UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

R.B., individually and on behalf of all others similarly situated, Plaintiff, v. **United Behavioral Health**, Defendant.	Case No. 1:21-cv-553 (DNH/CFH) **CLASS ACTION COMPLAINT** **DEMAND FOR JURY TRIAL**

Plaintiff R.B., on behalf of himself and on behalf of all others similarly situated, alleges, based on his knowledge, information, and belief, formed after an inquiry reasonable under the circumstances, the following:

INTRODUCTION AND NATURE OF THIS ACTION

1. Plaintiff R.B. challenges Defendant's standardized practice of excluding from coverage all mental health and substance abuse treatment services rendered at residential treatment centers where any component of the center's programming is considered unproven, experimental or investigational. This coverage approach is not in parity with how Defendant covers unproven, experimental or investigational programming in comparable settings, such as skilled nursing facilities and rehabilitation hospitals, which are considered "comparable" under the federal Mental Health Parity and Addiction Equity Act.

2. With this action, Plaintiff and class members seek to recover charges for services rendered at residential treatment center programs and further to enjoin Defendant from further violations of the Parity Act.

JURISDICTION AND VENUE

3. This Court has original jurisdiction under 28 U.S.C. § 1332(d) because: the amount in controversy exceeds $5 million, exclusive of interest and costs; more than two-thirds of the Class reside in states other than the state in which Defendant is a citizen; and at least one class member is diverse from the Defendant.

4. This Court also has jurisdiction under 28 U.S.C. § 1331, as it arises under federal law.

5. Venue is appropriate in this judicial district because the Plaintiff resides in this district, the Defendant conducts considerable business within this district, and many of the breaches described here occurred within this district.

6. In conformity with 29 U.S.C. §1132(h), Plaintiff will serve the original Complaint by certified mail on the Secretary of Labor and the Secretary of the Treasury.

PARTIES

7. Plaintiff R.B., at all material times, was an individual citizen and resident of Rensselaer, New York. At relevant times, R.B. worked full-time for General Electric Company, which provided and sponsored his health insurance. R.B. is a citizen of New York.

8. The mental health and substance abuse treatment services at issue in this action were received by R.B.'s son, J.B. J.B. was a minor at the time the services were received.

9. Because of the intensely private nature of the medical services rendered that will be discussed here, and because Plaintiff's son was a minor at the time of the events described, this Complaint is using initials instead of the names of Plaintiff and his son. In conformity with Local Rule 5.2, Planitff will file under seal, and serve to Defendant, a reference list disclosing the identities of Plaintff and his son.

10. Defendant United Behavioral Health, which operates under the brand OptumHealth Behavioral Solutions, is a corporation organized under California law with its principal place of business located in San Francisco, California. UBH is responsible for drafting and applying the internal level of care and coverage determinations described in this Complaint. Defendant also adjudicates all mental health and substance abuse treatment services mental healthcare and substance abuse claims for plaintiff's ERISA-regulated health insurance plans. In this Complaint, "UBH" refers to the named defendant and all parent, subsidiary, successor, predecessor and related entities to which these allegations pertain.

11. In light of its central role in the mental health and substance abuse treatment services mental health and substance abuse-related claim adjudication process, UBH is an ERISA fiduciary as defined by 29 U.S.C. § 1104(a). As such, it is legally required to discharge its duties "solely in the interests of the participants and beneficiaries" and for the "exclusive purpose" of providing benefits to participants and

their beneficiaries" and paying reasonable expenses of administering the plan. It must do so with reasonable "care, skill, prudence, and diligence" and in accordance with the terms of the plans it administers, so long as such terms are consistent with ERISA. As a fiduciary, UBH owes a duty of loyalty to plan participants and beneficiaries.

12. Plaintiff's relevant summary plan description is attached to this Complaint at **Exhibit A**.

FACTS

Insurance coverage promises

13. General Electric's certificate of coverage provides that it covers only "Eligible Expenses," which are "[s]ervices, supplies or treatments provided while the plan is in effect that are determined by the Claims Administrator to be:

- Appropriate for 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;
- Employed appropriately and effectively with respect to the type and level of care; and
- Within any limits imposed by the plan (e.g., number of visits).

Exhibit A, p. 101.

14. The plan further provides it will only cover the "Allowable Amount," which the certificate defines as "[t]he total dollar amount of an Eligible Expense that is determined by your Claims Administrator to be payable for a covered benefit.

- **For Network Provider —** Eligible Expenses are based on contracted rates with the Provider.
- **For out-of-Network Provider —** Eligible Expenses are based on:

> – Negotiated rates agreed to by the out-of-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors; or
> – A maximum payment allowance that will be the lowest of (a) the in-Network rate of the Claims Administrator, (b) the established Medicare reimbursement rates plus up to 25% or (c) the Provider's actual charges."

Exhibit A, p. 100.

15. The certificate only authorizes coverage for services deemed to be "Medically Necessary," which it defines as "[a] service, supply or procedure is Medically Necessary and appropriate only if, in the Claims Administrator's judgment and sole discretion, it is:

- Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the participant's illness, Injury or condition;
- Consistent with the symptom, diagnosis, prevention or treatment of the participant's illness, Injury or condition;
- The most appropriate supply, treatment or level of service that can be provided safely to the member and, if the member is an inpatient, cannot be provided safely on an outpatient basis;
- Not primarily for the convenience of the participant, his family or provider; and
- Not a part of, or associated with, the participant's scholastic, educational or vocational training."

Exhibit A, p. 103.

16. The certificate authorizes coverage for behavioral health and substance abuse treatment received at a licensed residential treatment facility. (**Exhibit A, p. 36).** The certificate also authorizes coverage at skilled nursing facilities. **(Exhibit A, p. 51).**

17. Equine therapy is not mentioned in the certificate.

J.B.'s background

18. J.B lives with his two adoptive parents, and has a younger adoptive sister.

19. J.B. has the following diagnoses: Major Depressive Disorder; Generalized Anxiety Disorder; Attention-Deficit Hyperactivity Disorder; Oppositional Defiant Disorder; Cannabis Use Disorder; Nicotine Dependence; Opioid Use Disorder; Hallucinogenic Use Disorder; Alcohol Use Disorder; and Parent-Adopted Child Conflict.

20. J.B.'s difficulties escalated in March 2020, resulting in conflicts at home with incidents of physical aggression such as punching walls, and running away for multiple days at a time. J.B suffered from insomnia and exhibited multiple depressive symptoms. J.B. was admitted to Newport Academy, a licensed residential treatment center, on March 27, 2020 and stayed until his discharge on June 8, 2020.

21. The treatment team at Newport Academy recommended J.B. transition immediately following discharge to a longer-term treatment program, concluding that his risk of relapse after returning home was too high, and also to provide the appropriate amount of time to address J.B.'s list of underlying co-morbid mental illness. Based on Newport Academy's recommendation, J.B started treatment at Arivaca Boys Ranch, an Arizona-licensed residential treatment center, on June 8, 2020.

22. Throughout J.B.'s treatment at Arivaca, two issues dominated his treatment. First, J.B. maintained that he would continue drug and alcohol use upon leaving Arivaca and, second, J.B. consistently struggled with social interactions.

23. J.B. was discharged from Arivaca on April 17, 2021. As of that date, he had incurred, and R.B. paid, $66,800 for mental health and substance abuse treatment services rendered at Arivaca.

24. Among other things, Arivaca offers individual counseling, group therapy, family therapy and addiction recovery.

Defendant's Denial of Coverage

25. Defendant denied R.B.'s claim for coverage. Under the certificate, R.B. is required to exhaust two internal appeals before he may commence litigation. Defendant denied R.B.'s first appeal on June 10, 2020 "[b]ased on the provider being unable to be authorized … due to the unproven therapy of equine therapy."

26. Defendant denied R.B.'s second appeal by letter dated December 10, 2020. The basis for denial was "[t]his facility has service components not consistent with Guidelines and are considered unproven." This second denial informed R.B. that "[a]ll internal appeals … have been exhausted."

CLASS ALLEGATIONS

27. R.B. brings this action individually and on behalf of the following Class pursuant to Rules 23(a) and 23(b)(1)-(3) of the Federal Rules of Civil Procedure:

> *All persons covered under ERISA-governed health care plans, administered or insured by United Behavioral Health, whose requests for coverage for mental health and substance abuse treatment services received at a licensed residential treatment center were denied in total based on its determination that a component of such services is considered experimental, investigational, or unproven (the "Class").*

28. Excluded from the Class are: the officers, directors, or employees of the Defendant; any judicial officer presiding over this action and the members of his/her immediate family and judicial staff.

29. The Class period began six years before the commencement of this action and concludes on the date the class is certified.

30. The exact number of members of the Class is currently unknown and unavailable to Plaintiff at this time, but it is estimated that the Class consists of several hundreds or thousands of Class members geographically dispersed throughout the United States. Accordingly, Class membership is so numerous that joinder of individual members of the Class is impracticable.

31. The Class is ascertainable because its members can be readily identified using Defendant's claims data. Membership of the Class is defined based on objective criteria.

32. **Predominance:** Common questions of law and fact exist that predominate over any questions affecting only individual Class members. These common legal and factual questions, which do not vary from Class member to Class member and which may be determined without reference to any Class member's individual circumstances, include but are not limited to:

a. Whether Defendant acted as an ERISA fiduciary when it made coverage denial determinations concerning mental health and substance abuse treatment services;

b. Whether Defendant applied a policy of total denial of coverage for mental health and substance abuse treatment services when it determined that a component of such services is experimental, investigational, or unproven;

c. Whether Defendant's creation, development, implementation, and application of such a policy of total denial of coverage for mental health and substance abuse treatment services violates the federal Parity Act, which is incorporated in ERISA;

d. Whether Class members are entitled to equitable relief, including but not limited to injunctive relief and equitable restitution; and

e. Whether Defendant is liable for attorneys' fees and costs.

33. Defendant engaged in a common course of conduct by Defendant that gives rise to all claims. The claims are typical of the claims of all Class members because Defendant injured all Class members through a uniform course of conduct and employing the same coverage practices for each and every Class member. The same legal theories apply to each Class member, and Plaintiff seeks the same forms of relief for all Class Members. There are no defenses available to Defendant that are unique to Plaintiff.

34. R.B. can fairly and adequately protect and represent the interests of each member of both classes because he has no conflict of interest in this cause of action with the class and its membership. R.B.'s interests are perfectly aligned with the members of the class and R.B. and the members of the class have a mutual interest in seeking damages and other relief against Defendant. R.B. is represented by competent and experienced class action counsel.

35. **Superiority –** A class action is superior to other available means for the fair and efficient adjudication of this controversy since individual litigation of all Class

member claims is impracticable. Even if every Class member could afford individual litigation, the court system could not. It would be unduly burdensome to the courts, in which individual litigation of hundreds of cases would proceed. Individual litigation presents a potential for inconsistent or contradictory judgments, the prospect of a race for the courthouse, and an inequitable allocation of recovery among those with equally meritorious claims. Individual litigation increases the expense and delay to all parties and the court system in resolving the legal and factual issues common to all Class members' claims relating to Defendant's unlawful conduct. By contrast, the class action device presents far fewer management difficulties and provides the benefit of a single adjudication, economies of scale, and comprehensive supervision by a single court.

36. In the alternative, this action may be properly maintained under Rules 23(b)(1) and (2) of the Federal Rules of Civil Procedures as a class action because:

a. the prosecution of separate actions by individual members of the Class would create a risk of inconsistent or varying adjudications with respect to individual Class members, which would establish incompatible standards of conduct for Defendant; or

b. the prosecution of separate by individual members of the Class would create a risk of adjudications with respect to individual members of the Class which would, as a practical matter, be dispositive of the interests of other members of the Class not parties to the adjudications, or substantially impair or impeded their ability to protect their interests; or

c. Defendant has acted or refused to act on grounds generally applicable to the Class, thereby making appropriate final injunctive or corresponding declaratory relief with respect to the Class as a whole.

COUNT I
CLAIM FOR PLAN BENEFITS

37. Plaintiff incorporates all other paragraphs of this Complaint and restates them.

38. Plaintiff brings this claim on his own behalf and on behalf of the Class under 29 U.S.C. § 1132(a)(1)(B) for violations of the Parity Act, which is incorporated into ERISA, at 29 U.S.C. § 1185a.

39. Under the Parity Act, health insurers must "treat sicknesses of the mind in the same way that they would a broken bone." *New York State Psychiatric Ass'n, Inc. v. United Health Grp.*, 980 F. Supp.2d 527, 542 (S.D.N.Y.), *aff'd in part, vacated in part*, 798 F.3d 125 (2d Cir. 2015).

40. A "treatment limitation" is a limit on either "the scope or duration of treatment." 29 U.S.C. § 1185(a)(3)(B)(iii).

41. Regulations promulgated under this statute focus the Court's analysis in two respects. First, both "quantitative" and "nonquantitative" treatment limitations may run afoul of the Parity Act. 45 C.F.R § 146-136(a). Whereas a quantitative limitation is reduceable to a number, a nonquantitative treatment limitation is any other limitation on the scope or duration of treatment. 45 C.F.R. § 146-136(c)(4)(i).

42. Second, any limitation applied to mental health treatment must be scrutinized by comparing it to the limitations placed on an analogous medical or surgical treatment in the same classification. 45 C.F.R. § 146-136(c)(2)(i)-(ii).

43. Defendant's denial of coverage for medically necessary services rendered at residential treatment centers because of the inclusion of some programming it finds unproven is not in parity with its coverage position for medically necessary services rendered at skilled nursing facilities and rehabilitation hospitals, which are services in the same classification as residential treatment center services and also comparable to residential treatment center services under the Parity Act. Where certain programming at skilled nursing facilities and rehabilitation facilities is found to be unproven, those services are not covered. But Defendant does not take the position that inclusion of those services voids all coverage obligations for services incurred at skilled nursing facilities and rehabilitation hospitals – just the services found to be unproven.

44. This disparate treatment in comparable services violates the federal Parity Act.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, on behalf of himself and the Class, prays for relief and judgment against Defendant as follows:

A. Certifying the Class pursuant to Rule 23 of the Federal Rules of Civil Procedure, appointing Plaintiff as a representative of the Class, and designating Plaintiff's counsel as Class Counsel;

B. Ordering Defendant to reprocess Class claims in a manner compliant with the federal Parity Act. In so doing, Defendant may not raise new coverage defenses to Class members' claims that it did not raise the first time;

C. For declaratory and equitable relief, including restitution and disgorgement;

D. Awarding Plaintiff and the Class the costs of prosecuting this action, including expert witness fees;

E. Awarding Plaintiff and the Class reasonable attorneys' fees and costs as allowable by law;

F. Awarding pre-judgment and post-judgment interest; and

G. Granting any other relief as this Court may deem just and proper.

JURY TRIAL DEMANDED

Plaintiff demands a trial by jury on all counts so triable.

Dated: May 12, 2021

Respectfully submitted,

/s/Randi A. Kassan
Randi A. Kassan (N.D.N.Y. Bar No. 517821)
MILBERG COLEMAN BRYSON PHILLIPS GROSSMAN LLC
100 Garden City Plaza, Suite 500
Garden City, NY 11530
Telephone: (516) 741-5600
rkassan@milberg.com

Greg Coleman
Arthur Stock
MILBERG COLEMAN BRYSON PHILLIPS GROSSMAN LLC

800 S. Gay Street, Suite 1100
Knoxville, TN 37929
Telephone : (865) 247-0080
gcoleman@milberg.com
astock@milberg.com

Jordan Lewis
JORDAN LEWIS, P.A.
4473 N.E. 11th Avenue
Fort Lauderdale, FL 33334
Telephone: (954) 616-8995
jordan@jml-lawfirm.com

Edward A. Wallace
Mark J. Tamblyn
WEXLER WALLCE LLP
55 West Monroe Street, Suite 3300
Chicago, IL 60603
Telephone: (312) 346-2222
eaw@wexlerwallace.com
mjt@wexlerwallace.com

Charles J. Crueger
Erin K. Dickinson
CRUEGER DICKINSON LLC
4532 N. Oakland Ave.
Whitefish Bay, WI 53211
Telephone : (414) 210-3900
cjc@cruegerdickinson.com
ekd@cruegerdickinson.com

Attorneys for Plaintiff

Your Benefits Handbook

Health Care Benefits

For Employees Eligible to Participate in GE Health Benefits for Production Employees

Effective January 1, 2016

This handbook is valid only if you receive it directly from Global Operations with a notice indicating it applies to you.

GE
Global Operations

One River Road
Schenectady, NY 12345

December 2018

Update to *Your Benefits Handbook – Health Care Benefits For Employees Eligible to Participate in GE Health Benefits for Production Employees*

This summary of material modifications describes changes to the medical and vision benefits under the GE Health Benefits for Production Employees, as amended (the "Plan"). This summary updates *Your Benefits Handbook—Health Care Benefits*, but these updates do not replace *Your Benefits Handbook*. You should review these updates and your handbook together to fully understand your benefits. You have the right to print or request a paper copy of this summary. To request a paper copy, please contact the GE Benefits Center at 1-800-252-5259. Any capitalized terms not defined here are defined in *Your Benefits Handbooks*.

These updates are effective January 1, 2019, unless otherwise noted.

GE MEDICAL, PRESCRIPTION DRUG, AND FSA UPDATES

Increased Maximum Contribution for Flexible Spending Accounts (FSAs) and Limited Purpose Flexible Spending Accounts (LPFSAs)

You may contribute up to $2,650 each year to your FSA/LPFSA.

Preventive Benefits

Effective October 16, 2018, Vitamin D supplements are no longer covered as preventive benefits.

New Telemedicine Vendor

Cleveland Clinic Express Care Online allows participants in GE Medical to connect with a health care Provider 24 hours a day, 7 days a week. You can consult with a health care Provider from your smartphone, tablet or computer. All Providers are licensed, credentialed and in-network.

To learn more about telemedicine, beginning January 1, 2019, visit https://clevelandclinic.org/GE.

2019 Out-of-Pocket Maximum

As of January 1, 2019, no individual family member can pay more out-of-pocket for eligible expenses than $7,900 (Options 1 & 2) or $6,750 (Option 3) or the combined family Out-of-

Pocket Maximum for the Plan option in which they are enrolled, whichever is less. Once the combined family Out-of-Pocket Maximum is met, the Plan will pay 100% of eligible expenses for the remainder of the year (including for a family member who has not met the individual Out-of-Pocket Maximum).

Changes to Tobacco Cessation Program

As of January 1, 2019, the QuitNet Tobacco Cessation Program will no longer be available. Accordingly, Section 1.8.3 of the Handbook is revised to read as follows:

1.8.3 TOBACCO CESSATION

If you use tobacco you may pay more for your coverage. A tobacco cessation program helps to eliminate nicotine, tobacco, and smoking dependence. The following are some available resources to help you and your family who are enrolled in GE medical benefits, quit.

1. Tobacco cessation counseling and certain prescribed products are covered at 100% in-Network, under your GE Medical. Contact the GE Prescription Drug Claims Administrator for a list of products and coverage details.

2. Health Coach from GE offers tobacco cessation coaching. Call Health Coach from GE at 1-866-272-6007 to get started, weekdays from 9:00 a.m. – 7:00 p.m., Eastern time.

3. There are a variety of resources available in states and communities throughout the country. Many offer free nicotine replacement therapy, coaching programs, and access to support groups. For an overview of resources provided by your state, go to gehealthcarehub.com > Health Care Programs And Resources > Tobacco Cessation Resources.

Retain this document for future reference with Your Benefits Handbook. If you would like to receive a hard copy of Your Benefits Handbook or have any questions about these materials, please contact the GE Benefits Center at 1-800-252-5259.

Further information can be found in the plan documents, which are available to you as described in Your Benefits Handbook — Eligibility and Administrative Information. If a provision described in this summary of material modifications 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.

The General Electric Company reserves the right to terminate, amend, suspend, replace or modify its benefit plans or programs at any time and for any reason, in its sole discretion. No individual has a vested right to any benefit under a GE welfare benefit plan or program.

GE
Global Operations
One River Road
Schenectady, NY 12345

December 2017

Update to *Your Benefits Handbook – Health Care Benefits For Employees Eligible to Participate in GE Health Benefits for Production Employees and Your Benefits Handbook—Eligibility and Administrative Information*

This summary of material modifications describes changes to the medical benefits under the GE Health Benefits for Production Employees Plan, as amended (the "Plan"). This summary updates *Your Benefits Handbook—Health Care Benefits* and *Your Benefits Handbook—Eligibility and Administrative Information*, but these updates do not replace *Your Benefits Handbooks*. You should review these updates and your handbooks together to fully understand your benefits. You have the right to print or request a paper copy of this summary. To request a paper copy, please contact the GE Benefits Center at 1-800-252-5259. Any capitalized terms not defined here are defined in *Your Benefits Handbooks*.

These updates are effective January 1, 2018.

GENERAL HEALTH CARE UPDATES

1. New Address for Requesting Copies of Plan Documents

To request a copy of a particular Plan document, or the document for another plan covered by *Your Benefits Handbook—Eligibility and Administrative Information*, you should write or call GE Global Services.

The address for GE Global Services has changed to:

GE Global Services
P.O. Box 5000
Schenectady, New York 12301
1-800-252-5259

(Be sure to specify the plan for which you want plan document(s) -- for example, the GE Health Benefits for Production Employees Plan.)

2. Updated Pay Transparency Non-Discrimination Provision

Per the requirements of U.S. Presidential Executive Order 13665, we are communicating the following statement:

PAY TRANSPARENCY NON-DISCRIMINATION PROVISION

The Company will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the Company, or (c) consistent with the Company's legal duty to furnish information. 41 CFR 60-1.35(c)

(This provision also applies to the Company where applicable by other law.)

GE MEDICAL, PRESCRIPTION DRUG, AND FSA UPDATES

1. Preventive Benefits Include Statins

Select generic statin drugs to treat high cholesterol will be covered as preventive benefits. Preventive benefits are prescribed drugs that are covered at 100% and are not subject to your Annual Deductible under all three GE Medical Options.

For a list of eligible drugs, contact the Prescription Drug Claims Administrator.

2. 2018 Out-of-Pocket Maximum

As of January 1, 2018, no individual family member can pay more out-of-pocket than $7,350 (Options 1 & 2) or $6,650 (Option 3) or the combined family Out-of-Pocket Maximum for the Plan option in which they are enrolled, whichever is less. Once the combined family Out-of-Pocket Maximum is met, the Plan will pay 100% of eligible expenses for the remainder of the year (including for a family member who has not met the individual Out-of-Pocket Maximum).

3. Increased Maximum Contribution for Flexible Spending Accounts (FSAs) and Limited Purpose Flexible Spending Accounts (LPFSAs)

Starting January 1, 2018, you may contribute up to $2,600 each year to your FSA/LPFSA.

Retain this document for future reference with Your Benefits Handbooks. If you would like to receive a hard copy of Your Benefits Handbooks or have any questions about these materials, please contact the GE Benefits Center at 1-800-252-5259.

Further information can be found in the official plan documents, which are available to you as described in Your Benefits Handbook — Eligibility and Administrative Information, as modified by this summary. If a provision described in this summary of material modifications 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.

The General Electric Company reserves the right to terminate, amend, suspend, replace or modify its plans at any time and for any reason, in its sole discretion. No individual has a vested right to any benefit under a plan.

GE
Global Operations
One River Road
Schenectady, NY 12345

February 2017

Update to *Your Benefits Handbook – Health Care Benefits For Employees Eligible to Participate in GE Health Benefits for Production Employees*

This summary of material modifications describes recent changes to the GE Health Benefits for Production Employees Plan, as amended (the "Plan"). This summary updates *Your Benefits Handbook—Health Care Benefits*, but these updates do not replace *Your Benefits Handbook*. You should review these updates and your handbook together to fully understand your benefits. You have the right to print or request a paper copy of this summary. To request a paper copy, please contact the GE Benefits Center at 1-800-252-5259. Any capitalized terms not defined here are defined in *Your Benefits Handbook*.

These updates are effective January 1, 2017.

1. Individual Out-of-Pocket Maximum For Each Family Member

In 2017 no individual family member can pay more out-of-pocket than $7,150 (Options 1 & 2), $6,550 (Option 3) or the combined family Out-of-Pocket Maximum for the Plan option in which they are enrolled, whichever is less. Once the combined family Out-of-Pocket Maximum is met, the Plan will pay 100% of eligible expenses for the remainder of the year (including for a family member who has not met the individual Out-of-Pocket Maximum).

2. Preventive Benefits Include Colonoscopy Prep Drugs

Prescribed colonoscopy prep drugs are now covered as preventive benefits. Preventive benefits are prescribed drugs that are covered at 100% and are not subject to your Annual Deductible under all three GE Medical Options.

3. Urgent Care, Convenience Care, and Immunizations at Specified Locations

If you present your GE Pharmacy Card or OptumRx ID card, you may pay less for convenience care services that you receive from CVS Minute Clinic or Walgreens Healthcare Clinic and urgent care services that you receive from MedExpress than from other providers, including other network providers.

Convenience care services include vaccines, physicals, screenings, treatment for minor injuries and skin conditions, monitoring and management of ongoing conditions, and wellness and preventive care. You may also pay less for immunizations provided at locations identified by OptumRx as charging negotiated rates. For more information, contact OptumRx or visit optumrx.com.

4. Limited Purpose Flexible Spending Accounts (LPFSAs) Are Now Available to Participants in GE Medical Option 1 or 2

If you are enrolled in either GE Medical Option 1 or 2, you will automatically be enrolled in a Health Reimbursement Account (HRA) which may be used to help you pay for most eligible health care expenses, except for dental or vision expenses. In addition, you are eligible to open a Flexible Spending Account (FSA) or a Limited Purpose Flexible Spending (LPFSA). An FSA is an account opened at your election by GE that you fund through pre-tax payroll deductions and use to pay for certain eligible medical, dental and vision expenses. An LPFSA is an account opened at your election by GE that is similar to an FSA, except that it is limited to paying dental and vision costs only. If you open an FSA, funds will be drawn from any available balance in your FSA first, then your HRA. If you open an LPFSA, reimbursements of medical expenses will be made from the HRA, and reimbursements of dental or vision expenses will be made from the LPFSA.

5. Increased Maximum Contribution for Flexible Spending Accounts (FSAs) and LPFSAs

You may contribute up to $2,550 each year to your FSA/LPFSA.

Retain this document for future reference with Your Benefits Handbook. If you would like to receive a hard copy of Your Benefits Handbook or have any questions about these materials, please contact the GE Benefits Center at 1-800-252-5259.

Further information can be found in the official plan documents, which are available to you as described in Your Benefits Handbook — Eligibility and Administrative Information. If a provision described in this summary of material modifications 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.

The General Electric Company reserves the right to terminate, amend, suspend, replace or modify the Plans, at any time and for any reason. No individual has a vested right to any benefit under a Plan.

IMPORTANT INFORMATION ABOUT THIS HANDBOOK

This handbook is part of the summary plan descriptions for health and certain other GE plans or programs described in this handbook (collectively referred to as the "Plans"), which are available to eligible Company Employees. The summary plan description for each Plan includes this book, *Your Benefits Handbook — Eligibility and Administrative Information*, and any document incorporated by reference. The summary plan description for each Plan also includes any modification to the summary plan description for that Plan dated after January 1, 2016.

The summary plan descriptions for the Plans contain important information about your benefits under the Plans but do not include full details of all Plan provisions. Further information can be found in the official plan documents, which are available to you as described in *Your Benefits Handbook — Eligibility and Administrative Information*. If a provision described in this handbook or another part of the summary plan description 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. Any capitalized terms that do not appear in the "Key Terms" section are described in *Your Benefits Handbook — Eligibility and Administrative Information*, the official plan documents, the relevant section in which the term appears, or in other documents incorporated by reference.

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

The General Electric Company reserves the right to terminate, amend, suspend, replace or modify the Plans, at any time and for any reason. No individual has a vested right to any benefit under a Plan.

If a Plan is terminated, you will not receive any further benefits under the Plan, other than payment of benefits for services or coverages incurred before the Plan was terminated. Any assets held in the GE Insurance Plan Trust for a Plan will be used solely to pay benefits or plan expenses in accordance with applicable Plan and trust provisions.

For Employees covered by a collective bargaining agreement, participation in the Plans shall only occur upon agreement by the Employees' union representative. If the Plans are incorporated by reference into a collective bargaining agreement, participation is only to the extent provided through the incorporation. If specific terms and conditions are contained in a collective bargaining agreement, the terms and conditions of such collective bargaining agreement will govern should a conflict arise between this handbook or the Plans and the terms and conditions of such agreement.

If you work for an Affiliate of the General Electric Company and you receive a copy of this handbook from Global Operations with a notice that it applies to you, your employer has chosen to offer you the benefits that are described in this handbook. As you read this material, you may see references to "GE" or "General Electric" used to identify specific benefit programs (e.g., "GE Medical") or related administrative service providers (e.g., "GE Prescription Drug Claims Administrator"). Despite these official titles, you should understand that the benefits described in this handbook are provided to you by your Company, although the General Electric Company is the sponsor of the Plans. You should read the definitions of "Affiliate" and "Company" in the "Key Terms" section to make sure you understand how these terms are used in this handbook.

Your participation in the Plans 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.

The benefits described in this handbook apply to Employees who:

- Are on the Active Payroll of the Company or are receiving Company-sponsored disability benefits as of January 1, 2016, or later;
- Are eligible to participate in the benefits described in this handbook, as outlined in this booklet and *Your Benefits Handbook — Eligibility and Administrative Information*; and
- Receive this handbook directly from Global Operations with a notice indicating that it applies to them.

Health Care Benefits

1.0 YOUR GE MEDICAL COVERAGE

The Company provides you with medical coverage options ("GE Medical" or "GE Medical Options"). It is up to you to choose the coverage that best meets the needs of you and your family.

1.1 MEDICAL PARTICIPATION

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

1.1.1 WHAT ARE MY GE MEDICAL OPTIONS?

Your GE Medical Options are:

- GE Medical Option 1 with Health Reimbursement Account (HRA);
- GE Medical Option 2 with HRA; and
- GE Medical Option 3 with Health Savings Account (HSA).

With GE Medical, you may select from one of the three options, so you can choose to pay more in payroll contributions and less when seeking care or pay less in payroll contributions and more when seeking care. Unless otherwise specified, your benefits start after you meet your Annual Deductible. See Section 1.5, "PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016" and Section 1.6, "ADDITIONAL COVERAGE DETAILS" for details on Plan coverage.

1.1.2 WHO IS ELIGIBLE?

You are eligible to enroll in GE Medical if you are:

- A full-time Company Employee;
- A part-time Company Employee; or
- Any other Company Employee who is eligible for GE Medical as described in the *Your Benefits Handbook — Eligibility and Administrative Information*

who, in each case, is part of a special classification of Employees eligible for GE Medical.

In most cases Employees eligible to participate in GE Medical include hourly Employees or nonexempt Employees in a manufacture-store-deliver-service position (MSDS position). Contact your human resources representative for more information.

If you are eligible, but are not a full-time Company Employee, special provisions apply. For example, you may pay different contribution rates. If you are eligible, you will be notified about your costs for coverage.

You are not eligible if you are not an eligible Company Employee as described in, or if you are in one of the excluded groups listed in, *Your Benefits Handbook — Eligibility and Administrative Information*.

YOUR DEPENDENTS

If you are eligible to enroll in GE Medical, you also may enroll your eligible Dependents. Eligible Dependents are described in *Your Benefits Handbook — Eligibility and Administrative Information*. Note that for your eligible Dependents to be covered under GE Medical, you must be covered yourself, and they must be covered under the same option in which you are enrolled and by the same Claims Administrator as the one assigned to you.

If you have Dependents who live away from home (e.g., children attending college), coverage is available through GE Medical nationally. For more information, call your Claims Administrator.

IF YOUR SPOUSE IS A COMPANY EMPLOYEE

If both you and your Spouse are eligible Company Employees, you may choose to either:

- **Enroll only one of you as a Company Employee** — The Spouse in the lower wage band must be covered as a Dependent of the higher wage band Employee (if you are both in the same wage band, either of you may enroll as the "Employee"); or
- **Enroll both yourself and your Spouse 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 option in which he or she is enrolled.

Please contact the GE Benefits Center at 1-800-252-5259 for additional details, including information related to your wage band.

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 GE Medical 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 is eligible for Medicare, but wishes to be covered as your Dependent under your GE Medical 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 in Medicare; or
- If you choose only Medicare, Company coverage will end as of the effective date of the change to Medicare. However, if you are considering retirement, please be aware that Medicare has specific rules and deadlines for enrollment in Medicare Part B. Contact Medicare prior to your retirement to confirm your eligibility and enrollment options.

1.1.3 WHAT HAPPENS WHEN I FIRST BECOME ELIGIBLE?

When you first become eligible, your options are as follows:

- You can enroll for coverage under GE Medical **within 63 days** after you become eligible. You will receive enrollment instructions for GE Medical.
- If you do not want any medical coverage from the Company, you can waive coverage **within 63 days** after you become eligible. To waive coverage, notify the GE Benefits Center or go to **OneHR.ge.com**. If you waive GE Medical coverage you will also waive prescription drug coverage, Behavioral Health and Substance Abuse Treatment coverage, and vision coverage, but not dental coverage.
- If you make no election — to enroll or to waive coverage by the end of the **63-day deadline**, you will automatically be enrolled in GE Medical Option 1 at the "Three or More" coverage level. See *Your Benefits Handbook — Eligibility and Administrative Information* for details about the GE Enrollment Safety Net. Coverage will be retroactive to your date of hire.

To cover a Dependent, you must provide each eligible Dependent's name, birth date and Social Security number (and you may be required to provide proof of eligibility).

If you have questions, you can call the GE Benefits Center at 1-800-252-5259.

1.1.4 WHEN CAN I MAKE CHANGES TO MY COVERAGE?

When you first become eligible for coverage under GE Medical, 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 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.** You can enroll or make changes within 63 days of events such as gaining a new Dependent, losing coverage under another medical plan, a change in employment status or relocation that affects your eligibility for a GE Medical Option, or other qualified status changes, as described in Section 3.1.4, "QUALIFIED STATUS CHANGES." Please note that you generally cannot change your GE Medical Option as a result of these events. Please refer to Section 3.1.4, "QUALIFIED STATUS CHANGES."

ADDING DEPENDENTS TO YOUR COVERAGE

You may add a Dependent after your initial enrollment at **OneHR.ge.com**, or by calling the GE Benefits Center at 1-800-252-5259. You may be required to show proof of eligibility. 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 must first enroll yourself and then you may also enroll 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 the qualified status change. Coverage will become effective retroactive to the date of the qualified status change.

In the case of a newborn child, you will have **90 days** from the birth of the child to add coverage, which will become retroactive to the date of birth, unless you are already enrolled at the "Three or More" coverage level, in which case coverage will be effective upon notice to the Company and will be retroactive to the date of birth. Timely claims submission requirements apply.

If you are enrolled in GE Medical when a new Dependent child first becomes eligible, the child will be automatically covered under your GE Medical Option for 31 days after the child first becomes eligible (or, in the case of a newborn child, for 90 days). If you wish to continue coverage for a Dependent child beyond this initial coverage period, you must call the GE Benefits Center at 1-800-252-5259 **within the 63-day period (or 90-day period for newborns**) described above.

The cost of your medical coverage will be adjusted to reflect any additional Dependents that are enrolled as of the effective date of coverage for the new Dependent.

DISCONTINUING COVERAGE

You may discontinue coverage for yourself or for 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 3.1.4, "QUALIFIED STATUS CHANGES" for more information.

1.1.5 HOW MUCH DOES COVERAGE COST?

You and the Company share the cost of your medical coverage. You pay your share of the cost through payroll deductions.

To help lower the cost to you, your contributions are deducted from your pay on a pre-tax basis, to the extent permitted by Internal Revenue Service (IRS) rules and state law. 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.

Paying contributions on a pre-tax basis will reduce the amount of your taxable compensation and, therefore, may decrease your Social Security benefits.

Your contributions for coverage are based on:

- The GE Medical Option you choose;
- Your Annual Pay (as defined in "KEY TERMS"), which is your Normal Straight-Time Annual Earnings (NSTAE), including your regular base pay. It also may include a portion of commissions and other variable pay;
- Your tobacco use status — see Section 1.1.6, "WHAT IF I AM A TOBACCO USER?";
- Whether your Spouse has coverage available, if employed (see Section 1.1.7, "WHAT IF MY SPOUSE'S EMPLOYER OFFERS COVERAGE?"); and
- The number of people you cover (see chart that follows).

COVERAGE CATEGORY	EXAMPLES
One Person	• Employee
Two Person	• Employee plus Spouse • Employee plus one child
Three or More	• Employee plus Spouse plus one or more children • Employee plus two or more children

If your pay changes, any change in contributions becomes effective on the date of the pay change.

Contribution rates are available prior to Annual Enrollment each year on **OneHR.ge.com** or by calling the GE Benefits Center at 1-800-252-5259. The contribution rates for 2016 (as well as the rates for 2017-2019) are described below.

WEEKLY CONTRIBUTIONS (2016)*

Annual Pay	1 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$14.45	$4.87	$0.00
$25,000-$37,499	$17.14	$7.55	$0.00
$37,500-$49,999	$18.75	$12.04	$0.54
$50,000-$74,999	$23.56	$16.85	$3.43
$75,000-$99,999	$29.44	$22.73	$7.40
$100,000-$149,999	$36.94	$30.23	$14.42
Greater than or equal to $150,000	$49.27	$42.56	$24.35

Annual Pay	2 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$28.91	$9.74	$0.48
$25,000-$37,499	$34.27	$15.11	$0.48
$37,500-$49,999	$37.48	$24.06	$1.05
$50,000-$74,999	$47.12	$33.70	$6.86
$75,000-$99,999	$58.91	$45.49	$14.82
$100,000-$149,999	$73.90	$60.48	$28.85
Greater than or equal to $150,000	$98.53	$85.11	$48.69

** Does not include any MANDATED BENEFITS AND TAXES as indicated on next page. Rates are for non-tobacco users. There is an annual surcharge of $625 ($11.98 weekly) added to rates for tobacco users.*

Annual Pay	3 or More Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$36.10	$12.13	$0.96
$25,000-$37,499	$42.84	$18.88	$0.96
$37,500-$49,999	$46.91	$30.13	$1.32
$50,000-$74,999	$58.91	$42.13	$8.59
$75,000-$99,999	$73.69	$56.91	$18.52
$100,000-$149,999	$92.32	$75.55	$36.06
Greater than or equal to $150,000	$123.16	$106.39	$60.86

WEEKLY CONTRIBUTIONS (2017)*

Annual Pay	1 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$16.48	$6.90	$2.03
$25,000-$37,499	$19.55	$9.96	$2.41
$37,500-$49,999	$21.39	$14.68	$3.18
$50,000-$74,999	$26.87	$20.16	$6.74
$75,000-$99,999	$33.58	$26.87	$11.54
$100,000-$149,999	$42.14	$35.43	$19.62
Greater than or equal to $150,000	$56.20	$49.49	$31.28

Annual Pay	2 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$32.98	$13.81	$4.55
$25,000-$37,499	$39.09	$19.93	$5.30
$37,500-$49,999	$42.75	$29.33	$6.32
$50,000-$74,999	$53.75	$40.33	$13.49
$75,000-$99,999	$67.19	$53.77	$23.10
$100,000-$149,999	$84.29	$70.87	$39.24
Greater than or equal to $150,000	$112.39	$98.97	$62.55

Annual Pay	3 or More Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$41.18	$17.21	$6.04
$25,000-$37,499	$48.87	$24.91	$6.99
$37,500-$49,999	$53.51	$36.73	$7.92
$50,000-$74,999	$67.19	$50.41	$16.87
$75,000-$99,999	$84.05	$67.27	$28.88
$100,000-$149,999	$105.30	$88.53	$49.04
Greater than or equal to $150,000	$140.48	$123.71	$78.18

** Does not include any MANDATED BENEFITS AND TAXES as indicated below. Rates are for non-tobacco users. There is an annual surcharge of $625 ($11.98 weekly) added to rates for tobacco users.*

WEEKLY CONTRIBUTIONS (2018)*

Annual Pay	1 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$18.77	$9.19	$4.32
$25,000-$37,499	$22.26	$12.67	$5.12
$37,500-$49,999	$24.36	$17.65	$6.15
$50,000-$74,999	$30.60	$23.89	$10.47
$75,000-$99,999	$38.24	$31.53	$16.20
$100,000-$149,999	$47.99	$41.28	$25.47
Greater than or equal to $150,000	$64.00	$57.29	$39.08

Annual Pay	2 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$37.55	$18.38	$9.12
$25,000-$37,499	$44.51	$25.35	$10.72
$37,500-$49,999	$48.68	$35.26	$12.25
$50,000-$74,999	$61.21	$47.79	$20.95
$75,000-$99,999	$76.51	$63.09	$32.42
$100,000-$149,999	$95.98	$82.56	$50.93
Greater than or equal to $150,000	$127.98	$114.56	$78.14

Annual Pay	3 or More Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$46.89	$22.92	$11.75
$25,000-$37,499	$55.65	$31.69	$13.77
$37,500-$49,999	$60.93	$44.15	$15.34
$50,000-$74,999	$76.51	$59.73	$26.19
$75,000-$99,999	$95.71	$78.93	$40.54
$100,000-$149,999	$119.91	$103.14	$63.65
Greater than or equal to $150,000	$159.97	$143.20	$97.67

** Does not include any MANDATED BENEFITS AND TAXES as indicated below. Rates are for non-tobacco users. There is an annual surcharge of $625 ($11.98 weekly) added to rates for tobacco users.*

WEEKLY CONTRIBUTIONS (2019)*

Annual Pay	1 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$21.34	$11.76	$6.89
$25,000-$37,499	$25.31	$15.72	$8.17
$37,500-$49,999	$27.70	$20.99	$9.49
$50,000-$74,999	$34.79	$28.08	$14.66
$75,000-$99,999	$43.48	$36.77	$21.44
$100,000-$149,999	$54.57	$47.86	$32.05
Greater than or equal to $150,000	$72.77	$66.06	$47.85

Annual Pay	2 Person Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$42.70	$23.53	$14.27
$25,000-$37,499	$50.61	$31.45	$16.82
$37,500-$49,999	$55.35	$41.93	$18.92
$50,000-$74,999	$69.60	$56.18	$29.34
$75,000-$99,999	$86.99	$73.57	$42.90
$100,000-$149,999	$109.13	$95.71	$64.08
Greater than or equal to $150,000	$145.52	$132.10	$95.68

Annual Pay	3 or More Contribution — Non-Tobacco User		
	Option 1	Option 2	Option 3
Less Than $25,000	$53.32	$29.35	$18.18
$25,000-$37,499	$63.28	$39.32	$21.40
$37,500-$49,999	$69.28	$52.50	$23.69
$50,000-$74,999	$86.99	$70.21	$36.67
$75,000-$99,999	$108.83	$92.05	$53.66
$100,000-$149,999	$136.34	$119.57	$80.08
Greater than or equal to $150,000	$181.89	$165.12	$119.59

** Does not include any MANDATED BENEFITS AND TAXES as indicated below. Rates are for non-tobacco users. There is an annual surcharge of $625 ($11.98 weekly) added to rates for tobacco users.*

MANDATED BENEFITS AND TAXES

If an applicable federal law mandates coverage or benefits in excess of what GE Medical provides, the Plan will provide the additional coverage or benefits. If you are impacted by such a law, your contributions may 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.

1.1.6 WHAT IF I AM A TOBACCO USER?

If you use tobacco, you will pay more for your coverage.

You will be required to state your tobacco use status each year when you make your Annual Enrollment elections. This applies to Employees only and not to Dependents. If you are a tobacco user, you can avoid the surcharge for the year by participating in a cessation program. Contact Health Coach from GE at 1-866-272-6007 and we'll help to connect you to one of the many resources available at no cost to help you quit. Additionally, if your personal physician determines that a tobacco cessation program or other resource to help you quit is not medically appropriate, we can accommodate your personal physician's recommendation with regard to medical appropriateness. If your physician's recommendation requires medical items or services to be furnished, those items or services will be subject to any cost-sharing requirements that would otherwise apply under the Plan.

1.1.7 WHAT IF MY SPOUSE'S EMPLOYER OFFERS COVERAGE?

If your Spouse is employed (other than by the Company) and has medical coverage available but declines that coverage, you will need to pay an additional contribution, above the normal rate to cover a Spouse, if you enroll him or her in GE Medical. The additional contribution amount is based on your Annual Pay. Rates may be found at **OneHR.ge.com** or by contacting the GE Benefits Center at 1-800-252-5259.

Employee's Annual Pay	Weekly Contribution Rates (Effective 1/1/2016)	Weekly Contribution Rates (Effective 1/1/2017)
Up to $24,999	$0	$0
$25,000 – $37,499	$10	$15
$37,500 – $49,999	$20	$25
$50,000 – $74,999	$30	$40
$75,000 – $99,999	$40	$50
$100,000 – $149,999	$50	$65
$150,000 or more	$50	$70

These contributions are in addition to the contributions displayed in the table in Section 1.1.5, "HOW MUCH DOES COVERAGE COST?"

You will be asked to certify periodically either that your working Spouse has coverage (and to provide information about that coverage) or that your Spouse's employer does not offer medical coverage to avoid the additional contribution requirement. If you do not respond, the additional contribution requirement is applied automatically by payroll deduction. Your additional contribution is subject to change on the effective date of any change in your pay or in your Spouse'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 or who are deemed by the Company to be "inactive" are not required to pay this additional contribution.

1.1.8 WHAT IF THERE IS OTHER COVERAGE?

GE Medical, 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 and Network payment provisions. In most cases, the Company 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 GE Medical. This is the same way your annual Out-of-Pocket Maximum (Annual Deductible and Co-insurance Maximum) is determined.

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

You will be required to provide information that the Claims Administrator needs to prevent duplication of benefits.

COORDINATION OF COVERAGE RULES

If you are covered by two or more plans, benefit payments follow the rules below in this order:

- GE Medical will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- When you have coverage under two or more medical plans and only one has coordination provisions, such as the GE Medical maintenance of benefits rule, the plan without coordination provisions will pay benefits first;
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a spouse, or dependent;
- If you are receiving COBRA continuation coverage under another employer plan, GE Medical will pay benefits first;
- Your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated; or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The Spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The Spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees;
- The plan that has covered the individual claimant the longest will pay first; and
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans. In such event, GE Medical will not pay more than it would have paid had it been the primary plan.

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 out-of-Network reimbursement levels, 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.
- 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 based on your Claims Administrator's policies and procedures.

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.

WHEN YOU OR YOUR DEPENDENT IS COVERED BY MEDICARE

If you as an active Employee, your Spouse, or other Dependent receives Social Security Disability Insurance benefits (SSDI) for 24 months or longer, GE Medical will remain the primary source of medical coverage. For individuals in treatment for End Stage Renal Disease (ESRD), GE Medical coverage will be primary, but only for the first 30 months, regardless of his or her age.

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

An individual who is a child of a covered Employee will be enrolled for coverage under GE Medical in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN) that, in either case, is determined by the Plan Administrator to meet the requirements for a QMCSO. A QMCSO is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. For more information about these orders or how to enroll a child in GE Medical pursuant to a QMCSO or NMSN please see *Your Benefits Handbook — Eligibility and Administrative Information* or contact the GE Benefits Center at 1-800-252-5259.

1.1.10 WHEN DOES COVERAGE END?

Subject to any right to purchase COBRA coverage (described below), your coverage under the Plan or GE Medical Option, as applicable, ends on the earliest of the following dates:

- The last day that you satisfy the applicable eligibility and participation requirements;
- The end of the period for which any required contributions have been paid;
- The effective date of an amendment to the Plan that terminates your coverage under a GE Medical Option or under the Plan as a whole, as applicable; 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 (in addition to the above):

- When your Dependent no longer meets eligibility requirements. See *Your Benefits Handbook — Eligibility and Administrative Information* for details; 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.

In cases of fraud, intentional misrepresentation, or underpayment of contributions, the Plan Administrator may retroactively terminate coverage and recover from you or a covered Dependent, at its option, the full value of any services and benefits provided during the period of ineligibility.

RETIREE COVERAGE

When you retire from active employment with the Company, you and your Dependents may be entitled to continue health care coverage under one of two Company plans:

- The GE Health Benefits for Production Retirees Plan, which provides benefits to certain eligible pre-65 retirees and eligible dependents.
- The GE Retiree Medical Plan, which provides benefits to certain eligible post-65 retirees and eligible dependents.

To be eligible for benefits under either plan, you and your dependents must meet the eligibility requirements described in the summary plan description for the plan. You can obtain a copy of the summary plan descriptions for the retiree plans by contacting the Plan Administrator. The Plan Administrator's contact information can be found in *Your Benefits Handbook — Eligibility and Administrative Information*, or by contacting the GE Benefits Center at 1-800-252-5259.

COBRA HEALTH COVERAGE

When GE Medical coverage 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). See *Your Benefits Handbook — Eligibility and Administrative Information* for details.

OTHER OPTIONS WHEN YOUR COVERAGE ENDS

If GE Medical coverage ends for any reason, you may purchase other health coverage alternatives that may be available to you, for example, through the health insurance marketplace.

WHAT IF...	
For information about how your medical coverage is affected by...	**Please refer to...**
Leave of absence	*Your Benefits Handbook — Vacation and Other Time Off*
Disability	*Your Benefits Handbook — Disability, Life and Other Benefits*
Your death	*Your Benefits Handbook — Disability, Life and Other Benefits*
Layoff, plant closing or office closing	*Your Benefits Handbook — Job Loss Benefits*, or see your human resources representative

1.1.11 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 (or less than 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 do not have to stay in the Hospital for the full federally mandated length if you and your doctor feel that it is not necessary. You should notify your Claims Administrator at the toll-free number on your medical ID card for a maternity stay beyond 48 or 96 hours, as applicable.

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 of the breast on which the mastectomy was performed;
- The cost of prostheses;
- Expenses for surgery and reconstruction of 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-insurance requirements apply with expenses paid at 80% in-Network and 60% out-of-Network, after the Annual Deductible is satisfied. Call your Claims Administrator for more information.

WHAT IS THE HEALTH INSURANCE MARKETPLACE (THE "MARKETPLACE")?

Also known as the "Exchange," the Marketplace is a new way to buy health insurance. It is designed to help you find health insurance that meets your needs. The Marketplace offers "one-stop shopping" to help you find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium for health insurance purchased through the Marketplace. Generally, all U.S. citizens and legal residents have access to individual health insurance policies through the Marketplace available in their state.

Because GE Medical meets the requirements for "minimum value" and is "affordable" as those terms are used under the Affordable Care Act ("ACA"), you will generally not be eligible for a federal subsidy through the Marketplace as long as you remain eligible for GE Medical as an Employee. However, if your coverage under GE Medical ends and you are eligible to purchase COBRA continued health coverage, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs by enrolling in coverage through the Marketplace instead of through COBRA.

Under the ACA, an employer-sponsored health plan meets the "minimum value" standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For 2016, a plan is considered "affordable" if the cost of employee only coverage under the lowest cost option is less than 9.66% of your household income for the year. This percentage is indexed annually and subject to change.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits health coverage discrimination and employment discrimination against employees based on their (or their family member's) 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, including participation in clinical research containing genetic services, by you or your family member(s); and
- The manifestation of a disease or disorder in an individual's family member.

The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by the Health Insurance Portability and Accountability Act (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 group on the basis of genetic information.

The Plan will not request or require you or any family member to undergo a genetic test. However, your Physician may request that you undergo a genetic test. The Plan may obtain and use the results of any genetic test to the extent required to make a determination regarding payment (e.g., where payment is made only for Medically Necessary treatment and the results of a genetic test are necessary to determine the medical necessity of the services provided). If you choose not to undergo genetic testing in such circumstances, the Plan may refuse to pay for items and services which require the results of a genetic test. 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 deductibles or cost-sharing in return for activities such as completing a health risk assessment that asks for family medical history or participating in a wellness program that requests genetic information);
- Computation of premiums or contributions (including discounts in return for activities such as completing a health risk assessment that asks for family medical history or participating in a wellness program that requests genetic information);
- 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 a determination of its medical appropriateness that 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. However, the Plan may collect genetic information when such information is obtained incidentally to the collection of other information concerning an individual, and such collection is not for underwriting purposes.

SUMMARY OF BENEFITS AND COVERAGE DOCUMENT

GE is required to provide a Summary of Benefits and Coverage (SBC) document to all active Employees eligible for medical coverage. You can find this document along with a glossary of terms at **ge.com/healthahead/healthcaredecisions** or by calling the GE Benefits Center at 1-800-252-5259. Upon request, a paper copy of the SBC materials will be provided free of charge. SBC materials may also be available in Spanish, Navajo, Tagalog, and Chinese.

NETWORK PROVISIONS

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 Claims Administrator, who manages these Networks, at the toll-free number listed on your medical ID card. If you participate in GE Medical, you can see a list of the Claims Administrators in *Your Benefits Handbook — Eligibility and Administrative Information*.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage you may be able to enroll yourself or your Dependents for coverage under GE Medical in the future, 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, adoption, or placement for adoption or **within 90 days** after the birth. Please refer to Section 3.1.4, "QUALIFIED STATUS CHANGES."

YOUR RIGHT TO PRIVACY

Federal and state law gives individuals broad protections over the privacy of their personal health information. In particular, regulations under the Health Insurance Portability and Accountability Act (HIPAA) 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. The Notice of Privacy Practices is available at **OneHR.ge.com** and in *Your Benefits Handbook — Eligibility and Administrative Information*. If you would like a paper copy, you may also contact the GE Benefits Center at 1-800-252-5259.

1.2 GE MEDICAL

1.2.1 HOW GE MEDICAL WORKS

GE Medical:

- Offers broad medical coverage, including:
  - Preventive screenings;
  - Doctor office visits;
  - Surgery, tests and other services;
  - Hospitalizations;
  - Prescription drugs;
  - Vision care; and
  - Behavioral health and substance abuse treatment.
- Allows you to choose your Provider (no referrals required). Generally, though, your costs will be lower if you use a Provider in the Claims Administrator's Network;
- Covers qualifying preventive screenings and services at 100% of the Allowable Amount when received from a Network Provider not subject to the Annual Deductible;
- Provides three coverage categories — One Person, Two Person, or Three-or-More coverage — so you can pick a coverage category appropriate for you and your family (Please refer to Section 1.1.5, "HOW MUCH DOES COVERAGE COST?";
- Allows you to choose from three Plan options that offer access to Savings Accounts to help you pay for Eligible Expenses including Co-insurance and Annual Deductibles; and
- Offers the benefit of health resources to help you take greater control over your and your family's health care decisions.

1.2.1.1 HOW DO I ACCESS NETWORK CARE?

The Claims Administrator or its affiliates arrange for health care Providers to participate in a Network. At your request, the Claims Administrator will send you a directory of Network Providers free of charge. Keep in mind, a Provider's Network status may change. To verify a Provider's status or to request a Provider directory, call the Claims Administrator at the toll-free number on your medical ID card or visit **OneHR.ge.com** or **ge.com/healthahead/healthcaredecisions** for online directories. Network Providers are independent practitioners and are not employees, agents, or representatives of GE or the Claims Administrator.

Coverage will also be provided at a Network level of benefits under the following circumstances, as determined by the Claims Administrator:

- 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; 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 (except for certain types of Durable Medical Equipment).

1.2.1.2 WHAT IF I GO OUT-OF-NETWORK?

When possible you should contact your Claims Administrator to inquire about the potentially greater cost of going to an out-of-Network Provider.

Generally, when you receive services from a Network Provider, you will pay less than you would if you receive the same care from an out-of-Network Provider. In most instances your out-of-pocket expenses will be less if you use a Network Provider.

When you go to an out-of-Network Provider (or when your care is otherwise considered to be "out-of-Network"), GE Medical covers most services at 60% of the Claims Administrator's Allowable Amount, after you meet an Annual Deductible. Once you meet an annual Out-of-Pocket Maximum, GE Medical pays 100% of the Claims Administrator's Allowable Amount.

The Claims Administrator determines out-of-Network Allowable Amounts. See the definitions of "Allowable Amount" and "Eligible Expense" in "KEY TERMS" at the end of this booklet for more information.

Please note that if you receive services, supplies or treatment from an out-of-Network Provider, you may be responsible for the charges exceeding the Allowable Amount, even if you have met your Annual Deductible and/or Out-of-Pocket Maximum. These charges are not accumulated toward your Annual Deductible or Out-of-Pocket Maximum.

Example: If an out-of-Network hospital charges $1,500 for an overnight stay and the Allowable Amount is $1,000, you would be responsible for the $500 difference and this $500 would not be applied to your Annual Deductible or Out-of-Pocket Maximum. If your Annual Deductible was met prior to the service, GE Medical would pay $600 (60% of $1,000). You would be responsible for $400 (40% of the Allowable Amount) in addition to the $500 difference between the charge for the service and the Allowable Amount.

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

- You should notify your Claims Administrator in advance for care in a Hospital, special facility or other program;
- You may also need to file claim forms (including an itemized bill, copies of your receipts and any other necessary documentation) for reimbursement of covered out-of-Network expenses; and
- You will be responsible for charges that exceed the Allowable Amount, which could be significant. Be sure to discuss your financial responsibility with the Provider.

1.2.1.3 WHAT ARE ELIGIBLE EXPENSES?

Eligible Expenses are determined according to the chart in Section 1.5, "PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016," and subject to all of the GE Medical Plan terms. For certain Eligible Expenses, GE Medical will not pay these expenses until you have met your Annual Deductible.

GE has delegated to the Claims Administrator the discretion and authority to decide whether a service, supply or treatment is an Eligible Expense and how the Eligible Expense will be determined and otherwise covered under GE Medical. In certain circumstances, for purposes of overall cost savings or efficiency, the Claims Administrator may, in its discretion, offer benefits for a service, supply or treatment that would not otherwise be an Eligible Expense. The fact that the Claims Administrator does so in any particular circumstance shall not in any way be deemed to require that GE Medical do so in the future or in other similar circumstances.

You are responsible for any service, supply or treatment that is not an Eligible Expense. Amounts you pay for such items do not count toward your Annual Deductible or Out-of-Pocket Maximum.

1.2.1.4 TIMELY CLAIMS FILING

All claims for Eligible Expenses incurred in a calendar year must be submitted by June 30 of the next following calendar year, unless you can show that it was not reasonably possible to do so.

1.2.1.5 PRIOR AUTHORIZATION

You are not required to obtain pre-authorization for treatment. However, in certain cases (e.g., infertility treatment) it is recommended to consult with your Claims Administrator to ensure that the Medically Necessary requirement is met (sometimes called "medical necessity") and that services are covered. Note that in-Network Providers may need to obtain pre-authorization based on their contract with the Claims Administrator(s). Please contact your Claims Administrator with any questions.

1.2.1.6 WHAT IS THE ANNUAL DEDUCTIBLE?

The Annual Deductible is the amount of Eligible Expenses for services received, both in-Network and out-of-Network, that you must pay each calendar year ***before the Plan will begin paying benefits for most services*** in that calendar year. Even if you are covering more than one person under GE Medical, there is one Annual Deductible that applies to all participants enrolled in the applicable GE Medical Option. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. The Annual Deductible resets every calendar year; there is no carryover.

The Annual Deductible applies to Allowable Amounts for most Eligible Expenses related to medical, behavioral and prescription drug services or items. If you are enrolled in GE Medical Option 1 or Option 2, the HRA Credits in your HRA can be used toward satisfaction of the Annual Deductible. If you are enrolled in GE Medical Option 3, any amounts in your HSA can be used toward satisfaction of the Annual Deductible.

Your Annual Deductible amount is based on the GE Medical option you select and your coverage category.

Current Annual Deductible amounts are available on **www.ge.com/healthahead/healthcaredecisions** or by calling the GE Benefits Center at 1-800-252-5259. Please see Section 1.2.1.10, "ANNUAL DEDUCTIBLES, CO-INSURANCE MAXIMUMS AND OUT-OF-POCKET MAXIMUMS" for the Annual Deductibles.

1.2.1.7 WHAT IS CO-INSURANCE AND THE CO-INSURANCE MAXIMUM?

Co-insurance is a fixed percentage of the Allowable Amount that you are required to pay up to the Co-insurance Maximum, for certain Eligible Expenses after you meet the Annual Deductible.

Let us assume that you receive care for outpatient surgery from a Network Provider. Since GE Medical pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your in-Network Co-insurance. Out-of-Network Co-insurance for most services is 40%. The Co-insurance you pay on Allowable Amounts for Eligible Expenses received both in- and out-of-Network are applied to your Co-insurance Maximum.

The Co-insurance Maximum applies to Allowable Amounts for most Eligible Expenses related to medical, behavioral and prescription drug services or items. Your Co-insurance Maximum amount is based on your plan option, the coverage category you select and 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 are absent on October 31, your Co-insurance Maximum is based on your Annual Pay when you were last at work.

Current Annual Deductible and Co-insurance Maximum amounts are available on **www.ge.com/healthahead/healthcaredecisions** or by calling the GE Benefits Center at 1-800-252-5259. Please see Section 1.2.1.10, "ANNUAL DEDUCTIBLES, CO-INSURANCE MAXIMUMS AND OUT-OF-POCKET MAXIMUMS" for the Co-Insurance Maximums.

1.2.1.8 WHAT IS THE OUT-OF-POCKET MAXIMUM (ANNUAL DEDUCTIBLE PLUS CO-INSURANCE MAXIMUM)?

The annual Out-of-Pocket Maximum, which is the sum of your Annual Deductible and your Co-insurance Maximum, is the most you pay each calendar year for Eligible Expenses that are received either in or out-of-Network. If your eligible out-of-pocket expenses in a calendar year exceed the Out-of-Pocket Maximum, GE Medical pays 100% of the Allowable Amount of Eligible Expenses through the end of the calendar year. The Out-of-Pocket Maximum includes Allowable Amounts for Eligible Expenses related to medical, behavioral and prescription drug services or items.

Your Out-of-Pocket Maximum amount is based on your plan option, the coverage category you select and 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 are absent on October 31, your Out-of-Pocket Maximum is based on your Annual Pay when you were last at work.

As of January 1, 2016, no individual family member will pay more out-of-pocket than $6,850 (Options 1 & 2), $6,550 (Option 3) or the combined family Out-of-Pocket Maximum for the plan option in which they are enrolled, whichever is less. These limits (i.e., $6,850 and $6,550) are subject to change each year. Once the combined family Out-of-Pocket Maximum is met, GE Medical will pay 100% of Eligible Expenses for the remainder of the year (including for a family member who has not met the individual Out-of-Pocket Maximum).

Please see Section 1.2.1.10, "ANNUAL DEDUCTIBLES, CO-INSURANCE MAXIMUMS AND OUT-OF-POCKET MAXIMUMS" for the Out-of-Pocket Maximums.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

PLAN FEATURES	APPLIES TO THE OUT-OF-POCKET MAXIMUM?
Prescription drug Annual Deductible, co-pay, or Co-insurance as covered by GE's Prescription Drug benefits	Yes
Annual Deductible	Yes
Co-insurance Payments	Yes
Charges for non-Eligible Expenses	No
Charges that exceed Eligible Expenses • Plan limits • Brand and generic drug difference	No
Charges that exceed Allowable Amounts	No

1.2.1.9 HOW DO DEDUCTIBLES AND CO-INSURANCE MAXIMUMS WORK FOR MID-YEAR ENROLLMENTS AND STATUS CHANGES?

If you are hired during the calendar year and enroll in GE Medical, you must meet the entire Annual Deductible and Co-insurance Maximum. Proration does not apply. If you enroll in Option 1 or 2, see Section 1.3.3, "HOW DO HRA CREDITS WORK FOR MID-YEAR ENROLLMENTS?" and Section 1.3.4, "WHAT ABOUT HRA CREDITS FOR MID-YEAR STATUS CHANGES?" to see how HRA Credits work for mid-year enrollments and status changes.

If you experience a mid-year qualified status change resulting in an allowable change to your coverage category, your Annual Deductible and Co-insurance Maximum may be adjusted. If you increase your coverage category (e.g., you change from One Person to Two Person coverage) your Annual Deductible and Co-insurance Maximum may be adjusted to your new coverage category for that calendar year minus any amounts already used in that calendar year. Any services rendered prior to the date of the qualified status change apply toward the Annual Deductible and Co-insurance Maximum amounts in effect on the date of service.

MID-YEAR CHANGES FOR NEWLY ELIGIBLE CHILDREN

If you are enrolled in Option 1 or 2 and add a Dependent child to your medical plan during the calendar year due to birth, adoption, placement for adoption or marriage, and the child was not previously eligible for coverage in that calendar year, your Annual Deductible, Co-insurance Maximum and HRA Credits will not change until the next calendar year. Your payroll contributions for coverage will increase accordingly.

If you decrease your coverage category (e.g., you change from Two Person to One Person coverage), your Annual Deductible is adjusted to the Annual Deductible and Co-insurance Maximum amount for the new coverage category for that calendar year less any amounts accumulated already in that calendar year.

If your coverage category changes mid-year, whether that change is a result of an increase or decrease in the number of Dependents covered, amounts accumulated under the previous coverage category's Annual Deductible and Co-insurance Maximum will count toward the new Annual Deductible and Co-insurance Maximum, up to the new amount.

If a covered individual begins coverage under COBRA, that individual's accumulated Annual Deductible and Co-insurance Maximum dollars will be transferred to his or her coverage under COBRA and deducted from the covered individual's remaining Annual Deductible and Co-insurance Maximum. If the COBRA participant moves to active coverage again, any amounts previously accumulated toward the Annual Deductible and Co-insurance Maximum in that year are forfeited. If your Claims Administrator changes at any time during the year, you should provide your new Claims Administrator with a recent Explanation of Benefits Form (EOB) to ensure that your Annual Deductible and Co-insurance Maximum accumulators are updated.

1.2.1.10 ANNUAL DEDUCTIBLES, CO-INSURANCE MAXIMUMS AND OUT-OF-POCKET MAXIMUMS

The current annual deductibles, co-insurance maximums, and out-of-pocket maximums are as described below.

Annual Pay	1 Person Deductible			1 Person Co-insurance Max			1 Person OOP Max		
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Less Than $25,000	$800	$1,200	$1,600	$450	$1,450	$1,950	$1,250	$2,650	$3,550
$25,000-$37,499	$800	$1,200	$1,600	$450	$1,450	$1,950	$1,250	$2,650	$3,550
$37,500-$49,999	$800	$1,200	$1,600	$950	$1,450	$1,950	$1,750	$2,650	$3,550
$50,000-$74,999	$800	$1,200	$1,600	$1,250	$1,750	$2,250	$2,050	$2,950	$3,850
$75,000-$99,999	$800	$1,200	$1,600	$1,750	$2,250	$2,750	$2,550	$3,450	$4,350
$100,000-$149,999	$800	$1,200	$1,600	$2,500	$3,000	$3,500	$3,300	$4,200	$5,100
Greater than or equal to $150,000	$800	$1,200	$1,600	$2,500	$3,000	$3,500	$3,300	$4,200	$5,100

Annual Pay	2 Person Deductible			2 Person Co-insurance Max			2 Person OOP Max		
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Less Than $25,000	$1,600	$2,400	$3,200	$675	$2,175	$2,925	$2,275	$4,575	$6,125
$25,000-$37,499	$1,600	$2,400	$3,200	$675	$2,175	$2,925	$2,275	$4,575	$6,125
$37,500-$49,999	$1,600	$2,400	$3,200	$1,425	$2,175	$2,925	$3,025	$4,575	$6,125
$50,000-$74,999	$1,600	$2,400	$3,200	$1,875	$2,625	$3,375	$3,475	$5,025	$6,575*
$75,000-$99,999	$1,600	$2,400	$3,200	$2,625	$3,375	$4,125	$4,225	$5,775	$7,325*
$100,000-$149,999	$1,600	$2,400	$3,200	$3,750	$4,500	$5,250	$5,350	$6,900*	$8,450*
Greater than or equal to $150,000	$1,600	$2,400	$3,200	$3,750	$4,500	$5,250	$5,350	$6,900*	$8,450*

Annual Pay	3 or More Deductible			3 or More Co-insurance Max			3 or More OOP Max		
	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3	Option 1	Option 2	Option 3
Less Than $25,000	$2,000	$3,000	$4,000	$900	$2,900	$3,900	$2,900	$5,900	$7,900*
$25,000-$37,499	$2,000	$3,000	$4,000	$900	$2,900	$3,900	$2,900	$5,900	$7,900*
$37,500-$49,999	$2,000	$3,000	$4,000	$1,900	$2,900	$3,900	$3,900	$5,900	$7,900*
$50,000-$74,999	$2,000	$3,000	$4,000	$2,500	$3,500	$4,500	$4,500	$6,500	$8,500*
$75,000-$99,999	$2,000	$3,000	$4,000	$3,500	$4,500	$5,500	$5,500	$7,500*	$9,500*
$100,000-$149,999	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$7,000*	$9,000*	$11,000*
Greater than or equal to $150,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$7,000*	$9,000*	$11,000*

** In accordance with new requirements under the Affordable Care Act (ACA), in 2016 no individual family member can pay more out-of-pocket than $6,850 (Options 1 & 2), $6,550 (Option 3) or the combined family out-of-pocket maximum for the Plan option in which they are enrolled, whichever is less. Once the combined family out-of-pocket maximum is met, the Plan will pay 100% of eligible expenses for the remainder of the year (including for a family member who has not met the individual out-of-pocket maximum).*

1.2.1.11 WHAT IF I NEED EMERGENCY CARE?

Treatment received as the result of an Emergency will be paid at an in-Network level even if you receive services at an out-of-Network facility. If you are admitted to the Hospital in an Emergency, you should call the Claims Administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances). See Section 1.6.13, "EMERGENCY HEALTH SERVICES" for more information.

1.2.1.12 WHAT IF I NEED CARE WHILE AWAY FROM HOME?

If you are vacationing or temporarily living outside the Network service area, you still may receive Network-level benefits for urgent, Medically Necessary treatment, including for prescription drugs. This also applies to students living away at school and to individuals traveling or on short work assignments outside the United States. Before obtaining urgent medical services out of your area, you should call the Claims Administrator for approval. Health Coach from GE or your Claims Administrator also may help you find a local doctor in the national Network and assist you in filing a claim for reimbursement at the Network level.

1.3 HOW THE HEALTH REIMBURSEMENT ACCOUNT (HRA) WORKS

An HRA is a tax-free account established by the Company to help you pay for most eligible health care expenses, except for dental or vision expenses. If you enroll in Option 1 or Option 2, GE will open your HRA automatically. The HRA is not available with Option 3.

The full amount of your HRA Credits will be available on January 1 of each plan year. You can use this money right away to reduce your medical expenses.

1.3.1 HRA CREDITS

Under GE Medical Option 1 and Option 2, the Company allocates a specified amount of HRA Credits into an HRA each calendar year in your name. The amount of HRA Credits allocated to your HRA annually is determined by GE and depends on your coverage category (One Person, Two Person or Three or More coverage) and not the number of individuals in your family. You are not permitted to make any contribution to your HRA, and your HRA does not accrue interest.

Options 1 and 2 annual HRA amounts:		
$600 for One Person coverage each year	**$900** for Two Person coverage each year	**$1,200** for Three or More coverage each year

Your HRA Credits may be used only for Eligible Expenses, except for dental or vision expenses. As long as you remain enrolled in Option 1 or 2, any remaining HRA Credits can be rolled over from year to year, with no limit to the amount you can roll over.

If your Option 1 or 2 coverage terminates for any reason other than retirement, your HRA Credits will be forfeited and the HRA Credits in your HRA will revert back to the Company, unless you elect COBRA health coverage. If you elect COBRA health coverage for Option 1 or 2, any HRA Credits remaining at the time employment terminates can be used to assist you in paying your medical expenses while COBRA health coverage is in effect. Please note that Dependents on COBRA may have the amount of their HRA Credits pro-rated and removed from family accrual. Any HRA Credits remaining at the time that COBRA coverage terminates will be forfeited when COBRA coverage ends, even if the COBRA participant re-enrolls in the plan.

If you retire directly from GE and are eligible for the GE Medical for Retirees Plan or a Retiree Reimbursement Account under the GE Retiree Medical Plan, your HRA Credits might transfer to those plans and remain available to you, subject to the terms of those plans.

ADMINISTRATIVE INFORMATION

The HRA is intended to qualify as an employer-provided medical reimbursement plan under Internal Revenue Code Section 105 and shall be interpreted in a manner that will accomplish that objective. Eligible Expenses reimbursed hereunder are intended to be eligible for exclusion from participants' gross income under Internal Revenue Code Section 105(b).

If you receive a reimbursement that is later determined to be a non-Eligible Expense, you are responsible to repay and hold harmless the Company for any liability the Company may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

The provisions described in the Administrative Information section of *Your Benefits Handbook — Eligibility and Administrative Information* apply to the HRA.

All claims must be submitted to the HRA administrator and substantiated on or before June 30 of the following year. Substantiation means providing proof that the service or supply was an Eligible Expense. In some cases, such as prescription drug claims paid using your savings account card, substantiation will occur automatically. **IRS regulations require substantiation of HRA funds.** At the discretion of the HRA Administrator, failure to do so will result in recoupment of unsubstantiated amounts, offsetting future claims, disabling of your savings account card, and/or imputation of income for unrecovered amounts.

1.3.2 HOW DO I USE THE HRA CREDITS?

When you receive services, you can use your HRA Credits to pay for Eligible Expenses related to medical, behavioral health, and pharmacy services and items (not vision or dental). For a list of Eligible Expenses, please call Health Coach from GE at 1-866-272-6007.

Because the HRA is governed by IRS rules, all HRA usage is subject to review and verification. Verification is proof that an expense is an Eligible Expense. You should keep documentation of reimbursed Eligible Expenses for future reference because you may be asked to submit it for verification. Documentation should contain:

- Patient name;
- Date of service/purchase;
- Amount paid for service;
- Provider (vendor) name; and
- Type of service.

Your Explanation of Benefits (EOB) is the best source of verification.

If you do not adequately verify HRA usage, the HRA administrator may:

- Request return of any reimbursements made;
- Offset future HRA-eligible expenses; and/or
- Treat any unsubstantiated expenses as taxable income.

If you do not satisfy your repayment obligation, your HRA may be suspended or terminated.

Note that Eligible Expenses reimbursed through the HRA cannot also be reimbursed through the FSA. Please also see Section 1.3.6, "HOW DOES A HEALTH CARE FSA WORK WITH THE HRA?"

TO PAY FOR HRA-ELIGIBLE PHARMACY EXPENSES

You will receive a GE Pharmacy Card from the HRA administrator. This card is a combined Pharmacy ID and HRA debit card. (If you also have a FSA, see Section 1.3.6, "HOW DOES A HEALTH CARE FSA WORK WITH THE HRA?") You can use this GE Pharmacy Card to pay for HRA-eligible pharmacy expenses at a Network pharmacy or through mail order.

In most cases, you will not have to submit verification.

TO PAY FOR HRA-ELIGIBLE MEDICAL AND BEHAVIORAL HEALTH EXPENSES

If you are in Option 1 or 2, you can choose between two methods to pay your HRA-eligible medical and behavioral health expenses using your HRA: Automatic Reimbursement or Manage Your Claims Online:

1. **Automatic Reimbursement.** After your claim has been processed by your Claims Administrator, the amount you need to pay your Provider will be automatically sent to you by direct deposit or check from your available HRA Credits. If you use this method, you generally will not have to submit a verification or a claim form. If you go to an out-of-Network Provider, you may have to submit verification to be reimbursed.
2. **Manage Your Claims Online.** After your claim has been processed by your Claims Administrator, you can use the HRA administrator's online portal to have payment sent to your Provider or reimburse yourself. If you use this method you, you generally will not have to submit verification or a claim form. If you go to an out-of-Network Provider, you may have to submit verification to be reimbursed.

NOTE: If you take no action during Annual Enrollment, you will remain in your current HRA-payment method. New hires will be enrolled in Automatic Reimbursement. You may change your reimbursement method at any time by calling WageWorks at 1-888-303-3006 or visiting your WageWorks portal at **www.wageworks.com/ge**.

TO PAY CLAIMS MANUALLY

You can always manually submit a medical claim form electronically through the HRA administrator's online portal. You can also print a claim form and fax or mail it. When submitting a claim form, you will have to send in verification. Please contact the HRA administrator if you have questions.

CLAIMS FILING DEADLINE

All claims for eligible HRA expenses incurred in a calendar year must be submitted for reimbursement by **June 30** of the next following calendar year.

1.3.3 HOW DO HRA CREDITS WORK FOR MID-YEAR ENROLLMENTS?

If you are hired during the calendar year and enroll in GE Medical Option 1 or Option 2, the Company will allocate a pro-rated amount of HRA Credits to your HRA. For example, if you enroll between January 1 through June 30 you will receive 100% of the HRA Credits for that year; if you enroll between July 1 through December 31 you will receive 50% of the HRA Credits for that year. HRA Credits will typically be available within two weeks of your enrollment.

1.3.4 WHAT ABOUT HRA CREDITS FOR MID-YEAR STATUS CHANGES?

If you experience a mid-year qualified status change resulting in an allowable change to your coverage category, your HRA Credits may be adjusted.

If you increase your coverage category (e.g., you change from One Person to Two Person coverage) your HRA Credits may be adjusted to your new coverage category for that calendar year minus any amounts already used in that calendar year. HRA Credits will be pro-rated, as described in Section 1.3.3, "HOW DO HRA CREDITS WORK FOR MID-YEAR ENROLLMENTS?" for new enrollments.

MID-YEAR CHANGES FOR NEWLY ELIGIBLE CHILDREN

If you are enrolled in Option 1 or 2 and add a Dependent child due to a birth, adoption or marriage to your medical plan in the middle of a calendar year, and the child was not previously eligible for coverage in that calendar year, your HRA Credit will not change until the next calendar year.

Any increase in your HRA credits can be used for services rendered before the date of the status change, as long as the expense is incurred in the same plan year as the increase. Any HRA Credits that had rolled over from previous calendar years will remain in your HRA.

If you decrease your coverage category (e.g., you change from Two Person to One Person coverage), your HRA Credits are not adjusted to your new coverage category for that calendar year. Any HRA Credits that had rolled over from previous calendar years will remain in your HRA.

1.3.5 WHEN YOUR SPOUSE IS ALSO A COMPANY EMPLOYEE

When your Spouse is also a Company Employee and:

- One of you is covered as a Dependent of the other; and
- The Dependent's wage band becomes the higher wage band (see Section 1.1.2, "IF YOUR SPOUSE IS A COMPANY EMPLOYEE") then at the Annual Enrollment following the wage band change noted above, the Dependent shall become the "Company Employee" and the previous Company Employee shall become the Dependent.

If you meet the above criteria, the HRA administrator will determine your HRA balance as of June 30 of the following plan year and will combine any remaining balance with the HRA credit/balance associated with the new account. This account reconciliation will be performed annually due to IRS regulations. Timely claims filing guidelines apply.

1.3.6 HOW DOES A HEALTH CARE FSA WORK WITH THE HRA?

If you elect to open a Health Care FSA, funds will be made available to you on the same GE Pharmacy Card as your HRA. When you pay for eligible expenses, funds will be drawn from any available balance in your FSA first, then your HRA. See Section 3.0, "FLEXIBLE SPENDING ACCOUNT (FSA)/LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA)."

1.4 HOW THE HEALTH SAVINGS ACCOUNT (HSA) WORKS

An HSA is a personal trust or custodial account that you can establish and use for reimbursement of IRS-qualified expenses incurred by you and your Dependents, as permitted by Section 223 of the Internal Revenue Code. If you enroll in GE Medical Option 3, you may choose to establish an HSA with a partner bank of your Claims Administrator or through the financial institution of your choice.

If you open an HSA with your Claims Administrator's partner bank, you can contribute through regular payroll deductions on a pre-tax basis through **OneHR.ge.com** or by calling the GE Benefits Center at 1-800-252-5259. This means you will immediately see the tax benefit in your paycheck. If you open an HSA on your own, you will need to make your own contributions directly. You will get the tax benefit of your HSA contributions when you file your income tax return the following year, similar to how the tax benefit of an IRA works.

An HSA will be subject to the terms and conditions of an agreement between you and your custodian or trustee. The HSA is not an employee benefit plan sponsored or maintained by the Company and is not subject to ERISA. The Company's role with respect to the HSA is limited to facilitating payroll deductions of your contributions if you establish an HSA with the Claims Administrator's partner bank. The Company has no authority or control over the funds deposited in your HSA. However, for administrative convenience, a general description of HSAs is provided in this section.

1.4.1 WHO IS ELIGIBLE AND HOW TO ENROLL

Under Internal Revenue Service (IRS) rules, you must be covered under an IRS qualified "high deductible health plan" in order to open an HSA. GE Medical Option 3 is intended to meet this requirement. In addition, you must ***not***:

- Be covered by any health plan considered non-qualified by the IRS. This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS;
- Participate in a regular health care FSA. Please note that this includes participation by your Spouse in a regular health care FSA through his or her own employer. However, you may participate in a Limited Purpose Flexible Spending Account (LPFSA) as described in Section 1.4.6, "HOW DOES A LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA) WORK WITH THE HSA?";
- Be entitled to benefits under Medicare (i.e., enrolled in Medicare);
- Have received VA medical benefits or services in the preceding three-month period;
- Be receiving benefits under TRICARE (unless you are receiving TRICARE as a veteran with a disability rating from the Department of Veterans Affairs); and
- Be claimed as a Dependent on another person's tax return.

Visit **www.irs.gov** for more information.

1.4.2 HSA REQUIREMENTS

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in an HSA until the earlier of either the date on which you file taxes for that year, or the date on which your contributions reach the contribution maximum. Note that if you become ineligible to contribute to an HSA, for example because coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS Web site at **www.irs.gov**, or call the GE Benefits Center at 1-800-252-5259.

If you enroll in your HSA within the year (not on January 1), you will still be allowed to contribute the maximum amount set by federal regulations if you remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment. Otherwise, you may contribute only a pro-rated amount or any contribution in excess of the pro-rated amount will be subject to tax and an additional excise tax.

Please Note — Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15 of the following year.

1.4.3 REIMBURSABLE EXPENSES

The funds in your HSA will be available to help you pay expenses such as:

- Your or your eligible Dependents' out-of-pocket costs for medical, dental, and vision services and items under GE Medical, including Annual Deductibles, co-payments and Co-insurance;
- Medical care that is not covered under the medical plan, but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time; and
- Medicare premiums.

Such expenses are "qualified health expenses", as long as they are incurred by you and your eligible Dependents, meaning your Spouse and any other family members whom you are allowed to file as Dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time. HSA funds used for such purposes are not subject to income or excise taxes. A complete description of, and a definitive and current list of what constitutes IRS-qualified health expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS Web site.

If you choose not to use your HSA funds to pay for any expenses that are eligible for reimbursement from the HSA, you will still be required to pay the Provider for services.

1.4.4 USING THE HSA FOR NON-QUALIFIED EXPENSES

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one that is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and an additional excise tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance (except Medicare premiums) without incurring a tax.

1.4.5 ROLLOVER FEATURE AND FEES

If you do not use all of the funds in your HSA during the calendar year, the balance will remain in your HSA and will roll over to the next calendar year. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA health coverage.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so **within 60 days** from the date that HSA funds are distributed to you to avoid paying taxes on the funds.

You may incur banking fees, similar to those you would pay for a typical checking account. Also, there may be additional fees if you withdraw money from an ATM using a debit card provided by your HSA financial institution.

If you change partner banks there may be account or transfer fees.

1.4.6 HOW DOES A LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA) WORK WITH THE HSA?

A Limited Purpose Flexible Spending Account (LPFSA) lets you set aside a portion of your earnings on a pre-tax basis to pay for eligible dental and vision expenses in addition to the money you put in your HSA. **You cannot use your LPSA for any medical, pharmacy or behavioral health expenses. However, you may also use funds in your HSA to pay for dental or vision expenses, that have not already been reimbursed through your LPFSA.**

At year end, any remaining HSA balances will automatically carry over to the following calendar year; however, restrictions apply to limit carryovers of LPFSA balances. See Section 3.0, "FLEXIBLE SPENDING ACCOUNT (FSA)/LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA)."

1.5 PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016

This table provides an overview of coverage levels under GE Medical. See also Section 1.6, "ADDITIONAL COVERAGE DETAILS," for a further description of benefits. **Please note that Eligible Expenses are paid up to Allowable Amounts.**

Eligible Expenses	Network Coverage	Out-of-Network Coverage
Acupuncture Services	80%, after your Annual Deductible	60%, after your Annual Deductible
Ambulance Service (including air ambulance) — Local Licensed Professional; When Medically Necessary, as determined by the Claims Administrator, to transport the patient to the nearest Hospital where appropriate treatment is available. If deemed not Medically Necessary by the Claims Administrator, will be denied in full.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.
Autism Spectrum Disorder Services	80%, after your Annual Deductible	60%, after your Annual Deductible
Behavioral Health and Substance Abuse Treatment		
• Inpatient and Intermediate, including halfway house	80%, after your Annual Deductible	60%, after your Annual Deductible
• Outpatient	80%, after your Annual Deductible	60%, after your Annual Deductible

Eligible Expenses	Network Coverage	Out-of-Network Coverage
Centers of Excellence as designated by GE	Certain services may be covered at the following enhanced benefit level: If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible. Travel and lodging reimbursement, up to a defined maximum, may be available to those who qualify.	Not covered
Chiropractic Care/Spinal Treatment — up to 15 Visits per calendar year	80%, after your Annual Deductible	60%, after your Annual Deductible
Christian Science Practitioners' Services	80%, after your Annual Deductible	60%, after your Annual Deductible
Clinical Trials	If you are enrolled in Option 1 or 2, Benefits provided under the terms of the Clinical Trial are covered at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	If you are enrolled in Option 1 or 2, benefits provided under the terms of the Clinical Trial are covered at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.
Corrective Prescription Lenses — Used to Treat a Medical Condition	80%, after your Annual Deductible	60%, after your Annual Deductible
Dental Services — Accidental and Certain Other Conditions	80%, after your Annual Deductible	60%, after your Annual Deductible
Diabetes Services		
• Diabetes Self-Management and Training/Diabetic Eye Examinations/ Foot Care	80%, after your Annual Deductible	60%, after your Annual Deductible
• Insulin pump and related supplies	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	60%, after your Annual Deductible
• Continuous glucose monitor and related supplies	80%, after your Annual Deductible	60%, after your Annual Deductible
• All other diabetic supplies	Diabetes supplies (including but not limited to insulin) and glucose monitors (excluding continuous glucose monitors), and in some cases, insulin pump supplies may also be covered under GE's Prescription Drug benefits. See Section 2.0, "PRESCRIPTION DRUG BENEFITS" for general coverage information.	Not covered
Durable Medical Equipment (DME)	80%, after your Annual Deductible	60%, after your Annual Deductible

Eligible Expenses	Network Coverage	Out-of-Network Coverage
Emergency Health Services		
• If your condition qualifies as an Emergency. See "Key Terms" at the end of this handbook for the definition.	80%, after your Annual Deductible	80%, after your Annual Deductible
• If the Claims Administrator determines that your condition does not qualify as an Emergency.	60%, after your Annual Deductible	60%, after your Annual Deductible
Foot Care (when needed for severe systemic disease)	80%, after your Annual Deductible	60%, after your Annual Deductible
Gender Re-assignment (one per lifetime)	80%, after your Annual Deductible	60%, after your Annual Deductible
Hearing Care		
• Hearing Aids (including hearing aid exams). Hearing aids must be Medically Necessary and Cost Effective. Two (one per ear) every three years. Fittings, repairs and adjustments as needed.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	100%, after your Annual Deductible
• Cochlear Implant Surgery	80%, after your Annual Deductible	60%, after your Annual Deductible
Home Health Care	80%, after your Annual Deductible	60%, after your Annual Deductible
Hospice Care	If you are enrolled in Options 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	If you are enrolled in Options 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.
Hospital-Inpatient Stay	80%, after your Annual Deductible	60%, after your Annual Deductible
Infertility Services (Assisted Reproductive Services) • Includes Reverse sterilization • Limited to $15,000 per person, per lifetime, medical and pharmacy combined	80%, after your Annual Deductible	Not covered
Injections in a Physician's Office or Outpatient Facility	80%, after your Annual Deductible	60%, after your Annual Deductible
Lab, X-Ray, Diagnostics and High-End Radiology — Outpatient	80%, after your Annual Deductible	60%, after your Annual Deductible
Nutritional Counseling	80%, after your Annual Deductible	60%, after your Annual Deductible
Obesity Surgery — Limited to one procedure per lifetime (whether or not provided in a Center of Excellence).		
• Physician's Services	80%, after your Annual Deductible	Not covered
• Hospital (non-Centers of Excellence) — Inpatient Stay	80%, after your Annual Deductible	Not covered

Eligible Expenses	Network Coverage	Out-of-Network Coverage
• Obesity Surgery Centers of Excellence – Travel and lodging expense guidelines apply when using a Center of Excellence. Prior authorization is recommended. Coverage is limited to $2,000 maximum per covered individual. Maximum includes companion cost. $50 per day for companion while patient is hospitalized, $100 per day for companion and patient when patient is not hospitalized. – See Section 1.6.24, "OBESITY SURGERY" for details on follow-up care at a Center of Excellence.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	Not covered
Orthotics	80%, after your Annual Deductible	60%, after your Annual Deductible
Ostomy Supplies	80%, after your Annual Deductible	60%, after your Annual Deductible
Physician's Services	80%, after your Annual Deductible	60%, after your Annual Deductible
Pregnancy — Maternity Services		
• Physician's Services (except pre-natal office visits, including home delivery)	80%, after your Annual Deductible	60%, after your Annual Deductible
• Hospital — Inpatient Stay	80%, after your Annual Deductible	60%, after your Annual Deductible
• Pre-natal Office Visits	100%, not subject to the Annual Deductible	Not covered
Preventive Screenings and Services (based on Section 1.6.29, "PREVENTIVE SCREENINGS AND SERVICES")		
• Related Physician's Office Services (including routine gynecological care)	100%, not subject to the Annual Deductible	Not covered
• Related Lab or Other Preventive Tests	100%, not subject to the Annual Deductible	Not covered
Prosthetic Devices	80%, after your Annual Deductible	60%, after your Annual Deductible
Reconstructive Procedures	80%, after your Annual Deductible	60%, after your Annual Deductible
Rehabilitation Services — Outpatient Therapy	80%, after your Annual Deductible	60%, after your Annual Deductible
Scopic Procedures — Outpatient Diagnostic and Therapeutic	80%, after your Annual Deductible	60%, after your Annual Deductible
Second Opinions		
• Company sponsored Cleveland Clinic program available free of charge through expert medical opinion program	100% coverage	Not Covered
• Other Second Opinions	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.

Eligible Expenses	Network Coverage	Out-of-Network Coverage
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (limited to 120 continuous days per stay per diagnosis or related diagnosis)	80%, after your Annual Deductible	60%, after your Annual Deductible
Substance Abuse Centers of Excellence	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	Not covered
Surgery — Outpatient	80%, after your Annual Deductible	60%, after your Annual Deductible
Temporomandibular Joint Dysfunction (TMJ), excludes appliances Surgical treatment when provided under the direction of a Physician	80%, after your Annual Deductible	60%, after your Annual Deductible
Therapeutic Treatments — Outpatient • Chemotherapy and radiation • All other treatments	 80%, after your Annual Deductible 80%, after your Annual Deductible	 80%, after your Annual Deductible 60%, after your Annual Deductible
Transplant Services • Non-Center of Excellence • Center of Excellence Travel and lodging expense guidelines apply when using a Center of Excellence. Prior authorization is recommended. Coverage is limited to $2,000 maximum per covered individual. Maximum includes companion cost. $50 per day for companion while patient is hospitalized, $100 per day for companion and patient when patient is not hospitalized. See Section 1.6.40, "TRANSPLANT SERVICES" for details on follow-up care at a Center of Excellence.	 80%, after your deductible If you are enrolled in Options 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	 60%, after your deductible Not covered
Urgent Care Centers	80%, after your Annual Deductible	60%, after your Annual Deductible
Wigs Not to exceed one per year. Covered on a cost-effective basis.	If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible.	100%, after your Annual Deductible

1.6 ADDITIONAL COVERAGE DETAILS

This section supplements Section 1.5, "PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016."

While the table provides you with benefit limitations along with Co-insurance and Annual Deductible information for each Eligible Expense, this section includes descriptions of the benefits. These descriptions include any additional limitations that may apply.

Services that are not covered are described in Section 1.7, "EXCLUSIONS."

1.6.1 ACUPUNCTURE SERVICES

GE Medical pays for acupuncture services for pain therapy provided that:

- Another method of pain management has failed; and
- The service is performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license (if state licensing is available) or who is certified by a national accrediting body:
  - Doctor of Medicine;
  - Doctor of Osteopathy;
  - Chiropractor; or
  - Acupuncturist.

Eligible Expenses include treatment of nausea as a result of:

- Chemotherapy;
- Pregnancy; and
- Post-operative procedures.

In addition, GE Medical pays for acupuncture services when used as general anesthesia in connection with a surgical procedure. In such cases, if the acupuncture is administered by an acupuncturist who is not a legally licensed Physician, acupuncture services will be covered only if under the supervision of a legally licensed Physician or surgeon.

In all other instances, charges for acupuncture will be covered only when actually performed by a Provider listed above and if generally recognized as an acceptable treatment for the illness or Injury.

1.6.2 AMBULANCE SERVICES — LOCAL PROFESSIONAL

GE Medical covers ambulance services and transportation provided by a licensed ambulance service (including air ambulance) when Medically Necessary to transport the patient to the nearest Hospital or facility where appropriate treatment is available. Services deemed not Medically Necessary by the Claims Administrator will be denied.

Out-of-Network services ordered by a Network Provider will be reimbursed at the Network level of benefits if determined Medically Necessary by Claims Administrator.

1.6.3 AUTISM SPECTRUM DISORDER SERVICES

See Sections 1.6.32, "REHABILITATION SERVICES — OUTPATIENT THERAPY" and 1.6.4, "BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT."

1.6.4 BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT

INPATIENT AND INTERMEDIATE, INCLUDING HALFWAY HOUSE

GE Medical covers behavioral health and substance abuse treatment, which is received on an inpatient or intermediate care basis in a Hospital or an alternate facility that provides behavioral health and substance abuse treatment.

GE Medical will pay only for treatment of the diagnoses identified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Benefits include detoxification from abusive chemicals or substances when necessary to protect your health.

If the Behavioral Health Claims Administrator determines that an inpatient stay is required, it is covered on a semi-private room (a room with two or more beds) basis, unless otherwise approved by the Behavioral Health Claims Administrator.

Benefits are available for Behavioral Health and Substance Abuse Treatment at a halfway house facility. A halfway house is a supervised accredited or licensed residential facility or program. To be eligible for these benefits, you must be actively involved in on-site or community-based outpatient individual, group and/or family treatment. Coverage is based on whether care is determined to be Medically Necessary. The number of days' stay will be determined by the Behavioral Health Claims Administrator, considering each patient's condition and circumstances.

See also Section 1.6.36, "SUBSTANCE ABUSE CENTERS OF EXCELLENCE."

Please remember medical necessity and place of treatment appropriateness are determined by the Claims Administrator. It is recommended to consult with your Claims Administrator to ensure "medical necessity" is met and services are covered. For services received by an out-of-Network provider, a pre-authorization is not required but it is recommended.

OUTPATIENT

GE Medical covers Behavioral Health and Substance Abuse Treatment received on an outpatient basis in a Provider's office or at an alternate facility, including the following:

- Behavioral Health/Substance Abuse evaluations and assessment;
- Diagnosis;
- Treatment planning;
- Referral services;
- Medication management;
- Short-term individual, family and group therapeutic services (including partial hospitalization and intensive outpatient therapy — generally run by an inpatient facility, but the patient may not remain at the facility overnight);
- Crisis intervention;
- Psychological testing; and
- Applied Behavioral Analysis (ABA) rendered by an appropriately licensed provider acting within the scope of his/her license in connection with a diagnosis of Autism Spectrum Disorder, if deemed appropriate by the Behavioral Health Claims Administrator.

Please remember medical necessity and place of treatment appropriateness are determined by the Claims Administrator. It is recommended to consult with your Claims Administrator to ensure "medical necessity" is met and services are covered. For services received by an out of Network provider, a pre-authorization is not required but it is recommended.

EMPLOYEE ASSISTANCE PROGRAMS

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 Claims Administrator to refer you to Providers within the treatment Network. Call Health Coach from GE at 1-866-272-6007 to learn about EAP services available in your area.

1.6.5 CENTERS OF EXCELLENCE AS DESIGNATED BY GE

Through an approved GE Center of Excellence, certain services designated by the Company may be covered at 100% and not subject to the Annual Deductible for Option 1 or 2. Option 3 provides 100% coverage after your Annual Deductible. Additionally, under the Centers of Excellence program, travel and lodging reimbursement, up to a defined maximum, may be available to those who qualify. For more details, contact Health Coach from GE at 1-866-272-6007.

1.6.6 CHIROPRACTIC CARE/SPINAL TREATMENT

GE Medical pays benefits for Spinal Treatment when provided by a Network or out-of-Network Spinal Treatment specialist in the specialist's office. Eligible Expenses include chiropractic and osteopathic manipulative therapy.

GE Medical gives the Claims Administrator the right to deny coverage if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Benefits include diagnosis and related services. GE Medical limits any combination of Network and out-of-Network services rendered by a chiropractor to one visit per day, up to 15 visits per calendar year.

1.6.7 CHRISTIAN SCIENCE PRACTITIONERS' SERVICES

GE Medical covers Christian Science practitioners services for healing purposes, when the provider is accredited by the Mother Church in Boston, Massachusetts and when the provider is in your presence when the treatment is performed.

1.6.8 CLINICAL TRIALS

GE Medical pays for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer;
- Cardiovascular disease (cardiac/stroke);
- Surgical musculoskeletal disorders of the spine, hip and knees; and
- Other diseases or disorders for which, as determined by the Claims Administrator, a Clinical Trial meets the criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial. Benefits are available only when you are clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials.

Routine patient care costs for Clinical Trials include:

- Eligible Expenses for which benefits are typically provided absent a Clinical Trial;
- Eligible Expenses required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Eligible Expenses needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
  - Certain Category B devices;
  - Certain promising interventions for patients with terminal illnesses; or
  - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical policy guidelines.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
  - National Institutes of Health (NIH) — (Includes National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - Department of Defense (DOD); or
  - Veterans Administration (VA).
- Have a written protocol that describes a scientifically sound study and has been approved by all relevant Institutional Review Boards (IRBs), as defined below, before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial to confirm that the Clinical Trial meets current standards for scientific merit and has the relevant IRB approvals; and
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of an Eligible Expense and is not otherwise excluded under the Plan.

OTHER CLINICAL TRIALS

In addition, Clinical Trials sponsored by other entities may also be covered if approved by the Claims Administrator, provided that the Clinical Trial has passed independent scientific review, has been approved by an Institutional Review Board (IRB) 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 IRB 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.

1.6.9 CORRECTIVE PRESCRIPTION LENSES

Lenses will be covered if used to treat a medical condition. For example, the Plan covers an initial pair of lenticular lenses for people who have had cataracts surgically removed. The Plan also covers Medically Necessary contact lenses when used as a bandage for treatment of keratoconus or similar conditions.

1.6.10 DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS

Dental services are covered by the Plan when all of the following are true:

- Treatment is necessary because of accidental damage to a sound, natural tooth;
- Dental damage did not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- Dental services are received from a doctor of dental surgery or a doctor of medical dentistry; and
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin, and that it:

- Has no decay;
- Has no filling on more than two surfaces;
- Has no gum disease associated with bone loss;
- Has no root canal therapy;
- Is not a dental implant; and
- Functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within 3 months of the accident and completed within 12 months of the accident or as reasonably soon thereafter as possible, and includes all examinations and treatment to complete the repair. Longer periods may be appropriate for children.

The following services are also covered by the Plan:

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system);
- Necessary orthodontic treatment for adults and children, required as a result of an Injury, will be covered under GE Dental Care, except for orthodontic treatment that would have been necessary in the absence of the Injury;
- Direct treatment of cancer or cleft palate, including orthodontia;
- Implants may be covered to treat a severe condition for which there are no alternative treatments, (i.e., dentures or bridges);
- Upper and lower jawbone surgery covered as required for direct treatment of acute traumatic Injury, tumor, cancer or congenital anomaly; and
- Medically Necessary hospitalization.

1.6.11 DIABETES SERVICES

GE Medical pays Benefits for Eligible Expenses identified below.	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Plan participants with diabetes.
Diabetic Self-Management Items	Insulin pumps and related pump supplies (Cost Effective model) are covered as part of your medical coverage. Coverage for continuous glucose monitors can be found in Section 1.6.12, "DURABLE MEDICAL EQUIPMENT (DME)." Diabetes supplies (including but not limited to insulin) and glucose monitors (excluding continuous glucose monitors), and in some cases insulin pump supplies may also be covered under GE's Prescription Drug benefits. See Section 2.0, "PRESCRIPTION DRUG BENEFITS" for general coverage information.

1.6.12 DURABLE MEDICAL EQUIPMENT (DME)

GE Medical pays for the rental or purchase of Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use;
- Used for medical purposes;
- Not of use to a person in the absence of a Sickness, Injury or disability;
- Durable enough to withstand repeated use; and
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment (See "KEY TERMS" at the end of this booklet for definition). Benefits are provided for a single unit of DME (example: one continuous glucose monitor) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen;
- Wheelchairs/custom fitted strollers;
- Hospital beds;
- Delivery pumps for tube feedings;
- Burn garments;
- Continuous glucose monitor and all related necessary supplies;
- Braces that straighten or change the shape of a body part, or treat curvature of the spine;
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces;
- Equipment for the treatment of chronic or acute respiratory failure or conditions;
- C-pap machines for treatment of sleep apnea;
- Circulators for post-surgical treatment;
- Crutches;
- Gait trainers;
- Home monitors when Medically Necessary and prescribed by a doctor;
- Pacemaker monitors;
- Prone standers;
- Portable EKG devices; and
- Surgical sleeves/burn compression sleeves.

GE Medical also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Please Note — DME is different from prosthetic devices — see Section 1.6.30, "PROSTHETIC DEVICES."

1.6.13 EMERGENCY HEALTH SERVICES

In an Emergency, seek help immediately. If you are admitted to the Hospital in an Emergency, you should call the Claims Administrator by the end of the next business day (unless it is not reasonably possible to do so under the circumstances). An "Emergency" is a serious medical condition or symptom resulting from Injury, sickness or Mental Illness, or substance abuse which arises suddenly and, in the judgment of a reasonable person, requires immediate treatment (generally within 24 hours of onset) to avoid jeopardy to your life or health — such as excessive bleeding, loss of consciousness or severe chest pain.

If it is not an Emergency, but a condition that needs urgent attention on a weekend or at night, contact your Physician or Claims Administrator. Conditions that do not require immediate treatment are not considered emergencies. If the Claims Administrator determines that your condition does not qualify as an Emergency and Emergency treatment was not authorized, services will be covered at 60%, after the Deductible, whether you used a Network or an out-of-Network emergency room.

1.6.14 FOOT CARE

Coverage is provided when needed in conjunction with severe systemic disease, such as diabetes.

1.6.15 GENDER RE-ASSIGNMENT

Gender re-assignment includes sexual reassignment surgery, mastectomy/chest reconstruction surgery, thyroid chondroplasty, behavioral health therapy and hormone therapy as determined by the Claims Administrator in accordance with the World Professional Association for Transgender Health (WPATH) standards of care. You must be age 18 or older, have persistent gender dysphoria and the capacity to make a fully informed decision. Limited to one re-assignment per lifetime under all GE Sponsored health plans combined.

1.6.16 HEARING CARE

Benefits are available for the following Eligible Expenses:

- Routine hearing aid exams limited to one per ear, every three years;
- Hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids must be Medically Necessary and cost-effective. Limited to one per ear, every three years; and
- Fitting, repairs, and adjustments as needed.

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Provider. Benefits are provided for the hearing aid and for charges associated with fitting and testing. Replacement parts (except for batteries) are covered.

Surgery to place a cochlear implant is also covered. Cochlear implantation can be either an inpatient or outpatient procedure. See Section 1.6.19, "HOSPITAL — INPATIENT STAY" and Section 1.6.37, "SURGERY — OUTPATIENT."

Be sure to discuss your financial responsibilities with your Provider.

1.6.17 HOME HEALTH CARE

Eligible Expenses are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- Ordered by a Physician;
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- Not considered Custodial Care; and
- Provided on a part-time, intermittent schedule when Skilled Care is required.

In addition, the following are covered when approved by the Claims Administrator:

- Medical supplies, prescription drugs and lab services; and
- Medical social services by a qualified social worker under a doctor's supervision.

Your Claims Administrator will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

1.6.18 HOSPICE CARE

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill (generally expected to live six months or less). Hospice care can be provided on an inpatient or outpatient basis, including at home, and includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members while the Plan participant is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital. All services must be billed by the hospice care program.

1.6.19 HOSPITAL — INPATIENT STAY

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay; and
- Room and board in a semi-private room (a room with two or more beds).

GE Medical will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for Hospital-based Physician services are described in Section 1.6.27, "PHYSICIAN'S SERVICES." Benefits include pre- and post-admission testing.

Benefits for Emergency admissions and admissions of less than 24 hours are described under Section 1.6.13, "EMERGENCY HEALTH SERVICES," Section 1.6.33, "SCOPIC PROCEDURES — OUTPATIENT DIAGNOSTIC AND THERAPEUTIC" and Section 1.6.39, "THERAPEUTIC TREATMENTS — OUTPATIENT," respectively.

For Out-of-Network Benefits, you should notify the Claims Administrator as follows:

- For elective admissions: Five business days before admission; and
- For Emergency admissions (also termed non-elective admissions): Within two business days, or as soon as is reasonably possible.

1.6.20 INFERTILITY SERVICES

GE Medical pays Benefits for infertility services and associated expenses by a Network Provider only including:

- Diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician (these services are not subject to the lifetime maximum benefit listed below);
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- Embryo transfer;
- Artificial insemination; and
- Reversal of voluntary sterilization.

Infertility services are limited to $15,000 (Company paid) per plan participant per lifetime under all GE-sponsored health plans combined. Eligible Expenses associated with infertility drugs (as covered by GE Prescription Drug benefits) are included within the $15,000 lifetime maximum.

For infertility services and supplies to be considered Eligible Expenses, you should contact the Claims Administrator prior to receiving services.

1.6.21 INJECTIONS IN A PHYSICIAN'S OFFICE OR OUTPATIENT FACILITY

Benefits are paid by GE Medical for injections administered in the Physician's office or an outpatient facility, such as allergy immunotherapy, when no other health service is received.

1.6.22 LAB, X-RAY, DIAGNOSTICS AND HIGH-END RADIOLOGY — OUTPATIENT

GE Medical pays for lab, x-ray, diagnostics and high-end services for sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or alternate facility. Also services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an inpatient or outpatient basis at a Hospital or alternate facility are covered. To ensure Medical Necessity, pre-determination is recommended.

Benefits for other Physician services are described in Section 1.6.27, "PHYSICIAN'S SERVICES." Lab, X-ray and diagnostic services for preventive screenings are described in Section 1.6.29, "PREVENTIVE SCREENINGS AND SERVICES."

1.6.23 NUTRITIONAL COUNSELING

GE Medical will pay for Eligible Expenses for medical education services when recommended by a Physician and provided by a registered dietician, clinical nutritionist, certified diabetic educator or a Physician, when:

- Education is required for a disease in which patient self-management is an important component of treatment; and
- There exists a knowledge deficit regarding the disease that requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- Coronary artery disease;
- Congestive heart failure;
- Diabetes;
- Severe obstructive airway disease;
- Gout (a form of arthritis);
- Renal failure;
- Phenylketonuria (a genetic disorder diagnosed at infancy); and
- Hyperlipidemia (excess of fatty substances in the blood).

Nutritional counseling can include telemedicine as well as Company-approved or sanctioned programs.

1.6.24 OBESITY SURGERY

GE Medical covers surgical treatment of obesity received on an inpatient basis by a Network Provider only, provided all of the following are true (unless otherwise determined by the Claims Administrator):

- You have a minimum Body Mass Index (BMI) of 40 or in some cases, a lower BMI accompanied by co-morbid conditions as determined by the Claims Administrator;
- You have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years;
- You are over the age of 21;
- The surgery is performed at a Network Hospital by a Network surgeon, even if there are no Network Hospitals near you; and
- Any other criteria required by your Claims Administrator.

Benefits are available for obesity surgery services that meet the definition of an Eligible Expense and are not Experimental or Investigational Services or Unproven Services.

Centers of Excellence: If you receive services from a Center of Excellence approved by the Claims Administrator services are covered at 100% and not subject to the Annual Deductible for Option 1 or 2. Option 3 offers 100% coverage after the Annual Deductible. Surgical services must be performed by a Network surgeon. If you accept treatment at such a facility, GE may cover reasonable expenses for lodging, transportation and meals for the patient and one member of the patient's immediate family. Please call the Centers of Excellence Travel and Lodging Support Line at 1-518-388-7797 for more information. Prior approval is recommended.

The following services specifically associated with obesity surgery are included in the Center of Excellence benefit:

- Pre-operative testing recommended by your bariatric surgeon and received up to 90 days before that surgery, including pre-surgical psychiatric evaluation;
- Pre- and post-surgery care rendered by the surgeon's office within 90 days of the bariatric surgery; and
- Nutritional counseling rendered within 90 days before or after the bariatric surgery, as recommended by the bariatric surgeon or Claims Administrator.

Benefits are limited to one procedure per lifetime under all GE sponsored health plans combined.

1.6.25 ORTHOTICS

Benefits are paid by the Plan for orthotic devices and supplies, including the initial purchase, fitting and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings and adjustments are included.

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; and
- Orthotic shoe inserts will be covered if custom molded and prescribed by a Physician.

Orthotic appliances may be replaced once per year if required. Additional replacements will be allowed more frequently for children due to growth, or for damaged, un-repairable appliances.

1.6.26 OSTOMY SUPPLIES

Benefits for Ostomy Supplies are covered such as:

- Pouches, face plates and belts;
- Irrigation sleeves, bags and catheters; and
- Skin barriers

1.6.27 PHYSICIAN'S SERVICES

GE Medical pays Physician fees for surgical procedures and other medical care, including:

- Eligible Expenses received in a Physician's (primary care or specialist) office for the evaluation and treatment of a Sickness or Injury. Or, received from a Physician in a Hospital (inpatient or outpatient), Skilled Nursing Facility, Inpatient Rehabilitation Facility, alternate facility or for Physician house calls.
- Anesthesia and its administration;
- Oxygen and its administration;
- Blood transfusions, including blood and blood plasma; and
- Vasectomy.

Benefits for preventive services are described under Section 1.6.29, "PREVENTIVE SCREENINGS AND SERVICES." Benefits for hearing care are described under Section 1.6.16, "HEARING CARE."

1.6.28 PREGNANCY — MATERNITY SERVICES

Benefits for Pregnancy will be paid at the same level as benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for postnatal care, delivery (including home delivery) and any related complications. Obstetrical services may be performed by a Physician or a licensed midwife who is a licensed registered nurse certified by the American College of Nurse Midwives. Prenatal office visits are covered under the preventive benefit. Benefits for preventive services are described under Section 1.6.29, "PREVENTIVE SCREENINGS AND SERVICES."

GE Medical will pay benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a pregnancy, benefits include the services of a genetic counselor when provided or referred by a Physician. These benefits are available to all plan participants in the immediate family. Eligible Expenses include related tests and treatment. Coverage for birth centers, where available, is also included.

For Out-of-Network Benefits, you should notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above.

1.6.29 PREVENTIVE SCREENINGS AND SERVICES

GE Medical pays for preventive screenings and services provided on an outpatient basis at a Physician's office or at an alternate facility or a Hospital, excluding services provided in an emergency room or inpatient setting.

In general, GE Medical pays for preventive screenings and services mandated by the Affordable Care Act, and based in part on the recommendations of the U.S. Preventive Services Task Force (USPSTF), as updated from time to time. 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. Medical necessity, frequency, condition, gender and/or age restrictions may apply. You should always ask your doctor if the screenings performed for or during your physical exam are consistent with the U.S. Preventive Services Task Force recommendations.

Examples of Eligible Expenses for Preventive Screenings include:

Cancer Screenings

- Breast cancer: mammography;
- Cervical cancer: laboratory testing;
- Colon cancer: sigmoidoscopy and colonoscopy;
- Prostate cancer: digital rectal exam and antigen (PSA) test;
- BRCA (Breast Cancer Susceptibility Gene) counseling;
- BRCA (Breast Cancer Susceptibility Gene) testing when medically appropriate for women;
- Chemoprevention of breast cancer counseling; and
- Annual lung cancer screening.

Annual Adult Physicals and Routine Gynecological Care

- Physical examinations;
- Routine gynecologic examinations;
- Primary preventive counseling;
- Electrocardiogram; and
- Other Screenings:
  - Obesity screening;
  - Osteoporosis screening;
  - Abdominal aortic aneurysm screening;
  - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse;
  - Screening for depression;
  - Behavioral counseling in primary care to promote healthy diet; and
  - Counseling and interventions to prevent tobacco use and tobacco-caused disease. See Section 1.8.3, "TOBACCO CESSATION."

Women's Preventive Care

- Contraceptives counseling;
- FDA approved contraception devices — including insertion/removal;
- Contraception — sterilization procedures;
- Prenatal care office visits; and
- Breast feeding counseling services and breast feeding supplies.

Pediatric prevention through age 21

- Well child care visits; and
- Screening Tests:
  - Newborn hearing;
  - Annual vision;
  - Developmental screening; and
  - Major depressive disorder screening.

Blood/Urine and Other Laboratory Tests to Screen for the Following

- Rh incompatibility (pregnant women only);
- Lipid Disorder — cholesterol, lipoprotein and triglycerides;
- Bacteriuria (for pregnant women only);
- Chlamydia infection;
- Gonorrhea;
- HIV;
- Syphilis infection;
- HPV detection;
- Diabetes type 2;
- Iron deficiency anemia;
- Sickle cell disease;
- Lead;
- Hepatitis C virus screenings for adults; and
- Hepatitis B screening.

Immunizations

- Influenza (including 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, rubella);
- Pneumococcal Polysaccharide (PPSV);
- Polio;
- Rotavirus (RV);
- Tetanus;
- Varicella (chickenpox); and
- Zoster (shingles) — Age restrictions apply.

For more information on preventive benefits covered under your pharmacy benefits, see Section 2.2.3, "PREVENTIVE BENEFITS."

1.6.30 PROSTHETIC DEVICES

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb, body part or tissue, or materials inserted into tissue for functional or therapeutic purposes, or help an impaired limb or body part work. Benefits include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies, including batteries and battery packs, 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, but are not limited to:

- Artificial limbs;
- Artificial eyes;
- Breast prosthesis following mastectomy (whether internal or external) as required by the Women's Health and Cancer Rights Act of 1998, including two mastectomy bras per year, wigs following chemotherapy treatment not to exceed one per year on a cost-effective basis (see Section 1.6.42, "WIGS"), and lymphedema stockings for the arm; and
- Aids and supports for defective parts of the body such as pacemakers, intraocular lenses and electronic speech aids.

If more than one prosthetic device can meet your functional needs, benefits payable cannot exceed the amount of the most cost-effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction.

Please Note — Prosthetic devices are different from DME — see Section 1.6.12, "DURABLE MEDICAL EQUIPMENT (DME)."

1.6.31 RECONSTRUCTIVE PROCEDURES

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures that are associated with an Injury, sickness or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Eligible Expense. You can contact the Claims Administrator at the telephone number on your ID card for more information about benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure.

The fact that a Plan participant may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

1.6.32 REHABILITATION SERVICES — OUTPATIENT THERAPY

GE Medical provides outpatient rehabilitation services for the following types of therapy:
- Physical therapy;
- Occupational therapy;
- Speech therapy to treat stuttering, stammering, or other articulation disorders;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

GE Medical will pay benefits for the treatment of disorders of speech therapy, language, voice, communication and auditory processing only when the speech impediment or dysfunction results from Injury, Sickness, stroke, Congenital Anomaly, autism spectrum disorder, developmental delay, or is needed following the placement of a cochlear implant.

The following diagnosis (including but not limited to) are covered:
- Autism Spectrum Disorder (no age limit);
- Cerebral Palsy;
- Coordination disorder;
- Hearing loss;
- Tongue disorder;
- Congenital anomalies; and
- Chromosomal abnormalities.

Speech therapy, physical therapy, occupational therapy and other medically appropriate care such as hippotherapy and sensory-behavior simulation are covered subject to review for medical necessity, even if it is to maintain the person's level of care/function. Treatment by a licensed medical Provider can be provided in a medical or educational setting, subject to medical necessity. Note that predetermination from the health plan is available and recommended.

In some cases, such treatments may be covered as a behavioral health benefit — see Section 1.6.4, "BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT" and Section 1.7.9, "BEHAVIORAL HEALTH/SUBSTANCE ABUSE."

Hippotherapy is covered for conditions such as:
- Autism Spectrum Disorder (no age limit);
- Cerebral palsy;
- Multiple Sclerosis (MS); and
- Certain motor function disorders.

1.6.33 SCOPIC PROCEDURES — OUTPATIENT DIAGNOSTIC AND THERAPEUTIC

GE Medical pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or alternate facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include sigmoidoscopy (not considered preventive) and endoscopy.

Please note that benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described in Section 1.6.37, "SURGERY — OUTPATIENT." Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

1.6.34 SECOND OPINIONS

You may request a second opinion before a Hospital admission, outpatient surgery or any other service. Second opinions are available through the Company-sponsored eCleveland Clinic online services or in a Physician's office.

1.6.35 SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY SERVICES

Facility services for an Inpatient Stay in a Skilled Nursing Facility (also termed "Skilled Nursing") or Inpatient Rehabilitation Facility are covered by the Plan. Skilled Nursing services are limited to 120 continuous days per stay, per diagnosis or related diagnosis. Benefits include:

- Non-Physician services and supplies received during the Inpatient Stay; and
- Room and board in a semi-private room (a room with two or more beds).

Benefits are available when Skilled Nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

The Claims Administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital; and
- You will receive Skilled Care services that are not primarily Custodial Care.

Skilled care is Skilled Nursing, skilled teaching and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a Physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- You are expected to improve to a predictable level of recovery.

Please Note — GE Medical does not pay benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician.

1.6.36 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.

1.6.37 SURGERY — OUTPATIENT

GE Medical pays for surgery and related services (including pre- and post-admission testing) received on an outpatient basis at a Hospital or alternate facility. Pre-determination of benefits is recommended.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment;
  - Anesthesia and its administration;
  - Oxygen and its administration; and
  - Blood transfusions, including blood and blood plasma.
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy).

1.6.38 TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

GE Medical covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect or pathology. Appliances are not covered.

Benefits are not available for charges for services that are dental in nature.

1.6.39 THERAPEUTIC TREATMENTS — OUTPATIENT

GE Medical pays benefits for therapeutic treatments received on an outpatient basis at a Hospital or alternate facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Eligible Expenses include medical education services that are provided on an outpatient basis at a Hospital or alternate facility by appropriately licensed or registered health care professionals when:

- Education is required for a disease in which patient self-management is an important component of treatment; and
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

In addition, coverage is provided for the following:

- Home infusion therapy — intravenous treatment administered in your home; and
- Home therapy for hemophilia — when your treatment program is accredited by the National Hemophiliac Foundation.

1.6.40 TRANSPLANT SERVICES

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplant procedures must be ordered by a Provider. Benefits are available to the donor and the recipient, when the recipient is covered under this Plan, for any of the organ and tissue transplants listed below provided the transplant meets the definition of an Eligible Expense and is not an Experimental or Investigational Service or an Unproven Service:

- Heart;
- Heart/lung;
- Lung;
- Kidney;
- Kidney/pancreas;
- Liver;
- Liver/kidney;
- Liver/intestinal;
- Pancreas;
- Intestinal; and
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of an Eligible Expense — please see below.

Benefits are also available for cornea transplants.

Donor costs that are directly related to organ removal are Eligible Expenses for which Benefits are payable through the organ recipient's coverage under the Plan.

The search for bone marrow and/or stem cells from a donor who is not biologically related to the patient is an Eligible Expense only for a transplant received at a facility designated by the Claims Administrator. If a separate charge is made for a bone marrow and/or stem cell search, the Plan will pay up to $25,000 for all charges made in connection with the search.

GE Medical has specific guidelines regarding benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Treatment is covered at 100% with no Annual Deductible for Options 1 and 2, and at 100% after the Annual Deductible for Option 3, if you receive services from a Center of Excellence approved by the Claims Administrator. If you accept treatment at such a facility, GE may cover reasonable expenses for lodging, transportation and meals for the patient and one member of the patient's immediate family. Please call the Centers of Excellence Travel and Lodging Support Line at 1-518-388-7797 for more information. Prior approval is recommended.

Follow up care received at a Center of Excellence is covered under the Centers of Excellence Benefit up to one year post-transplant, unless otherwise approved by the Claims Administrator.

1.6.41 URGENT CARE CENTER SERVICES

GE Medical provides benefits for services, including professional services, received at an Urgent Care Center. When Urgent Care services are provided in a Physician's office, the Plan pays benefits as described in Section 1.6.27, "PHYSICIAN'S SERVICES."

1.6.42 WIGS

GE Medical pays benefits for wigs and other scalp hair prostheses for hair loss due to medical illness or treatment of such illness, such as chemotherapy. Benefits are limited to one wig per year on a cost-effective basis.

1.7 EXCLUSIONS

GE Medical does not pay benefits for the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition.

When benefits are limited within any of the Eligible Expenses categories described in Section 1.6, "ADDITIONAL COVERAGE DETAILS," those limits are stated in the corresponding Eligible Expense category in Section 1.5, "PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016." Limits may also apply to some Eligible Expenses that fall under more than one Eligible Expense category. When this occurs, those limits are also stated in Section 1.5, "PLAN SUMMARY AND ELIGIBLE EXPENSES AS OF JANUARY 1, 2016." Please review all limits carefully, as the Plan will not pay benefits for any of the services, treatments, items or supplies that exceed these benefit limits. These services are not applied to the Annual Deductible or Out-of-Pocket Maximum. In certain circumstances, for purposes of overall cost savings or efficiency, the Claims Administrator may, in its discretion, offer benefits for services that would otherwise not be an Eligible Expense. The fact that the Claims Administrator does so in any particular circumstance shall not in any way be deemed to require that the Plan do so in other similar circumstances.

1.7.1 ALTERNATIVE TREATMENTS

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing (Holistic tissue massage);
- Any services, supplies or treatment rendered by a naturopathic or homeopathic Provider or Physician; and
- Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of The National Institutes of Health.

1.7.2 COMFORT AND CONVENIENCE

Supplies, equipment and similar incidentals for personal comfort. Examples include:

- Television;
- Telephone;
- Air conditioners;
- Beauty/barber service;
- Guest service;
- Air purifiers and filters;
- Dehumidifiers and humidifiers;
- Ergonomically correct chairs;
- Non-Hospital beds and comfort beds;
- Home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails and stair glides);
- Special lighting or other environmental modifiers; and
- Articles of clothing.

1.7.3 DENTAL

- Dental care, except as identified under Section 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS." This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the Plan, as identified in Section 1.6, "ADDITIONAL COVERAGE DETAILS."
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances; see Section 1.6, "ADDITIONAL COVERAGE DETAILS" and Section 1.6.38, "TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)" for what services are covered.
- Preventive dental care;
- Diagnosis or treatment of the teeth or gums. Examples include:
  - Extractions (including wisdom teeth);
  - Restoration and replacement of teeth;
  - Medical or surgical treatments of dental conditions; and
  - Services to improve dental clinical outcomes.
- Dental implants, except as identified under Section 4.3.2, "WHAT DOES THE GE DENTAL SCHEDULE OPTION COVER?," Section 4.4.2, "WHAT DOES THE GE DENTAL PREMIUM OPTION COVER?", and Section 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS";
- Dental X-rays, supplies and appliances and all associated expenses and anesthesia; and
- Treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate. See Section 4.0, "DENTAL CARE OPTIONS" for more information.

1.7.4 PRESCRIPTION DRUGS

- Prescription drugs for outpatient use that are filled by a prescription order or refill (such drugs may be covered under GE's Prescription Drug benefits);
- Self-injectable medications such as Humira, Enbrel, Rebif and Nutropin;
- Non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office;
- Over-the-counter drugs and treatments, except as otherwise allowed by this handbook; and
- Medication purchased at an out-of-Network pharmacy.

See Section 2.0, "PRESCRIPTION DRUG BENEFITS" for more information.

1.7.5 EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

Experimental or Investigational Services, supplies and treatments or Unproven Services, unless the Plan has agreed to cover them.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

1.7.6 FOOT CARE

- Routine foot care, except when needed for severe systemic disease. Routine foot care services that are not covered include:
  - Cutting or removal of corns and calluses;
  - Nail trimming or cutting; and
  - Debriding (removal of dead skin or underlying tissue).
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet;
  - Applying skin creams in order to maintain skin tone; and
  - Other services that are performed when there is not a localized sickness, Injury or symptom involving the foot.
- Treatment of flat feet; and
- Shoe Orthotics that are not prescribed by a Physician or molded.

1.7.7 JAWBONE SURGERY

Upper and lower jawbone surgery, except as required for direct treatment of acute traumatic Injury, tumor, cancer or congenital anomaly.

1.7.8 MEDICAL SUPPLIES AND APPLIANCES

Devices used specifically as safety items or to affect performance in sports-related activities; prescribed or non-prescribed medical and disposable supplies, except for ostomy bags and related supplies. Examples of supplies that are not covered include, but are not limited to:

- Ace bandages; and
- Tubings, nasal cannulas, connectors and masks that are not used in connection with Durable Medical Equipment (DME).

1.7.9 BEHAVIORAL HEALTH/SUBSTANCE ABUSE

- Services performed in connection with conditions not classified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
- Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention;
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
- Treatment for conduct and impulse control disorders, gambling addiction, personality disorders, paraphilias disorders and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the Claims Administrator;
- Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements, unless approved by the Claims Administrator;
- Psychosurgery (lobotomy);
- Pastoral counseling; and
- Services and supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Claims Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective, or are not consistent with:
  - Prevailing national standards of clinical practice for the treatment of such conditions;
  - Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; or
  - The Claims Administrator's level of care guidelines as modified from time to time.

The Claims Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

1.7.10 NUTRITION AND HEALTH EDUCATION

- When recommended by a Physician and provided by a registered dietician, nutritional or cosmetic therapy using high-dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy;
- Nutritional counseling for either individuals or groups, other than as provided under Section 1.6.23, "NUTRITIONAL COUNSELING";
- Food of any kind. Foods that are not covered include:
  - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition due to an illness or Injury, or unless they are specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU);
  - Infant formula available over the counter is always excluded even if it is an otherwise allowable enteral feeding or other nutritional and electrolyte formula;
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
  - Oral vitamins and minerals;
  - Meals you can order from a menu, for an additional charge, during an Inpatient Stay;
  - Other dietary and electrolyte supplements;

- Health club memberships and programs, and spa treatments; and
- Health education classes, including but not limited to asthma, tobacco cessation and weight control classes, unless approved by the Claims Administrator.

1.7.11 PHYSICAL APPEARANCE

Cosmetic surgery or treatment, except for functional birth defects; accidental Injury while covered under the plan; reconstructive surgery after illness; or to remedy a deformity, disfigurement or defect resulting from disease, Injury or Congenital Anomaly and as defined under the gender re-assignment section.

- Liposuction;
- Pharmacological regimens (such as Botox);
- Nutritional procedures or treatments;
- Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
- Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
- Physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
- Other expenses not related to the diagnosis or treatment of illness or Injury, such as weight-loss programs;
- Treatments for hair loss, growth or removal;
- A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty or mastopexy, unless approved by the Claims Administrator;
- Varicose vein treatment of the lower extremities, when it is considered cosmetic;
- Treatment of benign gynecomastia (abnormal breast enlargement in males);
- Non-genital, non-breast surgical and some pharmaceutical intervention is not covered, unless deemed Medically Necessary by the Claims Administrator and consistent with the World Professional Association for Transgender Health (WPATH) standards of care; and
- Reversal of genital surgery or reversal of surgery to revise sexual characteristics.

1.7.12 PREGNANCY AND INFERTILITY

- Surrogate parenting;
- Artificial reproductive treatments done for eugenic (selective breeding) purposes;
- Services provided by a doula (labor aide);
- Parenting, pre-natal or birthing classes;
- Donor ovum and semen and related costs, including collection, preparation and storage/thawing (including storage of one's own egg, sperm, zygote);
- Transport/shipping charges; and
- Fertility preservation, for example, due to impending cancer treatment.

1.7.13 PROVIDER SERVICES

- Performed by a Provider who is a family member by birth, adoption or marriage, including your Spouse, brother, sister, parent or child;
- Performed by a Provider on himself or herself;
- Performed by a Provider with your same legal residence;
- Performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license;
- Foreign language and sign language interpreters;
- Provided at a diagnostic facility (Hospital or free-standing) without a written order from a Provider;
- Which are self-directed to a free-standing or Hospital-based diagnostic facility; and ordered by a Provider affiliated with a diagnostic facility (Hospital or free-standing), when that Provider is not actively involved in your medical care:
  - Prior to ordering the service; or
  - After the service is received.

This exclusion does not apply to mammography testing.

1.7.14 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);
- No-fault automobile insurance;
- Under another plan;
- Under Workers' Compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
- While on active military duty (subject to the Company's Military Leave of Absence policy); and
- For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

1.7.15 TRANSPLANTS

- Health services for organ and tissue transplants:
  - Determined by the Claims Administrator not to be proven procedures for the involved diagnoses; and
  - Not consistent with the diagnosis of the condition.
- Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available).

When transplants are covered, donor expenses also will be covered if the donor's insurance does not provide such coverage, or if specifically required by facility contract.

1.7.16 TRAVEL (NON-MEDICAL)

- Travel in connection with health services provided in a foreign country, unless required in an Emergency;
- Certain non-medical expenses, such as travel to and from a facility and living accommodations for patients and family members, unless otherwise specified; and
- Ambulance services deemed not Medically Necessary by the Claims Administrator.

1.7.17 ROUTINE VISION CARE

Eye exams, lenses and eyeglass frames are excluded (see Section 5.0, "VISION CARE BENEFITS"), except as required to diagnose an illness or Injury. Exclusions include:

- Routine vision examinations, including refractive examinations, to determine the need for vision correction;
- Purchase cost of eyeglasses (with the exception of the items described in Section 1.6.9, "CORRECTIVE PRESCRIPTION LENSES"); or
- Fitting charges for assistive devices, amplifiers, eyeglasses and contact lenses; and
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy, unless approved by the Claims Administrator.

1.7.18 ALL OTHER EXCLUSIONS

- Autopsies, other coroner services and transportation services for a corpse;
- Charges for:
  - Missed appointments;
  - Room or facility reservations;
  - Completion of claim forms;
  - Record processing; or
  - Services, supplies or equipment that are advertised by the Provider as free.
- Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
- Charges prohibited by federal anti-kickback or self-referral statutes;
- Chelation therapy, except to treat heavy metal poisoning;
- Custodial care expenses that do not require the continuing services of a skilled medical or health care professional and which are furnished primarily to provide room and board, education, assistance with activities of daily living or other care for a mentally or physically disabled person;
- Diagnostic tests that are:
  - Delivered in other than a Physician's office or health care facility; and
  - Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.
- Domiciliary Care;
- Expenses for health services and supplies that:
  - Are not considered an Eligible Expense as determined by your Medical or Behavioral Health Claims Administrator;
  - Are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country;
  - Are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
  - You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan;
  - Exceed Eligible Expenses or any specified limitation;
  - An out-of-Network Provider waives the Annual Deductible or Co-insurance amounts; or
  - Exceed the Allowable Amount for an Eligible Expense.
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
  - Conducted for purposes of medical research;
  - In connection with travel of any kind;
  - Related to judicial or administrative proceedings or orders; or
  - Required to obtain or maintain a license of any type.
- Private duty nursing if provided on an inpatient basis;
- Respite care;
- Rest cures;
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
- Storage of blood, umbilical cord or other material for use in an Eligible Expense, except if needed for an imminent surgery; and
- Non-medical treatment for obesity, even if for morbid obesity; and surgical treatment of obesity, unless there is a diagnosis of morbid obesity as described under Section 1.6.24, "OBESITY SURGERY."

1.8 TOOLS AND RESOURCES

In addition to what GE Medical covers, you will have many phone-based resources — from lifestyle coaching and tracking tools to training modules and support groups — to help you assess your health and take action to improve it.

1.8.1 HEALTHAHEAD WEB SITE

The GE HealthAhead Web site — **www.ge.com/healthahead** — is your resource for many of your health-related questions. You can find information on your health care plan as well as:

- Tips and programs designed to help you start or maintain a healthy lifestyle;
- Tools to help you evaluate the health care resources that are available to you;
- Information on medical prevention; and
- Many other resources that are available to you 24 hours a day, 7 days a week.

1.8.2 WELLNESS RESOURCES

Lifestyle Coaching is available through Health Coach from GE. Your Lifestyle Coach will work with you over the phone to develop a plan to manage stress, improve your diet, increase physical activity and meet your other health goals. These services are confidential and voluntary.

To learn more about all of the wellness resources visit **www.ge.com/healthahead**.

HEALTH COACH FROM GE

A family of resources for your health and wellness.

Health Coach from GE 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, benefit and claims support and after-hours services.

Health Coach from GE is available weekdays from 9 a.m. to 7 p.m. Eastern time and 24 hours a day, 7 days a week for urgent after-hours care questions and options.

1.8.3 TOBACCO CESSATION

If you use tobacco you may pay more for your coverage. A tobacco cessation program helps to eliminate nicotine, tobacco, and smoking dependence. The following are some available resources to help you and your family who are enrolled in GE medical benefits, quit.

1. QuitNet Tobacco Cessation Program (**www.quitnet.com/ge**).
   - Nicotine Replacement Therapy (NRT)* products are available through QuitNet and delivered to your home at no cost to you. The products available through this program include The Nicoderm Patch, Nicorette Gum and Commit Lozenges.
   - QuitNet also provides access to expert resources and online support communities.

2. Tobacco cessation counseling and certain prescribed products are covered at 100% in Network, under your GE Medical. Contact the GE Prescription Drug Claims Administrator for a list of products and coverage details.

3. Health Coach from GE offers tobacco cessation coaching. Call Health Coach from GE at 1-866-272-6007 to get started, weekdays from 9:00 a.m. – 7:00 p.m., Eastern time.

1.9 SUBROGATION

The provisions of this section shall apply to any benefits under the Plan if a person or persons other than the participant on whose behalf a claim for such benefits is made is considered responsible (the "responsible person(s)") for the sickness or Injury causing the participant to incur expenses otherwise covered under the Plan ("covered expenses"). To the extent that payment for such covered expenses is made, or may potentially be made in the future, by or on behalf of such responsible person(s) (whether by settlement, judgment or in any other manner), any charges for such covered expenses so incurred shall be considered a general exclusion under the Plan and any such charges for covered expenses shall not be payable under the Plan. If benefits would be payable but for such general exclusion, such benefits shall be payable as an advance, conditioned on reimbursement, and payable only if all of the following conditions are met:

(i) A properly filed claim for benefits under the Plan is filed with the Claims Administrator;

(ii) Payment by or on behalf of the responsible person(s) has not been made and either subparagraph (A) or (B) below applies:
- (A) You (or in the event of incapacity, your legal representative) completes the third-party questionnaire and executes the reimbursement agreement provided by the Claims Administrator or Plan Administrator (such agreement shall provide that if you receive payment from or on behalf of the responsible person(s), you shall reimburse the Plan an amount equal to the amount of benefits received but not in excess of the amount(s) actually received from or on behalf of any responsible person(s) that relate to your covered expenses); provided that reimbursement amounts due to the Plan pursuant to the terms of a properly executed reimbursement agreement may be applied against any other present or future benefits, thereby, reducing such benefits payable to or on behalf of you or to another person who is under your Two Person or Three or More coverage; or
- (B) You provides the Claims Administrator with a first-priority lien in the amount of the benefits paid by the Plan, with such lien to be filed with the responsible person(s), the agent of the responsible person(s), or a court which has jurisdiction in the matter.

For purposes of this section, reimbursement will be made to the Plan regardless of whether you have been fully compensated (i.e., "made whole") by the settlement, verdict or insurance proceeds.

Constructive Trust. By accepting benefits under this Plan, you agree that if you receive any payment from any responsible party as a result of an Injury, illness or condition, you will serve as a constructive trustee over the funds that constitute such payment. This responsibility is a fiduciary duty to the Plan.

The Plan shall be subrogated to all rights to recovery which you have against any third-party for the amount the Plan has advanced for benefits (including the reasonable cash value of any benefits provided in the form of services), including all sources of third-party payments.

(i) You have the following obligations:
- (A) Immediately notify the Plan of (I) any and all responsible person(s) and of any third-party which you may have a claim against as a result of the sickness or Injury, including but not limited to, any insurance company providing coverage to you, and (II) any and all claims for damages made and/or legal actions filed on behalf of you in connection with the sickness or Injury;
- (B) Fully cooperate with the Plan and the Claims Administrator or the Plan Administrator in obtaining information about the sickness or Injury; and
- (C) Take such action to furnish relevant information and assistance and to execute and deliver all necessary instruments as may be required by the Claims Administrator or Plan Administrator.

(ii) GE Medical:
- (A) Shall have a lien against any responsible person(s) or other third-party for recovery to the extent of the benefits paid by the Plan for the subject sickness or Injury; and
- (B) Has the right to bring an action on its own behalf, or on behalf of you, against any responsible person(s) or other third-party involved in the subject sickness or Injury; and
- (C) Shall suspend the payment of any benefits under the Plan pending receipt from you of any acknowledgement, agreement, authorization, waiver or release deemed necessary by the Plan Administrator to exercise the rights and privileges of the Plan under this subsection.

If either the Plan Administrator, the Claims Administrator, the Plan or you brings an action against a responsible person or other third party, the party bringing the action shall give written notice of such action to the other parties and of the court in which the action is brought by personal service or registered or certified mail. Proof of such service shall be filed in such action. If either the Plan Administrator, the Claims Administrator, the Plan or you brings an action, the other parties may at any time before the trial on the facts, join as party plaintiffs or consolidate the action, if brought independently. You are solely responsible for any litigation expenses, including attorney's fees, incurred by you, in pursuing an action against a responsible person or other third-party. GE Medical shall only be responsible for those legal fees and expenses to which the Plan Administrator agrees in writing and shall not otherwise bear the costs of legal representatives obtained by you.

For purposes of both the third-party reimbursement and subrogation provisions detailed above:

- The term "third-party" means any person or entity from whom you may seek compensation for sickness or Injury because you believe that an act or omission of another person or entity caused the sickness or Injury that gave rise to the covered expenses that you seek to have paid or reimbursed by the Plan, and includes any insurance company that issues a motor vehicle liability insurance policy which may include in addition to liability coverage, medical expense payment coverage, uninsured and/or underinsured motorist liability coverage, no-fault insurance coverage and/or personal Injury protection coverage, or any other type of liability insurance policies which cover the participant or the responsible person, including but not limited to a homeowner's insurance policy and an excess or umbrella insurance policy under which you or the responsible person is insured; and the Plan's right to recover applies to the payment of insurance proceeds to you by any such insurance company pursuant to any such policy; and
- "You" means you or any covered Dependent.

2.0 PRESCRIPTION DRUG BENEFITS

All GE Medical options provide prescription drug coverage through Network retail pharmacies and through mail order. There is no coverage out-of-Network. However, if there is no Network pharmacy within 25 miles (driving) of your residence, you can ask the Prescription Drug Claims Administrator to treat a non-Network pharmacy as a Network pharmacy. If such out-of-Network pharmacy is approved in that instance, such approval shall automatically terminate if a Network pharmacy is added within 25 miles (driving) of your residence.

2.1. PRESCRIPTION DRUG PARTICIPATION

The following sections describe the Plan provisions that affect your eligibility for and participation in prescription drug coverage.

2.1.1 WHO IS ELIGIBLE?

You are eligible for prescription drug coverage if you are enrolled in any GE Medical option.

If you are eligible, coverage begins automatically when your GE Medical coverage begins. The same is true for your covered eligible Dependents. GE Prescription Drug coverage ends when you or your dependents' GE Medical coverage ends. For more information, see Section 1.1, "MEDICAL PARTICIPATION."

2.1.2 WHAT IF THERE IS OTHER COVERAGE?

If you have other prescription drug coverage, such as through a Spouse's plan at work or through Medicare, maintenance of benefits applies. See Section 1.1.8, "WHAT IF THERE IS OTHER COVERAGE?" Keep in mind that you must use your primary plan coverage first. To receive payment on a claim when GE Medical coverage is secondary, you must submit a claim form, including a copy of the Explanation of Benefits from the primary insurance plan, to your Prescription Drug Claims Administrator.

2.2 PRESCRIPTION DRUG COVERAGE

This section describes your options for purchasing prescription drugs through GE Medical. In most cases, you must meet your Annual Deductible before co-pays and Co-insurance apply. See Section 1.2.1.6, "WHAT IS THE ANNUAL DEDUCTIBLE?" and Section 1.2.1.7, "WHAT IS CO-INSURANCE AND CO-INSURANCE MAXIMUM?" Your out-of-pocket costs for prescription drugs are limited each year by the Out-of-Pocket Maximum, see Section 1.2.1.8, "WHAT IS THE OUT-OF-POCKET MAXIMUM (ANNUAL DEDUCTIBLE PLUS CO-INSURANCE MAXIMUM)."

Prescription Drug Type	Retail - For each 30 day supply, up to 90 day maximum	Mail Order (Up to a 90-day supply)
Generic Drugs	$12 co-pay, subject to your Annual Deductible	$24 co-pay, subject to your Annual Deductible
Brand Name Drugs	30% Co-insurance, subject to your Annual Deductible	20% Co-insurance, subject to your Annual Deductible
Specialty Drugs: As defined by the Plan Administrator	If you are enrolled in Option 1 or 2, coverage is at $90 co-pay, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at $90 co-pay, subject to the Annual Deductible.	If you are enrolled in Option 1 or 2, coverage is at $270 co-pay, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at $270 co-pay, subject to the Annual Deductible.
Targeted Drugs: Such as diabetes medications and high cholesterol	If you are enrolled in Option 1 or 2, coverage is at $12 co-pay, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at $12 co-pay, subject to the Annual Deductible.	If you are enrolled in Options 1 or 2, coverage is at $24 co-pay, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at $24 co-pay, subject to the Annual Deductible.
TAKE ADVANTAGE OF $4 AND $10 GENERIC PRESCRIPTIONS The GE Prescription Drug Claims Administrator offers certain generic prescriptions at low prices — $4 for a 30-day supply and $10 for a 90-day supply. Listed generic drugs are available in both retail stores approved by the GE Prescription Drug Claims Administrator and by mail, saving you time and money. To view the list of plan generics, go to the Prescription Drug Claims Administrator's Web site.		

Please Note —

- The Claims Administrator may ask you or your doctor to provide additional information before your prescription is filled.
- Prescriptions will be filled with generic or co-branded drugs whenever possible.
- Remember to show your prescription drug ID card when you use a Network pharmacy to access Network discounts and to have your costs applied to the Annual Deductible.
- Some drugs may have quantity limits. For additional information, contact the Prescription Drug Claims Administrator.
- Infertility drugs may require prior authorization and are subject to the infertility lifetime maximum. See Section 1.6.20, "INFERTILITY SERVICES."

2.2.1 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 brand Co-insurance — unless the brand-name drug is Medically Necessary, as determined by the Prescription Drug Claims Administrator. If your doctor feels that the brand-name drug is necessary to treat your condition, you will need to contact the Prescription Drug Claims Administrator. You will be given a form that your Physician can use to initiate the appeal process. If your appeal is approved, you pay the applicable Co-insurance for this brand-name drug, but will not have to pay the cost difference between this brand-name drug and its generic equivalent.

Please note that any amount that you are charged for the difference between brand-name and generic drugs does not apply to your Annual Deductible or Co-insurance Maximum.

2.2.2 ABOUT SPECIALTY AND TARGETED DRUGS

“Specialty” drugs are drugs determined by the Prescription Drug Claims Administrator: (a) to require special handling, patient training or administration (e.g., injection); or (b) to be drugs used to treat rare chronic, serious or genetic disease states. Generally, “Targeted” drugs are specified for certain conditions, such as diabetes and high cholesterol.

For a list of “Specialty” and “Targeted” drugs, contact the Prescription Drug Claims Administrator online or by phone.

2.2.3 PREVENTIVE BENEFITS

Certain prescribed drugs are covered as preventive benefits at 100% and are not subject to your Annual Deductible under all three GE Medical Options. These drugs are determined by the Prescription Drug Claims Administrator and include:

- For women only: prescribed over the counter (OTC) contraceptives, FDA approved generic contraceptive drugs, contraceptive devices and brand contraceptive drugs when deemed medically appropriate by the prescription drug Claims Administrator;
- Certain immunizations as recommended by the U.S. Preventive Services Task Force (USPSTF);
- Certain OTC drugs that are prescribed by a doctor and are based on US Preventive Services Task Force (USPSTF) recommendations, as updated from time to time. Age and gender restrictions apply:
  - Aspirin to prevent cardiovascular disease (CVD) (men and women) and low dose aspirin for pregnant women at risk for preeclampsia;
  - Iron supplementation in children;
  - Chemoprevention of dental caries (Cavities) — Fluoride Supplementation;
  - Supplementation with folic acid for women planning or capable of pregnancy;
  - Certain Tobacco Use and smoking cessation products (adults);
  - Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls; and
  - Breast cancer preventive medication for women with increased risk.

Medical necessity, frequency, condition, gender and or age restrictions may apply. For a list of preventive drugs and supplies, contact the Prescription Drug Claims Administrator.

2.2.4 DIABETIC SUPPLIES

Certain prescribed diabetic supplies are covered under GE Prescription Drug Benefits only when purchased through a Network pharmacy or mail order:

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

If you are enrolled in Option 1 or 2, coverage is at 100%, not subject to the Annual Deductible. If you are enrolled in Option 3, coverage is at 100%, subject to the Annual Deductible. See Section 1.6.11, "DIABETES SERVICES" and Section 1.6.12, "DURABLE MEDICAL EQUIPMENT (DME)."

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 mail order. Insulin pump, continuous glucose monitors and related supplies are covered as part of your GE Medical coverage.

2.2.5 MAIL ORDER

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 mail order.

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

This service is not available outside the United States. Here is how to order prescriptions through the mail:

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 the Prescription Drug Claims Administrator. You can send a check or money order, or you may authorize billing to your personal credit card, your savings account card or GE Pharmacy card. You can obtain forms by contacting the Prescription Drug Claims Administrator. Alternatively, your physician can order your prescription through mail order for you by contacting the Prescription Drug Claims Administrator; and
3. Receive your order — via U.S. Mail or UPS — within two weeks, along with instructions for ordering refills.

With your first order — you will need to include a completed patient profile (and whenever you need to update your personal or medical information). This helps alert the Prescription Drug Claims Administrator to potential interactions or problems with other prescription drugs you are 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.

You can order your prescription refills online or over the phone by contacting the Prescription Drug Claims Administrator.

2.2.6 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 medications whose use must be pre-authorized to be covered. 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 the Prescription Drug Claims Administrator.

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 the Prescription Drug Claims Administrator's web portal or by calling the administrator.

If your doctor wants to prescribe a medication on the prior authorization list, to initiate the review process, he or she should first contact the Prescription Drug Claims Administrator Prior Authorization Unit to determine whether the drug will be covered. If it is 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 does not contact the Prescription Drug Claims Administrator 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 Claims Administrator.

2.2.7 EXCLUSIONS

Drugs labeled "Caution — limited by federal law to investigational use," or Experimental or Investigational drugs, are generally excluded under the GE Prescription Drug Benefit. Such exclusions include:

- Actonel;
- Duexis;
- Caduet;
- Nexium;
- Prevacid nap kit;
- Treatments for hair loss, growth or removal;
- Vimovo;
- Zegerid powder packet;
- Most over the counter items, such as Vitamins, unless specifically listed as covered under the preventive pharmacy benefit;
- Prescription drugs purchased at out-of-Network pharmacies; and
- Over-the-counter medications and prescription medications for which there are over-the-counter equivalents in the prescribed strength.

This list is subject to change. Please check with the GE Prescription Drug Claims Administrator for the current list.

2.3 WHEN YOUR GE PRESCRIPTION DRUG COVERAGE ENDS

Your GE Prescription Drug coverage ends when your GE Medical coverage ends. The same is true for your dependents. See Section 1.1.10, "WHEN DOES COVERAGE END?"

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 *Your Benefits Handbook — Eligibility and Administrative Information* for more information.

3.0 FLEXIBLE SPENDING ACCOUNT (FSA)/LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (LPFSA)

A Flexible Spending Account (FSA) is an account opened on your behalf by GE that you fund through pre-tax payroll deductions and use to pay for certain eligible medical, dental and vision expenses. A Limited Purpose Flexible Spending Account (LPSA) is an account opened on your behalf by GE that is similar to an FSA except that it is limited to paying dental and vision costs only.

3.1 FSA/LPSA PARTICIPATION

The following sections describe the Plan provisions that affect your eligibility for and participation in the FSA and LPSA.

3.1.1 WHO IS ELIGIBLE?

You are eligible to set up an FSA/LPFSA if you are a Company Employee eligible for coverage under GE Medical or a GE Dental Care Option, as described in Section 1.1.2, "WHO IS ELIGIBLE?"

If you are enrolled in either GE Medical Option 1 or Option 2 or waive medical benefits you are eligible for a FSA. If you enroll in GE Medical Option 3, you are eligible to enroll only in a LPFSA (which can only be used to cover eligible dental and vision expenses).

For the purposes of the FSA/LPFSA, your eligible dependents include only those individuals who meet Internal Revenue Service (IRS) rules. Please be aware that if you receive a qualified medical child support order (QMCSO) that is determined by the Plan Administrator to meet the requirements for a QMCSO. The Plan is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. For information about these orders or how to enroll a child in an FSA/LPFSA pursuant to a QMCSO or NMSN please see *Your Benefits Handbook — Eligibility and Administrative Information* or contact the GE Benefits Center at 1-800-252-5259.

3.1.2 HOW DO I ENROLL?

You can open an FSA/LPFSA by enrolling during the Annual Enrollment period that is usually held each fall. During Annual Enrollment you may elect an FSA/LPFSA by enrolling at **OneHR.ge.com** or by calling the GE Benefits Center at 1-800-252-5259. 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 an FSA/LPFSA whenever you add a Dependent through a qualified change in family status, as described in Section 3.1.3, "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 your employment status changes and your FSA/LPFSA contributions are suspended, when you return to active status you must call the GE Benefits Center at 1-800-252-5259 **within 63 days** to resume participation as an active Employee.

3.1.3 WHEN CAN I CHANGE MY PARTICIPATION?

You may make changes to your FSA/LPFSA participation during the year only if you experience a qualified change in family status or experience a special enrollment opportunity as defined by law. Changes must be made **within 63 days** after your change in family status, or you will 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 FSA/LPFSA 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 effective date of the qualified status change. However, if you add a Dependent through birth or lose a Dependent through 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) provided you make the change **within 63 days** after the event. See Section 3.1.5, "WHEN DOES PARTICIPATION END?" If you do not take action **within 63 days** of the event, no changes will be permitted.

Please Note —

- After you have increased your FSA/LPFSA contributions due to a qualified change in family status, in order for expenses to be eligible for reimbursement from the increased balance in your FSA/LPFSA, 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 or supply is rendered, ordered or received.
- If you have a qualified status change that allows you to elect or increase the amount of your FSA/LPFSA, 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 increased 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.

- Any changes also must be consistent with your change in family status. For example, if you have a baby, you may elect an FSA or LPFSA or increase your contributions, but you may not decrease your contributions. The Company shall determine, based on prevailing IRS guidance, whether a requested change satisfies the general consistency requirement. If the general consistency requirement is satisfied, a requested election change must also satisfy the consistency requirements in the following table.

3.1.4 QUALIFIED STATUS CHANGES

The following table reflects the election changes that may be made under the Plan with respect to GE Medical and the FSA/LPFSA. In addition, any permitted election changes must be consistent with the option in which you are enrolled (i.e., Option 1, 2 or 3).

Event	GE Medical	Health Care FSA / LPFSA
Marriage	Employee may enroll newly-eligible Spouse and Dependent, or cancel Employee's or Dependent's coverage if other coverage becomes effective or is increased under Spouse's health plan. As a special enrollment opportunity, Employee may enroll himself or herself, as well as any eligible Dependents who were not previously enrolled.	Employee may enroll or increase election due to newly-eligible Spouse or Dependent, or decrease election if other coverage becomes effective for Employee or Dependent under Spouse's health plan.
Loss of Spouse (such as divorce, legal separation, annulment, death of Spouse)	Employee may cancel coverage only for former Spouse, or elect coverage for self or Dependent who loses coverage under former Spouse's health plan.	Employee may decrease election due to former Spouse losing eligibility, or enroll or increase election if coverage is lost under former Spouse's health plan.
Change in the Number of Employee's Dependents		
Gain Dependent (such as birth or adoption, or judgment, decree or order)	Employee may enroll newly-eligible Dependent, or cancel Employee's or Dependent's coverage if Employee becomes eligible under Spouse's health plan. As a special enrollment opportunity, Employee may enroll himself or herself as well as any eligible dependents who were not previously enrolled. Coverage is provided in accordance with a judgment, decree or order only if the individual is otherwise eligible.	Employee may enroll or increase election.
Loss of Dependent (such as death)	Employee may drop coverage only for Dependent who loses coverage.	Employee may decrease election.
Change in Employment Status That Establishes Eligibility		
Commencement of Employment by Employee	Employee may enroll self, Spouse or Dependent.	Employee may enroll.
Commencement of Employment by Spouse or Dependent	Employee may cancel coverage for self, Spouse or Dependent.	Employee may decrease election.
Change of Employment Status That Causes Loss of Eligibility		
Termination or Other Change (e.g., layoff or leave) in Employee's Employment Status	Employee may cancel coverage for self, Spouse or Dependent.	Employee may decrease election.
Termination or Other Change in Spouse's or Dependent's Employment Status	Employee may enroll self, Spouse or Dependent.	Employee may enroll or increase election.

Event	GE Medical	Health Care FSA / LPFSA
Change in Place of Physical Residence of Employee		
Relocate to area with different Claims Administrator	Employee may cancel or change Claim Administrators.	No change permitted.
Relocate to area where your current plan option is no longer available	Employee may cancel or change coverage.	No change permitted.
Changes in Cost or Coverage		
Significant Cost Changes	**Significant Cost Increase:** Employee may cancel coverage and elect other coverage, if available.	No change permitted.
	Significant Cost Decrease: Employee may enroll.	No change permitted.
Loss of Other Health Coverage	As a special enrollment, Employee may elect coverage for Employee, Spouse or Dependent that has lost other coverage.	Employee may enroll or increase election.
Eligible Employee Becomes Entitled to Medicare, Medicaid or State Children's Health Insurance (SCHIP)	Employee may elect to cancel coverage for Employee, Spouse or Dependent, as applicable.	Employee may decrease or revoke election or increase election if FSA is dropped.
Eligible Employee Loses Eligibility for Medicare, Medicaid or SCHIP	Employee may to commence coverage for Employee, Spouse or Dependent, as applicable.	Employee may increase or revoke election.
Open Enrollment Under Plan of Spouse's or Dependent's Employer	Employee may elect or cancel coverage for self or dependents.	No change permitted.

3.1.5 WHEN DOES PARTICIPATION END?

Your participation in the FSA/LPFSA generally ends:

- At the end of the year if you do not enroll for the next year;
- As of the effective date of any permitted mid-year revocation of your enrollment;
- When you are no longer eligible for any reason; or
- When the FSA/LPFSA is terminated.

Even after your participation ends, you may be permitted to file claims for your Eligible Expenses incurred during the period when you were making FSA/LPFSA contributions, up until the claims filing deadline.

CONTINUATION UNDER COBRA

In certain situations, you may be able to continue your participation in your FSA/LPFSA under a federal law called COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. 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 and you are eligible for COBRA, you may make contributions to your FSA/LPFA for the remainder of the calendar year in which you become eligible for COBRA, but only on an after-tax basis. For more information about continuing your Health Care FSA/LPFSA participation under COBRA, see "Health Care Flexible Spending Account (FSA)" in *Your Benefits Handbook — Eligibility and Administrative Information*.

You will not get the same tax advantages making after-tax contributions as with pre-tax contributions. However, continuing participation under COBRA allows you to claim money you have already contributed that you might otherwise forfeit because you will be permitted to submit claims for eligible expenses incurred during the COBRA period. If you do not elect COBRA, you cannot submit claims for eligible expenses incurred during the COBRA period.

If you return to work at the Company in the same calendar year in which you leave, you must contact the GE Benefits Center at 1-800-252-5259 within 63 days of your return to work to re-enroll in coverage. Alternatively, you can wait until the next Annual Enrollment to set up an FSA/LPFSA for the next calendar year.

FMLA AND MILITARY LEAVES

If you are on an FMLA or military leave, you may be eligible to continue your FSA/LPFSA participation and your contributions 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/LPFSA election while on FMLA or military leave, you must call the GE Benefits Center at 1-800-252-5259. If you return to work in the same calendar year, you may resume contributions to an FSA/LPFSA 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/LPFSA while on FMLA leave, your coverage may end when FMLA leave ends. To continue coverage, you must elect COBRA. If you do not elect FSA/LPFSA 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/LPFSA election. You must contact the GE Benefits Center at 1-800-252-5259 within 63 days of your qualified status change.

If you return to work at the Company in the same calendar year in which you leave, you must contact the GE Benefits Center at 1-800-252-5259 within 63 days of your return to work to re-enroll in coverage. Alternatively, you can wait until the next Annual Enrollment to set up an FSA/LPFSA for the next calendar year.

3.1.6 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 FSA/LPFSA 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.

WHAT IF...	
For information about how your FSA/LPFSA is affected by...	**Please refer to...**
Leave of absence	*Your Benefits Handbook — Vacation and Other Time Off*
Disability	*Your Benefits Handbook — Disability, Life and Other Benefits*
Your death	*Your Benefits Handbook — Disability, Life and Other Benefits*
Layoff, Plant Closing or office closing	*Your Benefits Handbook — Job Loss Benefits*, or see your human resources representative

3.2 HOW THE FSA/LPFSA ACCOUNT WORKS

First, you decide how much money you want to contribute to your FSA/LPFSA for the coming year. You can use your FSA/LPFSA to help pay your share of IRS-qualified expenses. Your contributions are deducted from your paycheck before Social Security, federal and, in most locations, state and local income taxes are calculated. Your contributions are contributed to your FSA/LPFSA account.

Your annual election amount is deducted from your pay in equal amounts throughout the year. You will see the first deduction from your paycheck that includes January 1.

The W-2 you receive at year-end, showing your annual earnings, will not include the contributions you made to your FSA/LPFSA. These contributions are not part of your taxable income.

HOW DO HEALTH CARE AND DEPENDENT DAY CARE FSAs DIFFER?

Both the Health Care FSA and the Dependent Day Care FSA help you save money by letting you set aside money from your paycheck on a pre-tax basis to pay your share of eligible expenses. But the two accounts differ in the following ways:

- The Health Care FSA lets you pay for IRS-qualified health care expenses incurred by you or your eligible dependents with pre-tax dollars;
- The Dependent Day Care FSA lets you pay for child or adult care for qualified dependents with pre-tax dollars;
- The Dependent Day Care FSA does not have a savings account card;
- The definition of a Dependent is different for each account;
- Under the Health Care FSA, claims made for IRS-qualified health care expenses are immediately reimbursable, up to the amount of your annual contribution. See Section 3.2.3, "HOW CAN I RECEIVE REIMBURSEMENT?"; and
- Under the Dependent Day Care FSA, claims made for IRS-qualified expenses are reimbursable only up to the amount of your account balance at the time you file your claim. The remainder of the reimbursable amount is held until more contributions are deducted from your pay and added to your account. See *Your Benefits Handbook — Work and Family, Education and Other Benefits* for details.

The two accounts have the following provisions in common:

- You cannot transfer money between the accounts; and
- You cannot be reimbursed for dependent day care claims from your health care account and vice versa.

3.2.1 HOW MUCH CAN I CONTRIBUTE TO MY FSA/LPFSA ACCOUNT?

You may contribute up to $2,500 each year to your FSA/LPFSA. The annual amount you elect will be deducted in equal installments from your paycheck during the year. If you have a qualified status change that allows you to change your contribution amount, the amount of any increase or reduction is governed by the rules described in Section 3.1.3, "WHEN CAN I CHANGE MY PARTICIPATION?"

3.2.2 WHAT EXPENSES ARE ELIGIBLE?

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. Expenses that have been ruled eligible by the IRS for reimbursement from an FSA/LPFSA 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 GE Medical covers;*
- 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;
- Qualified Expenses for health care services for yourself and your eligible dependents that are not covered by a medical, dental or vision plan*; and
- Prescribed over-the-counter items that are used to diagnose, treat or prevent a medical condition.*

**Remember you can use your LPFSA for qualified dental and vision expenses only.*

To be eligible for FSA/LPFSA reimbursement, these expenses cannot be reimbursed in any other way, such as through GE Medical, GE Dental Care, GE Vision Care, by your Spouse's health plan or by any other health care plan.

Because FSA/LPFSAs are subject to tax law, their rules and limits may be changed during the year by the IRS. If you have any questions about Eligible or ineligible Expenses, call the FSA/LPFSA Claims Administrator.

3.2.3 HOW CAN I RECEIVE REIMBURSEMENT?

For those enrolled in an FSA/LPFSA only, the FSA/LPFSA Administrator will send you an FSA debit card that will contain your full account balance and that may be used at approved Providers and merchants for any FSA/LPFSA-eligible expenses.

If you are enrolled in GE Medical Option 1 or Option 2, you will receive a GE Pharmacy debit card that can be used for FSA/LPFSA-eligible expenses incurred at Network pharmacies and mail order prescription services. Please see Section 1.3.6, "HOW DOES A HEALTH CARE FSA WORK WITH THE HRA?" for more information. To receive reimbursement for non-prescription drug eligible expenses, please see the section below, "To Pay for IRS Qualified FSA/LPFSA Eligible Expenses" and Section 1.3.2, "HOW DO I USE THE HRA CREDITS?"

USING YOUR FSA DEBIT CARD FOR FSA IRS ELIGIBLE PHARMACY EXPENSES

You may use your FSA debit card to pay for IRS eligible pharmacy expenses at a pharmacy or through mail order. In most cases, you will not have to submit verification. This does not apply to LPFSA because only dental or vision expenses are eligible for reimbursement.

TO PAY FOR IRS QUALIFIED FSA/LPFSA ELIGIBLE EXPENSES

You can choose between two methods to pay your IRS qualified FSA/LPFSA eligible expenses using your FSA/LPFSA: Automatic Reimbursement or Manage Your Claims Online.

1. **Automatic Reimbursement**. After your claim has been processed by your Claims Administrator, the amount you need to pay your Provider will be automatically sent to you by direct deposit or check from your available FSA/LPFSA balance. If you use this method you will not have to submit verification or a claim form, except that if you go to an out-of-Network Provider, you may have to submit verification to be reimbursed.

2. **Manage Your Claims Online.** After your claim has been processed by your Claims Administrator, you can use the FSA/LPFSA administrator's online portal to have payment sent to your Provider or reimburse yourself. If you use this method you will not have to submit verification or a claim form, except that if you go to an out-of-Network Provider, you may have to submit verification to be reimbursed.

NOTE: If you take no action during Annual Enrollment, you will remain in your current FSA/LPFSA payment method. New hires will be enrolled in Automatic Reimbursement. You may change your reimbursement method at any time by calling WageWorks at 1-888-303-3006 or visiting your WageWorks portal at **www.wageworks.com/ge**.

You can always manually submit a medical claim form electronically through the FSA/LPFSA administrator's online portal. You can also print a claim form and fax or mail it. When submitting a claim form, you will have to send in verification. Please contact the FSA/LPFSA Administrator if you have questions.

ORTHODONTIA REIMBURSEMENTS

Your FSA/LPFSA 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/LPFSA 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/LPFSA in the year in which you made the $2,400 payment, provided you contribute at least this amount to your FSA/LPFSA.

3.2.4 WHAT IF THERE IS MONEY LEFT IN MY FSA/LPFSA ACCOUNT?

FSA and LPFSA participants can carry over up to $500 of unused FSA or LPFSA funds with no restrictions on when those funds must be used. For example, up to $500 of any remaining balance from your FSA or LPFSA can be carried over into the next Plan year for use any time in that year or in subsequent Plan years. Any amount over $500 cannot be carried over and will be forfeited per IRS guidelines.

CLAIMS FILING DEADLINE

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 or supply is rendered, ordered or received. Any forfeited money is used for the administration of the accounts and to offset plan losses.

Because the FSA/LPFSA is governed by IRS rules, all FSA/LPFSA usage is subject to review and verification. All claims must be submitted to the FSA/LPFSA administrator and verified **on or before June 30** of the following year. Verification is proof that an expense is an Eligible Expense. You should keep your documentation for future reference because you may be asked to submit them for verification. In some cases, such as prescription drug claims paid using your debit card, verification will occur automatically (FSA only).

If you do not adequately verify FSA/LPFSA usage, you must repay the unverified amount. The FSA/LPFSA administrator may:

- Request return of any unverified payments;
- Offset future FSA/LPFSA-eligible expenses;
- Disable your debit card; and/or
- Treat any unverified expenses as taxable income.

If you do not satisfy your repayment obligation, your FSA/LPFSA may be suspended or terminated.

3.2.5 HOW WILL AN FSA/LPFSA AFFECT MY TAXES?

If your IRS-qualified expenses exceed the percent of your adjusted gross income as determined by the IRS, you can deduct them on your federal income tax return. However, if you participate in the FSA/LPFSA and you have already been reimbursed for an expense through your FSA/LPFSA, 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/LPFSA, 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.

3.2.6 CAN PARTICIPATION IN AN FSA/LPFSA AFFECT MY OTHER BENEFITS?

Generally, your other benefits are not affected by participation in an FSA/LPFSA. Even though you reduce your income for tax purposes by using an FSA/LPFSA, you are generally not reducing your pay for determining other pay-related benefits. Life insurance benefits, disability benefits and the Retirement Savings Plan (RSP) are based on your pay before FSA/LPFSA contributions are deducted.

SOCIAL SECURITY

Because Social Security taxes are not withheld on contributions to your FSA/LPFSA, the earnings used to calculate your Social Security benefits may be reduced if you participate in an FSA/LPFSA. This reduction in earnings may reduce the Social Security benefits to which you would otherwise be entitled.

The Social Security wage base is established by the federal government each year. If your earnings minus any contributions to your FSA/LPFSA equal or exceed the wage base, your Social Security benefits will not be affected by participating in the FSA/LPFSA. If your earnings minus any contributions to your FSA/LPFSA are less than the Social Security wage base, Social Security benefits may be reduced. The Social Security taxable wage base for 2016 is $118,500.

There is no simple way to estimate the effect that a one-year reduction in wages will have on your future Social Security benefits. This depends on your age, the kind of benefit being calculated (for example, a Social Security disability benefit as opposed to a Social Security old-age benefit) and your entire earnings history.

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.

For important information about the administration of GE Dental Care Options, see *Your Benefits Handbook — Eligibility and Administrative Information*.

4.1 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. The cost of coverage depends on your employment status as either a full-time or part- time Employee and the specific option you choose. Contribution rates are published each year and available at **OneHR.ge.com** or by contacting the GE Benefits Center at 1-800-252-5259.

4.1.1 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, orthodontia, oral surgery and more.

The key difference is that the GE Dental Schedule Option covers certain services, such as diagnostic, preventive, restorative and prosthodontic care, 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. Another difference is that the dental maximum for fillings, crowns, inlays, onlays, dentures, fixed bridges and dental implants ($2,500) under the GE Dental Schedule Option resets every two years; under the Dental Premium Option it resets every calendar year.

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 4.2.1, "HOW CAN I SAVE BY USING NETWORK DENTISTS?"

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	Paid up to scheduled amounts, up to a combined maximum of $2,500 over two consecutive calendar years for these services and for implants, crowns, inlays/onlays, dentures and bridges.	100% of reasonable, necessary and customary charges, up to a combined maximum of $2,500 per year for these services and for implants, crowns, inlays/onlays, dentures and bridges.
Crowns, inlays and onlays	Paid up to scheduled amounts, up to a combined maximum of $2,500 over two consecutive calendar years for these services and for implants, fillings, 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 implants, fillings, 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 implants, fillings, crowns and inlays/onlays.	50% of reasonable, necessary and customary charges, up to a combined maximum of $2,500 per year for these services and for implants, fillings, crowns and inlays/onlays.
Dental implants	50% of reasonable, necessary and customary charges, up to a combined maximum of $2,500 over two consecutive calendar years for these services and for fillings, crowns, inlays/onlays, dentures and bridges.	50% of reasonable, necessary and customary charges, up to a combined maximum of $2,500 per year for these services and for fillings, crowns, inlays/onlays, dentures and bridges.
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 (Full time Employees)	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 Claims Administrator. See Section 4.2.2, "HOW DOES REASONABLE, NECESSARY AND CUSTOMARY WORK?"

4.1.2 WHO IS ELIGIBLE?

You are eligible to enroll in a GE Dental Care option if you are eligible to enroll in a GE Medical Option as described in Section 1.1.2, "WHO IS ELIGIBLE?"

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

YOUR DEPENDENTS

If you are eligible to enroll in a GE Dental Care option, you also may enroll your eligible dependents. Eligible dependents are described in *Your Benefits Handbook — Eligibility and Administrative Information*. 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.

IF YOUR SPOUSE IS A COMPANY EMPLOYEE

If both you and your Spouse are eligible Company Employees, you may choose to either:

- **Enroll only one of you as a Company Employee** — the Spouse with the lower wage band must be covered as a Dependent of the higher wage band Employee (if you are both in the same wage band, either of you may enroll as the "Employee"); or
- **Enroll both yourself and your Spouse 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.

4.1.3 HOW DO I ENROLL WHEN I FIRST BECOME ELIGIBLE?

When you first become eligible, you will 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.

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

- Decide which GE Dental Care option you wish to enroll in; and
- Decide which level of coverage you want — coverage for yourself only, or for yourself and your eligible dependents.

You can enroll for coverage under a GE Dental Care option **within 63 days** after you become eligible. If you make no election by the end of the 63-day deadline, you will automatically be enrolled in the GE Dental Schedule Option at the "Three or More" coverage level. See *Your Benefits Handbook — Eligibility and Administrative Information* for details about the GE Enrollment Safety Net. 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 — To cover a dependent, you must provide each eligible Dependent's name, birth date and Social Security number. You may be required to provide proof of eligibility. Remember that all covered family members must participate in the same GE Dental Care option in which you participate.

Special provisions apply to Spouses who also work for the Company. See "IF YOUR SPOUSE IS A COMPANY EMPLOYEE" in Section 4.1.2, "WHO IS ELIGIBLE?"

HOW TO WAIVE COVERAGE

If you do not 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 at 1-800-252-5259.

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

If you are full-time and 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 you contact the GE Benefits Center at 1-800-252-5259.

4.1.4 WHEN CAN I MAKE CHANGES TO MY COVERAGE?

If you are a full-time Employee 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:

- **Under the GE Dental Schedule Option, at any time if you are not enrolled in a GE Dental Care Option.** Even if you do not 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 you contact the GE Benefits Center at 1-800-252-5259.
- **Under the GE Dental Premium Option, only after certain events.** These include adding a new Dependent due to marriage, losing coverage under another dental plan, a change in employment status or relocation that affects your eligibility for a GE Dental Care option or other qualified status changes. You have **63 days** to enroll in either GE Dental Care option or to make certain changes; and
- 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. If you are currently enrolled in a GE Dental Care option, you may switch to the other GE Dental Care option only during Annual Enrollment.

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

If you are a part-time Employee, you must make changes **within 63 days** of a qualified status change. Otherwise, you must wait for the next Annual Enrollment to elect coverage.

ADDING DEPENDENTS TO YOUR COVERAGE

To add a Dependent after your initial enrollment in either GE Dental Care option, you may do so at **OneHR.ge.com** or by calling the GE Benefits Center at 1-800-252-5259. You will need to enroll your Dependent within 63 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. No benefits will be paid until this information is provided.

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 must first enroll yourself and then you may also enroll 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 are full-time and 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 GE receives notification.

DISCONTINUING COVERAGE

Under the GE Dental Premium Option, 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. As noted above, you may enroll in or disenroll from the GE Dental Schedule Option at any time (if you are full-time) by contacting the GE Benefits Center at 1-800-252-5259.

IF YOU LOSE OTHER COVERAGE

If you waived GE dental coverage, and you or your Dependents subsequently 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 are full-time and enroll **more than 63 days** after losing other coverage, you may enroll only in the GE Dental Schedule Option, and coverage is effective on the enrollment date.

4.1.5 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; and
- **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. Contribution rates are available on **OneHr.ge.com** or **www.ge.com/healthahead**.

Note: If you are eligible as a part-time Company Employee, you will be required to pay contributions for any GE Dental Care option. If you are eligible, you will be notified about your cost for coverage.

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 and state law, 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.

LAWS AFFECTING THE COST OF DENTAL BENEFITS

If an applicable federal law mandates coverage or benefits in excess of what your GE Dental Care option pays, GE Dental Care will provide the additional coverage or benefits. If you are impacted by such a law, your contributions may 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.

4.1.6 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 and Network payment provisions. In most cases the Company 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 Claims Administrator.

You will be required to provide information that the Claims Administrator needs to prevent duplication of benefits.

WHEN YOUR SPOUSE HAS COVERAGE AT WORK

If you (and/or your Dependents) are covered by two or more plans, benefit payments follow the rules described in Section 1.1.8, "WHAT IF THERE IS OTHER COVERAGE?" Here is a brief summary of how coordination of dental benefits works when your Spouse has employer-sponsored dental coverage:

- **For you** — your GE Dental Care option is your primary coverage, if you are enrolled. Submit your dental bills to the Company plan first, then to your Spouse's plan;
- **For your Spouse** — your Spouse'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; and
- **For your children** — if your children are covered under both your GE Dental Care Option and your plan, the "birthday rule" determines which plan is primary. The plan covering the Spouse 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 for the longer period of time will pay first. The "birthday rule" also applies to your new Spouse if you are remarried.

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

A Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN) that, in either case, the Plan Administrator determines meets the requirements for a QMCSO may require a child to be covered under the GE Dental Care Option. For information about these orders or how to enroll a child in GE Dental Care pursuant to a QMCSO or NMSN please see *Your Benefits Handbook — Eligibility and Administrative Information* or contact the GE Benefits Center at 1-800-252-5259.

4.1.8 WHEN DOES COVERAGE END?

Subject to any right to purchase COBRA coverage (described below), coverage under GE Dental Care ends pursuant to the same rules as those described for termination of GE Medical or a GE Medical Option. See Section 1.1.10, "WHEN DOES COVERAGE END?"

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.

WHAT IF...	
For information about how your dental coverage is affected by...	**Please refer to...**
Leave of absence	*Your Benefits Handbook — Vacation and Other Time Off*
Disability	*Your Benefits Handbook — Disability, Life and Other Benefits*
Your death	*Your Benefits Handbook — Disability, Life and Other Benefits*
Layoff, Plant Closing or office closing	*Your Benefits Handbook — Job Loss Benefits,* or see your human resources representative

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 *Your Benefits Handbook — Eligibility and Administrative Information* for information about COBRA.

4.1.9 WHAT PRIVACY RIGHTS APPLY TO MY DENTAL RECORDS?

Federal and state law gives individuals broad protections over the privacy of their personal health information. In particular, regulations under the Health Insurance Portability and Accountability Act (HIPAA) 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. The Notice of Privacy Practices is available at **OneHR.ge.com** and in *Your Benefits Handbook — Eligibility and Administrative Information*. If you would like a paper copy, you may also contact the GE Benefits Center at 1-800-252-5259.

4.2 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 4.3.2, "WHAT DOES THE GE DENTAL SCHEDULE OPTION COVER?"; Section 4.4.2, "WHAT DOES THE GE DENTAL PREMIUM OPTION COVER?" and Section 4.5, "WHAT IS 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 GE Medical. If your dentist recommends one of these types of services, be sure to call the GE Dental Claims Administrator in advance to determine whether the service is payable under your GE Dental Care Option or GE Medical. For more information, see Section 4.2.3, "HOW DOES PREDETERMINATION OF BENEFITS WORK?" To determine whether the service would be covered under your GE Medical Plan, and to verify Network status, contact your Medical Claims Administrator. For accidental dental Injury treatment, see Section 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS."

4.2.1 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 **OneHR.ge.com** or by calling the GE Dental Benefit Claims Administrator. You are always free to choose any dental Provider.

4.2.2 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 Dental Benefit Claims Administrator.

However, some dental Providers who are not part of a preferred Provider Network may charge fees in excess of what is reasonable, necessary and customary. To help the Dental Benefit Claims 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 is considered** reasonable, necessary and customary. Most dentists are familiar with this concept. Refer your dentist directly to the Dental Benefit Claims Administrator if he or she has any questions. Also, discuss with your dentist and your Dental Benefit Claims Administrator the potential cost for services. See Section 4.2.3, "HOW DOES PREDETERMINATION OF BENEFITS WORK?"
2. **Read before signing** — do not agree in advance to pay your dentist or other dental Provider a specific amount. If you are asked to sign a statement before receiving dental services, read it carefully to make sure it does not 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 have followed these steps and your Provider insists that you pay additional amounts, contact the Dental Benefit Claims Administrator as soon as possible. The Dental Benefit Claims 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.

You will be responsible for charges above the reasonable, necessary and customary charges.

To find out how payments on a schedule work for the Dental Schedule Option- see Section 4.3.3, "HOW DOES THE SCHEDULE OF BENEFITS WORK?"

4.2.3 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 will be responsible for paying. Predetermination of benefits is recommended whenever your Provider proposes costly or extensive dental treatment.

Through this process, you will also be notified if your GE Dental Care option will pay benefits based on an alternative method of treatment; see Section 4.2.4. "WHAT IF AN ALTERNATIVE TREATMENT IS APPROPRIATE?"

Here is how to predetermine your benefits:

1. **Before treatment begins, ask your dentist to complete a dental claim form** — obtain a claim form from **OneHR.ge.com** or call the GE Dental Benefits Claims Center. 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 "Pretreatment Estimate" box;
   – Attach X-rays and other diagnostic information; and
   – Mail the form to the Dental Benefit Claims Administrator at the address shown on the form.
2. **Receive an estimate** — the Dental Benefit Claims 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 Dental Benefit Claims 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; see Section 4.2.4, "WHAT IF AN ALTERNATIVE TREATMENT IS APPROPRIATE?" for more information.
3. **Discuss any alternative treatment options with your dentist** — to determine the treatment plan that best meets your dental needs.

4.2.4 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 Dental Benefit Claims 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.

4.2.5 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 is 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 the dental claim form** — be sure to check the box authorizing direct payment to the dentist. Obtain a claim form from **OneHR.ge.com** or call the GE Dental Benefit Claims Administrator.
2. **Ask your dentist to complete the dentist portion of the form** — and mail the form to the Dental Benefit Claims Administrator at the address shown on the form.
3. **Receive notification** — the Dental Benefit Claims Administrator will pay your dentist directly. You will be notified of any amount you are responsible for paying.

IF YOU PAY THE BILL YOURSELF

1. **Complete and sign the employee portion of the dental claim form** — obtain a claim form from **OneHR.ge.com**, or call the GE Dental Benefits Claims Center.
2. **Ask your dentist to complete the dentist portion of the form.**
3. **Mail the form to the Dental Benefit Claims Administrator** — at the address shown on the form. Be sure to attach copies of your receipts, an itemized list of services and any other necessary documentation.
4. **Receive reimbursement** — the Dental Benefit Claims Administrator will send you a check for reimbursement according to plan benefits. You will also receive written notification.
5. **File claims by June 30** — All claims for Eligible Expenses incurred in a calendar year must be submitted by June 30 of the next following calendar year.

For information about the claims and appeals procedures of GE Dental Care, see *Your Benefits Handbook — Eligibility and Administrative Information*.

4.2.6 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
Michelle 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, bridges, and implants — 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.

FOR EXAMPLE - ORTHODONTIA
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 4.1.4, "WHEN CAN I MAKE CHANGES TO MY COVERAGE?"

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.

4.3 DENTAL PARTICIPATION

You 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.

4.3.1 HOW DOES THE GE DENTAL SCHEDULE OPTION WORK?

Here is 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 4.2.3, "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:
    - Dental implants;
    - Root canals and other endodontic services;
    - Gum treatment (periodontic services);
    - Oral surgery;
    - Braces and other orthodontic services for children; and
    - Treatment of accidental Injury not covered under your medical benefits (see Section 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS").

- **If the Dental Benefit Claims 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 4.2.4, "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 4.2.5, "HOW DO I CLAIM BENEFITS?"

4.3.2 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 Dental Benefit Claims Administrator determines that an alternative treatment is appropriate, benefits will be based on the alternative treatment. See Section 4.2.4, "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 4.3.5, "SCHEDULE OF BENEFITS." 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; and
- **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, inlays/onlays and crowns), called restorative services.

Benefits are paid up to scheduled amounts. The combined maximum benefit available for these services and for bridges, dentures and implants 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 4.3.5, "SCHEDULE OF BENEFITS" for details.

Covered restorative services include:

- **Fillings** — amalgam (silver), composite (tooth colored) fillings to restore the structure of teeth and to prevent further decay;
- **Inlays or onlays** — dental restoration (gold or porcelain) fabricated outside the oral cavity, then used to restore the structure of teeth and to prevent further decay; and
- **Crowns** — usually porcelain, gold or acrylic, used to cover the exposed portion of badly decayed or broken teeth.

BRIDGES, DENTURES AND IMPLANTS (PROSTHODONTIC CARE)

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

Benefits for bridges and dentures are paid up to scheduled amounts; implants are reimbursed at 50% of reasonable, necessary and customary charges. 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 4.3.5, "SCHEDULE OF BENEFITS" for details.

Covered prosthodontic services include:

- **Dentures** — to replace teeth or dentures that are more than five years old and no longer usable or repairable;
- **Fixed bridgework** — a permanent replacement for natural teeth, or for a partial appliance or bridgework that is more than five years old and no longer usable or repairable; and
- **Implants** — placement of an artificial or natural tooth into the gums.

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 4.2.2, "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; and
- **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 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS." 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 4.2.2, "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 4.2.2, "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**.

4.3.3 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 4.3.2, "WHAT DOES THE GE DENTAL SCHEDULE OPTION COVER?"

The schedule of benefits lists the maximum amount the Plan will pay for the specified dental procedure. 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.

Here is 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 4.3.4, "WHICH SCHEDULE APPLIES?"
2. **Find your dental procedure on the schedule** — see Section 4.3.5, "SCHEDULE OF BENEFITS." Procedures are listed by name and code number. If your procedure is not 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 4.2.3, "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 and you are responsible for the balance.

Keep in mind that if the Dental Benefits Claims Administrator determines that an alternative treatment is appropriate, your benefits will be based on the alternative treatment. See Section 4.2.4, "WHAT IF AN ALTERNATIVE TREATMENT IS APPROPRIATE?"

4.3.4 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) • Remainder of state	 C B
Connecticut • Southwestern area (zip codes 064-069) • Remainder of state	 C B
Delaware	B
Florida • Miami area (zip codes 330-334) • Remainder of state	 C B
Georgia • Atlanta area (zip codes 300-303) • Remainder of state	 B A
Hawaii	C
Idaho	A
Illinois • Chicago area (zip codes 600-608) • Remainder of state	 B A

STATE / CITY	SCHEDULE
Indiana • Gary area (zip codes 463-464) • Remainder of state	 B A
Iowa	A
Kansas	A
Kentucky	A
Louisiana	B
Maine	A
Maryland • Washington, DC area (zip codes 200-209) • Baltimore area (zip codes 210-214) • Remainder of state	 C B A
Massachusetts • Boston area (zip codes 017-024) • Remainder of state	 C B
Michigan • Detroit area (zip codes 480-482) • Remainder of state	 C B
Minnesota	A
Mississippi • Jackson area (zip code 392) • Remainder of state	 B A
Missouri • St. Louis area (zip codes 630-633) • Remainder of state	 B A
Montana	B
Nebraska	A
Nevada	C
New Hampshire	A
New Jersey • Southern area (zip codes 080-084) • Remainder of state	 B A
New Mexico	B
New York • New York City area (zip codes 100-119) • Buffalo/Rochester area (zip codes 140-146) • Eastern area (zip codes 120-129) • Remainder of state	 C B B A
North Carolina	A
North Dakota	A
Ohio • Cleveland (zip code 441) • Northeast area (zip codes 440 and 442-447) • Remainder of state	 C B A
Oklahoma	B

STATE / CITY	SCHEDULE
Oregon • Portland area (zip codes 970-972) • Remainder of state	 C 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) • Houston area (zip codes 770-776) • Remainder of state	 C C B
Utah	A
Vermont	A
Virginia • Washington, DC area (zip codes 220-223) • Portsmouth, Petersburg, Richmond area (zip codes 230-238) • Remainder of state	 C B A
Washington • Seattle area (zip codes 980-984) • Remainder of state	 C B
West Virginia	A
Wisconsin • Milwaukee area (zip codes 530-534) • Remainder of state	 B A
Wyoming	B
Outside the U.S.	C

4.3.5 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 4.2.3, "HOW DOES PREDETERMINATION OF BENEFITS WORK?"

	ADA Procedure Code	Effective 1/1/16 Schedule			Effective 1/1/17 Schedule		
		A	B	C	A	B	C
PREVENTIVE AND DIAGNOSTIC CARE							
	Clinical oral exams — maximum of two during any calendar year						
00120	Periodic oral evaluation	$33	$36	$44	$34	$38	$46
00150	Comprehensive oral evaluation	$48	$53	$63	$50	$55	$66
	Preventive cleanings — maximum of two during any calendar year						
01110	All adults and children age 13 and over	$69	$75	$92	$72	$78	$96
01120	Children up to age 13	$47	$50	$62	$49	$52	$65
	X-rays (radiographs)						
00210	Within the mouth — complete series (including bitewings); maximum of one during any three consecutive calendar years	$105	$113	$138	$110	$118	$144
00272	Bitewing — two films*	$29	$31	$38	$30	$32	$40
00274	Bitewing — four films*	$44	$48	$59	$46	$50	$62
	** Maximum of two sets of bitewing x-rays during any calendar year*						
	Fluoride treatments — maximum of one during any calendar year						
01208	Topical application of fluoride, excluding preventive cleanings, for adults and children	$23	$28	$32	$24	$29	$33
	Sealants — maximum of one application for each permanent tooth every 36 months						
01351	Permanent back teeth only, for children under age 14	$39	$42	$53	$41	$44	$55
	Space maintainers — including adjustments following installation						
01510	Fixed, unilateral type (limited to children under age 19, for replacement of prematurely lost temporary teeth)	$229	$250	$303	$239	$261	$317
RESTORATIVE SERVICES							
	Emergency treatment						
09110	Treatment for dental pain, minor procedures	$76	$83	$101	$79	$87	$106
	Amalgam restorations (fillings) — including polishing						
02140	One surface, primary or permanent	$47	$52	$63	$49	$54	$66
02150	Two surfaces, primary or permanent	$59	$65	$78	$62	$68	$82
02160	Three or more surfaces, primary or permanent	$67	$73	$88	$70	$76	$92

	ADA Procedure Code	Effective 1/1/16 Schedule			Effective 1/1/17 Schedule		
		A	B	C	A	B	C
RESTORATIVE SERVICES (Continued)							
	Resin restorations (plastic or acrylic fillings)						
02330	One surface, front tooth	$53	$57	$69	$55	$60	$72
02331	Two surfaces, front tooth	$63	$69	$84	$66	$72	$88
02332	Three or more surfaces, front tooth	$78	$86	$102	$82	$90	$107
02391	One surface, primary or permanent	$57	$61	$75	$60	$64	$78
02392	Two surfaces, primary or permanent	$76	$83	$100	$79	$87	$105
02393	Three or more surfaces, primary or permanent	$91	$101	$122	$95	$106	$127
	Metallic inlay restorations						
02510	Inlay – one surface	$267	$294	$365	$279	$307	$381
02520	Inlay – two surfaces	$338	$369	$448	$353	$386	$468
02530	Inlay – three surfaces	$387	$425	$515	$404	$444	$538
	Crowns — single restorations only						
02720	Resin with metallic crown	$427	$467	$566	$446	$488	$592
02750	Porcelain fused to metallic crown	$439	$481	$583	$459	$503	$609
02790	Full cast metallic crown	$424	$462	$560	$443	$483	$585
02920	Re-cement crown	$33	$36	$44	$34	$38	$46
02930	Prefabricated stainless steel crown, temporary tooth	$90	$100	$120	$94	$105	$125
02931	Prefabricated stainless steel crown, permanent tooth	$106	$116	$141	$111	$121	$147
PROSTHODONTIC SERVICES							
	Removable dentures — including six months of post-delivery care						
05110	Complete upper denture	$488	$533	$647	$510	$557	$676
05130	Immediate complete upper denture	$526	$575	$698	$550	$601	$729
05211	Partial upper denture — resin base (including any conventional clasps, rests and teeth)	$407	$508	$599	$425	$531	$626
05212	Partial lower denture — resin base (including any conventional clasps, rests and teeth)	$407	$513	$630	$425	$536	$658
05213	Partial upper denture — cast metal base with resin saddles (including any conventional clasps)	$559	$613	$743	$584	$641	$776
05214	Partial lower denture — cast metal base with resin saddles (including any conventional clasps, rests and teeth)	$559	$613	$743	$584	$641	$776
	Repairs to dentures						
05610	Repair resin saddle or base	$58	$62	$77	$61	$65	$80
05620	Repair cast framework	$70	$77	$93	$73	$80	$97
05630	Repair or replace broken clasp	$71	$77	$93	$74	$80	$97
05640	Repair broken tooth	$65	$70	$86	$68	$73	$90
05660	Add clasp to existing partial denture	$73	$82	$99	$76	$86	$103

	ADA Procedure Code	Effective 1/1/16 Schedule			Effective 1/1/17 Schedule		
		A	B	C	A	B	C
PROSTHODONTIC SERVICES (Continued)							
	Denture relining — maximum of one per denture during any three calendar years						
05750	Reline upper completed denture (laboratory)	$145	$158	$191	$152	$165	$200
05751	Reline lower completed denture (laboratory)	$145	$158	$191	$152	$165	$200
	Fixed prosthodontics (fixed bridges)						
06210	Bridge pontic — cast metal	$424	$462	$560	$443	$483	$585
06240	Bridge pontic — porcelain fused to metal	$439	$481	$583	$459	$503	$609
06750	Abutment crown — porcelain fused to metal	$439	$481	$583	$459	$503	$609
06790	Abutment crown — metal (full cast)	$424	$462	$560	$443	$483	$585
06930	Re-cement bridge	$47	$53	$63	$49	$55	$66

4.4 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, 100% for fillings and 80% for other restorative care inlays crowns), 50% for prosthodontic care (bridges, dentures and implants), 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.

4.4.1 HOW DOES THE GE DENTAL PREMIUM OPTION WORK?

Here is 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 GE Dental Premium Option 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.

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 **OneHR.ge.com** or call the GE Dental Benefits Claims Center.

4.4.2 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 Dental Benefit Claims Administrator determines that an alternative treatment is appropriate, benefits will be based on the alternative treatment. See Section 4.2.4, "WHAT IF AN ALTERNATIVE TREATMENT IS APPROPRIATE?"

PREVENTIVE AND DIAGNOSTIC CARE AND FILLINGS

The GE Dental Premium Option covers the major share of preventive and diagnostic services and fillings 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 1;
- **Emergency treatment** — immediate treatment for dental pain; and
- **Fillings** — amalgam (silver), composite (tooth colored) fillings to restore the structure of teeth and to prevent further decay. Fillings are subject to an annual maximum of $2,500, which also applies to crowns, inlays, onlays, and prosthodontic care (i.e., bridges, dentures and implants) (described below).

CROWNS, INLAYS AND ONLAYS

The GE Dental Premium Option covers the repair and restoration of natural teeth (inlays, onlays and crowns).

Crowns, inlays and onlays are paid at 80% of reasonable, necessary and customary charges. The combined maximum benefit available for these services and for bridges, fillings, dentures and implants is $2,500 per year.

Covered restorative services include:

- **Inlays or onlays** — dental restoration (gold or porcelain) fabricated outside the oral cavity, then used to restore the structure of teeth and to prevent further decay, and
- **Crowns** — usually porcelain, gold or acrylic, used to cover the exposed portion of badly decayed or broken teeth.

BRIDGES, DENTURES AND IMPLANTS (PROSTHODONTIC CARE)

The GE Dental Premium Option covers the construction and repair of bridges, dentures and implants, 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, inlays/onlays and crowns is $2,500 per year.

Covered prosthodontic services include:

- **Dentures** — to replace teeth or dentures that are more than five years old and no longer usable or repairable;
- **Fixed bridgework** — a permanent replacement for natural teeth or for a partial appliance or bridgework that is more than five years old and no longer usable or repairable; and
- **Implants** — placement of an artificial or natural tooth into the gums.

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; and
- **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 1.6.10, "DENTAL SERVICES — ACCIDENTAL AND CERTAIN OTHER CONDITIONS."

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 4.2.2, "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 Premium 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 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 4.2.2, "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**.

4.5 WHAT IS NOT COVERED?

Some services and supplies are not covered by either GE Dental Care Option.

Expenses not covered include:

- Services or supplies that are not considered reasonable, necessary and customary by the Dental Benefit Claims 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;
- 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;
- 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, except no-fault auto insurance);
  - 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).

4.6 SUBROGATION

The subrogation provisions described in Section 1.9, "SUBROGATION" shall apply to any benefits under the GE Dental Care options.

5.0 VISION CARE BENEFITS

GE Vision Care benefits are included under your GE Medical coverage. These benefits help 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 have exhausted your GE Vision Care benefits, the GE Vision Value Option offers significant savings on the cost of additional vision care services. Your Vision Care Claims Administrator — Davis Vision — is different from your GE Medical Claims Administrator.

For important information about the administration of GE Vision Care, see *Your Benefits Handbook — Eligibility and Administrative Information*.

5.1 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 GE Medical. No additional contributions are required.

In addition, at the same times that you are permitted to enroll or change your GE Medical Options as described in Section 1.1.4, "WHEN CAN I MAKE CHANGES TO MY COVERAGE?," you may enroll or change your enrollment in The GE Vision Premium Option, which provides additional vision benefits. **If you enroll in the GE Vision Premium Option, you may be required to pay a portion of the cost of coverage.**

5.1.1 WHO IS ELIGIBLE?

You are eligible for GE Vision Care if you are enrolled in GE Medical.

If you are eligible, coverage begins automatically when GE Medical 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 dependents. For example, if you have two covered dependents in your GE Vision Care Option, those same two dependents must be enrolled in GE Medical.

GE Vision Care coverage ends when you or your dependents' GE Medical coverage ends. For more information, see Section 1.1.10, "WHEN DOES COVERAGE END?"

5.1.2 WHAT IF THERE IS OTHER COVERAGE?

If you have other vision care coverage, such as through a Spouse's plan at work, maintenance of benefits applies. See Section 1.1.8, "WHAT IF THERE IS OTHER COVERAGE?"

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

A Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN) that, in either case, the Plan Administrator determines meets the requirements for a QMCSO, may require a child to be covered under the GE Vision Care Option. For information about these orders or how to enroll a child in GE Vision Care pursuant to a QMCSO or NMSN please see *Your Benefits Handbook — Eligibility and Administrative Information* or contact the GE Benefits Center at 1-800-252-5259.

5.2 HOW THE PLAN WORKS

GE Vision Care pays benefits, according to a schedule, for covered vision care services and supplies, as follows:

Under the GE Vision Standard Option, you are eligible for benefits:

- Every calendar year for an eye examination; every other calendar year for eyewear — for you and your eligible Dependents beginning in the calendar year after turning 19;
- Every calendar year for eye examination and eyewear — for your eligible Dependents through the end of the calendar year in which they turn 19; and
- Every calendar year eye examination and eyewear — for you and your eligible Dependents if you enroll in the Vision Premium Option.

Remember that you must file claims by June 30 for expenses that were incurred during the previous calendar year.

5.2.1 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.

GE VISION CARE			
Benefit	Vision Standard Option*		Vision Premium Option*
	Age 19 & Over**	Under Age 19	All Members
Eye Examination (including dilation)	Once every 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
Frames	Once every other calendar year	Once every calendar year	Once every calendar year
Contact Lenses (in lieu of spectacle lenses)	Once every other calendar year	Once every calendar year	Once every calendar year

** Only Employees enrolled in a GE Medical Option may be eligible for GE Vision Care Benefits.*
*** Beginning in the calendar year after turning age 19. See Section 5.2, "HOW THE PLAN WORKS."*
****In lieu of collection contact lenses, members may use their elective allowance toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. The elective allowance would apply toward all contact lenses received at a participating retail location.*

In-Network Benefits		
Benefit	**Vision Standard Option***	**Vision Premium Option***
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
Frames		
• In-Network Retail Allowance	$120	$150
• Collection frames may also be available onsite at no cost or for a $25 co-pay under the GE Vision Standard Option*		
Contact Lenses (in lieu of spectacle lenses)		
• Elective Allowance		
– Single Vision	Up to $130	Up to $200
– Bifocal	Up to $175	Up to $200
• Collection contact lenses with Fitting/Follow Up Care (in lieu of Elective Allowance), Non-collection contact lenses***		
– Disposable	Included (up to 4 boxes)	Included (up to 8 boxes)
– Planned Replacement	Included (up to 2 boxes)	Included (up to 4 boxes)
Spectacle Lens Options (may be selected at the point-of-service)		
• Edge Treatment	$0	$0
• Tints	$0	$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)	$0	$0
• Standard Progressive Lenses (PALs)	$50	$0
• Select PALs	$70	$5
• Premium PALs (Varilux™, etc.)	$90	$25
• Ultra PALs	$140	$75
• Anti-Reflective Coating (ARC)		
– Standard / Premium / Ultra	$35 / $48 / $60	$0 / $0 / $0
• Photochromic Lenses (Transitions®, etc.)	$65	$65
• Polarized Lenses	$75	$75
• High Index Lenses	$55	$55
Low Vision Services and Devices		
• One comprehensive evaluation every five years	Maximum reimbursement of $300 per evaluation	Maximum reimbursement of $300 per evaluation
• Low vision device allowance	$600 per device with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes	$600 per device with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes

** Only Employees enrolled in a GE Medical Option may be eligible for GE Vision Care Benefits.*
*** Beginning in the calendar year after turning age 19. See Section 5.2, "HOW THE PLAN WORKS."*
****In lieu of collection contact lenses, members may use their elective allowance toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. The elective allowance would apply toward all contact lenses received at a participating retail location.*

In-Network Benefits		
Benefit	**Vision Standard Option***	**Vision Premium Option***
• 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 by the Vision Care Claims Administrator.)	Maximum reimbursement of $100 for each visit	Maximum reimbursement of $100 for each visit
Value-Added Features		
• One-year Breakage Warranty	Included	Included
• **DavisVisionContacts.com** Mail Order Program	Included	Included
• Laser Vision Surgery	Laser vision discount	Laser vision discount, plus up to $250 lifetime allowance, per eye
• Vision Value Option	Included	Included
Out-of-Network Benefits		
Eye Examination	Up to $40	Up to $40
Spectacle Lenses, per pair		
• Single Vision	Up to $45	Up to $45
• Bifocal	Up to $70	Up to $70
• Trifocal	Up to $100	Up to $100
• Lenticular	Up to $120	Up to $120
Frames	Up to $45	Up to $45
Contact Lenses		
• Single Vision	Up to $100	Up to $100
• Bifocal	Up to $150	Up to $150
• Laser Vision Surgery	N/A	$250 lifetime allowance per eye

** Only Employees enrolled in a GE Medical Option may be eligible for GE Vision Care Benefits.*
*** Beginning in the calendar year after turning age 19. See Section 5.2, "HOW THE PLAN WORKS."*
****In lieu of collection contact lenses, members may use their elective allowance toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. The elective allowance would apply toward all contact lenses received at a participating retail location.*

MORE ABOUT LASER SURGERY

Laser surgery to correct vision impairment is not a covered service under GE Medical 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 or 5% off the advertised special for that surgery. Additional information is available at **www.davisvision.com/GE** or you can contact the Vision Care Claims Administrator.

Please Note — Amounts you pay for routine vision care, including the cost of glasses or contact lenses, do not count toward your GE Medical 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), call your Medical Claims Administrator in advance to determine whether and how the care will be covered.

5.2.2 ABOUT NETWORK PROVIDERS

The Vision Care Network includes optometrists, ophthalmologists and opticians who have been selected by the Vision Care Claims 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 **OneHR.ge.com** by contacting the Vision Care Claims Administrator.

When you go to a Network Provider, be sure to identify yourself as a Davis Vision participant through GE 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.**

For information about the claims and appeals procedures of GE Vision Care, see *Your Benefits Handbook — Eligibility and Administrative Information*.

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.

5.2.3 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). You will be responsible for any amount above the scheduled amount. Your out-of-pocket costs may be substantially higher than if you had used a Network Provider. In addition, you will need to file claim forms to be reimbursed for covered expenses.

INITIATING CLAIMS FOR OUT-OF-NETWORK BENEFITS

Here is how to request benefits for out-of-Network Vision Care services:

1. **Complete and sign the employee and patient information portions of a Vision Care claim form** — claim forms are available at **OneHR.ge.com** or by contacting the Vision Care Claims Administrator.
2. **Ask your Provider to complete the Provider portion of the form.**
3. **Mail the form to the Vision Care Claims 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 the Vision Care Claims Administrator directly, be sure to sign the section of the form authorizing payment to the Provider. You will be notified of any amount you are responsible for paying.

If you have a question or problem with a claim, call the Vision Care Claims Administrator. For information about the claims and appeals procedures of GE Vision Care, see *Your Benefits Handbook — Eligibility and Administrative Information*.

5.2.4 HOW CAN I ORDER CONTACT LENSES BY MAIL?

Ordering replacement contact lenses is made easy by using an online mail order program at **www.DavisVisionContacts.com**. Through **www.DavisVisionContacts.com** you will receive free shipping on orders over $99 and a 10% discount when ordering an annual supply of contact lenses through the Web site. The Web site brings you the convenience of being able to order contacts from your mobile device or tablet. And, the auto-reorder program ensures regular delivery of fresh contacts direct to your door.

Here's how you use **www.DavisVisionContacts.com**:

1. Visit the **www.DavisVisionContacts.com** Web site and register. Enter your contact lens prescription, order request and payment information. Your prescription will be verified by your Provider within 8 hours (Monday-Friday) and shipped within 48 hours. If you have questions on using the site or about products featured on the site, simply click on "Contact Us" or call 1-855-589-7911.
2. If you have not already used your GE Vision Care benefits for lenses, you may apply your out-of-Network reimbursement benefit towards your purchase. To receive your reimbursement, visit **www.DavisVision.com**, log in as a member, download, complete and submit the Out-of-Network Vision Care Claim. For additional details on submitting an Out-of-Network Vision Care Claim Form, please see Section 5.2.3. "WHAT IF I GO OUT-OF-NETWORK?"
3. If you have questions related to your member benefits, contact Davis Vision member services for GE members at 1-800-433-9375 or visit **www.DavisVision.com**.

5.2.5 WHAT IS NOT COVERED?

As with all health benefit plans, some expenses are not covered by GE Vision Care. Expenses not covered include:

- 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;
- Experimental or Investigational Services;
- Services covered under GE Medical; and
- Replacements due to loss or misuse, unless otherwise covered under the Plan.

5.3 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 have already used your GE Vision Care benefits.

For example, if you are over the age of 19 and enrolled in the GE Vision Standard Option, which pays benefits for eyewear every other calendar year, and you receive benefits for an eye exam and a pair of eyeglasses in 2016, you will not be eligible for additional plan benefits for eyeglasses until January 1, 2018. 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 is how to use the GE Vision Value Option for eye exams, lenses and frames:

1. **Call the Vision Care Administrator** — 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.

5.3.1 HOW MUCH CAN I SAVE?

Here is 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	$103	$46	$57
Single-vision eyeglass lenses	$78	$63	$15
Bifocal eyeglass lenses	$116	$91	$25
Trifocal eyeglass lenses	$147	$121	$26
Lenticular eyeglass lenses	$147	$138	$9
Plan Collection Contact Lenses	$240	$140	$100
Plan Collection Eyeglass frames	Up to $160	$49	Up to $111
Premium Progressive Lenses (Varilux®, etc.)	$198	$90	$108
Photochromic Lenses (Transition®, etc.)	$110	$65	$45

** As of 2016.*

MORE ABOUT EYEGLASS FRAMES

For only $49, you can purchase eyeglass frames from a select group with comparable retail values up to $160.

If you purchase eyeglass frames outside of the frame collection or if the frame collection is not available from your Network Provider, you will receive a $120 retail allowance toward the retail cost of the frames you select. You will 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 valued at $200. You receive a $120 retail allowance toward the frames, and pay the additional $80 to your Provider at the time of service.

MORE ABOUT CONTACT LENSES

For only $140, you can purchase collection contact lenses (typically, a six-month supply) available for most prescriptions. Evaluation, fitting and follow-up care will also be covered. Plan limits continue to apply.

If you purchase contacts outside of the collection, such as gas-permeable or toric lenses, you will need to pre-pay $104, and you will receive a $130 retail allowance toward the retail cost of your single-vision contacts. For Bifocal contact lenses, you will need to pre-pay $154, and you will receive $175 retail allowance toward the retail cost of your purchase. You will need to pay any remaining balance, including evaluation, fitting and follow-up care to your Provider at the time of service.

For example, you pre-pay $104 for single vision contact lenses. At the Network Provider, you select contact lenses valued at $200. You receive a $130 retail allowance toward the contact lenses and pay the additional $70 plus the evaluation, fitting and follow-up care charges to your Provider at the time of service.

See Section 5.2, "HOW THE PLAN WORKS" for other included lens options and lens options co-pays.

5.4 WHEN YOUR GE VISION CARE COVERAGE ENDS

Your GE Vision Care coverage ends when GE Medical coverage ends. The same is true for your Dependents.

Under federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended), 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 *Your Benefits Handbook — Eligibility and Administrative Information* for more information.

5.5 WHAT PRIVACY RIGHTS APPLY TO MY EYE EXAM RECORDS?

Federal and state law gives individuals broad protections over the privacy of their personal health information. In particular, regulations under the Health Insurance Portability and Accountability Act (HIPAA) 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. The Notice of Privacy Practices is available at **OneHR.ge.com** and in *Your Benefits Handbook — Eligibility and Administrative Information*. If you would like a paper copy, you may also contact the GE Benefits Center at 1-800-252-5259.

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.

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 may or may not be capitalized in the text of the handbook.

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.

Allowable Amount — The total dollar amount of an Eligible Expense that is determined by your Claims Administrator to be payable for a covered benefit.

- **For Network Provider** — Eligible Expenses are based on contracted rates with the Provider.
- **For out-of-Network Provider** — Eligible Expenses are based on:
  - Negotiated rates agreed to by the out-of-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors; or
  - A maximum payment allowance that will be the lowest of (a) the in-Network rate of the Claims Administrator, (b) the established Medicare reimbursement rates plus up to 25% or (c) the Provider's actual charges.

Please note that any amounts charged by the out-of-Network Provider over the Allowable Amount will be the patient's responsibility and will not go toward the Annual Deductible or Out-of-Pocket Maximum for the Plan. Accordingly, when possible you should contact your Claims Administrator to inquire about the potential cost of going to an out-of-Network Provider.

These provisions do not apply if you receive Eligible Expenses from an out-of-Network Provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the Provider, unless the Claims Administrator negotiates lower rates. For certain Eligible Expenses, you are required to pay a percentage in the form of Co-insurance.

Annual Deductible — The amount of Eligible Expenses for services received, both in-Network and out-of-Network, that you must pay each calendar year before the Plan will begin paying benefits for most services in that calendar year.

Annual Pay — Your Normal Straight-Time Annual Earnings (NSTAE), including your regular base pay. It also may include a portion of commissions and other variable pay.

Behavioral Health and Substance Abuse Treatment — Treatment for the following:

- Any diagnosis which is identified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including a psychological and/or physiological dependence on alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any diagnosis where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

Body Mass Index (BMI) — A calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Claims Administrator — An insurance company, or other company, that has been designated by the Company to adjudicate claims and/or administer all or part of a benefit plan on the Company's behalf.

Clinical Trial — A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Co-insurance — A fixed percentage of the Allowable Amount that you are required to pay up to the Co-insurance Maximum, for certain Eligible Expenses after you meet the Annual Deductible.

Co-insurance Maximum — The maximum Co-insurance amount you pay each calendar year for covered benefits after you have satisfied your Annual Deductible.

COBRA — The Consolidated Omnibus Budget Reconciliation Act of 1985: A federal law that requires employers to offer continued health coverage to certain Employees and their Dependents whose group health insurance has been terminated.

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. See *Your Benefits Handbook — Eligibility and Administrative Information*.

Congenital Anomaly — A physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Cosmetic Procedures — Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the appropriate Claims Administrator or otherwise noted as an Eligible Expense.

Cost Effective — The least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment, insulin pumps, hearing aids, wigs and prosthetic devices.

Custodial Care — Services that do not require special skills or training and that:
- Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible — See Annual Deductible.

Dependent — An individual who meets the eligibility requirements specified in the Plan. See *Your Benefits Handbook — Eligibility and Administrative Information* for more information. Proof may be required.

Domiciliary Care — Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) — Medical equipment that is all of the following:
- Used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Not disposable;
- Not of use to a person in the absence of a Sickness, Injury or their symptoms;
- Durable enough to withstand repeated use;
- Not implantable within the body; and
- Appropriate for use, and primarily used, within the home.

Eligible Expense — Services, supplies or treatments provided while the plan is in effect that are determined by the Claims Administrator to be:
- Appropriate for 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;
- Employed appropriately and effectively with respect to the type and level of care; and
- Within any limits imposed by the plan (e.g., number of visits).

Please note that any amounts charged by the out-of-Network Provider over the Allowable Amount are not Eligible Expenses and will be the patient's responsibility.

Emergency — A serious medical condition or symptom resulting from Injury, sickness or Mental Illness, or substance abuse which arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

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 (see *Your Benefits Handbook — Eligibility and Administrative Information* in this section "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.

ERISA — Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational Services — Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined by the Claims Administrator to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the purposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the purposed use;
- Subject to review and approval by an institutional review board for the purposed use; or
- The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Services covered as part of an approved Clinical Trial are not considered Experimental or Investigational.

Explanation of Benefits (EOB) — A statement provided by a Claims Administrator when payment is made to you, your Physician, or another health care professional that explains:

- The benefits provided (if any);
- The allowable reimbursement amounts;
- The Deductible;
- Co-insurance;
- Any other reductions taken;
- The net amount paid by the Plan; and
- The reason(s) why the service or supply was not covered by the Plan.

FMLA —The Family and Medical Leave Act of 1993.

Flexible Spending Account — An account opened on your behalf by GE that you fund through pre-tax payroll deductions and use to pay for certain eligible medical, dental and vision expenses.

GE Medical — The program of medical benefits offered under the GE Health Benefits for Production Employees Plan.

Health Reimbursement Account — A tax-free account established by the Company to help you pay for most eligible health care expenses, except for dental or vision expenses.

Health Savings Account — An account that you open when you are enrolled in a high deductible health plan and that you may use to reimburse eligible health expenses.

Home Health Agency — A program or organization authorized by law to provide health care services in the home.

Hospital — An institution, operated as required by law, which is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, behavioral health, substance abuse, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury — Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility — A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay — An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Limited Purpose Flexible Spending Account — An account opened on your behalf by GE that is similar to an FSA except that it is limited to paying dental and vision costs only.

Medicaid — A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary — A service, supply or procedure is Medically Necessary and appropriate only if, in the Claims Administrator's judgment and sole discretion, it is:

- Necessary and appropriate for the symptom, diagnosis, prevention or treatment of the participant's illness, Injury or condition;
- Consistent with the symptom, diagnosis, prevention or treatment of the participant's illness, Injury or condition;
- The most appropriate supply, treatment or level of service that can be provided safely to the member and, if the member is an inpatient, cannot be provided safely on an outpatient basis;
- Not primarily for the convenience of the participant, his family or provider; and
- Not a part of, or associated with, the participant's scholastic, educational or vocational training.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because a Provider prescribed them.

Medicare — Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Illness — Behavioral health or psychiatric diagnostic categories listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, unless they are listed in Section 1.7, "EXCLUSIONS."

Network — When used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the network of Providers.

A Provider may enter into an agreement to provide only certain Eligible Expenses, but not all Eligible Expenses, or to be a Network Provider for only some products. In this case, the Provider will be a Network Provider for the Eligible Expenses and products included in the participation agreement, and an out-of-Network Provider for other Eligible Expenses and products. The participation status of Providers will change from time to time.

Network Benefits — A description of how benefits are paid for Eligible Expenses provided by Network Provider.

Orthotics — Devices that straighten or change the shape of a body part, including but not limited to cranial banding and some types of braces.

Out-of-Network Benefits — A description of how benefits are paid for Eligible Expenses provided by out-of-Network Providers.

Out-of-Pocket Maximum — The Annual Deductible plus your Co-insurance Maximum. Once you meet your Out-of-Pocket Maximum in a given year, the Company pays 100% of the Allowable Amount of Eligible Expenses.

Over-the-counter drug or medication — A drug or medication that can be purchased without a Physician's prescription.

Physician — Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. A Christian Science practitioner is covered for healing purposes, provided the practitioner is accredited by the Mother Church in Boston, MA and is in the presence of the patient when the treatment is performed. The fact that a Provider is described as a Physician does not mean that benefits for services from that Provider are available to you under the Plan.

Plan — One or more of the plans and programs described in this handbook, as determined by the context in which it is used, including GE Medical (also known as GE Health Benefits), GE Dental Care Options, GE Vision Care, the Health Reimbursement Account, the Flexible Spending Account, and the Limited Purpose Flexible Spending Account.

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.

Pregnancy — Includes prenatal care, postnatal care, childbirth, and any complications associated with pregnancy.

Provider — A health care professional or facility operating as required by law.

Savings Accounts — Accounts to help you pay for your share of qualified medical expenses.

Sickness — Physical illness, disease or Pregnancy. The term Sickness as used in this handbook does not include Mental Illness or substance abuse, regardless of the cause or origin.

Skilled Care — Skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- A Physician orders them;
- They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- They require clinical training in order to be delivered safely and effectively; and
- They are not Custodial Care.

Skilled Nursing Facility — An institution that is: 1) primarily engaged in providing skilled nursing care, rehabilitation services and related care; 2) accredited by the Joint Commission on Accreditation of Healthcare Organizations; and 3) recognized by Medicare as a Skilled Nursing Facility.

Specialist — A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment — Detection or correction, by manual or mechanical means, of bone or joint dislocation(s) (subluxation) in the body to remove nerve interference or its effects. The nerve interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse — A person who is (or was, in the case of the Employee's or retiree's death) the legally married husband or wife of that Employee or retiree.

Unproven Services — Health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on well-conducted randomized controlled trials or well-conducted cohort studies.

In a randomized trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.

If you have a Sickness or Injury that is likely to cause death within one year of the request for treatment, the Claims Administrator and the Plan may, at their discretion, determine that an Unproven Service is a covered health service. For this to take place, the Claims Administrator and the Plan must determine that the procedure or treatment is:

- Proved to be safe and promising;
- Provided in a clinically controlled research setting; and
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care — Treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center — A facility that provides Urgent Care services, as defined above. In general, Urgent Care Centers:

- Do not require an appointment;
- Are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

CONTACT INFORMATION

You can find answers to your benefits questions at **OneHR.ge.com** and **ge.com/healthahead**. If you still cannot find what you need, take advantage of the many toll-free numbers listed below. Toll-free assistance is available during normal business hours in the United States (U.S. Eastern time).

CONFIRM YOUR COVERAGE	
You can obtain a statement confirming your GE coverage at OneHR.ge.com. Or, you can call the GE Benefits Center at 1-800-252-5259.	
MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUGS	
GE Medical participants — Find answers at OneHR.ge.com, or...	
Health Benefits Claims Administrator	Call the number on your medical ID card
Behavioral Health Claims Administrator	Call the number on your medical ID card
GE Prescription Drug Claims Administrator	Before 2017: CVS Caremark at 1-800-509-9891 On or after 1/1/2017: OptumRx at 1-800-509-9891
• For answers and referrals to Network Providers	Before 2017: Visit **www.caremark.com** On or after 1/1/2017: **www.optumrx.com**
Prescription Drug Claims Administrator Prior Authorization Unit	Before 2017: 1-800-294-5979 On or after 1/1/2017: 1-800-711-4555
Health Coach from GE	1-866-272-6007
• Professional, private healthcare guidance	
When GE health coverage ends — Find answers at OneHR.ge.com, or...	
GE COBRA Administrator	1-866-924-6931
GE Insurance Continuation Administrator	1-866-924-6931
Dental, Vision and Savings Accounts — Find answers at OneHR.ge.com, or...	
GE Dental Care Options	1-888-529-8474
• For answers and referrals to Network Providers	Visit **www.metlife.com/dental** for additional information
GE Vision Care	1-800-433-9375
• For answers and referrals to Network Providers	Visit **www.davisvision.com/GE** for additional information
GE Health Reimbursement Account	1-888-303-3006
• For answers about your account balance or claims status	
GE Flexible Spending Account and Limited Purpose Flexible Spending Account	1-888-303-3006
• For answers about your account balance or claims status	
OTHER GE BENEFITS	
GE Work/Life Connections	1-877-444-4306
• For educational and career counseling, adoption assistance and child and elder care assistance	1-800-873-1322 (for TTY/TDD service)
GE Dependent Day Care Flexible Spending Account	1-888-303-3006
• For answers about your account balance or claims status	

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Schenectady, NY 12345

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JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

R.B.

(b) County of Residence of First Listed Plaintiff Rensselaer, New York
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Randi A. Kassan (N.D.N.Y. Bar No. 517821) - MILBERG COLEMAN BRYSON PHILLIPS GROSSMAN LLC: 100 Garden City Plaza, Suite 500, Garden City, NY 11530
Telephone: (516) 741-5600, Email: rkassan@milberg.com

DEFENDANTS

United Behavioral Health

County of Residence of First Listed Defendant San Francisco, Californi
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☒ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☒ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding | ☐ 2 Removed from State Court | ☐ 3 Remanded from Appellate Court | ☐ 4 Reinstated or Reopened | ☐ 5 Transferred from Another District *(specify)* | ☐ 6 Multidistrict Litigation - Transfer | ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. 1132(d)

Brief description of cause:
Wrongful denial of insurance benefits for mental health and substance abuse treatment

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
5/12/2021

SIGNATURE OF ATTORNEY OF RECORD
/s/ Randi Kassan

FOR OFFICE USE ONLY

RECEIPT # ANYNDC-5522621 AMOUNT $402.00 APPLYING IFP _____ JUDGE DNH MAG. JUDGE CFH

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket. **PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.