologists, certified addiction counselors, social workers, hospitals and treatment centers has been set up to provide behavioral health and substance abuse treatment to Company employees and their families.

To be covered, all treatment must be medically necessary and approved in advance by the behavioral health benefits administrator. Advance approval is required for both network and out-of-network care; otherwise, your benefits will be reduced by half, up to a maximum of \$1,000.

When you obtain care from a network provider and your care is approved in advance by the behavioral health administrator, you receive maximum benefits. In areas where network providers are not available, the behavioral health administrator will work with you to find a provider, so that maximum benefits can be paid.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
GE Medical Benefits		
Care must be approved in advance by the behavioral health benefits administrator. Limits apply to behavioral health and substance abuse treatment combined.		
Covered services include:	Network	Out-of-Network <i>Benefits are paid up to reasonable, necessary and customary amounts.</i>
Outpatient visits	100% coverage, after you pay a \$15 co-pay for each office visit. Advance approval is required.	80% coverage, not subject to an annual deductible. Advance notification is required.

Hospital stays — Services performed by behavioral health or substance abuse treatment providers, such as psychiatrists or psychologists, during an inpatient hospital stay are covered as outpatient visits, but may be subject to a co-pay. See "Outpatient visits" on page 48.

100% coverage, after a \$300 co-pay (maximum of two co-pays per family per year*). **Advance approval is required.**

80% coverage, after your deductible.

Advance notification is required.

Halfway house — A halfway house is a supervised accredited or licensed residential facility or program as determined by the behavioral health administrator. You must be actively involved in onsite or community based outpatient individual, group and/or family treatment.

100% coverage.

Advance approval is required.

50% coverage, not subject to an annual deductible. Your share does not apply toward your out-of-pocket maximum.

Advance notification is required.

Substance Abuse Centers of Excellence — For the treatment of substance abuse, you may be offered an opportunity to use a Center of Excellence — a nationally recognized medical facility known for quality care and experience in treating substance abuse.

100% coverage.

Advance approval is required.

Not applicable (see "Hospital stays" on page 72).

If you accept treatment at a recommended Center of Excellence, treatment for relapse within one year is covered at 100%.

** Combined for medical-surgical and behavioral health inpatient hospital stays.*

DIAGNOSIS OF BEHAVIORAL HEALTH CONDITIONS

Diagnostic procedures and services used to determine a psychiatric condition, such as neuro-psychological testing, will be reimbursed based on the type of provider rendering the service (i.e., by the behavioral health administrator if provided by a psychiatric specialist, or otherwise by the medical benefits administrator).

MAXIMIZING BEHAVIORAL HEALTH BENEFITS

Please note EAP is not available to former employees or retirees. To make the most of your behavioral health and substance abuse benefits:

1. **Contact your local Employee Assistance Program (EAP) first** — for confidential assessment, counseling, short-term treatment and referrals — at no cost to you.
2. **For further treatment, call your behavioral health benefits administrator** — for advance approval; otherwise, your benefits will be reduced. See the back of your medical ID card for the phone number.

2.3.4.6 ACCIDENT-RELATED DENTAL SERVICES

Services for dental work and oral surgery are covered under GE Medical Benefits if they are for the initial repair of an injury to the jaw, sound teeth or dental appliances, mouth or face which are required as a result of an accident. Injury as a result of chewing or biting is not considered an accidental injury unless due to a foreign object. "Initial repair" means services performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. Longer periods may be appropriate for children.

Covered services include, but are not limited to:

- Oral examinations;
- Diagnostic x-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/maxillary reconstruction;
- Anesthesia; and
- Emergency care

Benefits will be payable in accordance with the type of service performed.

Necessary orthodontic treatment for adults and children, required as a result of an injury will also be covered under the dental plan, except for orthodontic treatment that would have been necessary in the absence of the injury.

2.3.4.7 SPECIAL COVERAGE FOR CLINICAL TRIALS

To provide Company employees with access to the latest medical research and clinical developments on cancer, heart disease, arthritis, asthma and many other serious or chronic illnesses, GE Medical Benefits covers expenses for investigational or experimental treatments.

GOVERNMENT-SPONSORED CLINICAL TRIALS

To be eligible for this coverage, you must qualify for, and participate in, a clinical research trial approved by the National Institutes of Health, the Food and Drug Administration, Centers for Disease Control, the Agency for Health Care Research and Quality, and the Department of Defense.

OTHER CLINICAL TRIALS

In addition, clinical trials sponsored by other entities may also be covered if approved by the benefits administrator, provided that the clinical trial has passed independent scientific review and has also been approved by an Institutional Review Board that will oversee the trial; and the clinical trial must be conducted in a setting and by personnel who maintain a high level of expertise because of their training, experience and volume of patients. An institutional review board is an independent ethics committee usually associated with a university or physician accrediting organization that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the aim to protect the rights and welfare of the subjects.

For the purposes of this provision, "independent scientific review" includes, but is not limited to:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
- Peer-reviewed literature or biomedical compendia from such sources as the National Institute of Health's National Library of Medicine.

Expenses associated with all other investigational or experimental treatments are not covered under the plan. See Section 2.4, "What's Not Covered."

For information about clinical trials, talk with your physician. Information on government-sponsored clinical trials is also available online at www.clinicaltrials.gov.

YOUR COSTS FOR CLINICAL TRIALS

The benefits available for clinical trials are 100%, not subject to deductible.

Please Note — If you choose to participate in a clinical trial, you must notify your benefits administrator before treatment begins. Benefits will be determined and paid, subject to plan provisions, only for those expenses that would not be eligible for reimbursement under research grants funded by the government or other sources, and which you would otherwise be obligated to pay if you were not covered under the plan. Certain nonmedical expenses related to clinical trials, such as travel to and from a facility and living accommodations for the patient and family members, are not covered by the plan.

2.4 WHAT'S NOT COVERED?

As with all medical plans, some services and supplies are not covered by GE Health Care Preferred or GE Medical Benefits. Expenses not covered include:

- Services that are not considered reasonable, necessary and customary;
- Expenses that exceed plan limits, such as the extra cost for a private hospital room when the semiprivate room rate is paid;
- Hospice care, home health care, independent private duty nursing, home infusion therapy, home dialysis and home therapy for hemophilia when the treatment has not been approved in advance;
- Expenses incurred before you or a dependent became covered by the plan;
- Hearing aid batteries;
- Over-the-counter medications, as well as prescription medications for which there are over-the-counter equivalents in the prescribed strength;
- Services received in a US government hospital for injuries or illnesses related to military service;
- Custodial care — expenses for care that does not require the continuing services of a skilled medical or health care professional and which is furnished primarily to provide room and board, education, assistance with activities of daily living or other care for a mentally or physically disabled person;
- Cosmetic surgery or treatment, except for functional birth defects; accidental injury while insured under a GE Medical Care Option; reconstructive surgery after illness; or to remedy a deformity, disfigurement or defect resulting from disease, injury or congenital anomaly;
- Expenses you are not required to pay, including expenses that you would not have been asked to pay if you did not have coverage under a Company plan;
- Certain nonmedical expenses, such as travel to and from a facility and living accommodations for patients and family members, unless otherwise specified;
- Dental care, except hospital services, implants, and accidental dental injury as set forth in Section 2.2.4.6, "Accident-related dental services" and Section 2.3.4.6, "Accident-related dental services" (see Section 4.0, "Dental Care Options" for dental coverage);
- Services or supplies to treat TMJ (temporomandibular joint dysfunction);
- Routine vision care, such as eye exams, lenses and eyeglass frames (see Section 5.0, "Vision Care Benefits" for vision coverage) except as required to diagnose illness or injury;
- Laser surgery to correct vision impairment, (except under The GE Vision Care Premium Option);
- Exercise equipment (e.g., treadmills);

- Reverse sterilizations;
- Transsexual surgery;
- Expenses eligible to be paid or reimbursed in some other way, such as by another Company-provided plan or by:
 - Medicare (subject to maintenance of benefits);
 - Legal action or settlement from a third party (other than by a personal insurance policy held by you or a member of your family);
 - Workers' Compensation;
 - Another employer's group medical plan (subject to maintenance of benefits);
 - Any federal, state or local government plan or program of any country (except Medicaid); or
 - No-fault automobile insurance;
- Services of a person who normally resides in your home or who is a member of your immediate family;
- Treatment for illness or injury resulting from any act of war, declared or undeclared;
- Services or supplies when you are not under the continuing care of a doctor or in the presence of the provider;
- Services or supplies related to naturopathic or homeopathic medicine, or massage therapy;
- Acupuncture, except (a) when performed by a licensed medical doctor, or (b) with respect to anesthesia services, when performed by, or under the supervision of, a licensed medical doctor;
- Experimental or investigational services, supplies and treatments, or clinical trials except as provided in Section 2.2.4.7, "Special coverage for clinical trials" and Section 2.3.4.7, "Special coverage for clinical trials";
- Expenses for procedures and services related to assisted reproductive services (and any medicinal therapies used in conjunction with such services), including but not limited to the following: artificial insemination, in-vitro fertilization (IVF), intra-uterine insemination (IUI), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT); services for the acquisition of sperm and sperm collection, preservation or transfer; and services for egg retrieval and storage; and
- Other expenses not related to the diagnosis or treatment of illness or injury, such as weight-loss programs, or services or programs that are primarily residential or educational (such as early intervention programs), even if performed by a licensed provider, unless specifically described as covered in Section 2.2.4, "What GE Health Care Preferred Covers" and Section 2.3.4, "What GE Medical Benefits Covers," such as certain types of preventive care.

2.5 ALTERNATIVE HEALTH PLANS

Alternatives to GE Health Care Preferred and GE Medical Benefits, such as health maintenance organizations (HMOs), may be available in certain regions.

Eligibility for dependents and coverage provisions may be determined by the alternative health plan benefits administrator, and your contributions will be determined annually by the Company.

If you transfer coverage to or from an alternative health plan option or to or from any GE Medical Care Option, the benefits you receive in all plans will generally count toward your annual limits and lifetime maximum.

If you elect an alternative health plan, vision care and prescription drug benefits may be provided through the plan, though benefits will differ. You may participate in a GE Dental Care Option and enroll in a GE Health Care Flexible Spending Account (FSA) and other Company benefits for which you're eligible.

You'll receive more information about your coverage, benefits and costs, as well as enrollment materials, if you live in an area where an alternative health plan option is available.

2.6 WHEN YOUR GE HEALTH COVERAGE ENDS

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, active employees may be eligible to continue health care coverage at your own expense — and in some cases at the Company's expense — when your GE health coverage ends. You also may convert your group medical coverage to an individual policy, but not your GE dental or vision coverage or your GE Health Care Flexible Spending Account (FSA).

2.6.1 KEY THINGS TO KNOW

Generally, your GE health coverage — medical, dental and vision — ends when:

- You resign or are terminated;
- You stop making contributions;
- You or your covered dependent becomes ineligible; or
- You retire and don't meet the requirements for retiree medical, dental and vision coverage.

Active employees may be eligible to continue their GE Medical Care Option (including vision coverage) and GE Dental Care Options coverage under COBRA.

Generally, you pay 102% of the full cost of continuing coverage elected under COBRA.

In certain cases, your COBRA health coverage will be paid for by the Company. The length of Company-paid COBRA health coverage depends on why your GE coverage ended.

The Company will pay for some or all of your COBRA health coverage as follows:

- Disability — at no cost to you;
- Leave of absence — with regular employee contributions; and
- Layoff — at no cost to you during the severance period if you have three or more years of continuous service when you are laid off (if you have fewer than three years of continuous service, you pay the same contributions as an active employee).

Your dependents whose GE health coverage ends can continue it through COBRA on their own for up to 36 months, depending on why their GE coverage ended.

Your spouse can elect COBRA health coverage in case of divorce or legal separation.

Your dependent children who lose eligibility through a change in age can elect COBRA health coverage.

Same-sex domestic partners and children of same-sex domestic partners may also elect coverage on the same basis as COBRA.

If you die while an active employee, the Company provides one year of health coverage for your covered survivors.

Your eligible surviving dependents can receive up to 36 months of COBRA health coverage, with the first 12 months paid by the Company.

If you die while retired...

Your eligible surviving dependents may continue medical, dental and vision coverage by paying the full cost of coverage.

2.6.2 KEY THINGS TO DO

DON'T MISS THE OPPORTUNITY

Elect COBRA health coverage within 60 days — after the change in status that qualifies you for COBRA health coverage or **within 60 days** after the GE COBRA administrator mails your election form, whichever is later. **If you miss the 60-day deadline, you cannot enroll.**

Notify the GE COBRA administrator within 60 days in the event of a divorce or legal separation or if a dependent child becomes ineligible for GE health care benefits — so the person losing coverage can elect COBRA health coverage. **Remember** — your children who graduate or become too old for GE coverage can continue health care coverage through COBRA only if you notify **both** the GE Benefits Center at **1-800-252-5259** and the GE COBRA administrator at **1-800-877-7994** of the change in their dependent status. To obtain continuation benefits for a same-sex domestic partner upon termination of the relationship or failure to meet the criteria for same-sex domestic partnership, the GE Benefits Center must be notified **within 60 days** of the event.

WHILE COVERED UNDER COBRA HEALTH COVERAGE

Pay any initial contribution required within 45 days — of the date you elect COBRA health coverage to avoid termination of coverage. Subsequent payments must be made **within 30 days** of the beginning of the coverage period. If you fail to make timely payments, your coverage will be terminated and will not be reinstated.

Notify the GE COBRA administrator within 31 days after your marriage or the birth or adoption of your child — if you want to purchase additional COBRA health coverage for your new spouse or dependent. Your spouse's or child's COBRA health coverage will be retroactive to the date of the marriage, birth or adoption.

Notify the GE COBRA administrator if you become totally disabled, as determined by the Social Security Administration — within the first 60 calendar days of your COBRA health coverage and you want to purchase COBRA health coverage for up to an additional 11 months. See Section 2.6.3.5, "How long does COBRA health coverage continue?"

WHEN YOUR COBRA HEALTH COVERAGE ENDS

Decide — whether you want to convert medical coverage to an individual policy. Conversion to an individual policy is not available for GE dental or vision coverage or a GE Health Care FSA.

2.6.3 HOW COBRA HEALTH COVERAGE WORKS

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires employers like the Company to allow covered employees and their covered dependents to continue health care coverage at their own expense under certain circumstances when coverage would otherwise end. The coverage described in this Section may change as permitted or required by changes in any applicable law.

WHEN YOU BECOME ELIGIBLE FOR COBRA HEALTH COVERAGE

You may apply for COBRA health coverage for yourself and/or your covered dependents if your GE coverage would otherwise end because you are no longer an active employee (unless you were terminated for gross misconduct), or because your hours have been reduced to the extent that you no longer qualify for GE coverage.

Your spouse and each of your covered dependents may apply for COBRA health coverage if their GE health coverage would otherwise end because of your death, divorce or entitlement to Medicare, or because your dependent child becomes ineligible as a result of reaching the maximum dependent age or for some other reason. See Section 1.3, "Who qualifies as an eligible dependent?" for a description of eligible dependents.

You may add a new child — to your COBRA health coverage **within 31 days** after the child's birth or placement for adoption. See Section 1.4, "Who qualifies as a child?"

Same-sex domestic partners may also receive benefits on the same basis and on the same terms and conditions described in this Section as spouses, and eligible children of same-sex domestic partners will receive coverage on the same basis as other dependent children.

2.6.3.1 WHAT DOES COBRA HEALTH COVERAGE PROVIDE?

COBRA lets you continue the same coverage you had before the event that qualified you for COBRA health coverage, including:

- GE Medical Care Option (including prescription drug coverage and GE Vision Care); and/or
- GE Dental Care Option; and/or
- GE Health Care Flexible Spending Account, with after-tax contributions, depending on your account balance at the time of the qualified change in status.

COBRA health coverage continues for up to 18, 29 or 36 months, depending on how you or your dependent becomes eligible. See Section 2.6.3.5, "How long does COBRA health coverage continue?"

2.6.3.2 HOW MUCH DOES COBRA COST?

If you elect continued coverage under COBRA, you are required to pay 102% of the plan's cost in most cases, except as provided in the following Section. This cost includes the portion that the Company had paid on your behalf. Premiums are charged on an individual or a family basis.

In case of disability — If you (or a dependent) are disabled when your COBRA health coverage begins or become disabled within the first 60 days of COBRA health coverage, you must pay 102% of the cost for up to 18 months, then 150% for up to the next 11 months. However, in certain cases, the Company will provide some or all of your continued coverage.

2.6.3.3 ARE THERE OTHER TYPES OF FUNDING FOR COBRA HEALTH COVERAGE?

The Company will pay the cost of up to the first 12 months of your COBRA health coverage (18 months in the case of a work-related disability) as long as your continuous service or service credits are maintained in the following cases:

- **Disability** — at no cost to you;
- **Leave of absence** — with regular employee contributions; and
- **Layoff** — at no cost to you if you were laid off after completing three or more years of continuous service (otherwise, regular contributions apply).

When your Company-provided COBRA health coverage ends, you will be offered the opportunity to continue the remaining portion of your COBRA health coverage at your own expense for as long as you remain eligible, for up to a total of 18 months of continued coverage. If you are eligible for these benefits, you will have 60 days to elect coverage even if you have previously rejected coverage.

IN CASE OF PLANT OR OFFICE CLOSING

If you lose your job because of a plant or office closing, coverage under your GE Medical Care Option (including GE Vision Care) will continue for up to 12 months, through Company-provided COBRA health coverage. If your service is terminated after you have completed three or more years of continuous service, the Company will pay the cost of up to the first 12 months of your COBRA health coverage. Otherwise, regular contributions apply.

When your Company-provided COBRA health coverage ends, you will be offered the opportunity to continue the remaining portion of your COBRA health coverage at your own expense for as long as you remain eligible, up to a total of 18 months of continued coverage.

TRADE ADJUSTMENT ACT TAX CREDIT

In certain cases, a job loss may qualify you for a tax credit to help pay for COBRA coverage. Under the Trade Adjustment Act of 2002 ("TAA"), employees who lose their jobs and are certified by the U.S. Department of Labor or a state agency to receive TAA benefits, are eligible for this tax credit.

2.6.3.4 HOW DO I ELECT COBRA?

You'll receive an election form and more information about COBRA health coverage when you become eligible, in most cases. In case of a divorce, legal separation or the ineligibility of a dependent child, however, you or your family member must notify the GE COBRA administrator in writing or by telephone **within 60 days** of the event in order to receive enrollment information and to elect COBRA health coverage.

Once you receive your election forms, you can elect COBRA health coverage in writing, or at www.ceridian-benefits.com.

CONTACTING THE GE COBRA ADMINISTRATOR

You can contact the GE COBRA administrator at:
COBRAServ National Service Center
3201 34th St. South
St. Petersburg, FL 33711-3828
Online: www.ceridian-benefits.com
Telephone: 1-800-877-7994
Fax: 1-727-865-3648

ENROLLMENT AND PAYMENT DEADLINES

You must elect COBRA health coverage **within 60 days** after an event qualifies you for COBRA or **60 days after** the GE COBRA administrator mails your election form, whichever is later. Coverage in either case is retroactive to the date of the qualifying event. Remember, you need to notify the administrator **within 60 days** if a dependent becomes eligible. You will have an additional 45 days from the date you return your election form to pay any back premiums necessary to avoid termination of coverage. Termination is effective as of the date of the event. Coverage is not in effect until all monies due have been received.

You will receive invoices from the GE COBRA administrator for your initial payment and for subsequent monthly COBRA payments. If you fail to make payments for your COBRA health coverage within the required time period stated on your invoice your coverage will end.

If you waive COBRA health coverage within the first 60 days, you may subsequently revoke the waiver but only before the end of that 60-day period. If you revoke your waiver, coverage will be reinstated retroactively only to the date the waiver was revoked.

2.6.3.5 HOW LONG DOES COBRA HEALTH COVERAGE CONTINUE?

GE MEDICAL CARE OPTIONS AND GE DENTAL CARE OPTIONS

The length of time COBRA medical (including vision) and dental coverage lasts depends on the event that caused your eligibility.

For 18 months — COBRA health coverage for you and/or your dependents continues for up to 18 months if GE health coverage would otherwise be lost due to:

- Your reduction in hours; or
- Your change from active to inactive work status due to your:
 - Resignation;
 - Discharge (except for discharge for gross misconduct);
 - Disability;
 - Plant or office closing;
 - Strike;
 - Layoff;
 - Leave of absence; or
 - Retirement; or
- Your entitlement to and subsequent participation in Medicare (rather than GE health coverage), which would cause your spouse and dependents to lose eligibility for GE health coverage.

For 29 months — COBRA health coverage continues for up to a total of 29 months if:

- You or a dependent eligible for COBRA is permanently disabled at the time of the qualifying event or becomes permanently disabled within the first 60 calendar days of COBRA health coverage (as determined by the Social Security Administration); **and**
- You or your dependent notifies the GE COBRA administrator of the determination within 60 calendar days after the date the determination of disability is issued by the Social Security Administration and before the end of the initial 18-month COBRA period. You will need to provide a copy of the disability determination.

For 36 months — COBRA health coverage for your spouse and/or your dependents continues for up to a total of 36 months from the date any one of the following events occurs:

- Your death;
- Your divorce;
- Your entitlement to Medicare (only if your spouse and/or dependents are already covered under COBRA; if not, no COBRA health coverage will be provided, except as provided above); or
- Your dependent ceases to be eligible for coverage.

If any of these events occur while a dependent is covered under COBRA (because of an 18-month event described above), COBRA health coverage may be continued for up to a total of 36 months from the date of the first qualifying event.

GE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

COBRA health coverage for the GE Health Care FSA will last until the end of the calendar year in which the qualifying event occurred, unless at the time of the event your account balance was less than or equal to the remaining FSA contributions due for the rest of that year. In such case, no COBRA health coverage will be available.

WHEN THERE IS OTHER COVERAGE

If you become entitled to Medicare benefits and then lose GE health coverage within the next 18 months because you are terminated or your hours are reduced, your eligible dependents can purchase COBRA health coverage for the longer of 36 months from the date you became eligible for Medicare or 18 months after you lose GE health coverage.

If you're covered under Medicare or another group health care plan at the time of the COBRA-qualifying event, you can keep that coverage and enroll for COBRA health coverage. If you're eligible for coverage under Medicare or another group health care plan at the time of the qualifying event — but you don't participate — you are eligible for COBRA health coverage, but COBRA health coverage will end if you subsequently enroll in Medicare or another group health care plan.

2.6.3.6 WHAT HAPPENS IF I DIE?

If you die, your covered dependents will be offered the opportunity to elect up to 36 months of COBRA health coverage. The first 12 months of coverage will be provided by the Company to your dependents at no cost. Before the end of the 12th month, participants will be notified of the required monthly COBRA premium payment to continue coverage for as long as they remain eligible, for up to a total of 36 months.

2.6.3.7 WHEN DOES COBRA HEALTH COVERAGE END?

COBRA health coverage ends on the earliest of the following:

- When you or your dependent becomes eligible for coverage under Medicare or another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition you or your dependent may have;
 - COBRA health coverage ends only for the person who becomes eligible for Medicare; individuals who are not eligible for Medicare may continue their COBRA health coverage;
- When you do not make payments as required;
- When the plan and other plans offered by the Company are terminated;
- If your coverage is extended due to disability, the date on which the Social Security Administration determines you are no longer disabled; or
- When the COBRA continuation period — 18, 29 or 36 months — ends.

CONVERSION

If your GE medical coverage ends for any reason, including exhaustion of COBRA health coverage, you may change your group coverage to a different policy. If you convert coverage, the coverage provisions may differ from the coverage you had as a Company employee. You must apply for conversion directly with the benefits administrator. To do so, you must call the benefits administrator at the number shown on your medical ID card to request a conversion form as soon as possible after the event. You must contact the benefits administrator and apply for conversion (i.e., complete and send the conversion form to the benefits administrator) **within 31 days** from the date your GE plan coverage ends.

Conversion to an individual policy is not available for GE dental or vision coverage or a GE Health Care FSA.

CERTIFICATION OF COVERAGE

When your COBRA health coverage ends, you will receive a certificate of coverage stating how long you were covered. Prior coverage may reduce the length of time you are subject to any pre-existing condition limit under a new plan. You also may request a certificate of coverage **within 24 months** after coverage ends by contacting the GE COBRA administrator at 1-800-877-7994.

PAY ON TIME

You will receive invoices for your initial and monthly COBRA payments. If you fail to make payments for your COBRA health coverage within the required time period stated on your invoice, your coverage will end and will not be reinstated.

2.7 SUBROGATION

If you receive reimbursement, or are entitled to receive reimbursement, for expenses previously paid by a Company-provided plan, the benefits administrator has the right to recover that amount from you or any third party who has primary obligation to make payment — a policy called subrogation.

Upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment for covered medical services made by the Responsible Party to a Covered Person to the full extent of benefits provided or to be provided by the plan. In addition, if a Covered Person receives any payment for covered medical services from any Responsible Party or Insurance Coverage the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay, up to and including the full amount the Covered Person receives from any Responsible Party. The following provisions set forth the rights of the plan.

- (a) **Constructive Trust.** By accepting benefits under this plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. This responsibility is a fiduciary duty to the plan.
- (b) **Lien Rights.** The plan will automatically have a lien to the extent of benefits paid for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan.

- (c) **First-Priority Claim.** By accepting benefits under this plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.
- (d) **Applicability to All Settlements and Judgments.** The terms of this section shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.
- (e) **Cooperation.** The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid and shall promptly notify the plan of the Covered Person's intention to pursue a claim.
- (f) **Definitions for Terms Used in this section.**
 - (i) "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party or any insurance coverage.
 - (ii) "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage such as no fault automobile insurance coverage or workers compensation coverage. Except as provided in the preceding sentence with respect to no-fault automobile insurance, the term "Insurance Coverage" does not include policies of insurance issued to the employee or to any family member who ordinarily resides in the employee's household.
 - (iii) "Covered Person" includes employees, retirees and dependents.

3.0 PRESCRIPTION DRUG BENEFITS

The GE Health Care Preferred and GE Medical Benefits options provide prescription drug coverage through retail pharmacies and through a mail order service. Your prescription drug coverage offers savings and convenience. You pay a co-pay for each prescription you order, up to an annual co-pay maximum.

3.1 KEY THINGS TO KNOW

GE Prescription Drug coverage pays benefits for prescription drugs purchased at network pharmacies and through the Mail Order Pharmacy Service.

- Prescriptions will be filled with generic or co-branded drugs whenever possible.
 - In some areas, network doctors may prescribe from an approved list of medications.
 - Under GE Health Care Preferred, prescription drugs purchased at out-of-network pharmacies are not covered.
-

When you use a network pharmacy...

You pay a co-pay for each prescription you order.

- Your co-pay will vary depending on the day-supply of medication and whether you purchase a generic, brand-name or specialty drug.
 - The benefits administrator, may ask you or your doctor to provide additional information before your prescription is filled.
 - Over-the-counter medications and prescription medications for which there are over-the-counter equivalents in the prescribed strength, are not covered.
-

When you use the Mail Order Pharmacy Service...

- You pay a co-pay for up to a 90-day supply of each prescription.
 - Your co-pay will vary depending on whether you purchase a generic, brand-name, or specialty drug.
-

Your out-of-pocket costs for co-pays are limited each year...

- By an annual prescription drug co-pay maximum.
 - You can lower costs by using a GE Health Care Flexible Spending Account.
-

3.2 KEY THINGS TO DO

Use generic or co-branded drugs whenever possible — generic and co-branded drugs contain the same active ingredients as the brand-name drug and are subject to the same Food and Drug Administration (FDA) standards for quality.

Order prescription drugs you need regularly by mail — you can get up to a 90-day supply of medication for less money, and have the added convenience of home delivery. Some drugs have quantity limits, certain controlled substances can only be filled 30 days at a time.

Go online to access information about the prescription drug plan — you can access information about your prescriptions, coverage, network pharmacies and order prescriptions and refills by mail at the CVS Caremark website, www.caremark.com.

Remember to show your prescription drug ID card when you use a network pharmacy — the ID card provides information about your coverage and co-pay amounts.

3.3 PRESCRIPTION DRUG PARTICIPATION

As a participant of GE Health Care Preferred or GE Medical Benefits, you have prescription drug coverage through retail pharmacies and through a mail order service.

3.3.1 WHO IS ELIGIBLE?

You are eligible for prescription drug coverage if you're enrolled in GE Health Care Preferred or GE Medical Benefits. If you join an alternative health plan, such as a Health Maintenance Organization (HMO), your prescription drug benefits will be different. Contact your prescription drug benefits administrator or your HMO for details.

If you are eligible, coverage begins automatically when your GE Medical Care Option coverage begins. The same is true for your dependents. GE Prescription Drug Coverage ends when your or your dependents' GE Medical Care Option coverage ends. For more information, see Section 2.1.3, "Medical Participation."

3.3.2 WHAT IF THERE IS OTHER COVERAGE?

If you have other prescription drug coverage, such as through a spouse's or same-sex domestic partner's plan at work or through Medicare, maintenance of benefits applies. See Section 2.1.3.6, "What if there is other coverage?"

3.4 PRESCRIPTION DRUG COVERAGE FOR GE HEALTH CARE PREFERRED AND GE MEDICAL BENEFITS

This Section describes your options for purchasing prescription drugs through GE Health Care Preferred and GE Medical Benefits.

Please Note —

- **Prescription drugs purchased at out-of-network pharmacies are not covered under GE Health Care Preferred.**
- Over-the-counter medications and prescription medications for which there are over-the-counter equivalents in the prescribed strength are not covered.
- The benefits administrator may ask you or your doctor to provide additional information before your prescription is filled.
- In some areas, network doctors may prescribe from an approved list of medicines.
- Prescriptions will be filled with generic or co-branded drugs whenever possible.

ABOUT SPECIALTY DRUGS

Specialty drugs are those that are generally used for the treatment of chronic or other serious illnesses. These medications are often available only through specialty pharmacies and are significantly more expensive than other prescription drugs.

Certain specialty drugs will no longer be covered as part of a physician's visit, and will only be covered under your GE Prescription Drug Benefits.

NETWORK PHARMACIES

Network pharmacies have agreed to charge reduced prescription drug rates. When you fill your prescription at a network pharmacy, you pay a co-pay for each prescription you order. For example, if your prescription is for a 21-day supply of medication (or any part thereof) you would pay:

- A \$12 co-pay for a generic drug (or the price of the prescription, if less); or
- A \$30 co-pay for a brand-name drug, whether or not a generic substitute is available (plus the difference in cost if a lower cost generic drug is available); or
- A \$30 co-pay for a specialty drug, whether or not a generic substitute is available (plus the difference in cost if a lower cost generic drug is available).

Your co-pay increases with the quantity of medication you request. If your prescription is for a 30-day supply, your co-pay will be \$24 for a generic drug (or the price of the prescription, if less) or \$60 for a brand-name drug (plus the difference in cost if a lower cost generic drug is available). For a specialty drug, your co-pay for a 30-day supply will be \$60.

You pay your co-pay directly to the pharmacist at the time of purchase — with no claim forms to file afterward. In addition, when you use a network pharmacy, each prescription is added to your personal medication history (including those medications purchased through mail order, as described in this section), which may help avoid potentially harmful drug interactions or other problems.

Please be sure to present your prescription drug ID card to your pharmacist each time you or your covered family member purchases a prescription drug. If you do not show your ID card when purchasing a prescription, you'll need to pay the pharmacy's full charge at the time of purchase and then file a claim form for reimbursement.

To find a network pharmacy in your area, visit www.caremark.com or call GE Prescription Drug Benefits at 1-800-509-9891.

OUT-OF-NETWORK PHARMACIES

Under GE Medical Benefits, you may also fill your prescriptions at an out-of-network pharmacy. You'll receive the benefits described above for prescriptions filled at a network pharmacy; **however, you'll need to pay the pharmacy's full charge at the time of purchase and then file a claim form for reimbursement.**

You can obtain a claim form at benefits.ge.com or CVS Caremark or by calling GE Prescription Drug Benefits at 1-800-509-9891.

YOUR COVERAGE						
If your prescription is for a supply of...	The plan pays 100%, after your co-pay* of...					
	Network pharmacy			Mail Order Pharmacy Service (one co-pay, for up to a 90-day supply)		
	Generic	Brand	Specialty	Generic	Brand	Specialty
Up to 21 days	\$12 (one co-pay)	\$30 (one co-pay)	\$30 (one co-pay)	\$20	\$65	\$65
22 - 42 days	\$24 (two co-pays)	\$60 (two co-pays)	\$60 (two co-pays)	\$20	\$65	\$65
43 - 63 days	\$36 (three co-pays)	\$90 (three co-pays)	\$90 (three co-pays)	\$20	\$65	\$65
64 - 84 days	\$48 (four co-pays)	\$120 (four co-pays)	\$120 (four co-pays)	\$20	\$65	\$65
85 - 90 days	\$60 (five co-pays)	\$150 (five co-pays)	\$150 (five co-pays)	\$20	\$65	\$65

* If your prescription costs less than the co-pay, you pay the cost of the prescription. If you or your doctor requests a brand-name prescription drug when a lower-cost generic or co-branded substitute is available, you pay the difference in price, in addition to your co-pay — unless the brand-name drug is medically necessary, as determined by the benefits administrator.

MAIL ORDER PHARMACY SERVICE

Through the Mail Order Pharmacy Service, you can order prescribed drugs through the mail conveniently and economically. The mail order service is especially valuable whenever you need medicines regularly, such as for long-term or health maintenance conditions. **Prescribed prenatal vitamins are covered only when purchased through the Mail Order Pharmacy Service.**

In addition, there are some medications, such as narcotics, that are available through the Mail Order Pharmacy Service, but which cannot be filled for a 90-day supply. Also, certain drugs may not be available through Mail Order Pharmacy Service.

With each order, you send a \$20 co-pay for generic drugs, a \$65 co-pay for brand-name drugs or a \$65 co-pay for specialty drugs (or the price of the prescription, if less) for each prescription, up to a 90-day supply. This service is not available outside the United States.

Here's how to use the Mail Order Pharmacy Service:

1. **Ask your doctor to write your prescription for up to a 90-day supply** — and refills for up to a one year supply.
2. **Mail your original prescription, a completed order form and your payment (which must accompany your order)** — to CVS Caremark. You can send a check or money order, or you may authorize billing to your personal credit card. You can obtain forms at www.caremark.com or by calling GE Prescription Drug Benefits at 1-800-509-9891.
3. **Receive your order** — via US Mail or UPS within two weeks, along with instructions for ordering refills.

For your first order — you'll need to include a completed patient profile with your first order (and whenever you need to update your personal or medical information). This helps alert the Mail Order Pharmacy Service pharmacist to potential interactions or problems with other prescription drugs you're currently taking. All information remains confidential.

To help make the transition to mail order easier, you also may want to ask your doctor to write an additional prescription that you can fill at your local retail pharmacy while your mail order is being processed.

To order refills — you can order your prescription refills online at www.caremark.com or over the phone by calling GE Prescription Drug Benefits at 1-800-509-9891.

ANNUAL PRESCRIPTION DRUG CO-PAY MAXIMUM

A prescription drug co-pay maximum limits your out-of-pocket expenses for covered network and mail-order prescription drug co-pays in one calendar year. The annual maximum is \$2,500 per participant or \$5,000 per family (two or more participants). Once you reach the annual co-pay maximum, the plan will pay 100% of covered co-pay expenses for the remainder of the calendar year. Plan rules concerning medical necessity and prior authorization will continue to apply.

Please Note — Expenses counting toward the prescription drug co-pay maximum **will not** apply to any other out-of-pocket maximum. In addition, the following expenses **will not** count towards the prescription drug co-pay maximum, and you will remain responsible for such expenses in the event you reach the maximum:

- Expenses incurred for prescriptions purchased at an out-of-network pharmacy; and
- Expenses incurred above the applicable co-pay when a brand-name or specialty drug is purchased and a lower cost generic or co-branded drug is available.

ABOUT GENERIC AND CO-BRANDED DRUGS

By law, generic and co-branded drugs contain the same active ingredients and are subject to the same Food and Drug Administration (FDA) standards for quality, strength and purity as brand name drugs. Generic drugs are called by their chemical name, rather than by a brand name chosen by the manufacturer. Co-branded drugs are made under license from the original manufacturer, and marketed under a different brand name.

If you or your doctor requests a brand-name prescription drug when a lower-cost generic or co-branded substitute is available, you pay the difference in price, in addition to your co-pay — unless the brand-name drug is medically necessary, as determined by the prescription drug benefits administrator. If your doctor feels that the brand-name drug is necessary to treat your condition, you will need to contact CVS Caremark. CVS Caremark will contact your doctor and, after talking with your doctor, make a final determination.

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUIREMENT

Prior authorization is a process to ensure that certain drugs are prescribed appropriately for specific conditions. It is not required for all drugs. Rather, it affects only a limited number of medications whose use must be pre-authorized to be covered under GE Prescription Drug Benefits. Drugs are listed based on the manufacturer's recommended uses, as defined by the Food and Drug Administration (FDA), and by the opinion of pharmaceutical and medical experts, as approved under the plan and compiled by CVS.

Examples of drug categories currently under review by GE Prescription Drug Benefits include:

- Angiotensin II receptor blockers;
- Anti-diabetic agents;
- Antihistamines;
- Anti-inflammatory drugs (for example, Celebrex);
- Anti-hypertensive therapy;
- Appetite suppressants and weight-loss agents;
- Alzheimer therapy;
- Biotech agents;
- Botulinum toxin;
- CNS stimulants;
- Dermatologicals (for example, Retin-A);
- Enteral nutritional supplements;
- Erectile dysfunction treatments (for example, Viagra);
- Erythroid stimulants;
- Fertility agents;
- Growth hormones;
- Hypnotic agents;
- Interferon;
- Lipid lowering agents;
- Misc. antivirals;
- Misc. pulmonary agents;
- MS therapy — interferon beta;
- Myeloid stimulants;
- Narcotic analgesics;
- Osteoporosis therapy;
- Proton pump inhibitors;
- Psychotherapeutic agents;
- Rheumatoid arthritis agents; and
- Smoking deterrents (after a specified amount of refills).

The list of drugs requiring prior authorization under the plan may be modified at any time, as new drugs come on to the market and prescribing practices change. A complete list of drugs subject to prior authorization is available at benefits.ge.com.

If your doctor wants to prescribe a medication on the prior authorization list, to initiate the review process, he or she should first contact GE Prescription Drug Benefits at 1-800-509-9891 to determine whether the drug will be covered. If it's determined that the drug is being prescribed for use outside the plan's conditions for coverage, you and your doctor will be sent a letter indicating that the drug will not be covered. If there are special circumstances that call for further consideration, your doctor may file an appeal in writing. Instructions for filing an appeal will be included in the letter to your doctor.

If your doctor doesn't contact GE Prescription Drug Benefits before you try to fill a prescription that requires prior authorization, you may experience difficulties in getting your prescription filled. You always have the option of paying the full cost of the prescription and submitting it for reimbursement later. **However, you will be reimbursed only if the prescription meets the coverage requirements, as determined by the prescription drug benefits administrator.**

DIABETIC SUPPLIES

Certain prescribed diabetic supplies are covered under GE Prescription Drug Benefits only when purchased through a network pharmacy or the Mail Order Pharmacy Service:

- Glucose monitors — one per year, with no co-pay;
- Insulin — applicable prescription drug co-pay applies;
- Syringes/needles — no co-pay; and
- Related supplies (for example, lancets, test strips and alcohol swabs) — no co-pay.

Please Note — Diabetic supplies purchased through other medical supply vendors will not be covered. These supplies are covered only when purchased through a network pharmacy or the Mail Order Pharmacy Service.

FAMILY PLANNING BENEFITS

Oral contraceptives (birth control pills) are covered under GE Prescription Drug Benefits. A standard package of 28 birth control pills can be purchased at a network pharmacy for a \$12 co-pay for a generic or \$30 for a brand name, while up to three packages can be purchased through the Mail Order Pharmacy Service for a \$20 co-pay for a generic or \$65 for a brand name. Make sure your doctor writes the prescription for a 90-day supply when using the Mail Order Pharmacy Service. Diaphragms can be purchased at a network pharmacy or through the Mail Order Pharmacy Service for the applicable co-pay. Over-the-counter contraceptives (that is, those available without a doctor's prescription) are not covered.

For information about additional family planning coverage provisions, see Section 2.4.4.3, "Surgery, tests and other services" (GE Health Care Preferred) and Section 2.5.4.2, "Doctors, medical services and supplies" (GE Medical Benefits).

3.5 WHEN YOUR GE PRESCRIPTION DRUG COVERAGE ENDS

Your GE Prescription Drug coverage ends when your GE Medical Care Option coverage ends. The same is true for your dependents.

Under federal law, you may be eligible to continue medical coverage, including prescription drug coverage, at your own expense — and in some cases at the Company's expense — when your GE medical coverage ends. However, you may not convert your prescription drug coverage to an individual policy. See Section 2.6, "When Your GE Health Coverage Ends" for more information.

4.0 DENTAL CARE OPTIONS

GE Dental Care Options are designed to encourage good preventive care to help you maintain healthy teeth and gums. The benefits will help you pay for a broad range of dental care and supplies. In many areas, you can also reduce your out-of-pocket costs by using dentists and other dental providers who participate in the dental care network.

WHAT'S COVERED

For a description of services and supplies covered by your GE Dental Care Option:

- See Section 4.5.2, "What does the GE Dental Schedule Option cover?"; or
- See Section 4.6.2, "What does the GE Dental Premium Option cover?"

4.1 KEY THINGS TO KNOW

GE provides dental coverage for you and your family to encourage good preventive care and to help you pay for other dental services.

If you're an eligible full-time employee:

- Coverage is automatic for you; you are enrolled in the GE Dental Schedule Option unless you elect the GE Dental Premium Option. Depending on the coverage you choose, contributions may be required.
- Whichever option you choose, you'll need to provide information about your dependents before benefits will be paid on their behalf. See Section 4.3.2, "Who is eligible?"

Eligible part-time employees can elect, and enroll in, either of the GE Dental Care Options. Contributions are required, regardless of which option you choose. See Section 4.3.2, "Who is eligible?"

You choose the option that best meets your needs and the needs of your family:

- GE Dental Schedule Option; or
- GE Dental Premium Option.

Through predetermination of benefits...

You can find out in advance what GE Dental Care Options will pay for covered services and supplies.

- For the GE Dental Schedule Option, see Section 4.5.1, "How does the GE Dental Schedule Option work?"
 - For the GE Dental Premium Option, see Section 4.6.1, "How does the GE Dental Premium Option work?"
-

Both options pay benefits based on the type of dental care you receive.

- GE Dental Schedule Option — benefits are paid according to a schedule of benefits in most cases; certain services are paid as a percentage of reasonable, necessary and customary charges.
- GE Dental Premium Option — benefits are paid as a percentage of reasonable, necessary and customary charges.

However, if the benefits administrator determines that an alternative treatment is appropriate, benefits under both options will be based on the alternative treatment. See Section 4.4.4, "What if an alternative treatment is appropriate?"

For both options, you can reduce your out-of-pocket dental care costs through the dental care network.

When you use network providers:

- You save on the cost of covered services and supplies; and
- You have no claim forms to file in most cases.

You have the opportunity to change your dental option...

Once each year during annual enrollment, usually held each fall.

If there is other coverage, benefits are coordinated to prevent duplication of payments — a feature called maintenance of benefits.

If another plan provides your primary coverage, the Company pays any difference between what you receive from your primary plan and what you would have received if your Company plan was your only coverage. You will never receive more than if the Company plan had been your only coverage.

If your spouse or same-sex domestic partner is also a Company employee, you may choose to:

- Enroll only one of you as a Company employee. The spouse or same-sex domestic partner with the lower salary must be covered as a dependent of the higher-paid employee; or
- Enroll both yourself and your spouse or same-sex domestic partner as Company employees.

If your spouse's or same-sex domestic partner's employer (other than the Company) offers dental coverage, your spouse or same-sex domestic partner can choose to:

- Be covered by his or her employer and receive no Company coverage;
- Be covered by his or her employer and also be covered by the Company as your dependent; or
- Waive his or her employer's coverage and instead be covered by the Company as your dependent.

For important information about the administration of GE Dental Care Options, see Section 8.0, "Administrative Information."

4.2 KEY THINGS TO DO

Decide whether you want dental coverage through the Company — within 63 days of first becoming eligible under a GE Dental Care Option, you may:

- Enroll for coverage, specifying the GE Dental Care Option you want and whether you want coverage for yourself or coverage for yourself and your eligible dependents;
- Waive Company dental coverage; or
- Make no dental coverage election. You will automatically be enrolled in the GE Dental Schedule Option for employee plus dependent coverage. See Section 4.3.3, "How do I enroll when I first become eligible?"

Make informed enrollment decisions — if you decide to enroll for dental coverage through the Company, it's up to you to decide which GE Dental Care Option best meets your and your family's needs. See Section 4.3.1, "What are my GE Dental Care Options?"

- You can check your current enrollment status at benefits.ge.com.
- You can change your dental option once each year during annual enrollment. See Section 4.3.4, "When can I make changes to my coverage?"

If your spouse or same-sex domestic partner is also a Company employee, you may choose to:

- Enroll only one of you as a Company employee. The spouse or same-sex domestic partner with the lower salary must be covered as a dependent of the higher-paid employee; or
- Enroll both yourself and your spouse or same-sex domestic partner as Company employees. See "If your spouse or same-sex domestic partner is a Company employee" in Section 4.3.2, "Who is eligible?"

If your spouse's or same-sex domestic partner's employer (other than the Company) offers dental coverage:

- Your spouse or same-sex domestic partner can choose to be covered by his or her employer and receive no Company dental coverage;
- Your spouse or same-sex domestic partner can choose to be covered by his or her employer and also be covered by the Company as your dependent; or
- Your spouse or same-sex domestic partner can waive his or her employer's coverage and instead be covered by the Company as your dependent. See Section 4.3.6, "What if there is other coverage?"

When coverage ends — you and your dependents may be eligible for continued dental coverage under COBRA if you enroll **within 60 days**. You make the election for your dependents. See Section 2.6, "When Your GE Health Coverage Ends."

Schedule preventive care — take advantage of ways to maintain your dental health through regular checkups and cleanings. See "Preventive and diagnostic care" in Section 4.5.2, "What does the GE Dental Schedule Option cover?" and Section 4.6.2, "What does the GE Dental Premium Option cover?"

Predetermine plan benefits — you can find out in advance what the plan will pay for major dental work through the plan's predetermination of benefits process. See Section 4.4.3, "How does predetermination of benefits work?"

If the benefits administrator determines that an alternative treatment is appropriate — the plan will pay benefits based on the alternative treatment. Be sure to discuss treatment options with your dentist. See Section 4.4.4, "What if an alternative treatment is appropriate?"

Use network dentists (where available) — to save on the cost of dental care under your GE Dental Care Option. See Section 4.4.1, "How can I save by using network dentists?"

Reduce your out-of-pocket dental costs — open a GE Health Care Flexible Spending Account each year to pay your share of dental expenses with pre-tax dollars. See Section 7.0, "Health Care Flexible Spending Account (FSA)."

4.3 DENTAL PARTICIPATION

You, as a Company employee, and your eligible dependents can participate in either of the two GE Dental Care Options: the GE Dental Schedule Option or the GE Dental Premium Option. Certain eligibility requirements differ for full-time and part-time Company employees. The cost of coverage may vary as well.

ADDITIONAL HEALTH CARE COVERAGE

The Company also provides medical and vision care coverage to help you meet your health care needs. See Section 2.0, "Medical Care Options" and Section 5.0, "Vision Care Benefits" for information.

4.3.1 WHAT ARE MY GE DENTAL CARE OPTIONS?

The Company offers you a choice between two options for your dental coverage — the GE Dental Schedule Option and the GE Dental Premium Option. Both options provide similar coverage for preventive care, diagnostic care, fillings, orthodontia, oral surgery and more.

The key difference is that the GE Dental Schedule Option covers certain services, such as diagnostic and preventive care, fillings, crowns and inlays, and dentures and fixed bridges, only up to an amount based on a benefit schedule. In contrast, the GE Dental Premium Option bases its coverage for all services on the dentist's reasonable, necessary and customary charges.

Under both options, you or your dentist submits claim forms. In addition, under both options, you can reduce your out-of-pocket expenses by using a network dentist. See Section 4.4.1, "How can I save by using network dentists?"

In certain locations, alternative dental plan options may be available. If an alternative dental plan option is available in your location, you will be notified.

YOUR GE DENTAL CARE OPTIONS AT A GLANCE — COVERED SERVICES

	GE DENTAL SCHEDULE OPTION	GE DENTAL PREMIUM OPTION
Diagnostic and preventive care	Paid up to scheduled amounts.	100% of reasonable, necessary and customary charges.
Fillings, crowns and inlays	Paid up to scheduled amounts, up to a combined maximum of \$2,500 over two consecutive calendar years for these services and for dentures and bridges.	80% of reasonable, necessary and customary charges, up to a combined maximum of \$2,500 per year for these services and for dentures and bridges.
Dentures and fixed bridges	Paid up to scheduled amounts, up to a combined maximum of \$2,500 over two consecutive calendar years for these services and for fillings and crowns.	50% of reasonable, necessary and customary charges, up to a combined maximum of \$2,500 per year for these services and for fillings and crowns.
Root canals, gum treatment and oral surgery	80% of reasonable, necessary and customary charges.	
Orthodontia (for children under age 19)	50% of charges, up to a lifetime maximum of \$2,500 under both GE Dental Care Options combined.	
Contributions through payroll deductions	None.	Required.

REASONABLE, NECESSARY AND CUSTOMARY

Depending on your GE Dental Care Option and the specific dental service you receive, benefits are paid according to a schedule of benefits or are based on reasonable, necessary and customary amounts, as determined by the benefits administrator. See the definition of reasonable, necessary and customary in "Key Terms" or see Section 4.4.2, "How does reasonable, necessary and customary work?"

4.3.2 WHO IS ELIGIBLE?

You are eligible to enroll in a GE Dental Care Option if you are:

- A full-time Company employee; or
- A part-time Company employee who is part of a special classification of employees eligible for GE Dental Care Options. If you are eligible as a part-time Company employee, special provisions apply. For example, you may pay different contribution rates. If you're eligible, you'll be notified about your costs for coverage.

Please Note — You can enroll for coverage under a GE Dental Care Option even if you waive coverage under a GE Medical Care Option.

YOUR DEPENDENTS

If you're eligible to enroll in a GE Dental Care Option, you also may enroll your eligible dependents. Eligible dependents are described under Section 1.3, "Who qualifies as an eligible dependent?" Note that for your eligible dependents to be covered under a GE Dental Care Option, you must be covered yourself, and they must be covered under the same option in which you are enrolled.

Special dependent eligibility requirements may apply if you enroll in a dental maintenance organization made available to you by the Company. Contact the specific plan for information.

IF YOUR SPOUSE OR SAME-SEX DOMESTIC PARTNER IS A COMPANY EMPLOYEE

If both you and your spouse or same-sex domestic partner are eligible Company employees, you may choose to either:

- **Enroll only one of you as a Company employee** — The spouse or same-sex domestic partner with the lower salary must be covered as a dependent of the higher-paid employee; or
- **Enroll both yourself and your spouse or same-sex domestic partner as Company employees** — In this case, either of you — but not both of you — may cover your children. The employee who covers the children must enroll them in the same GE Dental Care Option in which he or she is enrolled. In most cases, it will make financial sense for the spouse or same-sex domestic partner who earns less to cover the children.

You should consider the contributions, annual deductibles and annual out-of-pocket maximums for each alternative when making your decision.

IF YOUR CHILD IS A COMPANY EMPLOYEE

If both you and your child are eligible Company employees, you cannot cover your child under a GE Dental Care Option as your dependent. If your child is eligible for coverage, he or she must enroll as an employee.

ELIGIBILITY

For more information about eligibility requirements for you and your dependents, see Section 1.0, "Who is Eligible for GE Benefits?"

4.3.3 HOW DO I ENROLL WHEN I FIRST BECOME ELIGIBLE?

When you first become eligible, you'll receive information about your GE Dental Care Options, including enrollment instructions. If you have questions, you can call the GE Benefits Center at 1-800-252-5259.

You can enroll for coverage under a GE Dental Care Option **within 63 days** after you become eligible. If you make no election — to enroll or waive coverage — by the end of the 63-day deadline, you will automatically be enrolled for "default" dental coverage in the GE Dental Schedule Option for yourself and your eligible dependents. In both cases, coverage is effective as of the date you become eligible, as long as you are actively at work (or on vacation) on that day.

Please Note — Default coverage does not apply to employees hired prior to January 1, 2001.

IF YOU ARE REHIRED

If you are rehired within five years of the date you last worked for the Company and you do not make an enrollment election **during the 63-day enrollment period**, you will be automatically re-enrolled in the plan option in which you previously participated (or the nearest equivalent, if your original option is no longer available).

IF YOU DON'T WANT THE DEFAULT COVERAGE

If you don't want the default dental coverage, here's a general description of how to enroll yourself and your eligible dependents:

- Decide which GE Dental Care Option you wish to enroll in.
- Decide which level of coverage you want — coverage for yourself only, or for yourself and your eligible dependents.
- You will be instructed on how to make your dental coverage election.
- If an alternative dental care option is available in your area — you will be notified and told how to enroll.

Please Note — If you elect to cover dependents, you must provide each eligible dependent's name, birth date and Social Security number. Remember that all covered family members must participate in the same GE Dental Care Option in which you participate.

Special provisions apply to spouses or same-sex domestic partners who also work for the Company. See "If your spouse or same-sex domestic partner is a Company employee" in Section 4.3.2, "Who is eligible?"

HOW TO WAIVE COVERAGE

If you don't want any dental coverage from the Company, you can waive coverage. If you choose to waive coverage, you may do so during your initial benefits enrollment or by notifying the GE Benefits Center.

If you do not make an election — to waive or enroll in dental coverage — **within 63 days** of becoming eligible, you will receive default coverage — the GE Dental Schedule Option for yourself and your eligible dependents. Any applicable premiums will be automatically deducted from your paycheck. If you subsequently reduce or waive this default coverage, you will not be refunded for any premiums paid while you were covered.

ENROLLING WITHOUT A QUALIFIED STATUS CHANGE AFTER YOU'VE WAIVED COVERAGE WHEN FIRST ELIGIBLE

If you waive coverage when you are first eligible and subsequently want to enroll for coverage before the next annual enrollment, you may enroll in the GE Dental Schedule Option. Coverage is effective on the enrollment date — the date the benefits administrator receives notification.

YOUR ENROLLMENT CHOICES

Within 63 days of first becoming eligible for coverage under a GE Dental Care Option, you may:

- Enroll for coverage for yourself and your eligible dependents, specifying the GE Dental Care Option you want and whether you want coverage for you and your eligible dependents;
- Waive Company dental coverage; or
- Make no dental coverage election. You will automatically be enrolled for "default" coverage — the GE Dental Schedule Option at the family level (employee plus dependent coverage).

4.3.4 WHEN CAN I MAKE CHANGES TO MY COVERAGE?

When you first become eligible for coverage under a GE Dental Care Option, you have a **63-day enrollment opportunity** to specify the coverage you want. After this 63-day deadline passes, you will have the following opportunities to change your coverage:

- **After certain events**, such as adding a new dependent, losing coverage under another dental plan, transfer to a new work location or other qualified status changes, as described in "What is a qualified status change?" You have **63 days** to enroll in either GE Dental Care Option or to make certain changes.
- **At any time**. Even if you don't experience a qualified status change, if you are not participating in a GE Dental Care Option, you may enroll for coverage under the GE Dental Schedule Option at any time. In general, coverage is effective as of your enrollment date — the date the benefits administrator receives notification. If you are not currently enrolled in the GE Dental Premium Option, you may enroll only during annual enrollment.
- **Once each year, during annual enrollment:**
 - You can enroll yourself and eligible dependents in a GE Dental Care Option; or
 - If you are currently enrolled, you can switch your GE Dental Care Option.

Your coverage under the new option is effective on the following January 1 or the date announced during the annual enrollment period.

ADDING DEPENDENTS TO YOUR COVERAGE

To add a dependent after your initial enrollment in either GE Dental Care Option, you may do so at benefits.ge.com or by calling the GE Benefits Center at 1-800-252-5259. Be prepared to provide your date of marriage (if applicable) and each eligible dependent's name, birth date and Social Security number. No benefits will be paid until this information is provided.

- **If you don't have dependent coverage** — you'll need to enroll for dependent coverage **within 31 days** after your dependent becomes eligible (such as **within 63 days** after your marriage or your child's date of birth, adoption or placement for adoption). Be prepared to provide your date of marriage (if applicable) and each eligible dependent's name, birth date and Social Security number.
- **If you have dependent coverage** — you'll need to provide your date of marriage (if applicable) and each eligible dependent's name, birth date and Social Security number. Otherwise, benefits will be suspended until you call. (Note that you only need to call once for both medical and dental coverage.)

If you are not enrolled when you add a new dependent to your family as part of a qualified status change (e.g., marriage, birth or adoption) you may enroll yourself, or yourself and any other eligible dependents not already covered under the plan.

- **If you enroll yourself, or yourself and your eligible dependents within 63 days after adding a new dependent** — you may enroll in either GE Dental Care Option; coverage is effective on the date you added the new dependent to your family.
- **If you enroll yourself, or yourself and your eligible dependents more than 63 days after adding a new dependent** — you may enroll in the GE Dental Schedule Option; coverage is effective on the enrollment date — the date the benefits administrator receives notification.

DISCONTINUING COVERAGE

You may discontinue coverage for yourself or your eligible dependents once a year during annual enrollment or as a result of a qualified status change. However, if you later wish to resume coverage, you can do so only during annual enrollment unless you lose other coverage (as described below) or you add a dependent (as described above). In accordance with Internal Revenue Service (IRS) rules, if you wish to discontinue coverage outside of these events, your contributions for coverage will not be reduced until the next calendar year.

IF YOU LOSE OTHER COVERAGE

If you or your dependents lose coverage under another dental plan (such as a spouse's plan at work), you may enroll yourself and your eligible dependents in a GE Dental Care Option. If you enroll **within 63 days** of losing your other coverage, coverage is effective on the date the prior coverage ends.

If you enroll **more than 63 days** after losing other coverage, coverage is effective on the enrollment date — the date the benefits administrator receives notification.

WHAT IS A QUALIFIED STATUS CHANGE?

Qualified changes in status are:

- Your marriage, divorce or legal separation;
- Birth, adoption or marriage of a dependent;
- Death of your spouse or a dependent;
- Start or end of your spouse's employment;
- Your spouse's involuntary loss of health coverage;
- Your removal from the active payroll, for example, because of disability, layoff, leave of absence or strike, including leaves under the Family and Medical Leave Act of 1993 (FMLA);
- Your transfer to a new work location requiring a change in your Company-sponsored health coverage; and
- Your or your spouse's entitlement to Medicare.

MAKING CHANGES

Contact the GE Benefits Center at 1-800-252-5259 **within 63 days** of a qualified status change to make a change to your coverage.

4.3.5 HOW MUCH DOES COVERAGE COST?

The cost of coverage depends on the dental option you choose, as follows:

- **GE Dental Schedule Option** — if you are an eligible full-time employee, the Company pays the entire cost of coverage for you and your eligible dependents; there is no cost to you.
- **GE Dental Premium Option** — if you are an eligible full-time employee, you and the Company share the cost of coverage for yourself and your eligible dependents. Your share is to be determined annually and is subject to change.

To help lower the cost to you, any contributions that are deducted from your pay will be taken on a pre-tax basis to the extent permitted by IRS rules, unless you elect otherwise. This means contributions are taken before federal, state and Social Security taxes are calculated on your pay. These pre-tax contributions lower your taxable income, so you owe less in income and Social Security taxes. If you prefer, contributions may be deducted on an after-tax basis, provided you make the choice when you first enroll or during annual enrollment. In addition, if you make mid-year changes in your coverage that are not qualified status changes, any contributions will be taken on an after-tax basis for the remainder of the year.

TAX IMPLICATIONS FOR SAME-SEX DOMESTIC PARTNER COVERAGE

It's important that you understand the Internal Revenue Service (IRS) rules regarding the tax implications of enrolling a same-sex domestic partner or children that are not qualified tax dependents in health care and/or dental care option benefits. For any year, "qualified tax dependents" are individuals who are claimed on the employee's federal income tax return as a dependent. Please see IRS Publication 501 for the rules regarding who can be claimed as a dependent. If a same-sex domestic partner or child of a same-sex domestic partner is not a qualified tax dependent as defined above, the value of the health care and dental coverage provided will be added to your income and taxed accordingly. The value of this coverage amount will appear on your paycheck as imputed income.

LAWS AFFECTING BENEFITS

If an applicable federal, state or local government law mandates coverage or benefits in excess of what your GE Dental Care Option pays, the plan will provide the additional coverage or benefits. If you are subject to such a law, your contributions will be increased to pay the full cost of the additional coverage or benefits.

If a federal, state or local government applies a tax or surcharge on health care services, benefits or enrollment, the tax or surcharge will be considered a covered expense, subject to the applicable benefit payment provisions. Contributions for participants affected by the tax or surcharge will be increased to pay for half of the added cost to the plan or the Company resulting from the tax or surcharge. The Company pays the other half.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse or same-sex domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents for coverage under a GE Dental Care Option, provided that you request enrollment **within 63 days** after your other coverage ends. 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, provided that you request enrollment **within 63 days** after the marriage, birth, adoption or placement for adoption.

IF YOU'RE A PART-TIME EMPLOYEE

If you are eligible for coverage under a GE Dental Care Option as a part-time Company employee, special eligibility and cost provisions may apply. If you're eligible, you'll be notified about your costs for coverage.

THE PRE-TAX ADVANTAGE

By contributing on a pre-tax basis, you reduce your taxable income by the amount you pay for dental coverage — which reduces the taxes you pay.

4.3.6 WHAT IF THERE IS OTHER COVERAGE?

Your GE Dental Care Option, like many employer-sponsored plans, has a maintenance of benefits feature. This feature is designed to prevent duplication of payments when you or your dependents are covered by another group dental plan, such as a spouse's plan at work.

Under maintenance of benefits, the plan that is primarily responsible for a person's expenses — the plan that pays benefits first — is considered the primary coverage for that person. If another plan is primary, the Company pays the difference, if any, between what you receive from the other plan and what you would have received if your GE plan was your only coverage, according to plan provisions. You will never pay more than if the Company plan had been your only coverage.

The out-of-pocket cost calculations used to determine maintenance of benefit payments are based only on covered expenses under your GE Dental Care Option.

To receive payment on a claim when your GE Dental Care Option is secondary, you must submit a claim form, including a copy of the Explanation of Benefits from the primary insurance plan, to your GE dental benefits administrator.

You'll be required to provide information that the benefits administrator needs to prevent duplication of benefits.

WHEN YOUR SPOUSE OR SAME-SEX DOMESTIC PARTNER HAS COVERAGE AT WORK

Here's how maintenance of benefits works when your spouse or same-sex domestic partner has employer-sponsored dental coverage:

- **For you** — your GE Dental Care Option is your primary coverage, if you're enrolled. Submit your dental bills to the Company plan first, then to your spouse's or same-sex domestic partner's plan.
- **For your spouse or same-sex domestic partner** — your spouse's or same-sex domestic partner's employer-sponsored plan is primary, if he or she is enrolled. Submit his or her dental bills to the employer's plan first, then to the Company plan.
- **For your children** — if your children are covered under both your GE Dental Care Option and your spouse's or same-sex domestic partner's plan, the "birthday rule" determines which plan is primary. The plan covering the spouse or same-sex domestic partner whose birth date (month and day) falls earlier in the year is primary for the children. Submit your children's dental bills to the primary plan first, then to the other plan. If both of you have the same birth date, the plan covering you or your spouse or same-sex domestic partner for the longer period of time will pay first. The "birthday rule" also applies to your new spouse if you're remarried.

THE "BIRTHDAY RULE"

When children are covered by more than one parent's employer-sponsored dental plan, the parent whose birth date (month and day) falls earlier in the year provides primary coverage.

4.3.7 WHAT IF I RECEIVE A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)?

An individual who is a child of a covered employee shall be enrolled for coverage under the medical and/or dental plan, as applicable, in accordance with the direction of a qualified medical child support order (QMCSO) or a National Medical Support Notice (NMSN).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

- Provides for support of a dependent child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the appropriate plan; and
- Is "qualified" in that it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act Section 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage for a dependent child of a noncustodial parent who is (or will become) covered by a domestic relations order that provides for health care coverage.

If you receive one of these orders and have questions, or would like a copy of the QMCSO procedures at no cost to you, contact the GE QDRO Administration, PO Box 534277, St. Petersburg, FL 33747 (1-727-866-5907).

4.3.8 WHEN DOES COVERAGE END?

Coverage under your GE Dental Care Option ends on the earliest of the following dates:

- When your employment stops for any reason (such as resignation or termination) and your continuous service ends. Coverage may continue if you meet certain qualifications.
- The end of the period for which any required contributions have been paid, if you fail to make further contributions or you cancel your payroll deduction authorization, if applicable.
- When you transfer to a classification of employees not eligible for dental coverage.
- For represented employees, the day before the day you go on strike, unless the Company makes arrangements for coverage to continue.

Coverage for your dependent ends on the earlier of the following dates:

- When your dependent no longer meets eligibility requirements — for example, when your dependent child reaches the plan's age limit or graduates. See Section 1.3, "Who qualifies as an eligible dependent?"
- The end of the period for which any required contributions have been paid, if you fail to make further contributions or you cancel your payroll deduction authorization for dependent coverage, if applicable.

If a covered dependent is totally disabled when coverage would otherwise end, his or her coverage can continue as long as the disability continues, up to the end of the following calendar year.

CONTINUING DENTAL BENEFITS

Benefits will continue for up to 90 days if, at the time coverage ends for any reason (other than attainment of age 65 after retirement), you or your dependent has begun receiving the following dental services or supplies:

- Dentures, if the impressions were taken before coverage stopped;
- Crowns or fixed bridges, if the impressions were taken and the teeth were fully prepared before coverage stopped;
- Root canal therapy, if the tooth was opened before coverage stopped;
- Orthodontic treatment, if a full-banded program was started before coverage stopped; or
- Implant abutments and implant prosthetics if it was placed while coverage was in effect.

In addition, if at the time coverage ends because of a leave of absence, disability, layoff, plant closing or office closing, you or your dependent has begun a full-banded orthodontic treatment program, benefits under your GE Dental Care Option will continue for the rest of the treatment program.

Benefits that continue will be based on the plan provisions in effect on the date you or your dependent's coverage ends.

CERTIFICATION OF COVERAGE

When coverage under your GE Dental Care Option ends, you will receive a certificate of coverage stating how long you were covered. Prior coverage may reduce the length of time you are subject to any pre-existing condition limits under a new plan. You also may request a certificate of coverage from the GE COBRA administrator within 24 months after coverage ends. See Section 2.6.3.7, "When does COBRA health coverage end?"

COBRA HEALTH COVERAGE

When coverage under your GE Dental Care Option ends, you and/or your covered dependents may be eligible to purchase continued health coverage under a federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended). In some cases, the Company may pay for some or all of your COBRA health coverage. See Section 2.6, "When Your GE Health Coverage Ends."

CONTINUED COVERAGE

Under a federal law called COBRA, you and your covered dependents may be eligible to purchase continued health coverage when your GE coverage ends. See Section 2.6, "When Your GE Health Coverage Ends."

4.4 GE DENTAL CARE OPTIONS BASICS

This Section describes some of the basic features of the GE Dental Care Options that are common to both the GE Dental Schedule Option and the GE Dental Premium Option. In general, both options cover and exclude the same services and have the same eligibility provisions and frequency limits. You may enroll in either of the two options, and you can switch from one option to the other once each year during annual enrollment.

For more information about covered services, see Section 4.5.2, "What does the GE Dental Schedule Option cover?", Section 4.6.2, "What does the GE Dental Premium Option cover?" and Section 4.7, "What's Not Covered."

DENTAL VS. MEDICAL

Certain services which are not covered under your GE Dental Care Option (such as biopsies, grafts and scope procedures) may be payable under your GE Medical Care Option. If your dentist recommends one of these types of services, be sure to call the GE Dental Benefits Claims Center at 1-888-529-8474 in advance to determine whether the service is payable under your GE Dental Care Option or your GE Medical Care Option.

Remember, if it's covered under your GE Medical Care Option, you may need to obtain a referral or advance approval to receive the highest level of benefits. For more information, see Section 4.4.3, "How does predetermination of benefits work?"

For accidental dental injury treatment, see Section 2.2.4.6, "Accident-related dental services" and Section 2.3.4.6, "Accident-related dental services."

PLAN PROVISIONS

For more information on the provisions specific to each option, see Section 4.5.1, "How does the GE Dental Schedule Option work?" and Section 4.6.1, "How does the GE Dental Premium Option work?"

ADDITIONAL SAVINGS

You can pay your out-of-pocket costs for dental care with tax-free dollars — and save on your taxes — by using a GE Health Care Flexible Spending Account (FSA). See Section 7.0, "Health Care Flexible Spending Account (FSA)."

4.4.1 HOW CAN I SAVE BY USING NETWORK DENTISTS?

You can reduce your out-of-pocket dental care costs by using dentists and other dental care providers who participate in the dental care network, if available in your location. In the network, you pay less for covered dental services because reduced rates have been negotiated with network providers — in effect, maximizing the value of your benefits. In most cases, you have no claim forms to file; your network provider handles the paperwork for you.

A directory of providers in the network will be made available to you at no charge. You may access this information through benefits.ge.com or by calling the GE Dental Benefits Claims Center at 1-888-529-8474. You are always free to choose any dental provider.

ABOUT NETWORK PROVIDERS

Under the GE Dental Care Options, some or all of your covered benefits may be delivered by dentists or other dental care providers who participate in a network. The organizations that manage these networks may establish certain rules and provisions that determine how care is provided to participants. They may also include special payment arrangements and incentives for network providers. For example, the network may have "capitation" provisions, under which a network provider is paid based on the number of patients to whom the provider provides care, rather than being paid for each instance of service.

You should call your benefits administrator, who manages these networks, for information about any such provisions.

NETWORK ADVANTAGES

- Selected providers who are regularly reviewed for quality;
- Lower out-of-pocket costs; and
- No claim forms in most cases.

Find a network dentist at benefits.ge.com or call the GE Dental Benefits Claims Center at 1-888-529-8474.

4.4.2 HOW DOES REASONABLE, NECESSARY AND CUSTOMARY WORK?

Like many dental plans, GE Dental Care Options pay benefits based on reasonable, necessary and customary amounts, as determined by the benefits administrator. See the definition of reasonable, necessary and customary in "Key Terms."

However, some dental providers who are not part of a preferred provider network may charge fees in excess of what's reasonable, necessary and customary. To help the benefits administrator resolve these situations, be sure to follow these steps:

1. **Talk to your dentist** — Be sure your dentist or other dental provider knows that your Company provides benefits based on what's considered reasonable, necessary and customary. Most dentists are familiar with this concept. Refer your dentist directly to the benefits administrator if he or she has any questions. Also, discuss with your dentist and your benefits administrator the potential cost for services. See Section 4.4.3, "How does predetermination of benefits work?"

2. **Read before signing** — Don't agree in advance to pay your dentist or other dental provider a specific amount. If you're asked to sign a statement before receiving dental services, read it carefully to make sure it doesn't obligate you to a certain level of payment.
3. **Authorize direct payment, if possible** — If your provider agrees, you can authorize payment of benefits directly to your provider. Simply sign the "Payment of Benefits" Section of your claim form and ask your provider to file the claim.

If you've followed these steps and your provider insists that you pay additional amounts, contact the benefits administrator as soon as possible. The benefits administrator will work with the provider on your behalf. Please note, however, that the provider may continue to bill you while the situation remains unresolved.

4.4.3 HOW DOES PREDETERMINATION OF BENEFITS WORK?

Through a process called predetermination of benefits, you can find out in advance how much your GE Dental Care Option will pay for dental care — and how much you'll be responsible for paying. Predetermination of benefits is recommended whenever your dentist proposes costly or extensive dental treatment.

Through this process, you'll also be notified if your GE Dental Care Option will pay benefits based on an alternative method of treatment; see Section 4.4.4, "What if an alternative treatment is appropriate?"

Here's how to predetermine your benefits:

1. **Before treatment begins, ask your dentist to complete a dental claim form** — Obtain a claim form from benefits.ge.com or call the GE Dental Benefits Claims Center at 1-888-529-8474. Be sure to ask your dentist to:
 - Complete the dentist portion of the form, describing the proposed course of treatment and the charges;
 - Check the "Predetermination" box;
 - Attach x-rays and other diagnostic information; and
 - Mail the form to the benefits administrator at the address shown on the form.
2. **Receive an estimate** — The benefits administrator will review the proposed treatment and send you and your dentist a statement of what your GE Dental Care Option will pay. If the benefits administrator determines that an alternative method of treatment is more appropriate and cost-effective, your GE Dental Care Option will pay benefits based on the alternative treatment.
3. **Discuss any alternative treatment options with your dentist** — to determine the treatment plan that best meets your dental needs.

AVOID SURPRISES

Find out in advance what your GE Dental Care Option will pay before undergoing costly dental treatment by using the predetermination of benefits process.

4.4.4 WHAT IF AN ALTERNATIVE TREATMENT IS APPROPRIATE?

Often, there is more than one acceptable way to treat a particular dental problem. For example, a filling can be made of amalgam, acrylic or plastic.

In some cases, the benefits administrator may determine that an alternative method of treatment may be more appropriate and cost-effective than the method proposed by your dentist. As a result, your GE Dental Care Option will pay benefits based on the less expensive alternative treatment, even if you choose the more expensive treatment. You are responsible for charges in excess of what your GE Dental Care Option pays for an alternative method of treatment.

Through the predetermination of benefits process, you can find out in advance if benefits will be based on an alternative treatment. Then, you can discuss the treatment options with your dentist.

4.4.5 HOW DO I CLAIM BENEFITS?

When you use dentists and other dental care providers who participate in the dental care network, there are no claim forms to file in most cases.

Here's how to claim benefits when you use an out-of-network dental care provider:

IF YOU AUTHORIZE DIRECT PAYMENT

1. **Complete and sign the employee portion of a dental claim form** — Be sure to check the box authorizing direct payment to the dentist. Obtain a claim form from *benefits.ge.com* or call the GE Dental Benefits Claims Center at 1-888-529-8474.
2. **Ask your dentist to complete the dentist portion of the form** — and mail the form to the benefits administrator at the address shown on the form.
3. **Receive notification** — The benefits administrator will pay your dentist directly. You'll be notified of any amount you are responsible for paying.

IF YOU PAY THE BILL YOURSELF

1. **Complete and sign the employee portion of a dental claim form** — Obtain a claim form from *benefits.ge.com*, or call the GE Dental Benefits Claims Center at 1-888-529-8474.
2. **Ask your dentist to complete the dentist portion of the form.**
3. **Mail the form to the benefits administrator** — at the address shown on the form. Be sure to attach copies of your receipts and any other necessary documentation.
4. **Receive reimbursement** — The benefits administrator will send you a check for reimbursement according to plan benefits. You'll also receive written notification.

ADDITIONAL CLAIMS INFORMATION

- If your provider would like to file claims electronically, he or she should call the GE Dental Benefits Claims Center at 1-888-529-8474.
- The benefits administrator has the right to require a dental examination of any person for whom a claim is made.
- **You must file your claims by June 30** for expenses that were incurred during the previous calendar year, unless you can show that it was not reasonably possible to do so.
- If you have a question or problem with a claim, call the GE Dental Benefits Claims Center at 1-888-529-8474.

TIMELY FILING

You must file your dental claims **by June 30** for expenses that were incurred during the previous calendar year.

4.4.6 WHAT IF I CHANGE DENTAL OPTIONS?

You can change your dental options once each year during annual enrollment. After enrolling in the GE Dental Premium Option, you can elect the GE Dental Schedule Option at the next annual enrollment or vice versa. However, plan restrictions, such as annual or other frequency limits and lifetime maximums that apply to certain services, are combined under both GE Dental Care Options.

This means, for example, that any benefits that count toward your annual maximum under the GE Dental Premium Option will count toward your two-calendar year maximum under the GE Dental Schedule Option.

FOR EXAMPLE

Nicole enrolls in the GE Dental Premium Option. She uses \$1,200 of her annual maximum for inlays in one year. The next year, she enrolls in the GE Dental Schedule Option. Now, her annual maximum for services subject to an annual maximum under the GE Dental Schedule Option — fillings, crowns, inlays, dentures and bridges — is \$1,300 (the \$2,500 two-year maximum less the \$1,200 in benefits she received under the GE Dental Premium Option from the year before).

Note that if you are enrolled in the GE Dental Schedule Option and then enroll in the GE Dental Premium Option for the following year, the annual maximum will not be carried over.

If you receive orthodontic care and you switch GE Dental Care Options during annual enrollment, the lifetime maximum of \$2,500 per covered child still applies.

FOR EXAMPLE

Dean and his son enroll in the GE Dental Schedule Option. Dean uses \$900 of his son's lifetime maximum for braces in one year. The next year, Dean and his son enroll in the GE Dental Premium Option. Now, the remaining benefit available to his son for orthodontic services under the GE Dental Premium Option is \$1,600 (the \$2,500 lifetime maximum less the \$900 in benefits he has already received under the GE Dental Schedule Option).

For more information on when you can change your coverage, see Section 4.3.4, "When can I make changes to my coverage?"

4.5 GE DENTAL SCHEDULE OPTION

The GE Dental Schedule Option provides broad dental coverage for you and your family. It pays benefits in two ways: according to a schedule of benefits and as a percentage of reasonable, necessary and customary charges, depending on the type of dental care you receive. Certain age, frequency and lifetime limits may apply.

4.5.1 HOW DOES THE GE DENTAL SCHEDULE OPTION WORK?

Here's an overview of how the GE Dental Schedule Option works:

- **You go to a dental provider** — who charges a fee for each dental service or supply. You can reduce your out-of-pocket dental care costs by using dentists and other providers who participate in the dental care network, if available in your location.
- **You can find out in advance what the GE Dental Schedule Option will pay** — through the predetermination of benefits process. Predetermination is recommended whenever your dentist proposes costly or extensive dental treatment. See Section 4.4.3, "How does predetermination of benefits work?"
- **The GE Dental Schedule Option pays benefits** — according to:
 - A schedule of benefits for:
 - Preventive and diagnostic care;
 - Fillings, crowns and other restorative services; and
 - Bridges, dentures and other prosthodontic services.
 - A percentage of reasonable, necessary and customary charges for:
 - Root canals and other endodontic services;
 - Gum treatment (periodontic services);
 - Oral surgery;
 - Braces and other orthodontic services for children; and
 - Treatment of accidental injury.
- **If the benefits administrator determines that an alternative treatment is appropriate** — benefits will be based on the alternative treatment. You are responsible for charges in excess of what the GE Dental Schedule Option pays for an alternative treatment. For more information, see Section 4.4.4, "What if an alternative treatment is appropriate?"
- **You file claims** — for reimbursement of covered expenses. Some providers will allow you to authorize direct payment. In most cases, there are no claims to file when you use network dental care providers. For more information, see Section 4.4.5, "How do I claim benefits?"

4.5.2 WHAT DOES THE GE DENTAL SCHEDULE OPTION COVER?

The GE Dental Schedule Option provides coverage for a range of preventive, diagnostic, restorative, endodontic, periodontic, oral surgical and orthodontic services.

For restorative, endodontic, periodontic, oral surgical and orthodontic services, if the benefits administrator determines that an alternative treatment is appropriate, benefits will be based on the alternative treatment. See Section 4.4.4, "What if an alternative treatment is appropriate?"

PREVENTIVE AND DIAGNOSTIC CARE

The GE Dental Schedule Option covers the major share of preventive and diagnostic services to help you maintain healthy teeth and gums, and to detect dental problems early.

Benefits are paid up to scheduled amounts. See Section 4.5.5, "Schedule of benefits." Certain age and frequency limits also apply. Note that the schedule will change as of January 1, 2013.

Covered preventive and diagnostic services include:

- **Oral exams** — two checkups during each calendar year.
- **Preventive cleanings** — two during each calendar year.
- **Diagnostic procedures** — including:
 - Full mouth x-rays — once every three calendar years; and
 - Bitewing x-rays — two sets of x-rays during each calendar year.
- **Fluoride treatments** — one topical application of fluoride during each calendar year.
- **Sealants** — one treatment for each permanent molar every 36 months for children under age 14; does not include wisdom teeth.
- **Space maintainers** — fixed and unilateral, including adjustments, for children under age 19.
- **Emergency treatment** — immediate treatment for dental pain.

FILLINGS AND CROWNS (RESTORATIVE CARE)

The GE Dental Schedule Option covers the repair and restoration of natural teeth (fillings and crowns), called restorative services.

Benefits are paid up to scheduled amounts. The combined maximum benefit available for these services and for bridges and dentures is \$2,500 every two consecutive calendar years. This means that the most the GE Dental Schedule Option will pay in a calendar year for covered restorative and prosthodontic services is \$2,500, less what it paid for these services during the previous calendar year. See Section 4.5.5, "Schedule of benefits."

Covered restorative services include:

- **Fillings** — amalgam (silver), acrylic or plastic fillings to restore the structure of teeth and to prevent further decay.
- **Inlays or onlays** — amalgam (silver), acrylic or plastic fillings to restore the structure of teeth and to prevent further decay.
- **Crowns** — usually porcelain, gold or acrylic, used to cover the exposed portion of badly decayed or broken teeth.

BRIDGES AND DENTURES (PROSTHODONTIC CARE)

The GE Dental Schedule Option covers the construction and repair of bridges and dentures, called prosthodontic services.

Benefits for these services are paid up to scheduled amounts. The combined maximum benefit available for these services and for fillings and crowns is \$2,500 every two consecutive calendar years. This means that the most the GE Dental Schedule Option will pay in a calendar year for covered prosthodontic and restorative services is \$2,500, less what it paid for these services during the previous calendar year. See Section 4.5.5, "Schedule of benefits."

Covered prosthodontic services include:

- **Dentures** — to replace teeth removed while you were covered by the plan or to replace dentures that are more than five years old and no longer usable or repairable.
- **Fixed bridgework** — a permanent replacement for natural teeth removed while you were covered by the plan, or for a partial appliance or bridgework that is more than five years old and no longer usable or repairable.

ROOT CANALS, GUM TREATMENT AND ORAL SURGERY

The GE Dental Schedule Option covers the treatment of tooth pulp diseases, called endodontic services, and the treatment of diseases of the gum and surrounding tissue, called periodontic services, as well as oral surgery.

Benefits for these services are paid at 80% of reasonable, necessary and customary charges. See Section 4.4.2, "How does reasonable, necessary and customary work?"

Covered services include:

- **Endodontic services**
 - Root canal therapy
- **Periodontic services**
 - Gum treatment — including surgery for the treatment of gum disease when not performed in connection with the extraction, repair or replacement of teeth.
- **Oral surgery**
 - Extractions
- **X-rays** — related to the services in this category.
- **General anesthesia** — when medically necessary for any dental treatment.

ACCIDENTAL INJURY

The diagnosis and treatment of injury to healthy teeth and gums will generally be provided under Section 2.2.4.6, "Accident-related dental services" and Section 2.3.4.6, "Accident-related dental services".

For services not covered under the medical plan, benefits are paid at 80% of reasonable, necessary and customary charges, up to the dentist's charge. See Section 4.4.2, "How does reasonable, necessary and customary work?" For example, orthodontic treatment for adults and children required as a result of an injury will be covered under the GE Dental Schedule Option, except for orthodontic treatment that would have been necessary in the absence of the injury.

Covered services also include necessary orthodontic treatment required following surgery to correct a cleft palate condition.

CHILD ORTHODONTICS

The GE Dental Schedule Option covers services and supplies to correct the positioning of teeth and to control harmful habits with braces or other appliances, called orthodontic services, for covered children under age 19. An orthodontic treatment program begins when braces or other appliances are applied, and ends when they are removed. Benefits for these services are paid at 50% of reasonable, necessary and customary charges, up to a maximum of \$2,500 in total lifetime benefits under both GE Dental Care options combined, for covered children under age 19. See Section 4.4.2, "How does reasonable, necessary and customary work?"

Covered orthodontic services include:

- **Diagnosis and development of a treatment plan** — to correct crooked, crowded or protruding teeth;
- **Braces**;
- **Exams** — and related x-rays;
- **Appliances** — one arch to control harmful habits, and one arch for tooth guidance for each child; and
- **Appliance adjustments.**

Please Note — Your GE Health Care Flexible Spending Account (FSA) reimbursements for orthodontic expenses will be payable to you in the calendar year in which you make the payment for orthodontic services, rather than when the care is provided. Keep in mind that orthodontic treatments typically span two years. Be sure to base your FSA contributions on the out-of-pocket expenses you expect to pay during the current year. For example, if you pay \$2,400 at the onset of orthodontic treatment and \$1,200 is eligible for reimbursement from your GE Dental Care Option, you can be reimbursed for the remaining \$1,200 from your FSA in the year in which you made the \$2,400 payment, provided you contribute at least this amount to your FSA.

REASONABLE, NECESSARY AND CUSTOMARY

The GE Dental Schedule Option pays for root canals, gum treatment, oral surgery and orthodontia according to reasonable, necessary and customary amounts, as determined by the benefits administrator. See the definition of "reasonable, necessary and customary" in "Key Terms" or see Section 4.4.2, "How does reasonable, necessary and customary work?"

4.5.3 HOW DOES THE SCHEDULE OF BENEFITS WORK?

The GE Dental Schedule Option pays for certain services according to a schedule of benefits. Other services are paid as a percentage of reasonable, necessary and customary charges, as described in Section 4.5.2, "What does the GE Dental Schedule Option cover?"

The schedule of benefits lists the maximum amount the plan will pay for the specified dental procedures. One of three schedules — A, B or C — will apply, based on the location of your dentist's office. Certain age, frequency and dollar limits also apply.

These schedules are based on average dental charges. While the schedules are targeted to cover 100% or 50% of the average charge (depending on the service covered), the amount your dentist charges may differ from the targeted amount, resulting in reimbursement at a higher or lower level than the target.

Please Note — The dental schedules will change, effective January 1, 2013.

Here's how to use the schedule of benefits:

1. **Determine which schedule applies to you** — based on the location of your dentist's office. See Section 4.5.4, "Which schedule applies?"
2. **Find your dental procedure on the schedule** — See Section 4.5.5, "Schedule of benefits." Procedures are listed by name and code number. If your procedure isn't listed on the schedule, use the predetermination of benefits process to find out whether the procedure is covered and what the GE Dental Schedule Option will pay. See Section 4.4.3, "How does predetermination of benefits work?"
3. **Understand what the GE Dental Schedule Option will pay** — In general:
 - If your dentist's charge is less than the scheduled amount, the plan pays the full charge.
 - If your dentist's charge is more than the scheduled amount, the plan pays the scheduled amount; you are responsible for the balance.

Keep in mind that if the benefits administrator determines that an alternative treatment is appropriate, your benefits will be based on the alternative treatment. See Section 4.4.4, "What if an alternative treatment is appropriate?"

4.5.4 WHICH SCHEDULE APPLIES?

To determine which schedule of benefits applies to you — A, B or C — locate the area of your dentist's office on the list below.

STATE / CITY	SCHEDULE
Alabama	A
Alaska	C
Arizona	B
Arkansas	A
California	C
Colorado	
• Denver/Boulder area (zip codes 800-803)	C
• Remainder of state	B
Connecticut	
• Southwestern area (zip codes 064-069)	C
• Remainder of state	B
Delaware	B
District of Columbia	C
Florida	
• Miami area (zip codes 330-334)	C
• Remainder of state	B
Georgia	
• Atlanta area (zip codes 300-303)	B
• Remainder of state	A
Hawaii	C
Idaho	A
Illinois	
• Chicago area (zip codes 600-608)	B
• Remainder of state	A
Indiana	
• Gary area (zip codes 463-464)	B
• Remainder of state	A

STATE / CITY	SCHEDULE
Iowa	A
Kansas	A
Kentucky	A
Louisiana	B
Maine	A
Maryland	
• Washington, DC area (zip codes 200-209)	C
• Baltimore area (zip codes 210-214)	B
• Remainder of state	A
Massachusetts	
• Boston area (zip codes 017-024)	C
• Remainder of state	B
Michigan	
• Detroit area (zip codes 480-482)	C
• Remainder of state	B
Minnesota	A
Mississippi	
• Jackson area (zip code 392)	B
• Remainder of state	A
Missouri	
• St. Louis area (zip codes 630-633)	B
• Remainder of state	A
Montana	B
Nebraska	A
Nevada	C
New Hampshire	A
New Jersey	
• Southern area (zip codes 080-084)	B
• Remainder of state	C
New Mexico	B

STATE / CITY	SCHEDULE
New York	
• New York City area (zip codes 100-119)	C
• Buffalo/Rochester area (zip codes 140-146)	B
• Eastern area (zip codes 120-129)	B
• Remainder of state	A
North Carolina	A
North Dakota	A
Ohio	
• Cleveland (zip code 441)	C
• Northeast area (zip codes 440 and 442-447)	B
• Remainder of state	A
Oklahoma	B
Oregon	
• Portland area (zip codes 970-972)	C
• Remainder of state	B
Pennsylvania	B
Puerto Rico	C
Rhode Island	B
South Carolina	A
South Dakota	A
Tennessee	A
Texas	
• Dallas — Ft. Worth area (zip codes 705-753 and 760-761)	C
• Houston area (zip codes 770-776)	C
• Remainder of state	B
Utah	A
Vermont	A
Virginia	
• Washington, DC area (zip codes 220-223)	C
• Portsmouth, Petersburg, Richmond area (zip codes 230-238)	B
• Remainder of state	A

STATE / CITY	SCHEDULE
Washington	
• Seattle area (zip codes 980-984)	C
• Remainder of state	B
West Virginia	A
Wisconsin	
• Milwaukee area (zip codes 530-534)	B
• Remainder of state	A
Wyoming	B
Outside the U.S.	C

4.5.5 SCHEDULE OF BENEFITS

Use this schedule to determine the maximum amount the GE Dental Schedule Option will pay for certain procedures. The schedule includes the most common procedures covered under the plan, as defined by the American Dental Association (ADA). The ADA may change the procedure codes listed below from time to time. To find out what the plan pays, if anything, for procedures not listed here, use the predetermination of benefits process. See Section 4.4.3, "How does predetermination of benefits work?"

PREVENTIVE AND DIAGNOSTIC CARE							
ADA procedure code	Effective 1/1/09			Effective 1/1/13			
	Schedule			Schedule			
	A	B	C	A	B	C	
Clinical oral exams — maximum of two during any calendar year							
00120	Periodic oral evaluation	\$28	\$30	\$37	\$31	\$34	\$41
00150	Comprehensive oral evaluation	\$40	\$44	\$53	\$45	\$49	\$59
Preventive cleanings — maximum of two during any calendar year							
01110	All adults and children age 13 and over	\$57	\$62	\$77	\$64	\$70	\$86
01120	Children to age 13	\$39	\$42	\$52	\$44	\$47	\$58
X-rays (radiographs)							
00210	Within the mouth — complete series (including bitewings); maximum of one during any three consecutive calendar years	\$87	\$94	\$115	\$98	\$105	\$129
00272	Bitewing — two films*	\$24	\$26	\$31	\$27	\$29	\$35
00274	Bitewing — four films*	\$37	\$40	\$49	\$41	\$45	\$55
* Maximum of two sets of bitewing x-rays during any calendar year							

* Maximum of two sets of bitewing x-rays during any calendar year

PREVENTIVE AND DIAGNOSTIC CARE CONTINUED...

ADA procedure code		Effective 1/1/09			Effective 1/1/13		
		Schedule			Schedule		
		A	B	C	A	B	C
Fluoride treatments — maximum of one during any calendar year							
01203	Topical application of fluoride, excluding preventive cleanings, for children	\$19	\$23	\$26	\$21	\$26	\$29
01204	Topical application of fluoride, excluding preventive cleanings, for adults	\$19	\$23	\$27	\$21	\$26	\$30
Sealants — maximum of one application for each permanent tooth every 36 months							
01351	Permanent back teeth only, for children under age 14	\$32	\$35	\$44	\$36	\$39	\$49
Space maintainers — including adjustments following installation							
01510	Fixed, unilateral type (limited to children under age 19, for replacement of prematurely lost temporary teeth)	\$190	\$208	\$252	\$213	\$233	\$282
Emergency treatment							
09110	Treatment for dental pain, minor procedures	\$63	\$69	\$84	\$71	\$77	\$94

RESTORATIVE SERVICES

ADA procedure code		Effective 1/1/09			Effective 1/1/13		
		Schedule			Schedule		
		A	B	C	A	B	C
Amalgam restorations (fillings) — including polishing							
02140	One surface, primary or permanent	\$39	\$43	\$53	\$44	\$48	\$59
02150	Two surfaces, primary or permanent	\$49	\$54	\$65	\$55	\$61	\$73
02160	Three or more surfaces, primary or permanent	\$55	\$61	\$73	\$62	\$68	\$82

RESTORATIVE SERVICES CONTINUED...						
ADA procedure code	Effective 1/1/09			Effective 1/1/13		
	Schedule			Schedule		
	A	B	C	A	B	C
Resin restorations (plastic or acrylic fillings)						
02330 One surface, front tooth	\$44	\$47	\$57	\$49	\$53	\$64
02331 Two surfaces, front tooth	\$53	\$57	\$70	\$59	\$64	\$78
02332 Three or more surfaces, front tooth	\$65	\$71	\$85	\$73	\$80	\$95
02391 One surface, primary or permanent	\$47	\$51	\$62	\$53	\$57	\$70
02392 Two surfaces, primary or permanent	\$63	\$69	\$83	\$71	\$77	\$93
02393 Three or more surfaces, primary or permanent	\$76	\$84	\$102	\$85	\$94	\$114
Metallic inlay restorations						
02510 Inlay — one surface	\$222	\$244	\$303	\$249	\$274	\$340
02520 Inlay — two surfaces	\$281	\$307	\$372	\$315	\$344	\$417
02530 Inlay — three surfaces	\$322	\$353	\$428	\$361	\$396	\$480
Crowns — single restorations only						
02720 Resin with metallic crown	\$355	\$388	\$470	\$398	\$435	\$527
02750 Porcelain fused to metallic crown	\$365	\$400	\$484	\$409	\$448	\$543
02790 Full cast metallic crown	\$352	\$384	\$466	\$395	\$430	\$522
02930 Prefabricated stainless steel crown, temporary tooth	\$75	\$83	\$100	\$84	\$93	\$112
02931 Prefabricated stainless steel crown, permanent tooth	\$88	\$96	\$117	\$99	\$108	\$131
02920 Re-cement crown	\$28	\$30	\$37	\$31	\$34	\$41

PROSTHODONTIC SERVICES

ADA procedure code		Effective 1/1/09			Effective 1/1/13		
		Schedule			Schedule		
		A	B	C	A	B	C
Removable dentures — including six months of post-delivery care							
05110	Complete upper denture	\$406	\$443	\$538	\$455	\$497	\$603
05130	Immediate complete upper denture	\$437	\$478	\$580	\$490	\$536	\$650
05211	Partial upper denture — resin base (including any conventional clasps, rests and teeth)	\$338	\$422	\$498	\$379	\$473	\$558
05212	Partial lower denture — resin base (including any conventional clasps, rests and teeth)	\$338	\$426	\$524	\$379	\$478	\$587
05213	Partial upper denture — cast metal base with resin saddles (including any conventional clasps)	\$465	\$509	\$617	\$521	\$571	\$692
05214	Partial lower denture — cast metal base with resin saddles (including any conventional clasps, rests and teeth)	\$465	\$509	\$617	\$521	\$571	\$692
Repairs to dentures							
05610	Repair resin saddle or base	\$48	\$52	\$64	\$54	\$58	\$72
05620	Repair cast framework	\$58	\$64	\$78	\$65	\$72	\$87
05630	Repair or replace broken clasp	\$59	\$64	\$78	\$66	\$72	\$87
05640	Replace broken tooth	\$54	\$58	\$71	\$61	\$65	\$80
05660	Add clasp to existing partial denture	\$61	\$68	\$82	\$68	\$76	\$92
Denture relining — maximum of one per denture during any three calendar years							
05750	Reline upper completed denture (laboratory)	\$120	\$131	\$159	\$135	\$147	\$178
05751	Reline lower completed denture (laboratory)	\$120	\$131	\$159	\$135	\$147	\$178
Fixed prosthodontics (fixed bridges)							
06210	Bridge pontic — cast metal	\$352	\$384	\$466	\$395	\$430	\$522
06240	Bridge pontic — porcelain fused to metal	\$365	\$400	\$484	\$409	\$448	\$543
06750	Abutment crown — porcelain fused to metal	\$365	\$400	\$484	\$409	\$448	\$543
06790	Abutment crown — metal (full cast)	\$353	\$384	\$466	\$395	\$430	\$522
06930	Re-cement bridge	\$39	\$44	\$53	\$44	\$49	\$59

4.6 GE DENTAL PREMIUM OPTION

The GE Dental Premium Option offers broad dental coverage for you and your family. It pays benefits based on a percentage of reasonable, necessary and customary charges — 100% for preventive and diagnostic care, 80% for restorative care (fillings and crowns), 50% for prosthodontic care (bridges and dentures), 80% for root canals, gum treatment and oral surgery and 50% for child orthodontics. Certain age, frequency and lifetime limits may apply.

You may save by using dentists and other dental providers who participate in the dental care network, if available in your area.

NETWORK ADVANTAGES

- Selected providers who are regularly reviewed for quality;
- Lower out-of-pocket costs; and
- No claim forms in most cases.

Find a network dentist at benefits.ge.com or call the GE Dental Benefits Claims Center at 1-888-529-8474.

4.6.1 HOW DOES THE GE DENTAL PREMIUM OPTION WORK?

Here's an overview of how the GE Dental Premium Option works:

- **You go to a dental provider** — The provider charges a fee for each dental service. You can reduce your out-of-pocket dental costs by using dentists and other providers who participate in the dental care network, if available in your area.
- **The GE Dental Premium Option pays benefits** — In general, the plan pays a percentage of reasonable, necessary and customary charges for covered services.
- **You can find out in advance what the GE Dental Premium Option will pay** — through the predetermination of benefits process. Predetermination is recommended whenever your dentist proposes costly or extensive dental treatment.

4.6.2 WHAT DOES THE GE DENTAL PREMIUM OPTION COVER?

The GE Dental Premium Option provides coverage for a range of preventive, diagnostic, restorative, endodontic, periodontic, oral surgical and orthodontic services.

For restorative, endodontic, periodontic, oral surgical and orthodontic services, if the benefits administrator determines that an alternative treatment is appropriate, benefits will be based on the alternative treatment. See Section 4.4.4, "What if an alternative treatment is appropriate?"

PREVENTIVE AND DIAGNOSTIC CARE

The GE Dental Premium Option covers the major share of preventive and diagnostic services to help you maintain healthy teeth and gums, and to detect dental problems early.

Benefits are paid at 100% of reasonable, necessary and customary charges. Certain age and frequency limits also apply.

Covered preventive and diagnostic services include:

- **Oral exams** — two checkups during each calendar year.
- **Preventive cleanings** — two during each calendar year.
- **Diagnostic procedures** — including:
 - Full mouth x-rays — once every three calendar years; and
 - Bitewing x-rays — two sets of x-rays during each calendar year.
- **Fluoride treatments** — one topical application of fluoride during each calendar year.
- **Sealants** — one treatment for each permanent molar every 36 months for children under age 14; does not include wisdom teeth.
- **Space maintainers** — fixed and unilateral, including adjustments, for children under age 19.
- **Emergency treatment** — immediate treatment for dental pain.

FILLINGS AND CROWNS (RESTORATIVE CARE)

The GE Dental Premium Option covers the repair and restoration of natural teeth (fillings and crowns), called restorative services. Benefits are paid at 80% of reasonable, necessary and customary charges. The combined maximum benefit available for these services and for bridges and dentures is \$2,500 per year.

Covered restorative services include:

- **Fillings** — amalgam (silver), acrylic or plastic fillings to restore the structure of teeth and to prevent further decay.
- **Inlays or onlays** — amalgam (silver), acrylic or plastic fillings to restore the structure of teeth and to prevent further decay.
- **Crowns** — usually porcelain, gold or acrylic, used to cover the exposed portion of badly decayed or broken teeth.

BRIDGES AND DENTURES (PROSTHODONTIC CARE)

The GE Dental Premium Option covers the construction and repair of bridges and dentures, called prosthodontic services.

Benefits are paid at 50% of reasonable, necessary and customary charges. The combined maximum benefit available for these services and for fillings and crowns is \$2,500 per year.

Covered prosthodontic services include:

- **Dentures** — to replace teeth removed while you were covered by the plan or to replace dentures that are more than five years old and no longer usable or repairable.
- **Fixed bridgework** — a permanent replacement for natural teeth removed while you were covered by the plan, or for a partial appliance or bridgework that is more than five years old and no longer usable or repairable.

ROOT CANALS, GUM TREATMENT AND ORAL SURGERY

The GE Dental Premium Option covers the treatment of tooth pulp diseases, called endodontic services, and the treatment of diseases of the gum and surrounding tissue, called periodontic services, as well as oral surgery.

Benefits for these services are paid at 80% of reasonable, necessary and customary charges.

Covered services include:

- **Endodontic services** —
 - Root canal therapy
- **Periodontic services** —
 - Gum treatment — including surgery for the treatment of gum disease when not performed in connection with the extraction, repair or replacement of teeth.
- **Oral surgery** —
 - Extractions
- **X-rays** — related to the services in this category.
- **General anesthesia** — when medically necessary for any dental treatment.

ACCIDENTAL INJURY

The diagnosis and treatment of injury to healthy teeth and gums will generally be provided under Section 2.2.4.6, "Accident-related dental services" and Section 2.3.4.6, "Accident-related dental services".

For services not covered under the medical plan, benefits are paid at 80% of reasonable, necessary and customary charges, up to the dentist's charge. See Section 4.4.2, "How does reasonable, necessary and customary work?" For example, orthodontic treatment for adults and children required as a result of an injury will be covered under the GE Dental Schedule Option, except for orthodontic treatment that would have been necessary in the absence of the injury.

Covered services also include necessary orthodontic treatment required following surgery to correct a cleft palate condition.

CHILD ORTHODONTICS

The GE Dental Premium Option covers services and supplies to correct the positioning of teeth and to control harmful habits with braces or other appliances, called orthodontic services, for covered children under age 19. An orthodontic treatment program begins when braces or other appliances are applied, and ends when they are removed.

Benefits for these services are generally paid at 50% of reasonable, necessary and customary charges, up to a maximum of \$2,500 in total lifetime benefits under both GE Dental Care Options combined, for covered children under age 19.

Covered orthodontic services include:

- **Diagnosis and development of a treatment plan** — to correct crooked, crowded or protruding teeth;
- **Braces**;
- **Exams** — and related x-rays;
- **Appliances** — one arch to control harmful habits and one arch for tooth guidance for each child; and
- **Appliance adjustments**.

Please Note — Your GE Health Care Flexible Spending Account (FSA) reimbursements for orthodontic expenses will be payable to you in the calendar year in which you make the payment for orthodontic services, rather than when the care is provided. Keep in mind that orthodontic treatments typically span two years; be sure to base your FSA contributions on the out-of-pocket expenses you expect to pay during the current year. For example, if you pay \$2,400 at the onset of orthodontic treatment and \$1,200 is eligible for reimbursement from your GE Dental Care Option, you can be reimbursed for the remaining \$1,200 from your FSA in the year in which you made the \$2,400 payment, provided you contribute at least this amount to your FSA.

REASONABLE, NECESSARY AND CUSTOMARY

The GE Dental Premium Option pays for all services according to reasonable, necessary and customary amounts, as determined by the benefits administrator. See the definition of "reasonable, necessary and customary" in "Key Terms" or see Section 4.4.2, "How does reasonable, necessary and customary work?"

AVOID SURPRISES

Find out in advance what your GE Dental Care Option will pay before undergoing costly dental treatment by using the predetermination of benefits process. For more information, see Section 4.4.3, "How does predetermination of benefits work?"

4.7 WHAT'S NOT COVERED?

As with most dental plans, some services and supplies are not covered by either GE Dental Care Option. However, some of the services listed below may be considered eligible GE Health Care Flexible Spending Account expenses.

Expenses not covered include:

- Services or supplies that are not considered reasonable, necessary and customary by the benefits administrator, including experimental procedures that are not recognized by generally accepted professional dental standards as safe and effective in the treatment of illness or injury;
- Dental services or orthodontic treatment that began before you or a dependent became covered by either GE Dental Care Option;
- Replacement of teeth you or a dependent lost before becoming covered by the plan;
- Services or supplies not provided by a licensed dentist or doctor (or by a licensed dental hygienist under a dentist's or doctor's supervision);
- Anesthesia or drugs, unless medically necessary;
- Services or supplies:
 - That are provided primarily for cosmetic reasons;
 - To increase distance between the nose and chin (vertical dimension);
 - To restore meshing of upper and lower teeth (occlusion); or
 - To treat TMJ (temporomandibular joint dysfunction);
- Services of a person who normally resides in your home and who is a member of your immediate family;
- Tooth implants;
- Myofunctional therapy;
- Composite or porcelain materials (except for the 10 upper and 10 lower front teeth). An alternative benefit may apply;
- Expenses you are not required to pay;
- Replacement of appliances or dentures because of loss or theft;
- Adult orthodontics;
- Treatment for injury because of riot, insurrection, any act of war (declared or undeclared) or service in the armed forces of any government;
- Educational or training programs;
- Dietary instructions;
- Plaque control programs;
- Broken appointments;
- The completion and filing of claim forms;
- Fees above scheduled amounts; and
- Expenses eligible to be paid or reimbursed in some other way, such as by another Company-provided plan or by:
 - Legal action or settlement from a third party (other than by an insurance policy held by you or a member of your family);
 - Workers' Compensation;
 - Another employer's group health plan (subject to maintenance of benefits);
 - Medicare; or
 - Any federal, state or local government plan or program of any country (except Medicaid).

4.8 SUBROGATION

If you receive reimbursement, or are entitled to receive reimbursement, for expenses previously paid by a Company-provided plan, the benefits administrator has the right to recover that amount from you or any third party who has primary obligation to make payment — a policy called subrogation.

Upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment for covered medical services made by the Responsible Party to a Covered Person to the full extent of benefits provided, or to be provided by, the plan. In addition, if a Covered Person receives any payment for covered medical services from any Responsible Party or Insurance Coverage the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay, up to and including the full amount the Covered Person receives from any Responsible Party. The following provisions set forth the rights of the plan.

- (a) **Constructive Trust.** By accepting benefits under this plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. This responsibility is a fiduciary duty to the plan.
- (b) **Lien Rights.** The plan will automatically have a lien to the extent of benefits paid for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan.
- (c) **First-Priority Claim.** By accepting benefits under this plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.
- (d) **Applicability to All Settlements and Judgments.** The terms of this section shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.
- (e) **Cooperation.** The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid and shall promptly notify the plan of the Covered Person's intention to pursue a claim.
- (f) **Definitions for Terms Used in this section.**
 - (i) "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term Responsible Party includes the liability insurer of such party or any insurance coverage.
 - (ii) "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage such as no fault automobile insurance coverage or workers compensation coverage. Except as provided in the preceding sentence with respect to no-fault automobile insurance, the term "Insurance Coverage" does not include policies of insurance issued to the employee or to any family member who ordinarily resides in the employee's household.
 - (iii) "Covered Person" includes employees, retirees and dependents.

5.0 VISION CARE BENEFITS

GE Vision Care helps you pay for covered eye exams, lenses and eyeglass frames. You can save on the cost of vision care by using providers who participate in the vision care network and by ordering contact lenses by mail. And if you've exhausted your GE Vision Care benefits, the GE Vision Value Option offers significant savings on the cost of additional vision care services. If you're enrolled in GE Health Care Preferred, GE Medical Benefits or other alternative health plans, your vision care benefits administrator — Davis Vision — is different from your medical benefits administrator.

5.1 KEY THINGS TO KNOW

GE Vision Care pays benefits for covered routine eye exams, corrective prescription lenses and eyeglass frames.

If you're eligible, benefits are payable according to a schedule, as follows:

- Every other calendar year — for you and your eligible dependents age 19 and older;
- Every calendar year — for your eligible dependents under age 19.

See Section 5.4.1, "What does the plan cover?"

GE Vision Premium Option pays additional benefits if you elect to participate.

If elected, benefits are payable according to a schedule as follows:

- Every calendar year — for you and your eligible dependents.

See Section 5.4.1, "What does the plan cover?"

When you use a vision care network provider:

- You save on the cost of covered vision care;
 - You save on vision care the plan doesn't cover;
 - Most eyeglasses are warranted against breakage for one year; and
 - You have no claim forms to file.
-

You can order contact lenses at reduced costs...

Through a mail-order program called Lens 1-2-3®. See Section 5.4.4, "How can I save on contact lenses?"

If you've already used your GE Vision Care benefits, you can save on the cost of additional vision care in the network through the GE Vision Value Option.

For example, you can get another pair of eyeglasses or contacts at significantly reduced network rates before you're eligible again for plan benefits. See Section 5.5, "GE Vision Value Option."

GE Vision Care Customer Service Contact Information:

- **Call Davis Vision at 1-800-433-9375** — Representatives are available Monday through Friday, 8 a.m. to 11 p.m., Eastern time, on Saturday from 9 a.m. to 4 p.m. Eastern time and on Sunday from 12 p.m. to 4 p.m. Eastern time.
 - **For additional information, visit www.davisvision.com**
-

For important information about the administration of GE Vision Care, see Section 8.0, "Administrative Information."

5.2 KEY THINGS TO DO

Schedule regular eye exams — take advantage of plan benefits for routine eye exams. See Section 5.4.1, "What does the plan cover?"

Save on vision care:

- **Use vision care network providers** — to save on the cost of covered vision care, as well as on vision care services and supplies the plan doesn't cover. Be sure to identify yourself as a Davis Vision participant through GE benefits. See Section 5.4.2, "About network providers."
- **Order contact lenses by mail** — at competitive prices through Lens 1-2-3®. See Section 5.4.4, "How can I save on contact lenses?"
- **Use the GE Vision Value Option** — for network savings on the cost of additional vision care if you've already used your GE Vision Care benefits. See Section 5.5, "GE Vision Value Option."

Pay your out-of-pocket vision care costs with pre-tax dollars — open a GE Health Care Flexible Spending Account each year to reimburse your vision care expenses. See Section 7.0, "Health Care Flexible Spending Account (FSA)."

File out-of-network claims by June 30 — for expenses that were incurred during the previous calendar year. See "Initiating claims for out-of-network benefits" in Section 5.4.3, "What if I go out-of-network?"

When coverage ends — you and your dependents may be eligible for continued health coverage under COBRA if you enroll for COBRA medical coverage **within 60 days**. See Section 2.6, "When Your GE Health Coverage Ends."

5.3 VISION PARTICIPATION

Through GE Vision Care, eligible employees and their families can save on certain vision expenses, such as covered eye exams, prescription lenses and eyeglass frames, as part of their GE Medical Care Option coverage. GE Vision Care is included in your medical coverage under GE Health Care Preferred, GE Medical Benefits and certain alternative health plan options. No additional contributions are required. The GE Vision Premium Option can be elected for additional benefits and contributions will apply.

5.3.1 WHO IS ELIGIBLE?

You are eligible for GE Vision Care if you're enrolled in GE Health Care Preferred, GE Medical Benefits or other alternative health plans. If you join an alternative health plan, such as a Health Maintenance Organization (HMO), your GE Vision Care benefits may be different. Contact your alternative health plan's benefits administrator for details.

If you are eligible, coverage begins automatically when your GE Medical Care Option coverage begins. The same is true for your dependents.

Please note that your GE Vision Care dependents must be the same as your GE Medical Care dependents. For example, if you have two covered dependents in your GE Vision Care Option, those same two dependents must be enrolled in the GE Medical Care Option.

GE Vision Care coverage ends when you or your dependents' GE Medical Care Option coverage ends. For more information, see Section 2.1.3, "Medical Participation."

ELIGIBILITY

For more information about eligibility requirements for you and your dependents, see Section 1.0, "Who is Eligible for GE Benefits?"

5.3.2 WHAT IF THERE IS OTHER COVERAGE?

If you have other vision care coverage, such as through a spouse's or same-sex domestic partner's plan at work, maintenance of benefits applies. See Section 2.1.3.6, "What if there is other coverage?"

5.4 HOW THE PLAN WORKS

GE Vision Care pays benefits, according to a schedule, for covered vision care services and supplies, as follows:

- Every other calendar year — for you and your eligible dependents beginning in the calendar year after turning 19;
- Every calendar year — for your eligible dependents through the end of the calendar year in which they turn 19;
- Every calendar year for you and your eligible dependents if you enroll in the Vision Premium Option.

5.4.1 WHAT DOES THE PLAN COVER?

GE Vision Care pays benefits, according to a schedule, for covered routine eye exams, corrective prescription lenses and eyeglass frames.

Through the vision care network, you pay less for covered vision care services and supplies because reduced rates have been negotiated with network providers, in effect, maximizing the value of your benefits. You also save on services and supplies the plan doesn't cover, such as photosensitive (sun-sensitive) lenses and tinting. In addition, you have no claim forms to file; your network provider handles the paperwork for you.

GE VISION CARE			
Benefit	Vision Standard Option*		Vision Premium Option*
	19 & Over	Under 19	All Members
Eye Examination	Once every other calendar year	Once every calendar year	Once every calendar year
Spectacle Lenses	Once every other calendar year	Once every calendar year	Once every calendar year
Frame	Once every other calendar year	Once every calendar year	Once every calendar year
Contact Lenses (in lieu of eyeglasses)	Once every other calendar year	Once every calendar year	Once every calendar year
In-Network Benefits			
Eye Examination	Included		Included
Spectacle Lenses			
• All ranges of prescriptions	Included		Included
• Choice of glass or plastic lenses	Included		Included
• Glass-Gray #3 prescription sunglasses	Included		Included
Frame			
• In-Network Retail Allowance	\$120		\$150
• Certain frames may also be available onsite at no cost or for a \$25 co-pay			

* Only employees or retirees enrolled in a GE Medical Care Option may be eligible for GE Vision Care Benefits. The Vision Standard Option and Vision Premium Option benefits are not available to employees enrolled in an HMO. HMO participants may use the Vision Value Option.

GE VISION CARE CONTINUED...		
Benefit	Vision Standard Option*	
	19 & Over	Under 19
Vision Premium Option*		
All Members		
In-Network Benefits Continued...		
Contact Lenses (in lieu of eyeglasses)		
• Elective Allowance	Up to \$130	Up to \$200
• <i>Single Vision</i>	Up to \$175	Up to \$200
• <i>Bifocal</i>		
• Formulary with Fitting/Follow Up Care (in lieu of Elective Allowance), Nonformulary		
• <i>Standard, soft or daily wear</i>	Included	Included
• <i>Disposable</i>	Included (up to 4 boxes)	Included (up to 8 boxes)
• <i>Planned Replacement</i>	Included (up to 2 boxes)	Included (up to 4 boxes)
Spectacle Lens Options (may be selected at the point-of-service)		
• Edge Treatment	\$11	\$0
• Tints	\$11	\$0
• Scratch Resistant Coating (Single Vision or Multifocal)	\$0	\$0
• Scratch Protection Plan (Single Vision or Multifocal)	\$20/\$40	\$0
• Polycarbonate Lenses (Single Vision or Multifocal)	\$30**	\$0
• Standard Progressive Lenses (PALs)	\$65	\$0
• Select PALs	\$70	\$5
• Premium PALs (Varilux™, etc.)	\$90	\$25
• Ultra PALs	\$195	\$130
• Standard Anti-Reflective Coating (ARC)	\$35	\$0

* Only employees or retirees enrolled in a GE Medical Care Option may be eligible for GE Vision Care Benefits. The Vision Standard Option and Vision Premium Option benefits are not available to employees enrolled in an HMO. HMO participants may use the Vision Value Option.

** Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions $\geq \pm 6.00$ diopters.

Please Note — Amounts you pay for routine vision care, including the cost of glasses or contact lenses, do not count toward your GE Medical Care Option out-of-pocket maximum.

GE VISION CARE CONTINUED...

Benefit	Vision Standard Option*		Vision Premium Option*
	19 & Over	Under 19	All Members
In-Network Benefits Continued...			
Low Vision Services and Devices <ul style="list-style-type: none"> One comprehensive evaluation every five years Low vision device allowance Follow-up care: four visits in any five-year period. (Benefits are subject to an aggregate lifetime maximum of \$2,000 and must be approved in advance by the Claims Administrator) 	<p>Maximum reimbursement of \$300 per evaluation</p> <p>\$600 per device with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes</p> <p>Maximum reimbursement of \$100 for each visit</p>		<p>Maximum reimbursement of \$300 per evaluation</p> <p>\$600 per device with a lifetime maximum of \$1,200 for items such as high-power spectacles, magnifiers and telescopes</p> <p>Maximum reimbursement of \$100 for each visit</p>
Value-Added Features <ul style="list-style-type: none"> One-year Breakage Warranty Lens 1-2-3![®] Contact Lens Mail Order Program Laser Vision Surgery Vision Value Option 	<p>Included</p> <p>Included</p> <p>Laser Vision discount program participation</p> <p>Included</p>		<p>Included</p> <p>Included</p> <p>Laser Vision discount program participation, plus up to \$250 lifetime allowance, per eye</p> <p>Included</p>

* Only employees or retirees enrolled in a GE Medical Care Option may be eligible for GE Vision Care Benefits. The Vision Standard Option and Vision Premium Option benefits are not available to employees enrolled in an HMO. HMO participants may use the Vision Value Option.

** Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions $\geq \pm 6.00$ diopters.

GE VISION CARE CONTINUED...

Benefit	Vision Standard Option*		Vision Premium Option*
	19 & Over	Under 19	All Members
Out-of-Network Benefits			
Eye Examination	Up to \$40		Up to \$40
Spectacle Lenses, per pair			
• <i>Single Vision</i>	Up to \$45		Up to \$45
• <i>Bifocal</i>	Up to \$70		Up to \$70
• <i>Trifocal</i>	Up to \$100		Up to \$100
• <i>Lenticular</i>	Up to \$120		Up to \$120
Frames	Up to \$45		Up to \$45
Contact Lenses			
• <i>Single Vision</i>	Up to \$100		Up to \$100
• <i>Bifocal</i>	Up to \$150		Up to \$150
• <i>Laser Vision Surgery</i>	N/A		\$250 lifetime allowance per eye

* Only employees or retirees enrolled in a GE Medical Care Option may be eligible for GE Vision Care Benefits. The Vision Standard Option and Vision Premium Option benefits are not available to employees enrolled in an HMO. HMO participants may use the Vision Value Option.

** Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions $\geq \pm 6.00$ diopters.

Please Note — Amounts you pay for routine vision care, including the cost of glasses or contact lenses, do not count toward your GE Medical Care Option out-of-pocket maximum.

VISION VS. MEDICAL

If you need additional medical (ophthalmic) treatment beyond a routine periodic eye exam (that is, care beyond basic refraction/vision care services), be sure to call your medical benefits administrator **in advance** to determine whether and how the care will be covered. If care is covered under your GE Medical Care Option, you may need to obtain a referral or advance approval to receive the highest level of benefits.

NETWORK ADVANTAGES

- Selected providers who are regularly reviewed for quality.
- Lower out-of-pocket costs.
- One-year warranty against breakage for most eyeglasses.
- No claim forms.

5.4.2 ABOUT NETWORK PROVIDERS

The vision care network includes optometrists, ophthalmologists and opticians who have been selected by the benefits administrator and who undergo regular reviews for quality of care and service.

You must use a network provider to receive network benefits. A directory of providers in the network will be made available to you without charge. You may access this information at benefits.ge.com and www.davisvision.com, or by calling GE Vision Care at 1-800-433-9375.

When you go to a network provider, be sure to identify yourself as a Davis Vision participant through GE benefits.

VISION CARE PROVIDERS

- **Ophthalmologist** — a licensed doctor of medicine who specializes in the diagnosis and treatment of conditions of the eye, who performs eye surgery and vision exams and who prescribes lenses to improve vision.
- **Optometrist** — a doctor of optometry who is specifically trained to examine the eye for vision problems and eye disease and who performs vision exams and prescribes lenses.
- **Optician** — a technician legally qualified to supply eyeglasses according to a prescription written by an ophthalmologist or optometrist.

HOW YOU CAN SAVE

When you use providers from the vision care network, GE Vision Care covers the majority of eligible expenses, with little or no out-of-pocket cost to you. If you use out-of-network providers, you'll still receive vision benefits toward eligible expenses, but your out-of-pocket costs will be higher.

5.4.3 WHAT IF I GO OUT-OF-NETWORK?

If you use an out-of-network vision provider, you still receive GE Vision Care benefits (up to a scheduled amount), but your out-of-pocket costs may be substantially higher than if you had used a network provider. In addition, you'll need to file claim forms to be reimbursed for covered expenses.

INITIATING CLAIMS FOR OUT-OF-NETWORK BENEFITS

Here's how to request benefits for out-of-network vision care:

1. **Complete and sign the employee and patient information portions of a vision care claim form** — claim forms are available at benefits.ge.com and www.davisvision.com, or by calling the vision care administrator at 1-800-433-9375.
2. **Ask your provider to complete the provider portion of the form.**
3. **Mail the form to the benefits administrator** — at the address shown on the form. Be sure to attach a copy of your itemized receipt and any other necessary documentation. Claims must be submitted **by June 30** for expenses incurred during the prior calendar year.
4. **Receive reimbursement** — a check will be sent to your home reimbursing you according to plan benefits.

If your provider is willing to bill Davis Vision — the benefits administrator — directly, be sure to sign the section of the form authorizing payment to the provider. You'll be notified of any amount you are responsible for paying.

If you have a question or problem with a claim, call the vision care network at 1-800-433-9375.

5.4.4 HOW CAN I SAVE ON CONTACT LENSES?

You can save on the cost of contact lenses through a mail order program called Lens 1-2-3®. Through Lens 1-2-3®, you have access to a wide variety of contact lenses at competitive prices — as much as 50% off the retail cost when you order replacement lenses. You also receive a free contact lens cleaning and storing kit with each order.

If you have not already used your GE Vision Care benefits for lenses available to you, you receive a \$100 credit toward the reduced cost of your single-vision contacts or a \$150 credit toward the reduced cost of your bifocal contacts through Lens 1-2-3®. If you've already used your GE Vision Care benefits, you don't receive the credit, but you can pay Lens 1-2-3® directly and still take advantage of the program's discounted rates.

Here's how to use Lens 1-2-3®:

1. **Call Lens 1-2-3® at 1-800-536-7123** — and speak with a customer service representative. Representatives are available Monday through Friday, 8 a.m. to 9 p.m., Eastern time, on Saturday from 8 a.m. to 6 p.m., Eastern time, and on Sunday from 9 a.m. to 5:30 p.m., Eastern time.
2. **Identify yourself as a Davis Vision participant through GE benefits** — and tell the representative where you obtained your current contact lens prescription:
 - **If your prescription is from a vision network provider** — there's nothing else you need to do.
 - **If your prescription is from an out-of-network provider** — you'll be asked to fax or mail your prescription. Or, you can request that the customer service representative call your provider and get it for you. In some states, doctors may not be required to release contact lens prescription information.
3. **Receive your contact lenses by mail** — they will be shipped on the day you place your order. ("Special order" contacts may not be available for same-day shipping.)

TIMELY FILING

You must file your out-of-network vision care claims **by June 30** for expenses that were incurred during the previous calendar year.

5.4.5 WHAT'S NOT COVERED?

As with all health benefit plans, some expenses are not covered by GE Vision Care. Expenses not covered include:

- Dilation of the pupil;
- Nonprescription eyeglasses;
- Replacement of lost or broken lenses or eyeglass frames, except as provided according to the GE Vision Care frequency provisions and network warranty provisions; and
- Other expenses listed in Section 2.4, "What's Not Covered."

5.5 GE VISION VALUE OPTION

For the most part, the GE Vision Value Option is designed to help you benefit from network discounts on the cost of your additional vision care needs, if you've already used your GE Vision Care benefits.

For example, if you are enrolled in the GE Vision Standard Option, which pays benefits every other calendar year, and you receive benefits for an eye exam and a pair of eyeglasses in 2012, you won't be eligible for additional plan benefits for eyeglasses until January 1, 2014. However, you can take advantage of the GE Vision Value Option to get additional eye exams, lenses or frames at reduced network rates, until you become eligible again for plan benefits.

If you are enrolled in the GE Vision Premium Option, which pays benefits every calendar year, you can take advantage of the GE Vision Value Option to get additional lenses or frames at reduced network rates — for example, prescription sunglasses.

Through the GE Vision Value Option, eyeglass lenses and frames from the select group are unconditionally warranted against breakage during normal wear for one year. If your eyeglass lenses or frames break within one year, you can return them to the network provider and they will be repaired or replaced at no cost to you.

You also can use the GE Vision Value Option to lower the cost of laser surgery to correct vision impairment.

Here's how to use the GE Vision Value Option for eye exams, lenses and frames:

1. **Call the vision care administrator at 1-800-433-9375** — speak with a customer service representative about the services you anticipate purchasing (such as an eye exam, lenses and eyeglass frames). Representatives are available Monday through Friday, 8 a.m. to 11 p.m., Eastern time, on Saturday from 9 a.m. to 4 p.m., Eastern time and on Sunday from 12 p.m. to 4 p.m. Eastern time.
2. **Pre-pay for your anticipated services** — for your convenience, credit cards, personal checks and money orders are accepted.
3. **Schedule an appointment with a vision care network provider of your choice** — please allow 24 to 48 hours for credit card clearance and five business days for your check to be received before you schedule an appointment with a network provider.

VISION VALUE OPTION ADVANTAGE

If you are enrolled in a GE Medical Care Option, including alternative health plans, you can take advantage of the GE Vision Value Option.

5.5.1 HOW MUCH CAN I SAVE?

Here's what you pre-pay — and how much you save over retail prices — through the GE Vision Value Option. Retail costs may vary, depending on where you live. (These estimates do not include any special discounts that may be offered by retailers.)

For	Average retail cost*	Your GE Vision Value Option cost	Your potential savings
Eye exam	\$75	\$46	\$29
Single-vision eyeglass lenses	\$75	\$49	\$26
Bifocal eyeglass lenses	\$100	\$74	\$26
Trifocal eyeglass lenses	\$125	\$104	\$21
Lenticular eyeglass lenses	\$140	\$124	\$16
Single-vision contact lenses**	\$150	\$104	\$46
Bifocal contact lenses**	\$285	\$154	\$131
Eyeglass frames	Up to \$175	\$49	Up to \$126

* As of 2012.

** A co-pay may apply.

MORE ABOUT LASER SURGERY

Laser surgery to correct vision impairment is not a covered service under the GE Medical Care Options or GE Vision Care. However, it is covered in the GE Vision Premium Option, up to a \$250 lifetime allowance, per eye. You can reduce your out-of-pocket costs by having the procedure performed at a laser vision center that participates in the vision network. By using a Davis Vision laser surgery provider, you can save up to 25% of the reasonable and customary cost for that surgery. Additional information is available at benefits.ge.com and www.davisvision.com, or you can call 1-800-433-9375.

MORE ABOUT EYEGLASS FRAMES

For only \$49, you can purchase eyeglass frames from a select group with comparable retail prices up to \$175.

If you purchase eyeglass frames outside of the select group or if the select group is not available from your network provider, you'll receive a \$120 credit toward the retail cost of the frames you select. You'll need to pay any remaining balance to your provider at the time of service.

For example, you pre-pay \$49 for eyeglass frames. At the network provider, you select a frame priced at \$200. You receive a \$120 credit toward the frames, and pay the additional \$80 to your provider at the time of service.

MORE ABOUT CONTACT LENSES

For only \$104, you can purchase single-vision standard, daily-wear soft contact lenses and disposable contact lenses (typically, a three-month supply) from a select group, available for most prescriptions. If you choose these selected contacts, you'll need to pay an additional professional service fee, up to \$55, to your network provider at the time of service.

If you purchase contacts outside of the select group, such as gas-permeable or toric lenses, you'll need to pre-pay \$104, and you'll receive a \$130 credit toward the retail cost of your single-vision contacts. You'll need to pay any remaining balance, including fitting and follow-up care to your provider at the time of service.

Keep in mind that you may save even more when you order your contact lenses by mail through Lens 1-2-3®. See Section 5.4.4, "How can I save on contact lenses?" for more information.

ADDITIONAL SAVINGS

You can pay your out-of-pocket costs for laser surgery with tax-free dollars — and save on your taxes — by using a GE Health Care Flexible Spending Account (FSA). See Section 7.0, "Health Care Flexible Spending Account (FSA)." Before making your FSA election, ensure that you qualify as a candidate for laser surgery.

5.6 WHEN YOUR GE VISION CARE COVERAGE ENDS

Your GE Vision Care coverage ends when your GE Medical Care Option coverage ends. The same is true for your dependents.

Under federal law, you may be eligible to continue medical coverage, including vision care coverage, at your own expense — and in some cases at the Company's expense — when your GE medical coverage ends. However, you may not convert your vision care coverage to an individual policy. See Section 2.6, "When Your GE Health Coverage Ends." for more information.

6.0 CONTINUING COVERAGE IN SPECIAL CASES

In some situations, GE health care coverage can continue for you and your eligible dependents even when you are not actively employed by the Company. This Section describes how coverage can continue after you retire, in case you become disabled, for your survivors in case of your death, in case of layoff or work transfer and in case of plant closing. Please note that any continuing coverage and benefits are subject to amendment or termination rights and other limits to future benefits.

6.1 AFTER YOU RETIRE

When you retire, GE health care benefits provide important coverage. This Section describes special provisions for employees who meet eligibility requirements to continue health care benefits coverage after retirement. These benefits are subject to amendment or termination rights and other limits to future benefits.

6.1.1 WHO IS ELIGIBLE?

To be eligible for GE Medical Care Options, GE Dental Care Options, GE Vision Care, GE Pensioner Health Plans (after you reach age 65) and GE Life Insurance during retirement, you must:

- Retire directly from Company service at age 60 or older with at least 10 years of continuous service;
- Retire on a Disability Pension from the GE Pension Plan;
- Retire under the Special Early Retirement Option (SERO) of the GE Pension Plan; or
- Receive pension benefits under the Plant Closing Pension Option (PCPO) of the GE Pension Plan because you:
 - are under age 50 and would have 30 or more years of Pension Qualification Service (PQS) by the end of the calendar year in which your service is terminated because of the plant closing; or
 - would be age 50 or older with 25 to 29 years of PQS by the end of the calendar year in which your service is terminated because of the plant closing.

If you meet these requirements, you are eligible for coverage before and after you reach age 65. Please note, however, that many of the benefits change at age 65 and some may end. Also, please note that your cost for any continuing coverage may depend on the terms of your retirement, your age and your service, as noted in Section 6.1.2, "Your GE Medical Care Options before age 65." Section 6.1.3, "GE Dental Care Options." and Section 6.1.5, "Your GE Pensioner Health Plans at age 65."

IF YOU DON'T QUALIFY

If you don't meet the eligibility requirements noted for coverage before and after you reach age 65, your coverage under the GE health care plans ends when you retire.

However, you may have access to coverage under other provisions of GE's benefits:

- In some cases, former employees may be eligible for continued coverage through special benefits protection, as described in Section 6.4.4, "Protection for long-service employees."
- If you receive pension benefits under PCPO but do not meet the eligibility requirements above.
- If you are not eligible for continued coverage, you may be able to continue health care coverage under COBRA, as described in Section 2.6, "When Your GE Health Coverage Ends."

Optional health care coverage may be available once you reach age 65 — If you leave the Company for any reason at age 60 or older with less than 10 years of continuous service, regardless of whether your GE medical coverage continued, you are eligible to purchase coverage that supplements your Medicare benefits. This medical coverage is provided through the GE Pensioners Hospital Indemnity Plan and the GE Medicare Insurance Plan for Part B Benefits. Both of these plans are described in Section 6.1.5, "Your GE Pensioner Health Plans at age 65."

RETIRED?

If you leave the Company for any reason at age 60 or older with at least 10 years of continuous service, you are considered to be "retired" for purposes of determining eligibility for the continuing coverage provisions described here. Your coverage levels and cost depend on your length of service.

If you were eligible to retire on December 31, 1994

If you were age 60 with at least 10 years of continuous service on December 31, 1994, your GE medical, dental and vision coverage can be continued during retirement. You are eligible for these benefits at the same cost as employees who retired from the Company with at least 15 years of continuous service, as described in Section 6.1.2, "Your GE Medical Care Options before age 65." Section 6.1.3, "GE Dental Care Options" and Section 6.1.5, "Your GE Pensioner Health Plans at age 65." Your coverage options once you reach age 65 are also on the same terms as those for retirees with at least 15 years of continuous service.

OTHER CONTINUATION OPTIONS

For information on COBRA health coverage, see Section 2.6, "When Your GE Health Coverage Ends."

6.1.2 YOUR GE MEDICAL CARE OPTIONS BEFORE AGE 65

If you're eligible for continued medical coverage through the Company, your coverage continues under your GE Medical Care Option until you reach age 65. The provisions that apply to you as a retiree are the same as those that apply for active employees, and you remain eligible to change your GE Medical Care Option once a year — changing, for example, from GE Medical Benefits to GE Health Care Preferred or an alternative health plan, if available — during annual enrollment.

Coverage changes occur on the first day of the month in which you reach age 65 — or on the first day of the preceding month if your birth date falls on the first. Any coverage ending upon reaching age 65 would end the day before. For example, if your birthday is June 1, your coverage would end on April 30. However, one of two special circumstances may apply:

- **If your birthday is January 1** — you would be considered to have reached age 65 on December 1 of the previous year, and your coverage would end on November 30 of the previous year; or
- **If your birthday is on or between January 2 and February 1** — you would be considered to have reached age 65 on January 1, and your coverage would end on December 31 of the previous year.

This "age 65 rule" also applies to your spouse or same-sex domestic partner.

If you are eligible, you may also continue GE medical coverage for:

- **Your spouse** — until he or she reaches age 65;
- **Your same-sex domestic partner** — until he or she reaches age 65, provided that he or she was covered by you as a dependent under a GE Medical Care Option at the time of your retirement;
- **Your dependent children** — for as long as they remain eligible under the plan. See Section 1.3, "Who qualifies as an eligible dependent?" for more information. Note that if your dependent child ceases to be eligible for coverage through the Company, he or she may be able to continue health coverage under COBRA. See Section 2.6, "When Your GE Health Coverage Ends" for more information on COBRA health coverage.

PRE-65 CONTRIBUTIONS

To continue medical coverage through the Company, you'll need to pay required contributions.

If you had at least 10 but fewer than 15 years of continuous service when you retired...

- Then your contributions for medical coverage will be 25% of the average national cost for the applicable GE Medical Care Option and the coverage level — retiree only or retiree plus dependents — you select, adjusted annually.

If you had 15 or more years of continuous service and retired before January 1, 1998...

- Then your contributions for medical coverage will be based on your annual retirement income from the GE Pension Plan and any other Company or affiliate retirement plan.

If you had 15 or more years of continuous service, retired on or after January 1, 1998 and your normal straight-time annual earnings at the time you retired were less than \$60,000...

- Then your contributions for medical coverage will be based on your annual retirement income from the GE Pension Plan and any other Company or affiliate retirement plan.

If you had 15 or more years of continuous service, retired on or after January 1, 1998 and your normal straight-time annual earnings at the time you retired were \$60,000 or more...

- Then your contributions for medical coverage will be the contribution rate applicable to an active employee in the same pay classification from which you retired.

Deductibles and out-of-pocket maximums

If you had 15 or more years of continuous service, retired on or after January 1, 1998 and your normal straight-time annual earnings at the time you retired were \$60,000 or more, then the medical coverage deductibles and out-of-pocket maximums that apply under the GE medical coverage you elect will be based on your normal straight-time annual earnings as of your retirement date. See "What pay counts" in Section 2.1.3.5, "How much does coverage cost?"

In all other cases, the medical coverage deductibles and out-of-pocket maximums will be based on your annual retirement income from the GE Pension Plan and any other Company or affiliate retirement plan.

Medical coverage options in case of disability

If you or your spouse receives Social Security Disability Insurance benefits (SSDI) for 24 months or longer, Medicare becomes the primary source of medical coverage for the disabled person. That means Medicare pays benefits first and GE coverage becomes secondary. The GE plan pays the difference, if any, between what Medicare pays and what the GE plan would have paid if no other coverage applied.

If you are affected, the Company pays the basic Medicare Part B premium for you and your spouse, until age 65. If you enroll late, Medicare will charge you a higher premium for Part B coverage. The Company does not pay the additional premium cost, so it's important to enroll promptly. When determining what your GE Medical Care Option pays, the Company assumes the disabled person is enrolled in both Medicare Part A and Part B.

If you or your spouse remains disabled upon reaching age 65, your GE Medical Care Option coverage will continue until the end of the calendar year following the year in which you reach age 65, as described in Section 6.2, "In Case of Disability". After that coverage ends, you may enroll for any of the GE Pensioner Health Plans for which you are eligible.

REACHING AGE 65

For purposes of the GE medical and dental care options for pensioners, participants "reach age 65" on the first of the month in which the participant's 65th birthday occurs — or on the first of the preceding month if the birth date falls on the first. Any coverage ending upon reaching age 65 would end the day before.

6.1.3 GE DENTAL CARE OPTIONS

If you're eligible as described in Section 6.1.1, "Who is eligible?" dental coverage under your GE Dental Care Option continues until you reach age 65, except for Plant Closing Pension Option (PCPO) recipients, who are generally eligible for dental coverage for only 12 months. However, PCPO recipients with 30 years or more Pension Qualified Service (PQS) or age 50 or older with 25 through 29 years PQS will be eligible for the same dental benefits currently offered to employees who retire at age 60.

Benefits may continue longer for certain dental services, if treatment has already begun at the time your coverage ends. Refer to Section 4.3.8, "When does coverage end?" for details.

If you are eligible for continued dental coverage to age 65, coverage may also continue for:

- **Your spouse** — until he or she reaches age 65 or until your coverage ends, if earlier; and
 - **Your dependent children** — as long as they remain eligible under the plan or until your coverage ends, if earlier.
- See Section 1.3, "Who qualifies as an eligible dependent?" for more information.

Note that if your spouse or dependent child ceases to be eligible for coverage through the Company, he or she may be able to continue coverage under COBRA for up to 36 months, up to age 65. See Section 2.6, "When Your GE Health Coverage Ends" for more information on COBRA health coverage.

When you reach age 65, coverage under this plan ends for you and any eligible dependents.

Coverage changes occur on the first day of the month in which you reach age 65 — or on the first day of the preceding month if your birth date falls on the first. Any coverage ending upon reaching age 65 would end the day before. For example, if your birthday is June 1, your coverage would end on April 30. However, one of two special circumstances may apply:

- **If your birthday is January 1** — you would be considered to have reached age 65 on December 1 of the previous year, and your coverage would end on November 30 of the previous year; or
- **If your birthday is on or between January 2 and February 1** — you would be considered to have reached age 65 on January 1, and your coverage would end on December 31 of the previous year.

This "age 65 rule" also applies to your spouse.

Paying for pre-65 dental coverage

If you had 15 or more years of continuous service when you retired...

- Then, provided you pay any required contributions for the GE Dental Care Option you selected, the Company will provide continued dental coverage for you and your eligible dependents until you reach age 65.
- If you enroll for dental coverage under the GE Dental Premium Option, you will have to pay added contributions, above those described for the GE Dental Schedule Option.

If you had at least 10 but fewer than 15 years of continuous service when you retired...

- Then your contributions for dental coverage under the GE Dental Schedule Option will be 25% of the average national cost for this coverage option and the coverage level — retiree only or retiree plus dependents — you select, adjusted annually.
- If you enroll for dental coverage under the GE Dental Premium Option, you will have to pay added contributions, above those described for the GE Dental Schedule Option.

If you or your spouse remains disabled upon reaching age 65, your GE Dental Care Option coverage will continue until the end of the calendar year following the year in which you reach age 65, as described in Section 6.2, "In Case of Disability."

6.1.4 GE VISION CARE

If you are eligible and continue coverage under a GE Medical Care Option (other than certain alternative health plans), your GE Vision Care benefits continue for as long as your GE Medical Care Option coverage continues. See Section 5.3.1, "Who is eligible?"

6.1.5 YOUR GE PENSIONER HEALTH PLANS AT AGE 65

Please note this section does not apply to active employees. See *Your Benefits Handbook — Retiree Health and Life* for details. Coverage for you under your GE Medical Care Option ends when you reach age 65, unless you are disabled (see Section 6.1.2, "Your GE Medical Care Options before age 65"). Coverage for your spouse also ends when he or she reaches age 65. At 65, Medicare becomes the primary source of medical coverage.

If you reach age 65 and any of your dependents (including your spouse) are still eligible for coverage from the Company, the dependents' coverage will continue under the GE Medical Care Option you elect for as long as they remain eligible.

Coverage changes occur on the first day of the month in which you reach age 65 — or on the first of the preceding month if your birth date falls on the first. This "age 65 rule" also applies to your spouse, and his or her coverage will be treated separately from yours. For example, if your spouse is older than you, when he or she reaches age 65 your spouse's coverage under a GE Medical Care Option will end, but you will continue to be covered under your GE Medical Care Option until you reach age 65.

If you're eligible for the GE Pensioner Health Plans once you reach age 65, the Company provides you with three options:

- **GE Medicare Benefit Plans** — These plans offer a traditional approach to health care coverage, in which Medicare provides primary health coverage and the GE plans provide supplemental coverage. The plans work together with your Medicare coverage to help you pay some of the health care expenses not paid by Medicare Parts A and B. If you are eligible, you may enroll in any or all of these plans, based on your need for coverage.
- **GE MedicarePlus** — GE MedicarePlus provides eligible retirees, who live in areas where the plan is available, with a single, comprehensive health benefit plan that includes the coverage you get with Medicare Parts A and B and the GE Medicare Benefit Plans, plus additional benefits that Medicare and the GE Medicare Benefit Plans do not offer.

You choose the approach you feel is best for you from the options available where you live. If you are eligible, you also may cover your spouse under any of these plans for which you are eligible, provided he or she is age 65 or older.

GE Medicare Benefit Plans	GE MedicarePlus
<ul style="list-style-type: none">• GE Medical Care Plan for Pensioners	<ul style="list-style-type: none">• Comprehensive health benefits through a single plan, including preventive care and prescription drug benefits
<ul style="list-style-type: none">• GE Pensioners Hospital Indemnity Plan	<ul style="list-style-type: none">• May include dental, vision and hearing benefits
<ul style="list-style-type: none">• GE Pensioners Prescription Drug Plan	<ul style="list-style-type: none">• Low out-of-pocket expenses
<ul style="list-style-type: none">• GE Medicare Insurance Plan	<ul style="list-style-type: none">• To participate, you must be enrolled in Medicare Part B

GE Pensioner Vision Value Option
Available under all of the above.

GE Medicare Benefit Plans

The GE Medicare Benefit Plans work together with your Medicare coverage to help you pay some of the health care expenses not paid by Medicare Parts A and B. If you are eligible, you may enroll in any or all of these plans, based on your need for coverage.

- **GE Medical Care Plan for Pensioners** — helps you pay your Medicare co-pays for hospital admissions covered by Medicare Part A.
- **GE Pensioners Hospital Indemnity Plan** — helps you pay your Medicare co-pays for hospital admissions covered by Medicare Part A. You pay the full cost of this plan.
- **GE Pensioners Prescription Drug Plan** — helps you purchase prescribed medicines not covered by Medicare.
- **GE Medicare Insurance Plan for Part B Benefits** — helps you pay for your share of the cost of doctors' expenses and other expenses covered by Medicare Part B. You pay the full cost of this plan.

GE MedicarePlus

GE MedicarePlus is a program that provides the benefits of Medicare Parts A and B and the GE Medicare Benefit Plans, plus additional benefits such as preventive care, dental, vision and hearing benefits. GE MedicarePlus offers these benefits through Medicare Health Maintenance Organizations (HMOs) that have been federally approved to offer Medicare coverage. Special benefit packages for GE retirees have been negotiated with these Medicare HMOs. The resulting program offers simplicity and savings — simplicity because there is almost no paperwork and savings because GE MedicarePlus provides comprehensive coverage at a lower out-of-pocket cost.

With GE MedicarePlus there are no deductibles to meet — instead, you pay a low, fixed co-pay for doctors' office visits. Coverage is available for inpatient hospital stays and you also receive comprehensive preventive care coverage and prescription drug benefits. In some areas, GE MedicarePlus may include dental, vision and hearing care benefits.

To receive all the benefits GE MedicarePlus offers, you must use the providers and health care facilities that are part of the Medicare HMO you join when you enroll in GE MedicarePlus. If you don't use your HMO's providers and follow the Medicare HMO's referral procedures, your care won't be covered.

You decide if GE MedicarePlus is right for you. More information will be provided just before you reach age 65.

GE Pensioner Vision Value Option

The GE Pensioner Vision Value Option helps you cover the cost of vision care by providing you access to the vision care network. Through the vision care network, available in most locations, you can purchase vision care services at discounted prices. Because you pre-pay for services, you don't have to file any claim forms.

This program is available to you and your eligible spouse if you are age 65 or older and participate in the GE Medical Care Plan for Pensioners or GE MedicarePlus.

6.2 IN CASE OF DISABILITY

If you become disabled, GE health care benefits provide important coverage. If you must pay contributions for this coverage, you will do so as described in Section 8.1.6, "How do I pay for coverage when not on the payroll?"

If you retire because of a disability, your benefits continue according to the provisions described in Section 6.1, "After You Retire."

6.2.1 GE MEDICAL, DENTAL AND VISION COVERAGE

If you are totally disabled (as defined below) and your continuous service or service credits are maintained, your GE medical, dental and vision coverage will continue for you and any eligible dependents as long as you remain disabled

- **Up to 12 months** — if your disability is not work-related.
- **Up to 18 months** — if you are disabled by an illness or injury that is work-related as determined by Workers' Compensation.

If your health care coverage is continued under these terms, the Company provides it at no cost to you.

Benefits may continue longer for certain dental services, if treatment has already begun at the time your coverage ends. Refer to Section 4.3.8, "When does coverage end?" for details.

COBRA health coverage — When Company-provided medical, dental and vision coverage ends, you may be eligible to extend coverage up to a total of 29 months (including the period of Company-provided coverage) by purchasing additional coverage through COBRA. COBRA health coverage is described in Section 2.6, "When Your GE Health Coverage Ends." For more information, you can also contact the GE COBRA administrator online at www.ceridian-benefits.com or by calling 1-800-877-7994 (1-727-864-3300).

If you qualify for a GE Disability Pension, medical benefits are continued according to the provisions described in Section 6.1, "After You Retire."

DIFFERENT BENEFITS FOR RETIREES

The benefits available to you if you retire because of a disability are described in Section 6.1, "After You Retire."

6.2.2 GE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

If you participate in a GE Health Care Flexible Spending Account (FSA), pre-tax contributions to your FSA generally end when your pay ends. However, during any period of disability leave that is considered FMLA leave, you can choose to:

- Continue your participation in your GE Health Care FSA through pre-tax payroll deductions if you continue to receive pay or through after-tax contributions if your pay does not continue; or
- Suspend your GE Health Care FSA participation while you are out on leave and elect to resume participation when you return to work. In this case, your election will be proportionately adjusted for the amount of time you were out on leave.

If you continue your participation in a GE Health Care FSA while you are on an FMLA leave and do not return to work at the end of your FMLA leave because you are still disabled, you may be able continue your participation on an after-tax basis through COBRA. If you are eligible for continuation through COBRA, your participation will continue only through the end of the calendar year. For more details, see "GE Health Care Flexible Spending Account (FSA)" in Section 2.6.3.5, "How long does COBRA health coverage continue?"

6.3 IN CASE OF YOUR DEATH

The following section outlines how your GE benefits are affected if you die while a Company employee and how coverage can continue for your survivors.

6.3.1 GE MEDICAL, DENTAL AND VISION COVERAGE

If you die, your dependents are eligible to receive up to 36 months total of medical, dental and vision coverage through COBRA, with the first 12 months paid for by the Company. COBRA health coverage is described in more detail in Section 2.6, "When Your GE Health Coverage Ends."

Dental benefits may continue longer for certain dental services, if treatment has already begun at the time coverage ended, as described in Section 4.3.8, "When does coverage end?"

6.3.2 MEDICAL AND VISION COVERAGE BEYOND ONE YEAR

Your dependents' medical options before age 65

Under certain circumstances, your surviving dependents may continue medical and vision coverage beyond the 12 months of Company-provided coverage by paying the required contributions. Contributions generally equal 25% of the plan's cost for providing your dependents with medical coverage. The cost is determined by the Company as of April 1 of each year. Contributions must be paid each month in advance.

Your dependents will be eligible for this extended medical and vision coverage if your death occurs:

- When you are an active employee:
 - age 50 or older with 25 or more years of continuous service;
 - age 60 or older with 10 or more years of continuous service; or
 - with 30 or more years of continuous service, regardless of age;
- During retirement with at least 10 years of continuous service, including Disability Pension or Special Early Retirement Option (SERO), before the first of the month of your 65th birthday; or
- While you are receiving retirement benefits under the Plant Closing Pension Option (PCPO) with at least 30 years of Pension Qualification Service (PQS) or if you are age 50 or older with 25 to 29 years of PQS by the end of the calendar year in which your service is terminated because of the plant closing.

Coverage may be continued for:

- **Your spouse** — until he or she reaches age 65 or until the date of his or her remarriage, if earlier; and
- **Your dependent children** — for as long as they remain eligible under the plan.

GE Pensioner Health Plans at age 65

Please note this section does not apply to active employees. See *Your Benefits Handbook — Retiree Health and Life* for details.

If your surviving spouse was eligible for the continuing GE medical coverage described above and has not remarried upon reaching age 65, Medicare becomes your spouse's primary source of medical coverage — the primary payer — at age 65. Please note: If your spouse remarries, he or she will no longer be eligible for GE medical coverage.

Coverage changes occur on the first day of the month in which your spouse reaches age 65 — or on the first of the preceding month if your spouse's birthday falls on the first. Any coverage ending upon reaching age 65 would end the day before. For example, if your spouse's birthday is June 1, his or her coverage would end on April 30. However, one of two special circumstances may apply:

- **If your spouse's birthday is January 1** — he or she would be considered to have reached age 65 on December 1 of the previous year, and his or her coverage would end on November 30 of the previous year; or
- **If your spouse's birthday is on or between January 2 and February 1** — he or she would be considered to have reached age 65 on January 1, and his or her coverage would end on December 31 of the previous year.

The Company provides your eligible, unmarried surviving spouse with three options for obtaining health benefits at age 65 through the GE Pensioner Health Plans:

- **GE Medicare Benefit Plans** — These plans offer a traditional approach to health care coverage, in which Medicare provides primary health coverage and the GE plans provide supplemental coverage. The plans work together with your spouse's Medicare coverage to help pay some of the health care expenses not paid by Medicare Parts A and B. Your spouse chooses from among several GE plans, depending on his or her needs.
- **GE MedicarePlus** — GE MedicarePlus provides surviving spouses, who live in areas where the plan is available, with a single, comprehensive health benefit plan that includes the coverage provided by Medicare Parts A and B and the GE Medicare Benefit Plans, plus additional benefits that Medicare and the GE Medicare Benefit Plans do not offer.

Your spouse chooses the approach he or she feels is best from the options available where your spouse lives.

GE Medicare Benefit Plans	GE MedicarePlus
<ul style="list-style-type: none">• GE Medical Care Plan for Pensioners	<ul style="list-style-type: none">• Comprehensive health benefits through a single plan, including preventive care and prescription drug benefits
<ul style="list-style-type: none">• GE Pensioners Hospital Indemnity Plan	<ul style="list-style-type: none">• May include dental, vision and hearing benefits
<ul style="list-style-type: none">• GE Pensioners Prescription Drug Plan	<ul style="list-style-type: none">• Low out-of-pocket expenses
<ul style="list-style-type: none">• GE Medicare Insurance Plan	<ul style="list-style-type: none">• To participate, you must be enrolled in Medicare Part B

GE Pensioner Vision Value Option

Available under all of the above.

GE Medicare Benefit Plans

The GE Medicare Benefit Plans work together with your spouse's Medicare coverage to help pay some of the health care expenses not paid by Medicare Parts A and B. If your spouse is eligible, he or she may enroll in any or all of these plans, based on his or her need for coverage.

- **GE Medical Care Plan for Pensioners** — helps your spouse pay his or her Medicare co-pays for hospital admissions covered by Medicare Part A.
- **GE Pensioners Hospital Indemnity Plan** — helps your spouse pay his or her Medicare co-pays for hospital admissions covered by Medicare Part A. Your spouse pays the full cost of this plan.
- **GE Pensioners Prescription Drug Plan** — helps your spouse purchase prescribed medicines not covered by Medicare.
- **GE Medicare Insurance Plan for Part B Benefits** — helps your spouse pay for his or her share of the cost of doctors' expenses and other expenses covered by Medicare Part B. Your spouse pays the full cost of this plan.

GE MedicarePlus

GE MedicarePlus is a program that provides all the benefits of Medicare Parts A and B, all the coverage your spouse would get from the GE Medicare Benefit Plans, plus additional health care benefits not available from either Medicare or the GE Medicare Benefit Plans. GE MedicarePlus offers these benefits through Medicare Health Maintenance Organizations (HMOs) that have been federally approved to offer Medicare coverage. Special benefit packages for Company retirees and eligible surviving spouses have been negotiated with these Medicare HMOs. The resulting program offers simplicity and savings — simplicity because there is almost no paperwork and savings because GE MedicarePlus provides comprehensive coverage at a lower out-of-pocket cost.

With GE MedicarePlus there are no deductibles to meet — instead, your spouse pays a low, fixed co-pay for doctors' office visits. Coverage is available for inpatient hospital stays and your spouse also receives comprehensive preventive care coverage and prescription drug benefits. In some areas, GE MedicarePlus may include dental, vision and hearing care benefits.

To receive all the benefits GE MedicarePlus offers, your spouse must use the providers and health care facilities that are part of the Medicare HMO he or she joins when your spouse enrolls in GE MedicarePlus. If your spouse doesn't use the HMO's providers and follow the Medicare HMO's referral procedures, your spouse's care won't be covered.

Your spouse decides if the GE MedicarePlus approach is right for him or her. More information will be provided just before your spouse reaches age 65.

GE Pensioner Vision Value Option

The GE Pensioner Vision Value Option helps your spouse cover the cost of vision care by providing access to the vision care network. Through the vision care network, available in most locations, your spouse can purchase vision care services, including laser surgery to correct vision impairment, at discounted prices. Because your spouse pre-pays for services, your spouse doesn't have to file any claim forms.

CONTINUING HEALTH COVERAGE THROUGH COBRA

For information on COBRA, see Section 2.6, "When Your GE Health Coverage Ends."

SURVIVING SPOUSE

A surviving spouse should call the GE Pension Benefits Inquiry Center at 1-800-432-3450 for details on the GE Pensioner Health Plans, including the GE Medicare Part B Premium Reimbursement Option.

IF YOUR SPOUSE DECIDES TO SWITCH BACK

If your spouse enrolls in GE MedicarePlus and later decides that this option is not right for him or her, your spouse can return to traditional coverage under the GE Medicare Benefit Plans.

6.4 IN CASE OF LAYOFF OR WORK TRANSFER

If you are directly affected by a layoff or work transfer, GE health care benefits provide a source of important coverage, such as medical benefits.

If you retire upon layoff or work transfer...

- Then your benefits continue according to the provisions described in Section 6.1, "After You Retire."

LUMP-SUM CONSIDERATIONS

If you elect the special lump-sum option for your layoff benefits, your continuous service ends and all GE benefits end, including GE-provided health coverage. However, you may continue health coverage after your termination date through COBRA, by paying the full COBRA cost.

LONG-SERVICE EMPLOYEES

GE provides added benefits eligibility for certain long-service employees. See Section 6.4.4, "Protection for long-service employees" on page 144.

6.4.1 GE MEDICAL CARE OPTIONS (INCLUDING GE VISION CARE)

If you are directly affected by a layoff or work transfer, the Company continues coverage under your GE Medical Care Option and GE Vision Care for you and your eligible dependents for up to 12 months as long as your continuous service or service credits are maintained. Your medical and vision coverage continues:

- **With no contributions** — if you are directly affected by a layoff or work transfer after completing three or more years of continuous service; or
- **With contributions** — if you are directly affected by a layoff or work transfer before completing three years of continuous service. You will pay the same amount that active employees pay for the same coverage.

If contributions are required, you'll need to pay your contributions according to the payment schedule outlined in Section 8.1.6, "How do I pay for coverage when not on the payroll?"

If you have at least 25 years of service, you may be eligible for extended coverage through special benefits protection. If you qualify, you can continue medical coverage for yourself and your eligible dependents. See Section 6.4.4, "Protection for long-service employees."

6.4.2 GE DENTAL CARE OPTIONS

If you are directly affected by a layoff or work transfer, the Company continues dental coverage under your GE Dental Care Option for you and your eligible dependents for up to 12 months, as long as your continuous service or service credits are maintained. Your dental coverage continues:

- **With no contributions** — if you are directly affected by a layoff or work transfer after completing three or more years of continuous service; or
- **With contributions** — if you are directly affected by a layoff or work transfer before completing three years of continuous service. You will pay the same amount that active employees pay for the same coverage.

If contributions are required, you'll need to pay your contributions according to the payment schedule outlined in Section 8.1.6, "How do I pay for coverage when not on the payroll?"

Benefits may continue longer for certain dental services, if treatment has already begun at the time your coverage ends. See Section 4.3.8, "When does coverage end?" for details.

6.4.3 MEDICAL, DENTAL AND VISION COVERAGE UNDER COBRA

At the end of Company-provided medical, dental and vision coverage, you may be able to extend coverage by purchasing additional health coverage through COBRA. COBRA health coverage is described in Section 2.6, "When Your GE Health Coverage Ends."

6.4.4 PROTECTION FOR LONG-SERVICE EMPLOYEES

In certain cases, GE's health benefit plans include provisions that allow for extended coverage for long-service employees. You are eligible for special benefits protection for certain health care benefits if:

- Your service terminated on or after June 27, 1988 because of a plant closing or transfer to a successor employer or after you had been on layoff for 12 months with protected service and you had at least 25 years of continuous service on the date of your layoff; or
- Your service terminated on or after July 1, 1991 because of a plant closing, transfer to a successor employer or after you had been on layoff for 12 months with protected service and at the time your service terminated you had at least 25 years of Pension Qualification Service (PQS).

With special benefits protection, you may continue participating in a GE Medical Care Option, including vision coverage, after any Company-provided coverage ends, until the first of the month in which you reach age 65, provided you pay contributions equal to 50% of the plan's cost. After you reach age 65, you are eligible for the GE Medical Care Plan for Pensioners and the GE Pensioners Prescription Drug Plan, provided you pay the required contributions (approximately 50% of the plan's cost). You may also enroll for other GE Pensioner Health Plans, as described in Section 6.1.5, "Your GE Pensioner Health Plans at age 65." Your surviving spouse and eligible dependents may be able to continue this coverage in the event of your death.

6.5 IN CASE OF PLANT CLOSING

If you lose your job as a direct result of a plant closing, GE health care benefits provide important coverage, such as medical benefits.

If you retire at the time of a plant closing, your benefits continue according to the provisions described in Section 6.1, "After You Retire." If you retire under the Plant Closing Retirement Option (PCPO), your benefits are described here, in Section 6.5.

6.5.1 GE MEDICAL CARE OPTIONS (INCLUDING GE VISION CARE)

If you lose your job because of a plant closing, coverage under your GE Medical Care Option and GE Vision Care continues for you and your eligible dependents for up to 12 months. Your medical and vision coverage continues:

- **With no contributions** — if your service is terminated because of the plant closing after you have completed three or more years of continuous service; or
- **With contributions** — if your service is terminated because of the plant closing before you have completed three years of continuous service. You will pay the same amount that active employees pay for the same coverage.

If contributions are required, you'll need to pay your contributions according to the payment schedule outlined in Section 8.1.6, "How do I pay for coverage when not on the payroll?"

If you have at least 25 years of service, you may be eligible for extended coverage through special benefits protection. If you qualify, you can continue medical coverage for you and your eligible dependents. See Section 6.4.4, "Protection for long-service employees."

6.5.2 GE DENTAL CARE OPTIONS

If you lose your job because of a plant closing, the Company continues dental coverage under your GE Dental Care Option for you and your eligible dependents for up to 12 months. Your coverage continues:

- **With no contributions** — if your service is terminated because of the plant closing after you have completed three or more years of continuous service; or
- **With contributions** — if your service is terminated because of the plant closing before you have completed three years of continuous service. You will pay the same amount that active employees pay for the same coverage.

If contributions are required, you'll need to pay your contributions according to the payment schedule outlined in Section 8.1.6, "How do I pay for coverage when not on the payroll?"

Benefits may continue longer for certain dental services if treatment has already begun at the time your coverage ends. See Section 4.3.8, "When does coverage end?" for details.

6.5.3 MEDICAL, DENTAL AND VISION COVERAGE UNDER COBRA

At the end of Company-provided medical, dental and vision coverage, you may extend coverage by purchasing additional health coverage through COBRA. COBRA health coverage is described in Section 2.6, "When Your GE Health Coverage Ends."

6.5.4 EXPANDED ELIGIBILITY FOR CONTINUING HEALTH COVERAGE

If you are age 50 or older with 25 or more years of continuous service by the end of the calendar year in which your service is terminated because of the plant closing, you are eligible for extended health coverage, which is the same as the medical benefits currently offered to employees who retire at age 60.

7.0 HEALTH CARE FLEXIBLE SPENDING ACCOUNT

A GE Health Care Flexible Spending Account (FSA) helps you pay for a range of medically related expenses on a pre-tax basis, through payroll deductions that you set. If you are still receiving pay, you may continue your FSA on a pre-tax basis. If you are not on the Company's active payroll (e.g., under COBRA), you may be eligible to contribute your FSA participation on an after-tax basis.

7.1 KEY THINGS TO KNOW

Use a GE Health Care FSA to save money on taxes and eligible expenses.

The money you contribute is deducted from your paycheck on a pre-tax basis, effectively reducing your taxable income. It's paid back to you — tax-free — when you file claims for eligible expenses. In many cases, your health benefits administrator will forward your eligible expenses directly to your FSA — saving you time as well as money. See Section 7.4.3, "How do I file for reimbursement?"

You can contribute up to \$5,000 each year.

The minimum contribution is \$100 for the year.

You need to enroll each year to participate, even if you participated during the prior year.

Employees must enroll each year during annual enrollment. If you are a new employee, you have 63 days after becoming eligible to enroll.

You can make changes during the year if you have a qualified change in family status.

Qualified changes in family status include birth, adoption, marriage, divorce or death. See Section 7.3.3, "When can I change my participation?"

Eligible expenses should be incurred by December 31, though there is a grace period.

An expense is considered incurred not when you make the payment, but when the service is rendered or the supply is received.

Under IRS rules, you are permitted to incur eligible expenses through March 15 of the following year. Any money left in your account after all eligible expenses have been reimbursed will be forfeited. See Section 7.4.4, "What if there is money left in my account?"

You have **until June 30** of the following year to file claims for reimbursement for the prior year.

Health care expenses reimbursed through your FSA cannot also be claimed on your tax return.

Decide before you enroll which method will work best for your situation.

For important information about the administration of GE Flexible Spending Accounts, see Section 8.0, "Administrative Information."

7.2 KEY THINGS TO DO

DETERMINE IF PARTICIPATING IN THE GE HEALTH CARE FSA CAN SAVE YOU MONEY

Estimate your out-of-pocket health care expenses for the calendar year — then decide if you want to participate and how much to contribute. See Section 7.4.7, "What expenses are eligible?" for the list of eligible expenses. To help estimate your expenses, use the simple online calculators at benefits.ge.com, available during annual enrollment.

Remember — even if you forfeit some money at the end of the year, you may still realize a tax savings for the year.

TO PARTICIPATE IN THE GE HEALTH CARE FSA

Enroll during annual enrollment — at benefits.ge.com or by calling the GE Benefits Center at 1-800-252-5259. You must enroll each year.

If you are a new employee — enroll **within 63 days** after becoming eligible.

Use direct deposit — so your reimbursements can be deposited directly into your bank account.

DON'T MISS THE DEADLINES

End of the calendar year — eligible expenses should be incurred by **December 31**. However, IRS rules allow a "grace period" through March 15 of the following year to use up any remaining balance. Please note that an expense is considered incurred not when you make the payment, but when the service is rendered or the supply is received. In October, it's a good idea to review your FSA account balance and plan to use any remaining money before year-end.

File claims by June 30 — to avoid forfeiture. See Section 7.4.4, "What if there is money left in my account?"

Family status changes — make any changes to your FSA contributions **within 63 days** of a qualified family status change.

7.3 GE HEALTH CARE FSA PARTICIPATION

The GE Health Care Flexible Spending Account (FSA) helps you save money on your share of certain medical, dental and vision expenses, such as deductibles and co-pays, as well as items your health plans do not cover, such as laser vision surgery or extra eyeglasses.

7.3.1 WHO IS ELIGIBLE?

You are eligible to set up a GE Health Care FSA if you are a Company employee eligible for coverage under a GE Medical or Dental Care Option, as described in Section 2.1.3.2, "Who is eligible?" (medical) and Section 4.3.2, "Who is eligible?" (dental).

For the purposes of the GE Health Care FSA, your eligible dependents include only those individuals you claim as a dependent on your income tax return. Please be aware that if you receive a qualified medical child support order (QMCSO), the plan is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. See Section 2.1.3.7, "What if I receive a qualified medical child support order (QMCSO)?" (medical) and Section 4.3.7, "What if I receive a qualified medical child support order (QMCSO)?" (dental).

7.3.2 HOW DO I ENROLL?

To open a GE Health Care FSA, you enroll during annual enrollment, usually held each fall. Your election takes effect on January 1 of the following calendar year (unless you are not on active payroll status on that date), and stays in effect for the entire year. You must re-enroll each year.

You also may open a GE Health Care FSA whenever you add a dependent through a qualified change in family status, as described in Section 7.3.3, "When can I change my participation?"

If you are a newly eligible employee, you must enroll **within 63 days** after becoming eligible, or you will have to wait until the next annual enrollment.

If you have direct deposit of your paycheck, your FSA reimbursement will also be deposited directly into your bank account. Since most GE benefits administrators automatically forward eligible expenses to the GE FSA Claims Center, this means you will save money with minimal paperwork. You may also choose to have your FSA reimbursement mailed to you instead. Your banking information will automatically be updated for FSA reimbursements if you change it with payroll. FSA reimbursements will be deposited into your "Balance Account." Your Balance Account is the account that receives the remaining balance of funds after all other direct deposit disbursements are made. If you only have one direct deposit account, this will be your Balance Account. If you have one direct deposit account that receives a flat amount and the balance of your pay is issued as a paper check, your FSA reimbursement will also be issued as a paper check. If you have questions about direct deposit, please contact the GE Payroll Center at 1-800-315-1082 between the hours of 9 a.m. and 5 p.m., Eastern time.

If your employment status changes and you suspend your FSA contributions, when you return to active status you must call the GE Benefits Center at 1-800-252-5259 **within 63 days** to resume participating as an active employee.

7.3.3 WHEN CAN I CHANGE MY PARTICIPATION?

You may make changes to your FSA participation during the year only if you experience a qualified change in family status.

Qualified changes in family status are:

- Your marriage, divorce or legal separation;
- Birth, adoption or marriage of a dependent;
- Death of your spouse or a dependent;
- Start or end of your spouse's employment;
- Your spouse's involuntary loss of health coverage;
- Your removal from or return to the active payroll, for example, because of disability, layoff, leave of absence or strike, including leaves under the Family and Medical Leave Act of 1993 (FMLA);
- Your transfer to a new work location requiring a change in your Company-sponsored health coverage; and
- Your or your spouse's entitlement to Medicare.

Please Note — The above changes concerning dependents apply only to those dependents who meet Internal Revenue Service (IRS) rules pertaining to dependent status.

Changes must be made **within 63 days** after your change in family status, or you'll need to wait until the next annual enrollment to make a change. For example, if you get married and want to increase contributions to your GE Health Care FSA to cover your new spouse's eligible expenses, you must do so **within 63 days** after your marriage.

In most cases, your change in contributions will be effective on the first day of the month following the date you make the change. However, if you add or lose a dependent through birth or death, your change in participation will be retroactive to the date of the event (if you are an active employee or within your FMLA period — See "FMLA and Military Leaves" in Section 5.3.4, "When does participation end?"), provided you make the change **within 63 days** after the event.

Please Note —

- For expenses to be eligible for reimbursement from the increased balance in your FSA after you have increased your FSA contributions due to a qualified change in family status, they must have been incurred on or after the date of the qualifying change; and
- An expense is considered incurred not when you make the payment, but when the service is rendered or the supply is received.

Any changes also must be consistent with your change in family status. For example, if you have a baby, you may set up an account or increase your contributions, but you may not decrease your contributions. If you have a qualified status change that allows you to elect or increase the amount of your FSA account, please note that you must have sufficient pay remaining for that calendar year to cover the election on a pre-tax basis out of your payroll. If you do not have enough pay to cover the election, it will be reduced to the amount of pay that you do have or canceled if there are no more pay periods remaining. Also, any reduction in your election amount will be made on a prospective basis only, and cannot be less than the higher of claims paid or contributions already made in the plan year.

WHEN YOU RETURN TO WORK

When you return to work, you must contact the GE Benefits Center **within 63 days** to re-establish, verify or change your Flexible Spending Account election. Any reduction in your election amount will be made on a prospective basis only, and cannot be less than the higher of claims paid or contributions already made in the plan year.

7.3.4 WHEN DOES PARTICIPATION END?

Your participation in the GE Health Care FSA generally ends when you can no longer contribute to your FSA on a pre-tax basis. Even after your participation ends, you can file claims for your eligible health care expenses incurred during the period when you were making FSA contributions, up until the claims filing deadline.

CONTINUATION UNDER COBRA

In certain situations, you may be able to continue your participation in your GE Health Care FSA under a federal law called COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, when you leave the Company. COBRA allows eligible employees and their covered dependents to continue health care coverage at their own expense under certain circumstances when coverage would otherwise end. Special rules apply if you are on a leave under the Family and Medical Leave Act of 1993 (known as an FMLA leave), as described in this section under "FMLA and Military Leaves."

If you leave the Company or become inactive for reasons other than an FMLA leave, you may be able to continue making contributions to your GE Health Care FSA, depending on the balance in your account at the time you leave, if your FSA balance is greater than the remaining FSA contributions due for the rest of the year. If your FSA balance is equal to or less than your remaining FSA contributions for the year, you will not be offered COBRA. If you are eligible, you may only make contributions on an after-tax basis, and only through the end of the calendar year in which you become eligible for COBRA.

For more information about continuing your Health Care FSA participation under COBRA, see "GE Health Care Flexible Spending Account (FSA)" in Section 2.6.3.5, "How long does COBRA health coverage continue?"

If you are able to continue your participation, you'll make contributions by personal check. Although you won't get the same tax advantages making after-tax contributions as with pre-tax contributions, continuing participation under COBRA allows you to claim money you have already contributed that you might otherwise forfeit.

By continuing to make contributions through COBRA, you also preserve your ability to resume participation on a pre-tax basis if you return to the Company. In general, if you return to work at the Company in the same year in which you leave, you may resume pre-tax payroll contributions only if you made contributions during your absence. To resume your contributions, call the GE Benefits Center at 1-800-252-5259. Alternatively, you can wait until the next annual enrollment to set up an FSA for the next calendar year.

For more information about COBRA, see Section 2.6, "When Your GE Health Coverage Ends."

FMLA AND MILITARY LEAVES

If you are on an FMLA or military leave, you may be eligible to continue your GE Health Care FSA participation on either a pre-tax or after-tax basis, which will continue to be deducted out of your disability or military differential pay, depending on whether your leave is paid or unpaid. If you wish to cancel your FSA election while on FMLA or military leave, you must call the GE Benefits Center. If you return to work in the same calendar year, you may resume contributions to a GE Health Care FSA even if you did not contribute while you were on leave. In this case, your contribution election will be proportionately adjusted for the amount of time you were out on leave.

If you continue participation in an FSA while on FMLA leave, your coverage ends when FMLA leave ends. To continue coverage, you must elect COBRA. If you do not elect FSA COBRA once your FMLA leave ends, claims incurred during that period will not be reimbursed. If you have a qualified status change while out on FMLA, you can change your FSA election. However, your coverage will end when your FMLA leave ends, unless you return to work or elect COBRA if you do not return to work.

COBRA HEALTH COVERAGE

Under a federal law called COBRA, you may be eligible to continue contributing to your GE Health Care FSA on an after-tax basis when you leave the active payroll. See Section 2.6, "When Your GE Health Coverage Ends."

7.4 HOW THE ACCOUNT WORKS

First, you decide how much money you want to contribute to your GE Health Care FSA for the coming year. Estimate your expenses carefully. To help determine the amount of money you want to set aside, you can use the simple online calculators at benefits.ge.com, available during annual enrollment.

Your contributions are deducted from your paycheck before Social Security, federal and, in most locations, state and local income taxes are calculated. This money is contributed to your GE Health Care FSA account.

When you have an eligible expense, you generally pay the provider first and then file a claim with the FSA administrator to be reimbursed for that expense. In certain cases, expenses are submitted for reimbursement automatically — such as your out-of-pocket expenses under GE Medical Benefits, GE Prescription Drug Benefits, your GE Dental Care Option, your GE Vision Care Option and, in most cases, GE Health Care Preferred. You are reimbursed for eligible expenses from your GE Health Care FSA with pre-tax dollars. Check with your benefits administrator to confirm that automatic submission is available.

The W-2 you receive at year-end, showing your annual earnings, will not include the contributions you made to your FSA. These contributions are not part of your taxable income.

In exchange for the tax savings, **federal law requires you to forfeit any money left in your account that is not used to pay for eligible expenses.**

7.4.1 HOW MUCH CAN I CONTRIBUTE TO MY ACCOUNT?

You may contribute from \$100 to \$5,000 each year to your GE Health Care FSA. The annual amount you elect will be deducted in equal installments from your paycheck during the year.

7.4.2 HOW CAN AN FSA HELP ME SAVE?

If you participate in the GE Health Care FSA, your savings will depend on how much you contribute and your tax bracket. The following example illustrates potential savings.

FOR EXAMPLE

Mia, who earns \$50,000 a year, covers herself and her two children under GE Health Care Preferred. She contributes \$2,500 to a GE Health Care FSA this year to cover her family's health care costs, including \$2,000 for her children's orthodontia work and \$500 in additional eligible expenses. Here's how Mia saves money in one year using a GE Health Care FSA:

	Without an FSA	With an FSA
Mia's annual income	\$50,000	\$50,000
GE Health Care FSA contributions	0	- 2,500
Taxable income	\$50,000	\$47,500
Estimated federal income tax*	-4,233	- 3,858
Social Security tax	- 3,825	- 3,634
Family medical and dental expenses	- 2,500	- 2,500
Reimbursement from GE Health Care FSA	0	+2,500
Annual spendable income	\$39,443	\$40,009
Savings in one year		\$566

** Assumes single, head of household with two dependents, using 2007 marginal tax rates. This is just one example, and is based on federal income and Social Security taxes only. Your specific tax savings may differ and you may also save on state and local taxes. Tax savings estimates can be provided for you during enrollment.*

Please Note — Mia could have incurred these expenses in February and been reimbursed for the full amount, even though she had only contributed to the account for two months.

7.4.3 HOW DO I FILE FOR REIMBURSEMENT?

Most GE health plans will submit claims for you automatically, such as your out-of-pocket expenses under GE Medical Benefits, GE Prescription Drug Benefits, your GE Dental Care Option, your GE Vision Care Option and GE Health Care Preferred. Check with your medical benefits administrator (at the phone number on the back of your medical ID card) to see if the health plan you are enrolled in offers automatic claims submission. If your claims are not submitted automatically, follow these steps:

1. Pay the health care expense when it is due. Be sure to get an itemized receipt from the doctor, clinic or other provider.
2. Complete and sign a GE FSA claim form and attach the receipts for all the expenses you are claiming. If applicable, attach any Explanation of Benefits (EOB) you received from a GE health plan or another health plan to show your out-of-pocket costs. Forms are available at benefits.ge.com or from the GE FSA Claims Center at 1-866-300-2306.
3. Send your completed form and the attachments to the GE FSA administrator at the address on the form.

You are reimbursed for eligible expenses from your GE Health Care FSA with pre-tax dollars. You can be reimbursed for any amount submitted, if you use direct deposit. If you do not use direct deposit, you will receive reimbursement when you have at least \$10 due to you (if less than \$10 of your annual contribution remains in your account or if you are filing a claim after the end of the year, you can receive a reimbursement of less than \$10).

If you also participate in the GE Dependent Day Care FSA, the reimbursement check you receive may include reimbursement for any GE Dependent Day Care FSA claims you have submitted.

ORTHODONTIA REIMBURSEMENTS

Please Note — Your GE Health Care FSA reimbursements for orthodontia expenses will be payable to you in the calendar year in which **you make the payment** for orthodontic services. Keep in mind that orthodontic treatments typically span two years. You should base your FSA contributions on the out-of-pocket expenses you expect to pay during each calendar year. For example, if you pay \$4,000 at the onset of orthodontic treatment, and \$2,500 is eligible for reimbursement from your GE Dental Care Option, you can be reimbursed for the remaining \$1,500 from your FSA in the year in which you made the \$4,000 payment, provided you contribute at least this amount to your FSA.

7.4.4 WHAT IF THERE IS MONEY LEFT IN MY ACCOUNT?

Your GE Health Care FSA helps you save money — just remember to estimate expenses carefully before you enroll. Do not set aside more than you expect you'll need in your FSA. If, at the end of the year, your balance exceeds your anticipated medical expenses, you may want to use the balance for qualified expenses, such as prescription sunglasses or an extra set of contact lenses.

If you don't use all the money you contribute to your account during the year, the Internal Revenue Service (IRS) requires that you forfeit the remaining balance. However, you may still realize a tax savings, even if you forfeit money at the end of the year.

Eligible expenses should be **incurred by December 31**, but under the IRS "grace period" rules, you have through March 15 of the following year to incur claims. Even though you will be able to take advantage of the grace period to incur claims, you should estimate your expenses for the calendar year and use the grace period in case you overestimated the amount you would spend.

Here is how the grace period works — grace period claims (for the period between January 1 and March 15) will initially be paid from your **current calendar year FSA election**. After the claims submission deadline, June 30, the FSA administrator will determine any leftover balance for the preceding calendar year. That balance will be reduced by the amount of the grace period claims, but not below zero, and your current calendar year account will be credited accordingly. If you do not have an FSA election for the current calendar year, your claims for the preceding year will be paid out of the previous year's balance immediately.

You have **until June 30** of the following year to file claims for reimbursement. With the exception of orthodontia, an eligible expense is considered incurred not when you make the payment, but when the service is rendered or the supply is received.

Any forfeited money is used for the administration of the accounts and to offset plan losses.

TIMELY FILING

You must submit claims **by June 30** for expenses incurred by December 31 of the prior year.

7.4.5 HOW WILL AN FSA AFFECT MY TAXES?

If your eligible health care expenses exceed 7.5% of your adjusted gross income, you can deduct them on your federal income tax return. However, if you participate in the GE Health Care FSA and you've already been reimbursed for an expense through your FSA, you cannot claim that expense on your tax return.

The federal tax deduction usually is available only to people with extremely high medical expenses that are not covered by a health care plan. In general, the tax savings are greater with the FSA, but your situation may be different. If you expect high medical, dental or vision expenses or if you are enrolled in a tax-qualified long-term care plan, you may want to consult a tax expert to determine which approach will work best for you.

7.4.6 CAN PARTICIPATION IN AN FSA AFFECT MY OTHER BENEFITS?

Generally, your other benefits are not affected by participation in an FSA. Even though you reduce your income for tax purposes by using an FSA, you are not reducing your pay for determining other pay-related benefits. Those benefits — such as life insurance, disability and the GE Savings and Security Program (S&SP) — are based on your pay before FSA contributions are deducted.

SOCIAL SECURITY

FSA participation may affect your future Social Security retirement benefits. This will happen if your taxable pay is below the Social Security taxable wage base (or if your contributions to a GE Health Care FSA reduce your taxable pay below the wage base). The 2012 wage base is \$102,000, and is subject to change annually by the IRS. For most employees, however, the immediate tax savings from using an FSA outweigh any possible reduction in Social Security benefits.

7.4.7 WHAT EXPENSES ARE ELIGIBLE?

Expenses that have been ruled eligible by the Internal Revenue Service (IRS) for reimbursement from a GE Health Care FSA include your share of:

- Medical expenses for yourself and your eligible dependents (again, those who qualify as dependents under IRS rules), such as co-pays, deductibles and amounts above what your GE Medical Care Option pays;
- Dental expenses for yourself and your eligible dependents, such as dental co-pays, amounts that exceed GE dental schedules and your share for orthodontics;
- Vision expenses, including those not covered under GE Vision Care; and
- Expenses for health care services for yourself and your eligible dependents that are not covered by a medical, dental or vision plan.

To be eligible for FSA reimbursement, these expenses cannot be reimbursed in any other way, such as through your GE medical, dental or vision benefits, by your spouse's or same-sex domestic partner's health plan or by any other health care plan. Medical expenses eligible for reimbursement generally are those recognized by the IRS, as described in IRS Publication #502. However, expenses for long-term care are not eligible, even though long-term care costs are tax deductible.

Please Note — For expenses to be eligible for reimbursement from an increased balance in your FSA after you have increased your FSA contributions due to a qualified change in family status (for example, you increase your contribution because you adopt a child), they must have been incurred on or after the date of the qualifying change. An expense is considered incurred not when you make the payment, but when the service is rendered or the supply is received.

Because FSAs are subject to tax law, their rules and limits (including the examples listed below) may be changed during the year by the IRS. If you have any questions about eligible or ineligible expenses, call a plan specialist at the GE FSA Claims Center at 1-866-300-2306.

EXAMPLES

Other eligible expenses (some of which may be covered in part by GE benefits) include:

- Acupuncture;
- Alcoholism treatment;
- Ambulance services;
- Annual deductibles;
- Artificial limbs or teeth;
- Birth control pills;
- Birth prevention surgery;
- Braille books, magazines;
- Capital improvements — medically required;
- Car — handicapped-related equipment/design;
- Chiropractors;
- Cholesterol tests;
- Christian Science practitioner;
- Contact lenses and lens solution;
- Co-pays;
- Crutches;
- Dental charges;
- Doctor's fees;
- Drug addiction treatment;
- Ear-wax removal products;
- Eyeglasses (including tints and coatings for prescription eyeglasses);
- Guide dog;
- Hearing aids;
- Hearing care;
- Hospital services;
- Insulin;
- Laboratory fees;
- Lamaze and similar birthing classes;
- Laser surgery to correct vision impairment;
- Lead-based paint removal;
- Learning disability training;
- Lifetime care advance payments;
- Medical information plan;
- Mileage to and from health care services;
- Nursing home;
- Nursing services;
- Organ transplants;
- Orthodontia;
- Orthotics, insoles, and arch supports (prescription and over-the-counter);
- Oxygen and oxygen equipment;
- Physical exams;
- Prenatal vitamins, over-the-counter and prescribed;
- Prescription drugs and prescribed vitamins;
- Psychiatric treatment;
- Psychologist fees;
- Smoking cessation programs and related drugs;
- Special equipment for the deaf (TV/telephone);
- Special home — mentally retarded;
- Special schools for the handicapped;
- Sunscreen and sunblock;
- Transportation to and from health care services;
- Vision care; and
- X-ray fees.

ELIGIBLE OVER-THE-COUNTER DRUG EXPENSES

For more information about eligible over-the-counter drug expenses, go to benefits.ge.com.

INCURRED EXPENSES

With the exception of orthodontia, an eligible expense is incurred when the service or supply is provided, not when you make the payment for it.

7.4.8 WHAT'S NOT ELIGIBLE?

Some health care expenses are not eligible for reimbursement from a GE Health Care FSA. For example, you can't be reimbursed for:

- Cosmetic surgery/dentistry;
- Cosmetics and hair-replacement treatments;
- Custodial care;
- Dancing or swimming lessons;
- Exercise equipment;
- Expenses reimbursed under a GE health plan or any other health plan, such as your spouse's employer's plan;
- Family counseling;
- Funeral expenses;
- Hair growth treatments*;
- Health club dues;
- Health insurance premiums and contributions;
- Marriage counseling;
- Maternity clothes;
- Meals;
- Over-the-counter vitamins and nutritional supplements*;
- Weight-loss programs not related to treatment of a specific ailment or disease.*

** Certain types of over-the-counter drugs and medicines may be reimbursed if they are not used for cosmetic purposes and are supported by a doctor's statement, as permitted by the IRS.*

8.0 ADMINISTRATIVE INFORMATION

Although the Company is not required by law to provide any of the benefits described in this handbook, federal law does regulate certain kinds of plans when they are offered. This section describes your legal rights under the federal laws called the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Health Insurance Portability and Accountability Act of 1996, or HIPAA, and contains important administrative information.

8.1 PLAN BASICS

This section provides important administrative information about the plans described in this handbook.

FOR EMPLOYEES NOT CONVERSANT IN ENGLISH

If you have a limited knowledge of the English language and have difficulty understanding this description, you should contact your supervisor to obtain assistance in the language most familiar to you.

PARA LOS EMPLEADOS QUE NO TIENEN MUCHO CONOCIMIENTO DEL INGLES

Comuníquese con su supervisor para obtener ayuda en su idioma si tiene dificultad en comprender la descripción en inglés.

8.1.1 WHAT IS GE'S EMPLOYER IDENTIFICATION NUMBER?

The employer identification number (EIN) assigned to General Electric Company (as the sponsor of the plans described in this handbook) by the Internal Revenue Service is 14-0689340.

8.1.2 WHO IS THE PLAN ADMINISTRATOR?

The plan administrator has authority to control and manage the operation and administration of each of the plans described in this handbook and is the agent for service of legal process.

The plan administrator for the plans described in this handbook, except as otherwise noted, is:

General Electric Company
3135 Easton Turnpike
Fairfield, CT 06828
1-800-432-3450

Legal process also may be served on any trustee responsible for the administration of any applicable trust.

8.1.3 HOW CAN I ACCESS OFFICIAL PLAN DOCUMENTS?

As noted in "Important Information About This Handbook" on the inside front cover, the descriptions in this handbook are subject to the provisions of the official plan documents and other governing instruments. Copies of the official plan documents, as well as the latest annual reports of plan operations and summary plan descriptions of the plans, are available for your review during normal working hours at your local human resources office or at:

GE Corporate Human Resources
3135 Easton Turnpike
Fairfield, CT 06828

For a list of plans as of January 1, 2012, see Section 8.2, "Additional Plan Information as of January 1, 2012."

To request a copy of a particular plan document, write or call:

GE Benefits Center
P.O. Box 60040
Fort Myers, FL 33906
1-800-252-5259

(Be sure to specify the plan for which you want plan document(s) — for example, the GE Life, Disability and Medical Plan.)

To request a copy of a collective bargaining agreement that provides for benefits summarized in this handbook, write or call:

GE Corporate Human Resources
3135 Easton Turnpike
Fairfield, CT 06828
1-800-432-3450

8.1.4 WHAT ARE THE CLAIMS AND APPEALS PROCEDURES?

To receive or apply for benefits, you or your beneficiary must take appropriate action, which usually requires visiting Web sites, making certain phone calls or filing forms, as described throughout this handbook. Forms required to receive or apply for benefits under the plans are available from your human resources representative or through US Employee Services. Telephone numbers are noted throughout this handbook where appropriate and also are listed in "Contacts." Before pursuing the claims and appeals procedures described below, employees covered under a collective bargaining agreement may use the grievance procedure contained in that agreement to pursue any claims that are denied.

The plan administrator or a designated representative, such as the claims administrator, the Pension Board or an insurer of benefits, has the authority and responsibility to interpret the provisions of the respective plans. The nature of this authority and the discretion afforded these persons are detailed in the applicable plan documents.

FOR MEDICAL PLANS

The following describes the claims and appeals procedures for your medical coverage, as required by federal regulations.

CLAIMS DECISIONS

Submitting a claim

This section describes what a Covered Person (or his or her authorized representative) must do to file a claim for benefits and is applicable to GE Medicare Benefit Plans and the Elfun Medicare Benefits Plan (unless otherwise noted).

- A claim must be filed with the claims administrator in writing and delivered to the claims administrator, by mail (postage prepaid), by facsimile or by email. However, a submission to obtain Pre-authorization may also be filed with the claims administrator by telephone. (This applies to dental coverage only with respect to Urgent Care Claims.)
- Claims must be submitted to the claims administrator at the address indicated in the documents describing the plan or the claimant's identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.
- Also, claims submissions must be in a format acceptable to the claims administrator and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the plan.

- submissions must be timely. Claims should be filed as soon as reasonably possible after they are incurred, and in no event later than June 30 of the year after the close of the calendar year during which they are incurred or after the date when a Covered Person's coverage under the plan (including any continuation coverage) ends. Plan benefits are only available for claims that are incurred by a Covered Person during the period that he or she is covered under the plan.
- Post-Service Claims submissions must be complete. They must contain, at a minimum:
 - The name of the Covered Person who incurred the expenses.
 - The name and address of the provider.
 - The diagnosis of the condition.
 - The procedure or nature of the treatment.
 - The date of and place where the procedure or treatment has been or will be provided.
 - The amount billed and the amount of expenses not paid through coverage other than GE coverage, as appropriate.
 - Evidence that substantiates the nature, amount and timeliness of each covered expense in a format that is acceptable according to industry standards and in compliance with applicable law.

Presentation of a prescription to a pharmacy does not constitute a claim. If a Covered Person is required to pay the cost of a covered prescription drug, however, he or she may submit a claim based on that amount to the claims administrator.

A general request for an interpretation of benefit plan provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of eligibility provisions, should be directed to the Plan Administrator.

PROCEDURAL DEFECTS

If a Pre-Service Claim submission is not made in accordance with procedural requirements, the claims administrator will notify the claimant of the procedural deficiency and how it may be cured within five (5) days (or within 24 hours, in the case of an Urgent Care Claim) following the failure. A Post-Service Claim that is not submitted in accordance with these claims procedures will be returned to the submitter.

ASSIGNMENTS AND REPRESENTATIVES

A Covered Person may assign his or her right to receive plan benefits to a health care provider only with the consent of the claims administrator, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the claims administrator, then the plan will not consider an assignment to have been made. An assignment is not binding until the claims administrator receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a Covered Person, benefits will be paid to that health care provider.

In addition, a Covered Person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of individually identifiable health information with respect to the claim to the applicable benefits plan, the claims administrator and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the claims administrator, then the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the claims administrator in advance, or at the time an authorized representative commences a course of action on behalf of a claimant. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the claimant to the claimant, which the claims administrator may verify with the claimant prior to recognizing the authorized representative status.

- In any event, a health care provider with knowledge of a claimant's medical or dental condition acting in connection with an Urgent Care Claim will be recognized by the plan as the claimant's authorized representative.

Covered Persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the Covered Person, such as whether and how to appeal a claim denial.

CLAIMS DECISIONS

After submission of a claim by a claimant, the claims administrator will notify the claimant within a reasonable time, as follows:

Pre-Service Claims

The claims administrator will notify the claimant of a favorable or adverse determination within a reasonable time appropriate to the circumstances, but no later than 15 days after receipt of the claim by the plan.

However, this period may be extended by an additional 15 days, if the claims administrator determines that the extension is necessary due to matters beyond the control of the plan. The claims administrator will notify the affected claimant of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the claims administrator expects to make a decision.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information.

Urgent Care Claims

The claims administrator will determine whether a claim is an Urgent Care Claim. This determination will be made on the basis of information furnished by or on behalf of a claimant. In making this determination, the claims administrator will exercise its judgment, with deference to the judgment of a physician with knowledge of the claimant's condition. Accordingly, the claims administrator may require a claimant to clarify the medical or dental urgency and circumstances that support the Urgent Care Claim for expedited decision-making.

The claims administrator will notify the claimant of a favorable or adverse determination as soon as possible, taking into account the exigencies particular to the claimant's situation, but not later than 72 hours after receipt of the Urgent Care Claim by the claims administrator.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the applicable plan, notice will be provided by the claims administrator as soon as possible, but not more than 24 hours after receipt of the Urgent Care Claim by the claims administrator. The notice will describe the specific information necessary to complete the claim.

The claimant will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information — but not less than 48 hours. The claims administrator will notify the claimant of an Urgent Care Claim determination as soon as possible, but in no event more than 48 hours after the earlier of (1) the claims administrator receipt of the specified information; or (2) the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Decisions

The claims administrator will notify a claimant of a Concurrent Care Decision that involves a reduction in or termination of benefits that have been Pre-Authorized. The claims administrator will provide the notice sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a claimant to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the claims administrator as soon as possible, taking into account the medical or dental exigencies. The claims administrator will notify a claimant of the benefit determination, whether adverse or not within 24 hours after receipt of the claim, provided that the claim is submitted to the claims administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims

The claims administrator will notify the claimant of a favorable or adverse determination within a reasonable time, but not later than 30 days after receipt of the claim.

However, this period may be extended by an additional 15 days, if the claims administrator determines that the extension is necessary due to matters beyond the control of the plan. The claims administrator will notify the affected claimant of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which a decision will be made.

If the reason for the extension is because of the claimant's failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The claimant will have at least 45 days from the date the notice is received to provide the specified information. The claims administrator will make a decision no later than 15 days after the earlier of the date on which the information provided by the claimant is received by the claims administrator or the expiration of the time allowed for submission of the additional information.

Times for Decisions

The periods of time for claims decisions presented above begin when a claim is received by the plan, in accordance with these claims procedures. However, the time periods described above for the claims administrator to decide your claim or appeal will not run while the claims administrator is waiting for you to provide information that it has requested.

INITIAL DENIAL NOTICES

Notice of a claim denial (including a partial denial) will be provided to claimants by mail, postage prepaid, by facsimile, or by email, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving Urgent Care Claims may be provided to a claimant orally within the time frames noted above for expedited Urgent Care Claim decisions. If oral notice is given, written notification will be provided to the claimant no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific plan provisions on which the determination is based, and a description of the review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review. The notice will also disclose any rule, guideline, exclusion, limit or similar criterion that was relied on to deny the claim. A copy of the rule, guideline, exclusion, limit or similar criterion relied upon will be provided to a claimant free of charge upon request.

If the adverse determination is based on medical or dental necessity, experimental or investigational treatment, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an Urgent Care Claim, the notice will provide a description of the expedited review procedures applicable to such claims.

APPEALS OF ADVERSE DETERMINATIONS

A claimant must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a claimant in writing to the claims administrator, in person, or by mail, postage prepaid.

However, a claimant on appeal may request an expedited appeal of an adverse Urgent Care Claim decision orally or in writing. In such case, all necessary information, including the benefit determination on review, will be transmitted by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law. Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person that made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim. The individuals from the claims administrator deciding your appeal will not give deference to the initial decision to deny the claim.

A claimant may review relevant documents free of charge, and may submit issues and comments in writing. In addition, a claimant on appeal may, upon request, discover the identity of medical, dental or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial being appealed was based in whole or in part on a medical or dental judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

TIME PERIOD FOR DECISIONS ON APPEAL

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims. As soon as possible, but not later than 72 hours after the claims administrator has received the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next three days.)

Pre-Service Claims. Within a reasonable period, but not later than 30 days after the claims administrator has received the appeal request.

Post-Service Claims. Within a reasonable period, but not later than 60 days after the claims administrator has received the appeal request.

Concurrent Care Decisions. Within the time periods specified above, depending on the type of claim involved.

APPEAL DENIAL NOTICES

Notice of a benefit determination on appeal will be provided to claimants by mail, postage prepaid, by facsimile, or by email, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will state the specific reason or reasons for the adverse determination and the specific plan provisions on which the determination is based.

The notice will also disclose any internal plan rule, protocol or similar criterion that was relied on to deny the claim on appeal. A copy of the rule, protocol or similar criterion relied upon will be provided to a claimant free of charge upon request.

If the adverse determination is based on a medical or dental necessity, or experimental or investigational treatment, or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the claimant on appeal will be entitled to receive upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.
2. Submitted, considered or generated in the course of making the benefit determination.
3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.
4. That constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment without regard to whether the statement was relied on.

EXHAUSTION

Upon completion of the appeals process, a claimant will have exhausted his or her administrative remedies under the plan. If the claims administrator fails to complete a claim determination or appeal within the time limits set forth above, the claimant may treat the claim or appeal as having been denied, and the claimant may proceed to the next level in the review process.

LEGAL ACTIONS AND LIMITATIONS

A civil action may not be brought with respect to plan benefits until all remedies under the plan have been exhausted.

FOR ALL OTHER PLANS

If a claim for benefits is denied in whole or in part, you (or your beneficiary) will receive a written notice within 90 days — or within 180 days under special circumstances. Notification will be provided by the claims administrator or by the Company. The notice will include:

- The reason for the denial, with specific reference to the pertinent plan provisions on which the denial is based;
- A description of any information or materials necessary to process the claim properly and the reasons why the materials are needed; and
- An explanation of the claims review procedure.

You (or your beneficiary) must file a written request for reconsideration to the claims administrator or the Company within 60 days after receiving the denial. Your request should be accompanied by documents or records in support of the appeal. The claims administrator or the Company will respond within 60 days — or 120 days under special circumstances — after receipt of the appeal, explaining the reasons for the decision, with specific reference to the plan provisions on which the decision is based.

8.1.5 CAN THE PLANS BE CHANGED, REPLACED OR TERMINATED?

GE expects and intends to continue the benefits described in this handbook indefinitely, but reserves the right to terminate, amend or replace the programs or plans, in whole or in part (to the extent permitted by law), at any time and for any reason, by action of the Board of Directors of General Electric Company or such persons as it may designate.

A decision to terminate, amend or replace a plan may be due to changes in federal law or state laws governing qualified retirement or welfare benefits, the requirements of the Internal Revenue Service, ERISA or any other reason. A plan change may include transferring all or a portion of plan assets and debts to another plan (which may be maintained by a successor employer or some other unaffiliated entity) or splitting a plan into two or more parts.

If a welfare plan is terminated, you will not receive any further benefits under the plan — other than payment of benefits for losses or expenses incurred before the plan was terminated. For plans funded through the GE Insurance Plan Trust, any assets held in the trust will be used solely to pay benefits for losses or expenses in accordance with applicable plan and trust provisions.

In the event of a strike — Benefits available to represented employees are subject to long-standing provisions that terminate coverage for strike participants. Under some circumstances, however, the Company may make arrangements to continue coverage under some plans.

8.1.6 HOW DO I PAY FOR COVERAGE WHEN NOT ON THE PAYROLL?

If you (or your dependents) are eligible to continue coverage(s), such as medical or dependent life insurance coverage, when you are not receiving a Company paycheck or GE pension benefits, you may, if you wish, choose to pay the total of all required contributions in advance, according to the following schedule. You will be notified if these payment options are available to you.

If the amount you owe each month totals...	Then you pay...
More than \$20	On a monthly basis
\$5 to \$20	On a quarterly basis
Less than \$5	On an annual basis

If you continue Personal Excess Liability coverage, you will pay annual premiums directly to the insurance company. You'll be sent invoices for the amounts due. If you don't pay contributions as required, your benefits coverage will end.

8.1.7 HOW ARE THE PLANS FUNDED?

Many of the plans described in this handbook are funded through trusts. The funds of the GE benefit plans, as indicated below, are held for the benefit of plan participants in the following trusts, and may be used by the trusts to defray certain plan expenses:

- GE Insurance Plan Trust — GE Life, Disability and Medical Plan

Trustees responsible for the administration of the trust are all officers of GE Asset Management Inc. As of January 18, 2012, the trustees are:

- Dmitri L. Stockton — President and Chief Executive Officer
- Paul M. Colonna — President and Chief Investment Officer, Fixed Income
- Michael J. Cosgrove — President, Mutual Funds and Global Investment Programs
- George A. Bicher — Executive Vice President, Chief Risk Officer
- Tracie A. Winbigler — Executive Vice President, Chief Financial Officer
- Ralph R. Layman — President and Chief Investment Officer, Public Equities
- Matthew J. Simpson — Executive Vice President and General Counsel
- David W. Wiederecht — President and Chief Investment Officer, Investment Strategies
- Donald W. Torey — President and Chief Investment Officer, Alternative Investments
- Gregory B. Hartch — Senior Vice President, Strategy and Business Development Leader

All of the trustees can be contacted at:

GE Asset Management, Inc.
1600 Summer Street
Stamford, CT 06905

Benefits from other plans are paid from the assets of the Company or through insurance policies.

BENEFITS QUESTIONS?

Use this handbook as your primary resource for answers. If you need additional information or assistance, contact your human resources representative, payroll, the benefits administrator or one of the other appropriate parties listed in "Contacts."

8.1.8 WHAT ARE MY RIGHTS UNDER ERISA?

As a participant in the GE benefit plans described in this handbook, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Under ERISA, plan participants are entitled to:

- Examine, without charge, at the plan administrator's office and at major Company locations, all plan documents, 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 Employee Benefits Security Administration (EBSA).
- Obtain copies of all plan documents, including insurance contracts, collective bargaining agreements, and the latest annual report (Form 5500 Series) and updated summary plan descriptions, upon written request to the plan administrator (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 provide each plan participant with a copy of this "summary annual report."

CONTINUE GROUP HEALTH PLAN COVERAGE

In addition, for some of the Company's group health plans you, your spouse and your eligible dependents may have rights under a law commonly known as COBRA to continue your health coverage when it would otherwise end. For details on your rights under COBRA, see Section 2.6, "When Your GE Health Coverage Ends."

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights to plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the plans or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit under the plans is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decisions without charge, and to appeal any denial, all within certain time schedules. See Section 8.1.4, "What are the claims and appeals procedures?" for details.

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 (as may be adjusted for inflation) until you receive the materials, unless the materials were not sent for reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the procedures referred to in the Section above, titled "What are the claims and appeals procedures?" 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 party 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 submit inquiries in the manner referred to throughout this handbook. 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 Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

8.1.9 WHAT ARE MY RIGHTS UNDER THE HIPAA PRIVACY REGULATIONS?

YOUR RIGHT TO PRIVACY

The Department of Health and Human Services has issued comprehensive federal regulations that give individuals broad protections over the privacy of their personal health information. These regulations, issued under the Health Insurance Portability and Accountability Act (HIPAA), protect the confidentiality of your personal health information and allow you access to your medical records. These regulations apply to the GE health benefit plans described in this handbook, and those plans will be referred to collectively in this section as the "Plan."

This section summarizes your rights under the HIPAA privacy regulations and acts as the Plan's *Notice of Privacy Practices*.

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes the ways that the Plan may use and disclose plan participants' protected health information to carry out treatment, payment and health care operations, and for other purposes that are permitted or required by law. It also sets out the Plan's legal obligations concerning protected health information. Additionally, this Notice describes plan participants' rights to access and control their protected health information.

Please review the following information carefully.

PLAN RESPONSIBILITIES

The Plan is required by law to maintain the privacy of plan participants' protected health information, and is also required to provide plan participants with a copy of this Notice. The Plan must abide by the terms of this Notice. The provisions of this Notice may be changed from time to time, and such changes may affect all protected health information maintained by the benefit plans. If the terms of this Notice are materially changed, a revised Notice will be provided to plan participants.

WHAT IS "PROTECTED HEALTH INFORMATION"?

Protected health information is individually identifiable health information, including demographic information, collected from a plan participant or created or received by a health care provider, a health plan (including the Plan), a plan participant's employer, or a health care clearinghouse and that relates to the following information regarding the plan participant: 1) past, present or future physical or behavioral health or condition; 2) the provision of health care; or 3) the past, present or future payment for the provision of health care.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan has the right to use and disclose your protected health information for several different purposes. The examples below illustrate the types of uses and disclosures that may be made without written authorization by the plan participant.

PAYMENT

Protected health information may be used or disclosed to evaluate plan experience, to determine cost share, or otherwise fulfill responsibilities for coverage and providing benefits as established under your benefit plan. For example, protected health information may be disclosed when a provider requests information regarding eligibility for coverage or to determine if a treatment received was medically necessary.

HEALTH CARE OPERATIONS

The Plan may use or disclose your protected health information to support its business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, business planning and business development. For example, we may use such information: 1) to provide plan participants with information about disease management programs; 2) to respond to a customer service inquiry; 3) to review the quality of services being provided under the plans; or 4) to conduct audits or medical review of claims activity.

TREATMENT

Although the Plan does not provide treatment, the Plan may disclose protected health information to health care providers for their treatment purposes. For example, the Plan may provide protected health information to health care providers in an emergency situation should the provider seek information about previous treatments received by a plan participant and be unable to contact previous health care providers.

PLAN SPONSOR

The plans may disclose your protected health information to the Company, acting as plan sponsor, for purposes related to the operation of the health benefit plan, such as eligibility, enrollment, payment, audit and accounting functions. The Company is not permitted to use protected health information for any purpose other than administration of the Plan.

ENROLLED DEPENDENTS AND FAMILY MEMBERS

In some cases, plan participants may receive mail or email enrollments forms or other materials containing protected health information about themselves or their dependents.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of other possible ways in which the Plan may (and is permitted to) use or disclose your protected health information.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities.

REQUIRED BY LAW

The Plan may use or disclose protected health information to the extent that federal, state or local law requires the use or disclosure. For example, the Plan is required to disclose protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining plan compliance with the HIPAA Privacy Regulations.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose protected health information for public health activities that are permitted or required by law. For example, information may be used or disclosed for the purpose of preventing or controlling disease, injury or disability.

ABUSE OR NEGLECT

The Plan may disclose protected health information to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose protected health information to a governmental entity authorized to receive such information if the Plan has reason to believe that a plan participant has been a victim of abuse, neglect or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose protected health information: 1) in the course of any judicial or administrative proceeding; 2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and 3) in response to a subpoena, a discovery request or other lawful process.

LAW ENFORCEMENT

Under certain conditions, the Plan may disclose protected health information to law enforcement officials. Some of the reasons for such a disclosure may include: 1) it is required by law or some other legal process; 2) it is necessary to locate or identify a suspect, fugitive, material witness or missing person; and 3) it is necessary to provide evidence of a crime that occurred on our premises.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS

The Plan may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors.

ORGAN DONATION

The Plan may disclose protected health information to an entity engaged in the process of organ, eye, or tissue donation or transplantation for the purpose of facilitating such donation and transplantation.

RESEARCH

The Plan may disclose protected health information for research purposes, subject to strict legal restrictions.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose protected health information, in the event that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY; PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. The Plan also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

INMATES

The Plan may disclose protected health information relating to an inmate of a correctional institution to the correctional institution so it may provide health care to such inmates or to assure the health and safety of such inmates and the health and safety of others, including for the safety of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose protected health information to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

OTHERS INVOLVED IN PLAN PARTICIPANT'S HEALTH CARE

Unless the plan participant objects, the Plan may disclose protected health information to a friend or family member that the plan participant has identified as being involved in his or her health care. The Plan also may disclose information to an entity assisting in a disaster relief effort so that family members can be notified about a plan participant's condition, status and location. If the plan participant is not present or able to agree to these disclosures of his or her protected health information, then the Plan may, using its professional judgment, determine whether the disclosure is in the plan participant's best interest.

OTHER USES AND DISCLOSURES OF PLAN PARTICIPANT'S PROTECTED HEALTH INFORMATION

Other uses and disclosures of protected health information that are not described above will be made only with written authorization of the affected plan participant. Once an authorization has been provided, the plan participant may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information already used or disclosed in reliance on the authorization.

PLAN PARTICIPANTS' RIGHTS

The following is a description of plan participants' rights with respect to their protected health information.

RIGHT TO INSPECT AND COPY

Plan participants have the right to inspect and obtain a copy of their protected health information, with some limited exceptions. Such records will usually include enrollment, billing, claims payment, case or medical management records or records that are used to make decisions about health care benefits. To inspect and obtain a copy of protected health information that is contained in a designated record set, the plan participant must submit a request in writing. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with such a request. The Plan may deny a request to inspect and copy protected health information in certain limited circumstances. If a plan participant is denied access to his or her information, the plan participant may request that the denial be reviewed.

RIGHT TO AMEND

If a plan participant believes that his or her protected health information is incorrect or incomplete, he or she may request that the Plan amend the information. The request must be in writing. Additionally, the request should include the reason the amendment is necessary. In certain cases, the Plan may deny a request for an amendment, including if it is not in writing or does not include a reason that supports the request. In addition, requests may be denied if the protected health information in question:

- Is accurate and complete;
- Was not created by the Plan;
- Is not part of the protected health information kept by or for the Plan; or;
- Is not part of the protected health information which a plan participant would be permitted to inspect and copy.

If a request is denied, the plan participant has the right to file a statement of disagreement, though the Plan has the right to rebut that statement of disagreement.

RIGHT TO REQUEST A RESTRICTION

Plan participants have the right to request a restriction on the protected health information used or disclosed for payment or health care operations. The Plan is not required to agree to any restriction. Even if the Plan does agree to the restriction, the information may be used or disclosed if it is needed to provide emergency treatment. Requests for restriction must be in writing, and should contain: 1) the information to be limited; and 2) the desired method to limit use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a plan participant believes that a disclosure of all or part of his or her protected health information may endanger him or her, the plan participant may reasonably request that the Plan communicates regarding the information in an alternative manner or at an alternative location. For example, a plan participant may request to be contacted only via his or her work address or work email. Requests for restriction must be in writing and contain: 1) which protected health information is to be communicated in an alternative manner or at an alternative location; and 2) a statement that the disclosure of all or part of this information in a manner inconsistent with the requested instructions would put the individual in danger. In addition, if a plan participant requests confidential communications from a claims administrator providing services under the Plan, and the Plan receives notice from that claims administrator granting the request, the Plan will cause its other claims administrator to honor the request.

RIGHT TO AN ACCOUNTING

Plan participants have a right to an accounting of most disclosures of their protected health information that are for reasons other than payment or health care operations. An accounting will include the date(s) of the disclosure, to whom the disclosure was made, a brief description of the information disclosed and the purpose for the disclosure. Requests for an accounting must be in writing, and may be for disclosures made up to six years before the date of the request, but in no event for disclosures made before April 14, 2003. A first request within a 12-month period will be free. For additional requests, the plans may charge you for the costs of providing the request. The requester will be notified of the cost involved, and the requester may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO A PAPER COPY OF THIS NOTICE

Plan participants have the right to a paper copy of this Notice, even if the individual has previously agreed to accept this Notice electronically.

FOR MORE INFORMATION, TO MAKE A WRITTEN REQUEST OR TO MAKE A COMPLAINT ABOUT THE HANDLING OF PROTECTED HEALTH INFORMATION?

A plan participant who has any questions about these privacy policies and procedures or wants to make any of the written requests mentioned in this Notice may contact the Privacy Leader at GE US Employee Services, PO Box 6024, Schenectady, NY 12301-6024.

In addition, any plan participant who believes that the Company has violated his/her privacy rights may file a complaint by writing to the same address. A plan participant may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant issue; and (4) be filed within 180 days of the time the plan participant became or should have become aware of the problem.

The Company will not penalize or in any other way retaliate against a plan participant for filing a complaint with the Secretary or with GE.

8.1.10 WHICH GE AFFILIATES ARE PARTICIPATING COMPANIES?

As of January 1, 2012, General Electric Company (3135 Easton Turnpike, Fairfield, CT 06828) has employees eligible to participate in certain of the GE benefit plans listed in Section 8.2, "Additional Plan Information as of January 1, 2012," subject to applicable collective bargaining agreements.

Certain GE affiliates also are companies with employees eligible to participate in certain of these GE benefit plans, subject to applicable collective bargaining agreements. You may receive, upon written request, information as to whether a particular affiliate is such a participating company and, if so, that company's address. You should send your written request to:

General Electric Company
US Employee Services
One River Road
Building 5, 6 East
Schenectady, NY 12345

8.2 ADDITIONAL PLAN INFORMATION AS OF JANUARY 1, 2012

GE LIFE, DISABILITY AND MEDICAL PLAN

- **The plan includes components, known as:**
 - GE Medical Care Options
 - GE Health Care Preferred
 - GE Medical Benefits
 - GE Dental Care Options
 - GE Vision Care
 - GE Flexible Spending Accounts(For details on these components, see the description for each, below.)
- **Plan number** — 502
- **Plan type** — welfare plan, with specific welfare plan types noted for each of the components listed above
- Plan 502 and all the components listed below are maintained pursuant to a collective bargaining agreement

For the components of the GE Life, Disability and Medical Plan, the following details apply:

GE HEALTH CARE PREFERRED

- **Plan type** — medical welfare plan
- **Benefits administrators** — The GE Health Care Preferred benefits administrators are listed in Section 8.3, "GE Health Care Preferred Benefits Administrators."
- **Source of contributions** — the Company and plan participants
- **Source of funding** — GE Insurance Plan Trust
- **How benefits are paid** — by the plan's benefits administrators. The benefits administrators may also be responsible for the selection, operation and administration of health care provider networks.

GE MEDICAL BENEFITS

- **Plan type** — medical welfare plan
- **Benefits administrators** — The benefits administrators (for the regions and services noted) are:
 - For prescription drugs, in all regions:
CVS Caremark Corporation
P.O. Box 52196
Phoenix, Arizona 85072-2196
 - For behavioral health and substance abuse care, in all regions:
Optum Health
6300 Olsen Memorial Hwy
Golden Valley, MN 55427
- Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, AL 35298
- **Source of contributions** — the Company and participants
- **Source of funding** — GE Insurance Plan Trust
- **How benefits are paid** — by the plan's benefits administrators. The benefits administrators may also be responsible for the selection, operation and administration of health care provider networks.

GE DENTAL CARE OPTIONS

- **Plan type** — dental welfare plan
- **Benefits administrator** — Metropolitan Life Insurance Company, 125 Business Park Drive, Utica, NY 13502
- **Source of contributions** — the Company and participants
- **Source of funding** — GE Insurance Plan Trust
- **How benefits are paid** — by the plan's benefits administrator. The benefits administrator may also be responsible for the selection, operation and administration of health care provider networks.

GE VISION CARE

- **Plan type** — medical welfare plan
- **Benefits administrator** — Davis Vision, PO Box 1440, Latham, NY 12110
- **Source of contributions** — the Company and participants
- **Source of funding** — GE Insurance Plan Trust
- **How benefits are paid** — by the plan's benefits administrator. The benefits administrator may also be responsible for the selection, operation and administration of health care provider networks.

GE FLEXIBLE SPENDING ACCOUNTS

- **Plan type** — welfare plan
- **Benefits administrator** — Ceridian, GE FSA Claims Center, PO Box 534255, St. Petersburg, FL 33747-4255
- **Source of contributions** — participants
- **Source of funding** — GE Insurance Plan Trust
- **How reimbursements are made** — by the benefits administrator

FOR ALL PLANS

The plan year for the plans described in this handbook begins January 1 and ends December 31.

8.3 GE HEALTH CARE PREFERRED BENEFITS ADMINISTRATORS

GE HEALTH CARE PREFERRED BENEFITS ADMINISTRATORS

AETNA

1425 Union Meeting Road — U21S
Blue Bell, PA 19422
Region: Massachusetts

BLUECHOICE HEALTHPLAN

3060 Alpine Dr.
Columbia, SC 29223

BLUE CROSS BLUE SHIELD OF ALABAMA

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, AL 35298

CAPITAL DISTRICT PHYSICIANS HEALTHCARE NETWORK INC.

CDPHP Patroon Creek Corporate Center
500 Patroon Creek Blvd.
Albany, New York 12206-1057

HEALTHAMERICA AND HEALTHASSURANCE

3721 TechPort Drive
Harrisburg, PA 17106-7103

UNITEDHEALTHCARE

UnitedHealthcare
GE AMT
185 Asylum Street, CT039-18A
Hartford, CT 06103

OTHER REGIONAL HEALTH CARE OPTIONS BENEFITS ADMINISTRATORS

UPMC HEALTH PLAN

U.S. Steel Tower, 25th Floor
600 Grant Street
Pittsburgh, PA 15219

KEY TERMS

This section provides brief explanations, in nontechnical language, of important terms used in this handbook. In most cases, these same words are "defined terms" contained in the applicable GE plan documents and have detailed technical definitions, which are summarized below.

In general, capitalization of key terms has been avoided to make the handbook easier to read and understand. The use of lowercase lettering in the handbook is not intended to alter the defined meaning or importance of any term. If a word is capitalized in the summary below, it is also capitalized in the text of the handbook when it is intended to have the meaning described in this section.

active payroll — On the "active payroll" means you are receiving a regular paycheck directly from the Company to pay your wages for services you are currently providing to the Company.

affiliate — A business entity owned in whole or in part, directly or indirectly, by General Electric Company. Affiliate generally refers to a business entity in which GE has a 50% or more interest.

benefits administrator — An insurance company, or other company, that has been designated by the Company to pay claims and/or administer a benefit plan on the Company's behalf.

birth center — A freestanding facility that offers comprehensive maternity care to patients who are expected to have an uncomplicated pregnancy and childbirth. The facility must have a pre-arranged agreement with a nearby hospital for emergency care if complications occur.

COBRA — The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. A federal law requiring employers to allow former employees and/or their covered dependents to continue health care coverage under certain circumstances when coverage would otherwise end.

Company — General Electric Company and its affiliates that participate in the applicable GE benefit plan. The term "Company" means the affiliate that maintains you on its active payroll. However, when used in connection with sponsorship of the plans and programs described in this handbook, "Company" refers to the General Electric Company. For a list of affiliates and the plans in which they participate, see Section 8.1.10, "Which GE affiliates are participating companies?"

continuity of service date — The calendar date on which your continuous service is based.

continuous service — More complete details are included in the Company's Continuity of Service Rules.

custodial care — Care that does not require the continuing services of a skilled medical or health care professional and which is furnished primarily to provide room and board, education, assistance with activities of daily living or other care for a mentally or physically disabled person.

employee — An individual on the active payroll of the Company. Not included are:

- Employees covered by a collective bargaining agreement that does not provide for participation in the applicable plan or program;
- Employees of affiliates that do not participate in the applicable plan or program (participating affiliates are listed in Section 8.1.10, "Which GE affiliates are participating companies?");
- Individuals classified by the Company as leased employees, contingent workers or as independent contractors;
- Any individuals engaged under an agreement that states that they are not eligible to participate in the applicable plan or program;
- Any other individuals who provide services to the Company but are not on the active payroll of the Company; and
- Special classifications of employees that are not eligible, as determined by the Company.

In the event you are denied eligibility because you are not treated as an employee, your reclassification as an employee will not entitle you to participate in the applicable plan or program.

experimental or investigational — As determined by the benefits administrator, a service, supply or treatment that is not generally recognized as an accepted practice among physicians who are specialists in the field of the illness or the injury and that:

- Is in the clinical research or investigational stage; or
- Requires approval by the Food and Drug Administration or other government agency which has not been granted at the time the service or supply is rendered; or
- Has not demonstrated clinical effectiveness and safety for the diagnosis or treatment of the illness or injury through controlled clinical trials published in peer review literature.

Services covered as part of an approved clinical trial are not considered experimental or investigational.

extended care facility — An institution that is: primarily engaged in providing skilled nursing care, rehabilitation services and related care; accredited by the Joint Commission on Accreditation of Healthcare Organizations; and recognized by Medicare as a skilled nursing facility.

hospital — A legally licensed facility that provides a broad range of medical and surgical services for the sick and injured under the supervision of a medical staff and including 24-hour-a-day skilled nursing care.

indemnity — A traditional indemnity health care plan requires participants to pay their health care providers for medical services at the time the services are provided and subsequently submit claims to the plan. The plan then indemnifies the participant financially by paying for all or part of the covered expenses. These plans generally have no network of health care providers, and participants can see any doctor they choose.

managed care — A health care system in which the primary care physician provides basic and preventive care. The primary care physician also coordinates the patient's care with all other health care providers. Many managed care systems require referrals to specialists and plan approval before certain services will be covered.

medically necessary — See "reasonable, necessary and customary."

over-the-counter drug or medication — A drug or medication that can be purchased without a physician's prescription. The IRS has ruled that over-the-counter items that are used to diagnose, treat or prevent a medical condition may be eligible for reimbursement under a Health Care Flexible Spending Account (FSA).

Pension Board — The committee appointed by the Board of Directors of General Electric Company to administer certain other GE benefit plans.

Pension Qualification Service (PQS) — Your credited service through December 31, 1975, rounded to the next full year, plus each calendar year after 1975 in which you are credited with at least 1,000 hours of service while you participate in the GE Pension Plan. (Part-time employees need proportionately fewer hours of service to receive a year of PQS.) PQS is generally used to determine eligibility for pension benefits. If you transfer between a nonparticipating affiliate and the Company, or if your business is acquired by the Company, you may receive PQS credit for some or all of your service with the nonparticipating affiliate or the acquired business.

permanent job-loss event — Circumstances under which jobs are lost as a direct result of one of the following Company actions: plant closing; work transfer; installation of automated manufacturing or office machine or introduction of a robot; discontinuation of a discrete, unreplaced product line; or any other reduction in the work force of indefinite duration.

plan administrator — General Electric Company.

plan year — A 12-month period beginning January 1 and ending December 31.

plant closing — A plant closing occurs when the Company announces its intention and carries out plans to discontinue all operations at a Company-owned or -leased plant, service shop or other facility. A plant closing does not occur when an operation is transferred or sold to a successor employer that offers continued employment, when operations are discontinued in part or when the former operations are replaced with other operations, either larger or smaller. In the case of a sale or transfer of operations to a successor employer, employees not offered employment with the successor employer or with the Company will be eligible for the same benefits offered to employees who are laid off.

plant closing date — The earliest date on which employees may be terminated for a plant closing. An individual employee's plant closing termination date may be scheduled after the location's plant closing date, depending on business needs.

Plant Closing Pension Option (PCPO) — A GE Pension Plan provision, available for retirements occurring on or before July 1, 2007, that allows you to receive certain pension benefits if you have at least 30 years of Pension Qualification Service (PQS) or if you meet age and service requirements when you are directly affected by a plant closing.

reasonable, necessary and customary — When applied in reference to a service, supply or treatment, the term "reasonable, necessary and customary" means that such services, supplies or treatments are:

- Appropriate and consistent with the diagnosis or symptoms;
- Consistent with accepted medical standards;
- Not experimental or investigational;
- Not provided solely on a convenience or personal basis; and
- Employed appropriately, effectively and safely with respect to the type and level of care.

In addition, the amounts paid with respect to such services, supplies or treatments must be reasonable and customary for your geographic area, taking into account the nature and complexity of such service, supply or treatment; the amounts paid on behalf of other individuals with similar conditions; and the type of provider.

same-sex domestic partners — A committed relationship between two unmarried adults of the same sex meeting the following criteria:

- The employee and partner may not be related by blood to a degree of kinship that would prevent marriage under the applicable law of the state of residence;
- The relationship must be exclusive and the parties must have lived together in the same household for a minimum of 12 consecutive months prior to enrollment and continue to live together for the duration of coverage;
- Both parties must be 18 years of age or older; and
- Both parties must be jointly responsible for each other's welfare and financial obligations, or the same-sex domestic partner chiefly dependent on the employee for care and financial support.

Proof of same-sex domestic partnership requires a signed affidavit affirming that the above requirements are met. A signed affidavit is not required in states that permit a form of legal union, but proof of such legal union must be provided.

Shutdown (primary) — One or more periods of time of at least one week duration during which a plant is closed for vacation purposes. Where permitted by law, employees may be required to take their paid vacation, if any, up to the length of the Shutdown period(s), during this time.

Special Early Retirement Option (SERO) — A GE Pension Plan provision, available for retirements occurring on or before July 1, 2007, that allows you to retire as early as age 55 if you have at least 25 years of Pension Qualification Service (PQS) when you are directly affected by a permanent job-loss event. Certain other employees with 30 or more years of PQS may also be eligible.

spouse — A person of the opposite sex of the employee or retiree who is (or was, in the case of the employee's or retiree's death) the husband or wife of that employee or retiree.

temporary employee — An individual on the active payroll with a work assignment that is expected to be limited to less than 52 weeks. Temporary employees may include those employees hired into college cooperative education programs (co-ops) and those on internship assignments.

work transfer — The terms "transfer of work," "to transfer work" and "work transfer" mean the discontinuance of ongoing work at one location coupled with the assignment of the same work to a different location, including subcontracting the same work to another employer, if such assignment of work would directly cause a decrease in the number of employees performing such work at the first location.

INDEX

You likely have your own preferences for finding information in detailed reference materials such as your handbook. For example, you can use the Table of Contents to help find specific items based on each section's title. In addition, the "Key Things to Know" and "Key Things to Do" summaries often include cross-references to more detailed information within the module.

If you prefer using an index, the one below can take you directly to many items. Please note, however, that the index does not include every subject described in this handbook. It is an index specifically for the content of this module. Additionally, the index does not include all of the definitions in the "Key Terms" section or all of the service centers listed in this handbook.

The online version of this handbook offers you the option to search for the information you need using a search tool that scans the full text of the handbook.

A

- Accidental injury, dental coverage
 - and **GE Health Care Preferred** — Section 2.2.4.6, "Accident-related dental services" on page 51
 - and **GE Medical Benefits** — Section 2.3.4.6, "Accident-related dental services" on page 73
- Active employee, eligibility, see Section 1.1, "How can I tell if I am eligible?" on page 9
- Administrator, plan, see Section 8.1.2, "Who is the plan administrator?" on page 159
- Adopted children, eligibility, see Section 1.4, "Who qualifies as a child?" on page 11
- Adult children, dependent eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Affiliates, eligibility for employees of, see Section 1.1, "How can I tell if I am eligible?" on page 9
- Affiliates, participating in plan, see Section 8.1.10, "Which GE affiliates are participating companies?" on page 174
- Age 65, working after, effect on medical coverage, see Section 2.1.3.2, "Who is eligible?" on page 17
- Alcohol abuse
 - and **GE Health Care Preferred** — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49
 - and **GE Medical Benefits** — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
- Alternative coverage, medical, see Section 2.5, "Alternative health plans" on page 75
- Alternative treatment, dental, see Section 4.4.4, "What if an alternative treatment is appropriate?" on page 106
- Amendment, of plan, see Section 8.1.5, "Can the plans be changed, replaced or terminated?" on page 166

- Appeals, see Section 8.1.4, "What are the claims and appeals procedures?" on page 160
- Armed forces, effect on eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Automatic enrollment, see Enrollment

B

- Birthday rule
 - and **dental coverage** — Section 4.3.6, "What if there is other coverage?" on page 100
 - and **medical coverage** — Section 2.1.3.7, "What if there is other coverage?" on page 21
 - and **same-sex domestic partner coverage** — Section 2.1.3.6, "What if my spouse or same-sex domestic partner's employer offers coverage?" on page 21
- Braces, GE Dental Premium Option, see Section 4.6.2, "What does the GE Dental Premium Option cover?" on page 119
- Braces, GE Dental Schedule Option, see Section 4.5.2, "What does the GE Dental Schedule Option cover?" on page 108

C

- Capitation, see Section 2.1.3.10, "What other provisions may apply?" on page 25
- Case management, GE Medical Benefits, see Section 2.3.4.4, "Hospitals, special facilities and programs" on page 67
- Changing benefits or benefit plans, see Section 8.1.5, "Can the plans be changed, replaced or terminated?" on page 166
- Changing coverage
 - and **dental** — Section 4.3.4, "When can I make changes to my coverage?" on page 98
 - and **medical** — Section 2.1.3.4, "When can I make changes to my coverage?" on page 19
- Changing dental options, see Section 4.4.6, "What if I change dental options?" on page 107
- Children who are Company employees
 - and **dental coverage** — Section 4.3.2, "Who is eligible?" on page 95
 - and **medical coverage** — Section 2.1.3.2, "Who is eligible?" on page 17
- Children, eligibility, see Section 1.4, "Who qualifies as a child?" on page 11
- Chiropractic care, GE Health Care Preferred
 - and **GE Health Care Preferred** — Section 2.2.4.2, "Doctors and other providers" on page 37
 - and **GE Medical Benefits** — Section 2.3.4.2, "Doctors, medical services and supplies" on page 63
- Christian Science practitioners
 - and **GE Health Care Preferred** — Section 2.2.4.2, "Doctors and other providers" on page 37
 - and **GE Medical Benefits** — Section 2.3.4.2, "Doctors, medical services and supplies" on page 63
- Claim deadline
 - and **dental** — Section 4.4.5, "How do I claim benefits?" on page 106
 - and **GE Health Care Flexible Spending Account** — Section 7.4.3, "How do I file for reimbursement?" on page 154
 - and **GE Health Care Preferred** — Section 2.2.3.4, "What if I go out-of-network?" on page 31
 - and **GE Medical Benefits** — Section 2.3.3.6, "How do I claim benefits?" on page 59
 - and **GE Vision Care Benefits** — Section 5.4.3, "What if I go out-of-network?" on page 130
- Claims procedures, general information, see Section 8.1.4, "What are the claims and appeals procedures?" on page 160
- Claims
 - and **dental** — Section 4.4.5, "How do I claim benefits?" on page 106
 - and **GE Health Care Flexible Spending Account** — Section 7.4.3, "How do I file for reimbursement?" on page 154
 - and **GE Medical Benefits** — Section 2.3.3.6, "How do I claim benefits?" on page 59
 - and **GE Health Care Preferred, out-of-network** — Section 2.2.3.4, "What if I go out-of-network?" on page 31
 - and **GE Vision Care Benefits** — Section 5.4.3, "What if I go out-of-network?" on page 130
- Clinical trials
 - and **GE Health Care Preferred** — Section 2.2.4.7, "Special coverage for clinical trials" on page 51
 - and **GE Medical Benefits** — Section 2.3.4.7 "Special coverage for clinical trials" on page 73
- COBRA coverage, see Section 2.6, "When Your GE Health Coverage Ends" on page 76
- COLAs, see Section 6.1.2, "Your GE Medical Care Options before age 65" on page 136
- Company employee, see Section 1.1, "How can I tell if I am eligible?" on page 9
- Compensation, see Pay
- Contact lenses, see Section 5.4.4, "How can I save on contact lenses?" on page 131
- Continuing coverage
 - and **death** — Section 6.3, "In Case of Your Death" on page 142
 - and **disability** — Section 6.2, "In Case of Disability" on page 141
 - and **layoff** — Section 6.4, "In Case of Layoff or Work Transfer" on page 145
 - and **plant closing** — Section 6.5, "In Case of Plant Closing" on page 146
 - and **retirement** — Section 6.1, "After You Retire" on page 134
 - and **work transfer** — Section 6.4, "In Case of Layoff or Work Transfer" on page 145
- Contractors, ineligibility, see Section 1.2, "Who is not eligible for benefits?" on page 9
- Converting coverage, COBRA coverage, see Section 2.6.3.7, "When does COBRA health coverage end?" on page 81
- Converting coverage
 - and **dental** — Section 4.3.8, "When does coverage end?" on page 102
 - and **medical** — Section 2.1.3.9, "When does coverage end?" on page 24

- Coordination of benefits, medical coverage, see Section 2.1.3.6, "What if my spouse's or same-sex domestic partner's employer offers coverage?" on page 21
- Cost of COBRA coverage
 - and **before Company support** — Section 2.6.3.2, "How much does COBRA cost?" on page 78
 - and **with Company support** — Section 2.6.3.3, "Are there other types of funding for COBRA health coverage?" on page 79
- Cost of coverage
 - and **dental** — Section 4.3.5, "How much does coverage cost?" on page 99
 - and **GE Vision Care** — Section 5.3, "Vision Participation" on page 125
 - and **medical** — Section 2.1.3.5, "How much does coverage cost?" on page 20
 - and **paying while not on payroll** — Section 8.1.6, "How do I pay for coverage when not on the payroll?" on page 166
- Court orders, medical child support
 - and **effect on dental coverage** — Section 4.3.7, "What if I receive a qualified medical child support order (QMCSO)?" on page 101
 - and **effect on medical coverage** — Section 2.1.3.8, "What if I receive a qualified medical child support order (QMCSO)?" on page 23
- Coverage certificates
 - and **COBRA** — Section 2.6.3.7, "When does COBRA health coverage end?" on page 81
 - and **dental** — Section 4.3.8, "When does coverage end?" on page 102
 - and **medical** — Section 2.1.3.9, "When does coverage end?" on page 24
- Covered expenses
 - and **GE Dental Schedule Option** — Section 4.5.2, "What does the GE Dental Schedule Option cover?" on page 108
 - and **GE Dental Premium Option** — Section 4.6.2, "What does the GE Dental Premium Option cover?" on page 119
 - and **GE Health Care Flexible Spending Account** — Section 7.4.7, "What expenses are eligible?" on page 156
 - and **GE Health Care Preferred** — Section 2.2.4, "What GE Health Care Preferred Covers" on page 35
 - and **GE Medical Benefits** — Section 2.3.4, "What GE Medical Benefits Covers" on page 60
 - and **Vision Care Benefits** — Section 5.4.1, "What does the plan cover?" on page 126

D

- Davis Vision, see Section 5.4.2, "About network providers?" on page 130
- Deadlines for adding dependents, COBRA coverage, see Section 2.6.3, "How COBRA Health Coverage Works" on page 78
- Deadlines for changes
 - and **dental** — Section 4.3.4, "When can I make changes to my coverage?" on page 98
 - and **GE Health Care Flexible Spending Account** — Section 7.3.3, "When can I change my participation?" on page 150
 - and **medical** — Section 2.1.3.4, "When can I make changes to my coverage?" on page 19
- Deadlines for enrolling
 - and **COBRA** — Section 2.6.3.4, "How do I elect COBRA?" on page 79
 - and **dental** — Section 4.3.3, "How do I enroll when I first become eligible?" on page 96
 - and **GE Health Care Flexible Spending Account** — Section 7.3.2, "How do I enroll?" on page 150
 - and **medical** — Section 2.1.3.3, "How do I enroll when I first become eligible?" on page 18
- Deadlines for payment, COBRA coverage, see Section 2.6.3.4, "How do I elect COBRA?" on page 79
- Death
 - and **effect on COBRA coverage** — Section 2.6.3.6, "What happens if I die?" on page 81
 - and **effect on other benefits** — Section 6.3, "In Case of Your Death" on page 142
- Deductible
 - and **GE Medical Benefits** — Section 2.3.3.3, "What's my deductible?" on page 57
 - and **out-of-network, GE Health Care Preferred** — Section 2.2.3.4, "What if I go out-of-network?" on page 31
- Default coverage
 - and **dental** — Section 4.3.3, "How do I enroll when I first become eligible?" on page 96
 - and **medical** — Section 2.1.3.3, "How do I enroll when I first become eligible?" on page 18
- Dental coverage options, see Section 4.3.1, "What are my GE Dental Care Options?" on page 94
- Dental Premium Option, GE, see Section 4.6, "GE Dental Premium Option" on page 119
- Dental Schedule Option, GE, see Section 4.5, "GE Dental Schedule Option" on page 108

- Dependents, adding
 - and **dental** — Section 4.3.4, "When can I make changes to my coverage?" on page 98
 - and **GE Health Care Flexible Spending Account** — Section 7.3.3, "When can I change my participation?" on page 150
 - and **medical** — Section 2.1.3.4, "When can I make changes to my coverage?" on page 19
- Dependents, eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Disability, effect on dependents' eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Disability, effect on eligibility and duration, COBRA coverage, see Section 2.6.3.5, "How long does COBRA health coverage continue?" on page 80
- Disability, effect on other benefits, see Section 6.2, "In Case of Disability" on page 141
- Drug abuse
 - and **GE Health Care Preferred** — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49
 - and **GE Medical Benefits**—Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71

E

- Eligibility
 - and **COBRA** — Section 2.6.3, "How COBRA Health Coverage Works" on page 78
 - and **Company employees' dependents** — Section 1.3, "Who qualifies as an eligible dependent?" on page 9
 - and **dental** — Section 4.3.2, "Who is eligible?" on page 95
 - and **GE Health Care Flexible Spending Account** — Section 7.3.1, "Who is eligible?" on page 149
 - and **GE Vision Care** — Section 5.3.1, "Who is eligible?" on page 125
 - and **general information** — Section 1.0, "Who is Eligible for GE Benefits?" on page 9
 - and **medical** — Section 2.1.3.2, "Who is eligible?" on page 17
 - and **you as the Company employee** — Section 1.1, "How can I tell if I am eligible?" on page 9
- Emergency care
 - and **GE Health Care Preferred** — Section 2.2.3.2, "What do I do in an emergency?" on page 30
 - and **GE Medical Benefits** — Section 2.3.3.2, "When must I call the benefits administrator?" on page 56
- Employee Assistance Programs (EAPs)
 - and **GE Health Care Preferred** — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49

- and **GE Medical Benefits** — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
- Employer Identification Number, see Section 8.1.1, "What is GE's employer identification number?" on page 159
- Enrollment deadlines
 - and **dental** — Section 4.3.3, "How do I enroll when I first become eligible?" on page 96
 - and **medical** — Section 2.1.3.3, "How do I enroll when I first become eligible?" on page 18
- Enrollment
 - and **COBRA** — Section 2.6.3.4, "How do I elect COBRA?" on page 79
 - and **dental** — Section 4.3.3, "How do I enroll when I first become eligible?" on page 96
 - and **GE Health Care Flexible Spending Account** — Section 7.3.2, "How do I enroll?" on page 150
 - and **medical** — Section 2.1.3.3, "How do I enroll when I first become eligible?" on page 18
- ERISA, see Section 8.1.8, "What are my rights under ERISA?" on page 167
- Exams, periodic, GE Health Care Preferred, see Section 2.2.4.1, "Preventive screenings" on page 35
- Exclusions
 - and **dental** — Section 4.7, "What's Not Covered?" on page 122
 - and **GE Health Care Flexible Spending Account** — Section 7.4.8, "What's not eligible?" on page 158
 - and **medical** — Section 2.4, "What's Not Covered?" on page 74
 - and **vision** — Section 5.4.5, "What's not covered?" on page 131

F

- Family members, dependent eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Family planning, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Flexible Spending Account (FSA), Health Care
 - and **contributions** — Section 7.4.1, "How much can I contribute to my account?" on page 153
 - and **eligibility** — Section 7.3.1, "Who is eligible?" on page 149
 - and **general information** — Section 7.0, "Health Care Flexible Spending Account (FSA)" on page 148
- Funding of benefits, see Section 8.1.7, "How are the plans funded?" on page 167

G

- Generic drugs, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Guardians, court-appointed, see Section 1.4, "Who qualifies as a child?" on page 11

H

- Health Care Flexible Spending Account (FSA)
 - and **contributions** — Section 7.4.1, "How much can I contribute to my account?" on page 153
 - and **eligibility** — Section 7.3.1, "Who is eligible?" on page 149
 - and **general information** — Section 7.0, "Health Care Flexible Spending Account (FSA)" on page 148
- Health Care Preferred benefits administrators, see Section 8.3, "GE Health Care Preferred Benefits Administrators" on page 176
- Health Care Preferred, GE, see Section 2.2, "GE Health Care Preferred" on page 27
- Health Coach from GE, see Section 2.1.1, "Key Things to Know" on page 13
- HMOs, see Section 2.5, "Alternative Health Plans" on page 75
- Home Delivery Pharmacy Service, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Home health care
 - and **GE Health Care Preferred** — Section 2.2.4.4, "Hospitals, special facilities and programs" on page 45
 - and **GE Medical Benefits** — Section 2.3.4.4, "Hospitals, special facilities and programs" on page 67
- Hospice care
 - and **GE Health Care Preferred** — Section 2.2.4.4, "Hospitals, special facilities and programs" on page 45
 - and **GE Medical Benefits** — Section 2.3.4.4, "Hospitals, special facilities and programs" on page 67
- Hospital care
 - and **GE Health Care Preferred** — Section 2.2.4.4, "Hospitals, special facilities and programs" on page 45
 - and **GE Medical Benefits** — Section 2.3.4.4, "Hospitals, special facilities and programs" on page 67

I

- Incentives, network physicians, see Section 2.1.3.10, "What other provisions may apply?" on page 25
- Indemnity coverage, GE Medical Benefits, see Section 2.3, "GE Medical Benefits" on page 52
- Individuals not eligible, see Section 1.2, "Who is not eligible for benefits?" on page 9
- Ineligible, general information, see Section 1.2, "Who is not eligible for benefits?" on page 9

L

- Laser surgery, vision, see Section 5.5.1, "How much can I save?" on page 133
- Leased employees, ineligibility, see Section 1.2, "Who is not eligible for benefits?" on page 9
- Lens 1-2-3®, see Section 5.4.4, "How can I save on contact lenses?" on page 131
- Location, dental schedule, see Section 4.5.4, "Which schedule applies?" on page 112
- Losing other coverage
 - and **dental** — Section 4.3.4, "When can I make changes to my coverage?" on page 98
 - and **medical** — Section 2.1.3.4, "When can I make changes to my coverage?" on page 19

M

- Mail order prescriptions, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Maintenance of benefits
 - and **medical** — Section 2.1.3.6, "What if my spouse's or same-sex domestic partner's employer offers coverage?" on page 21
 - and **vision** — Section 5.3.2, "What if there is other coverage?" on page 126
- Mandated mastectomy benefits, see Section 2.1.3.10, "What other provisions may apply?" on page 25
- Mandated maternity benefits, see Section 2.1.3.10, "What other provisions may apply?" on page 25
- Medical coverage options, see Section 2.1.3.1, "What are my GE Medical Care Options?" on page 14
- Medicare coverage, effect on medical coverage, see Section 2.1.3.6, "What if my spouse's or same-sex domestic partner's employer offers coverage?" on page 21

- Behavioral health coverage
 - and GE Health Care Preferred — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49
 - and GE Medical Benefits — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
- Military service, effect on eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9

N

- Network care
 - and **GE Health Care Preferred** — Section 2.2.3.1, "How do I access network care?" on page 29
 - and **GE Vision Care Benefits** — Section 5.4.2, "About network providers" on page 130
- Network Pharmacies, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Network provider directory, GE Health Care Preferred, see Section 2.2.3.1, "How do I access network care?" on page 29
- Network providers
 - and **dental** — Section 4.4.1, "How can I save by using network dentists?" on page 104
 - and **medical** — Section 2.2.3.1, "How do I access network care?" on page 29
 - and **vision** — Section 5.4.2, "About network providers?" on page 130
- Network rules, medical, see Section 2.1.3.10, "What other provisions may apply?" on page 25

O

- Orthodontics
 - and **GE Dental Premium Option** — Section 4.6.2, "What does the GE Dental Premium Option cover?" on page 119
 - and **GE Dental Schedule Option** — Section 4.5.2, "What does the GE Dental Schedule Option cover?" on page 108
- Other coverage
 - and **dental** — Section 4.3.6, "What if there is other coverage?" on page 100
 - and **medical** — Section 2.1.3.6, "What if my spouse or same-sex domestic partner's employer offers coverage?" on page 21 and Section 2.1.3.7, "What if there is other coverage?" on page 21
 - and **vision** — Section 5.3.2, "What if there is other coverage?" on page 126

- Out-of-area medical coverage, see Section 2.1.3.2, "Who is eligible?" on page 17
- Out-of-network care, GE Health Care Preferred, see Section 2.2.3.4, "What if I go out-of-network?" on page 31
- Out-of-network coverage, vision, see Section 5.4.3, "What if I go out-of-network?" on page 130
- Out-of-pocket maximum
 - and **GE Medical Benefits** — Section 2.3.3.4, "What's my out-of-pocket maximum?" on page 58
 - and **out-of-network, GE Health Care Preferred** — Section 2.2.3.4, "What if I go out-of-network?" on page 31

P

- Participating affiliates, see Section 8.1.10, "Which GE affiliates are participating companies?" on page 174
- Participation in benefits, general information, see Section 1.0, "Who is eligible for GE Benefits?" on page 9
- Patient Advocate Line (PAL), see Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
- Pay, definition, medical coverage cost, see Section 2.1.3.5, "How much does coverage cost?" on page 20
- Payment arrangements, network, see Section 2.1.3.10, "What other provisions may apply?" on page 25
- Payroll deductions
 - and **dental** — Section 4.3.5, "How much does coverage cost?" on page 99
 - and **GE Health Care Flexible Spending Account** — Section 7.4.1, "How much can I contribute to my account?" on page 153
 - and **medical** — Section 2.1.3.5, "How much does coverage cost?" on page 20
- PCP (Primary Care Physician), GE Health Care Preferred, see Section 2.2.3, "How GE Health Care Preferred Works" on page 29
- Physicals, GE Health Care Preferred, see Section 2.2.4.1, "Preventive care and health screenings" on page 35
- Plan administration, see Section 8.0, "Administrative Information" on page 159
- Plan administrator, see Section 8.1.2, "Who is the plan administrator?" on page 159
- Plan documents, see Section 8.1.3, "How can I access official plan documents?" on page 159

- Predetermination of benefits, see Section 4.4.3, "How does predetermination of benefits work?" on page 105
- Pre-existing conditions, medical, see Section 2.1.3.4, "When can I make changes to my coverage?" on page 19
- Preferred providers, GE Medical Benefits, see Section 2.3.3.1, "How can I save by using preferred providers?" on page 56
- Prescription drug co-pay maximum, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Prescription drugs, see Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Preventive care
 - and **GE Health Care Preferred** — Section 2.2.4.1, "Preventive screenings" on page 35
 - and **GE Medical Benefits** — Section 2.3.4.1, "Preventive screenings" on page 61
- Primary care physician, GE Health Care Preferred, see Section 2.2.3, "How GE Health Care Preferred Works" on page 29
- Prior authorization
 - and **GE Medical Benefits** — Section 2.3.3.2 "When must I call the benefits administrator?" on page 56
 - and **behavioral health care, GE Medical Benefits** — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
 - and **prescription drugs** — Section 3.4, "Prescription Drug Coverage for GE Health Care Preferred and GE Medical Benefits" on page 85
- Psychiatric care
 - and **GE Health Care Preferred** — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49
 - and **GE Medical Benefits** — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71

Q

- Qualified medical child support orders (QMCSOs)
 - and **effect on dental coverage** — Section 4.3.7, "What if I receive a qualified medical child support order (QMCSO)?" on page 101
 - and **effect on medical coverage** — Section 2.1.3.8, "What if I receive a qualified medical child support order (QMCSO)?" on page 23
- Qualified status change
 - and **dental** — Section 4.3.4, "When can I make changes to my coverage?" on page 98

- and **GE Health Care Flexible Spending Account** — Section 7.3.3, "When can I change my participation" on page 150
- and **medical** — Section 2.1.3.4, "When can I make changes to my coverage?" on page 19

R

- Reasonable, necessary and customary charges
 - and **dental benefits** — Section 4.4.2, "How does reasonable, necessary and customary work?" on page 104
 - and **GE Medical Benefits** — Section 2.3.3.5, "How does reasonable, necessary and customary work?" on page 59
- Reciprocal coverage, medical, see Section 2.1.3.2, "Who is eligible?" on page 17
- Rights under ERISA, see Section 8.1.8, "What are my rights under ERISA?" on page 167

S

- Same-sex domestic partners
 - and **medical eligibility** — Section 2.1.3.2, "Who is eligible?" on page 17
 - and **dental eligibility** — Section 4.3.2, "Who is eligible?" on page 95
- Schedule of dental benefits, see Section 4.5.5, "Schedule of benefits" on page 115
- Second opinions
 - and **GE Health Care Preferred** — Section 2.2.4.3, "Surgery, tests and other services" on page 39
 - and **GE Medical Benefits** — Section 2.3.4.4, "Hospitals, special facilities and programs" on page 67
- Spouse or same-sex domestic partner who is a Company employee
 - and **dental** — Section 4.3.2, "Who is eligible?" on page 95
 - and **medical** — Section 2.1.3.2, "Who is eligible?" on page 17
- Spouse or same sex domestic partner, dependent eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Stepchildren, dependent eligibility, see Section 1.4, "Who qualifies as a child?" on page 11
- Students, care while away from home, GE Health Care Preferred, see Section 2.2.3.3, "What if I need care while away from home?" on page 31

- Students, dependent eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9
- Substance abuse
 - and **GE Health Care Preferred** — Section 2.2.4.5, "Behavioral health and substance abuse treatment" on page 49
 - and **GE Medical Benefits** — Section 2.3.4.5, "Behavioral health and substance abuse treatment" on page 71
- Surcharges on health care
 - and **effect on dental coverage costs** — Section 4.3.5, "How much does coverage cost?" on page 99
 - and **effect on medical coverage costs** — Section 2.1.3.5, "How much does coverage cost?" on page 20
- Surgery
 - and **GE Health Care Preferred** — Section 2.2.4.3, "Surgery, tests and other services" on page 39
 - and **GE Medical Benefits** — Section 2.3.4.3, "Surgery, tests and other services" on page 66

T

- Taxes on health care
 - and **effect on dental coverage cost** — Section 4.3.5, "How much does coverage cost?" on page 99
 - and **effect on health care flexible spending account** — Section 7.4.5, "How will an FSA affect my taxes?" on page 156
 - and **effect on medical coverage cost** — Section 2.1.3.5, "How much does coverage cost?" on page 20
- Termination, of plan, see Section 8.1.5, "Can the plans be changed, replaced or terminated?" on page 166
- Therapy
 - and **GE Health Care Preferred** — Section 2.2.4.2, "Doctors and other providers" on page 37
 - and **GE Medical Benefits** — Section 2.3.4.2, "Doctors, medical services and supplies" on page 63
- Travel, care during, GE Health Care Preferred, see Section 2.2.3.3, "What if I need care while away from home?" on page 31

U

- United States residence, effect on eligibility, see Section 1.3, "Who qualifies as an eligible dependent?" on page 9

V

- Vacation, care during, GE Health Care Preferred, see Section 2.2.3.3, "What if I need care while away from home?" on page 31
- Vision Care, GE, see Section 5.0, "Vision Care Benefits" on page 124
- Vision Value Option, GE, see Section 5.5, "GE Vision Value Option" on page 132

W

- Waiving coverage
 - and **dental** — Section 4.3.3, "How do I enroll when I first become eligible?" on page 96
 - and **medical** — Section 2.1.3.3, "How do I enroll when I first become eligible?" on page 18
- Well-child care
 - and **GE Health Care Preferred** — Section 2.2.4.1, "Preventive screenings" on page 35
 - and **GE Medical Benefits** — Section 2.3.4.1, "Preventive screenings" on page 61
- What's covered
 - and **GE Dental Premium Option** — Section 4.6.2, "What does the GE Dental Premium Option cover?" on page 119
 - and **GE Dental Schedule Option** — Section 4.5.2, "What does the GE Dental Schedule Option cover?" on page 108
 - and **GE Health Care Flexible Spending Account** — Section 7.4.7, "What expenses are eligible?" on page 156
 - and **GE Health Care Preferred** — Section 2.2.4, "What GE Health Care Preferred Covers" on page 35
 - and **GE Medical Benefits** — Section 2.3.4, "What GE Medical Benefits Covers" on page 60
 - and **GE Vision Care** — Section 5.4.1, "What does the plan cover?" on page 126
- What's not covered
 - and **dental** — Section 4.7, "What's Not Covered?" on page 122
 - and **health care flexible spending account** — Section 7.4.8, "What's not eligible?" on page 158
 - and **medical** — Section 2.4, "What's Not Covered?" on page 74
 - and **vision** — Section 5.4.5, "What's not covered?" on page 131

GE Benefits Center

8000 Baymeadows Way
Jacksonville, FL 32256



Recycled Paper
HCCO-12
Printed in U.S.A.