Your GM Benefits Summary Plan Description

A Handbook for Salaried Employees in the United States with a Service Date prior to January 1, 2001

Dear GM Salaried Employee:

General Motors offers one of the most competitive and comprehensive arrays of benefits in the country. This updated booklet, "Your GM Benefits," summarizes these great benefit options. There are detailed information and instructions to help you manage your benefits and make the best choices for your situation.

Today's GM benefits are an important element in your financial planning and in securing the health and future for you and your family. The information in this booklet can serve as a reference tool and answer questions you may have about your Flexible Benefit Options. Use this booklet in conjunction with your Total Compensation Statement (TCS) and other numerous on-line reference materials available through gmbenefits.com, all of which provide you with specific information about the value of your GM benefits. These tools will help you make important benefit decisions during the annual Flex enrollment period.

If you should have any questions regarding the material covered in this booklet, please contact the appropriate activity as listed on pages 3 and 4.

Sincerely,

Kathleen S. Barclay
Vice President
Global Human Resources

Your Benefits as a GM Salaried Employee

This booklet presents general information only and is designed to give you a broad picture of the added value of working with General Motors. It is not a contract and does not modify your month-to-month employment relationship or the terms of any benefit plan or program. Any reference to the payment of benefits is conditioned upon your eligibility to receive them. Each of these Programs or Plans has its own terms and conditions which in all respects control the benefits provided. General Motors Corporation reserves the rights to amend, change, or terminate the Plans and Programs described in this booklet. The Plans and Programs can be amended only in writing by an appropriate committee or individual as authorized by the Board of Directors. No other oral or written statements can change the terms of a benefit Plan or Program.

The Salaried Retirement Program, Savings-Stock Purchase Program, Layoff Benefit Plan, and Flexible Benefits Program may be subject to receipt of acceptable governmental rulings.

The information set forth in this booklet describing benefit plans and programs generally is applicable to General Motors regular salaried employees with a service date prior to January 1, 2001 employed on or after January 1, 2004.

For each of the Plans and Programs described in this booklet, the term “Employee” shall not include contract employees, bundled services employees, consultants, other similarly situated individuals, or individuals who have represented themselves to be independent contractors.

The following classes of individuals are ineligible to participate in the Plans and Programs described in this booklet, regardless of any other plan terms to the contrary, and regardless of whether the individual is a common-law employee of the Corporation:

(1) Any individual who provides services to the Corporation where there is an agreement with a separate company under which the services are provided. Such individuals are commonly referred to by the Corporation as “contract employees” or “bundled-services employees”;

(2) Any individual who has signed an independent contractor agreement, consulting agreement, or other similar personal service contract with the Corporation;

(3) Any individual that the Corporation classifies as an independent contractor, consultant, contract employee, or bundled-services employee during the period the individual is so classified by the Corporation.

The purpose of this provision is to exclude from participation in the Plans and Programs described in this booklet all persons who may actually be common-law employees of the Corporation, but who are not paid as though they were employees of the Corporation, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion is correct.

FOR BENEFITS INFORMATION AND ASSISTANCE

GM Benefits & Services Center (GM BSC)
gmbenefits.com
1-800-489-GMGM (4646)
TTY - 1-877-347-5225

The GM Benefits & Services Center (GM BSC) is the best source of information for the programs listed below:

DISABILITY
- Sickness and Accident Benefits
- Extended Disability Benefits

FLEXIBLE COMPENSATION PAYMENT (FCP)

FLEXIBLE SPENDING ACCOUNTS
- Dependent Care Spending Account
- Health Care Spending Account

HEALTH CARE RELATED SERVICES
- Health Care
- Extended Care
- Dental
- Vision
- Prescription Drug
- COBRA

LIFE INSURANCE
- Basic Life
- Optional Life, Dependent Life & Personal Accident

RETIREMENT PROGRAM

SAVING-STOCK PURCHASE PROGRAM (S-SPP)

STOCK OPTIONS

OTHER PROGRAMS & SERVICES
- Reporting a Death/Survivor Services
- Wage & Employment Verification
- Dependent Scholarship
- Tuition Reimbursement
- Adoption Assistance
- Layoff Benefits
- Service Awards

PLEASE NOTE: Programs whose services are <u>not</u> administered by the GM BSC may be accessed at the websites and phone numbers below:

	WEBSITE	PHONE #
• **WorkLife Plus/Behavioral Health**	www.worklifeplus.gm.com	1-800-280-6507
• **Care Management**		1-877-299-4635
• **WorkLife Resource and Referral**	www.liveandworkwell.com	1-800-684-3074
		1-800-898-1118 (TTY)
• **LifeSteps**	www.lifesteps.com	
• **Mental Health/Substance Abuse**		1-888-865-2960
ADDITIONAL SAVINGS PLANS		
• College 529 Plans		
Fidelity Investments	http://fidelity.com/goto/collegesave	1-800-544-2270
Putnam	http://www.gmira.com	1-800-634-1591
TIAA CREFF	http://www.529Michigan.com	1-888-529-4461
• GMAC Demand Notes	www.demandnotes.com	1-888-271-4066
• Personal Retirement Income Plan (Putnam)	www.gmira.com	1-800-343-0909
VEHICLE PROGRAMS		
• Vehicle Purchase Plan	www.gmfamilyfirst.com	1-800-235-4646
• Smart Lease Program	www.gmacfs.com	1-800-327-6278
• GM Protection Plan	gmppdirect.com	1-800-981-4677
• Motors Insurance Corporation (MIC)	www.gmacfs.com	1-800-642-6464
OTHER PROGRAMS & SERVICES		
• Financial Planning (AYCO)	www.aycofinancialnetwork.com/clients/mim	1-800-437-6383
• Long Term Care (John Hancock)		1-800-200-6773
		1-800-255-1808 (TTY)
• Medicare	www.medicare.gov	1-800-MEDICARE
• Social Security Administration	www.socialsecurity.gov	1-800-772-1213
		1-800-325-0778 (TTY)
• GMAC Bank Education Loans	www.edloans.gmacbank.com	1-800-500-9876

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Your General Motors Benefit Program is made up of plans designed to work together to help you meet many personal and financial needs now and in the future.

These plans can help you through various events in your lifetime. Page numbers are provided for your reference.	Lifetime Event							
	Saving for Your Future	If You Need Health Care	If You Become Disabled	If You Are Laid Off	If You Retire	Social Security Information	In the Event of Death	Your Surviving Spouse's Coverage
	Page	**Page**	**Page**	**Page**	**Page**	**Page**	**Page**	**Page**
Savings-Stock Purchase Program	11		92	106	119		130	
Enhanced Variable Pay Plan	21							
Flexible Benefits Program			35	35	35	35	35	
Spending Accounts	31	31	35	35	35	35	35	
Health Care Program		37	92	105	120	73	131	132
Disability Coverages			83	106		89		
Layoff Benefit Plan		105	106	101	105		104	
Retirement Program					108	117	128	117
Life Insurance Coverages			92	106	120		123	123

Events That May Require Action

Benefit	GM Servicing Centers to Contact	Change in Marital Status	Birth or Adoption of a Child	Death of Dependent	Death of Employee	If You Become Disabled	If You Become Terminally Ill	If You Wish to Change Beneficiaries	Employment Status Change, You or Your Spouse
Health Care	GM Benefits & Services Center 1-800-489-4646	Add/Delete Dependent	Add Dependent	Delete Dependent	Review Survivor Eligibility		Review Hospice Coverage		Review Enrollment Decision
Flexible Spending Accounts	GM Benefits & Services Center 1-800-489-4646	Review Contribution Rate and Account Balance	Review Contribution Rate and Account Balance	Review Contribution Rate and Account Balance					Review Contribution Rate and Account Balance
Basic Life Insurance	GM Benefits & Services Center 1-800-489-4646	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary			Review Applicability of A.B.O.	Review Beneficiary	
Optional Life Insurance	GM Benefits & Services Center 1-800-489-4646	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary	Review Coverage, Amount and Beneficiary				Review Beneficiary	
Dependent Life Insurance	GM Benefits & Services Center 1-800-489-4646	Review Coverage and Amount	Review Coverage and Amount	Review Coverage and Amount	Review Coverage and Beneficiary				
Personal Accident Insurance	GM Benefits & Services Center 1-800-489-4646	Review Coverage and Beneficiary	Review Coverage and Amount	Review Coverage and Amount		Review Applicability of Benefit		Review Beneficiary	
Life Insurance Claims	GM Benefits & Services Center 1-800-489-4646			Report Death	Report Death				
Disability	GM Benefits & Services Center 1-800-489-4646					Request Claim Form			
Salaried Retirement Program	GM Benefits & Services Center 1-800-489-4646	Update Beneficiary	Review Beneficiary	Review Beneficiary	Report Death		Apply for Disability Retirement	Review Beneficiary	
Savings-Stock Purchase Program	GM Benefits & Services Center 1-800-489-4646	Update Beneficiary	Review Beneficiary	Review Beneficiary	Report Death		Review Beneficiary	Review Beneficiary	Review Contribution Rate and/or Investment Options

Benefit election changes due to family status changes must be requested within 31 days of the event.

Your Capital Accumulation Opportunities

This section is designed to help you better understand various capital accumulation opportunities available to you as a GM salaried employee. The Savings-Stock Purchase Program, Putnam Personal Retirement Income Plan and GMAC Demand Notes can be used to accumulate savings for your future financial security. The Enhanced Variable Pay Plan recognizes the contribution you have made and provides you with a long-term capital accumulation opportunity.

You will want to read these summaries carefully. After doing so, you will be better prepared to make decisions appropriate to your personal financial needs and goals.

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Savings-Stock Purchase Program

The purpose of the Savings-Stock Purchase Program ("S-SPP," "the Program") is to help you accumulate savings, while at the same time providing you with an opportunity to acquire an equity investment in GM.

Eligibility

You are eligible to participate in the Program after you have completed six months of GM service and are (1) a regular salaried employee, (2) a flexible service employee, (3) a part-time employee, (4) a regular employee-temporary assignment (RETA), or (5) a temporary employee. Additionally, you are immediately eligible to participate if you are rehired after previously terminating employment from GM and you were previously eligible to participate in the Program.

Your participation in the Program is voluntary. You may discontinue Program participation at any time.

Enrollment

To enroll in the Program, ***or change your existing enrollment***, simply log on to the Program's website through the GM Intranet (Socrates) or through the Internet at gmbenefits.com and click on the Savings Plans Online tab. You may also call the GM Benefits & Services Center toll-free, at 1-800-489-4646.

If you are a newly hired employee, enrollment information will automatically be mailed to your home approximately 21 days before you are eligible to participate in the Program. Additionally, S-SPP enrollment information may be viewed by you, at any time, on the Program's website. ***If you are a rehired employee*** who was previously eligible to participate in the Program and want to enroll immediately, you will need to call the GM Benefits & Services Center at 1-800-489-4646 and speak with a representative.

Access to Your Account

When you participate in the Program, you must establish, through the GM Benefits & Services Center, a confidential identification number that is personal to you (Personal Identification Number or "PIN"). This confidential PIN limits access to your S-SPP account to only you. You may, at any time, change your PIN. Moreover, you may only access your own account information and initiate transactions by telephone, or the Internet, using your confidential PIN and Social Security number or Customer ID (a Customer ID is an identifier you create to use in place of your Social Security number). ***You should not give anyone your PIN.***

How the Program Works

Employee Contributions

You may elect to contribute, through payroll deductions, up to 50% of your eligible salary into the Program. Subject to tax regulations, ***your contributions may be made on an after-tax basis, called Regular Savings, or a pre-tax basis, called Deferred Savings,*** or any combination of after-tax and pre-tax payroll deductions. Your total contributions may only exceed 50% of your eligible salary as described below.

You may also contribute to the S-SPP, (1) the cash payout amount to which you may be entitled under the GM Enhanced Variable Pay Plan (EVP), or if applicable the GM Locomotive Group Performance Pay Plan (LGPP) and (2) the Flexible Compensation Payment (FCP). You may elect to contribute an amount up to 100%, in 10% increments, of your EVP or LGPP cash payout to your S-SPP account to the extent permissible under federal tax law. The EVP or LGPP cash payout amount may only be contributed on a pre-tax basis. You may elect to contribute 100% of your FCP into your S-SPP account during any calendar year a FCP is made by GM. The FCP will be made on a pre-tax basis until a tax law limit is reached, at which point any remaining FCP will be contributed on an after-tax basis to the extent permissible under federal tax law.

Also, if you are age 50 or over, or will attain age 50 by the end of the calendar year and are contributing at least 6% of your eligible salary to the S-SPP, you may be eligible to make "catch-up" contributions to your S-SPP account to the extent allowed by federal tax law. Catch-up contributions are in addition to your regular S-SPP payroll contributions. Your may elect from 1% to 50% of your eligible salary as catch-up contributions. Catch-up contributions may only be made on a pre-tax basis and only after your contributions become subject to specific limitations as described in the S-SPP Prospectus under Tax Considerations. The Prospectus can be obtained from the GM Benefits

& Services Center by calling 1-800-489-4646 or accessing the S-SPP website through Socrates or at gmbenefits.com. The maximum annual amount of catch-up contributions you may be eligible to contribute will be based on the following schedule: $4,000 in 2005, $5,000 in 2006, and thereafter indexed for inflation in $500 increments.

You may make Regular and Deferred Savings ***by payroll deductions only.*** You may change the amount of your contributions at any time. The amount you elect to contribute may be limited by federal tax law. You should review Tax Considerations on page 18 for more detail.

GM Contributions

GM will "match" or, in other words, contribute to your S-SPP account, 50% of the amount you contribute up to 6% of your eligible salary. This match is subject to change at GM's discretion and is dependent upon the economic conditions of the business. All GM matching contributions are invested in the GM $1-2/3 Par Value Common Stock Fund.

Your contributions above 6% of your salary are not matched by GM. Your Flexible Compensation Payment, Enhanced Variable Pay or Locomotive Group Performance Pay cash payout amount and any catch-up contributions contributed to the S-SPP also are not matched by GM. If you are a temporary employee GM does not match any contributions you make to the S-SPP.

If you were hired on or after January 1, 1993, and (1) have completed six months of service, and (2) are eligible to participate in the S-SPP, GM automatically contributes an amount equal to 1% of your eligible salary to your S-SPP account, whether or not you elect to participate in the S-SPP. This additional contribution, called the "1% GM Benefit Contribution," is provided because you receive different post-retirement benefit treatment from GM than employees hired prior to January 1, 1993. The 1% GM Benefit Contribution will be invested in the GM $1-2/3 Par Value Common Stock Fund. If you are classified by GM as a flexible service employee, temporary employee, contract employee, bundled services employee, consultant, other similarly situated individual, or individual who represents them self to be an independent contractor, you are not eligible for the 1% GM benefit contribution.

GM contributions (which hereinafter include "GM matching contributions" and the "1% GM Benefit Contribution" unless otherwise specified) vest immediately upon allocation to your account if you have three or more years of credited service. If you have less than three years of credited service, GM contributions vest on January 1 following the calendar year in which such contributions are made, or, if earlier, upon your attaining three years of credited service. However, if you are part of a divestiture, split-off, or spin-off and you have less than three years of credited service, all assets in your account shall be fully vested at the time of such transaction.

GM contributions are required to be invested in the GM $1-2/3 Par Value Common Stock Fund during the 12-month calendar year in which the contributions are made (January through December). This period is referred to as the ***"Required Retention Period."*** Upon completion of the Required Retention Period, you may exchange GM contributions invested in the GM $1-2/3 Par Value Common Stock Fund among any of the investment options offered under the Program.

Rollover Contributions From Other ELIGIBLE Retirement Plans

Once you are eligible to participate in the S-SPP, you may make a rollover contribution to the Program. The rollover amount may not exceed the taxable portion of cash proceeds received from a traditional Individual Retirement Account (IRA). Also you may make a rollover contribution to the Program of the taxable and/or nontaxable cash proceeds from other eligible retirement plans as described in the Program's prospectus. Additionally, cash proceeds received under a Qualified Domestic Relations Order from another eligible retirement plan may also be contributed to the Program. Rollover contributions must be made (1) by a "direct rollover," or (2) within 60 days from the date you receive a distribution from the other plan.

Corporation matching contributions are not credited on any rollover contributions you make to the Program.

Investment of Your Contributions

One-half of your contributions up to 6% of eligible salary must be invested in the GM $1-2/3 Par Value Common Stock Fund and remain in this Fund during the Required Retention Period.

The remainder of your contributions may be invested, as you elect, in 10% increments in any of the Program's investment options.

Your investment option elections will remain in effect until you change them. The Program provides you with the flexibility to change your investment options on any business day.

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

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

Additionally, the fact that an option is available for investment under the Program should not be construed by you as a recommendation by GM for investment in that option.

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

Information About the Investment Options

General Motors Investment Management Corporation, a wholly owned subsidiary of GM, and an SEC-registered investment advisor advises GM in developing the Program investment options and has overall responsibility for monitoring the investment options.

Currently, almost 70 investment options are available to you in the S-SPP. With so many investment options from which to choose, individual fund selections can be challenging. To help narrow your choices to a set of funds that may be right for you, the S-SPP investment options are organized into three Pathways. Although the three Pathways lead to different groups of investment options, all the investment options in the S-SPP are available to you at any time. You can mix options from any of the three Pathways.

Pathway One
Includes four Promark Target Portfolios and six Fidelity Freedom Funds that are each designed to be a single choice option that produces a diversified portfolio. You may want to consider these option choices if you are new to investing, unfamiliar with investment concepts, or looking for diversified investment choices that require minimal involvement by you.

Pathway Two
Includes option choices you may want to consider if you have some knowledge of investing and asset allocation and you wish to select from a group of style-specific funds, known as the Promark Funds. These options are designed to offer you the "building blocks" for a well-diversified portfolio.

Pathway Three
Includes option choices you may want to consider if you are an experienced investor who wishes to build a customized, diversified portfolio from a large selection of Fidelity and other mutual funds, and you have the time to select and actively monitor your portfolio.

Available Investment Options
A listing of the investment options currently available under the Program, depicted by Pathway category, is listed on the next page. **Before you invest in a fund, please read the relevant prospectus for the fund.** A detailed description of each of the Promark Funds and Company Stock Funds is contained in the S-SPP Prospectus. A detailed description of the Fidelity and other mutual funds is included in the individual mutual fund's prospectus. Prospectuses can be obtained from the GM Benefits & Services Center by either calling 1-800-489-4646 or accessing the S-SPP website through Socrates or at gmbenefits.com.

Pathway One

Code	Fund Name
	PROMARK TARGET PORTFOLIOS
(92821)	Promark Target Portfolio: Income
(92822)	Promark Target Portfolio: Conservative Growth
(92823)	Promark Target Portfolio: Moderate Growth
(92825)	Promark Target Portfolio: Dynamic Growth

Code	Fund Name
	FIDELITY FREEDOM FUNDS®
(00369)	Fidelity Freedom Income Fund®
(00370)	Fidelity Freedom 2000 Fund®
(00371)	Fidelity Freedom 2010 Fund®
(00372)	Fidelity Freedom 2020 Fund®
(00373)	Fidelity Freedom 2030 Fund®
(00718)	Fidelity Freedom 2040 Fund®

Pathway Two

Code	Fund Name
	U. S. EQUITY FUNDS
(92805)	Promark Large Cap Blend Fund
(92808)	Promark Large Cap Value Fund
(92806)	Promark Large Cap Growth Fund
(99315)	Promark Large Cap Index Fund
(96320)	Promark Social Equity Fund
(92809)	Promark Mid Cap Blend Fund
(92811)	Promark Small Cap Value Fund
(92810)	Promark Small Cap Growth Fund
	U.S. FIXED INCOME FUNDS
(99327)	Promark Income Fund
(92816)	Promark High Quality Bond Fund
(92818)	Promark High Yield Bond Fund

Code	Fund Name
	INTERNATIONAL EQUITY FUNDS
(92813)	Promark International Equity Fund
(92815)	Promark Emerging Markets Equity Fund
	SPECIALTY/SECTOR FUNDS
(92827)	Promark Balanced Fund
(92820)	Promark Real Estate Securities Fund
	COMPANY STOCK FUNDS
(99303)	General Motors $1-2/3 Par Value Common Stock Fund
(46684)	DIRECTV Group Common Stock Fund†
(91848)	Delphi Common Stock Fund†
(99308)	EDS Common Stock Fund†
(93746)	Raytheon Company Common Stock Fund†
(46686)	News Corporation Preferred ADS Fund†

†No new contributions or exchanges are permitted into these funds.

Pathway Three

Code	Fund Name
	U. S. EQUITY FUNDS
(93884)	Ariel Fund
(93885)	Ariel Appreciation Fund
(93967)	Domini Social Equity Fund
(00324)	Fidelity Aggressive Growth Fund
(00312)	Fidelity Blue Chip Growth Fund
(00307)	Fidelity Capital Appreciation Fund
(00022)	Fidelity Contrafund
(00330)	Fidelity Dividend Growth Fund
(00023)	Fidelity Equity-Income Fund
(00319)	Fidelity Equity-Income II Fund
(00332)	Fidelity Export and Multinational Fund
(00500)	Fidelity Fifty
(00003)	Fidelity Fund
(00025)	Fidelity Growth Company Fund
(00027)	Fidelity Growth & Income Portfolio
(00073)	Fidelity Independence Fund
(00316)	Fidelity Low-Priced Stock Fund
(00021)	Fidelity Magellan Fund
(00337)	Fidelity Mid-Cap Stock Fund
(00093)	Fidelity OTC Portfolio
(00336)	Fidelity Small Cap Independence Fund
(00039)	Fidelity Value Fund
(93895)	Newberger Berman Socially Responsive Trust
	U. S. FIXED INCOME FUNDS
(00038)	Fidelity Capital & Income Fund
(00453)	Spartan Government Income Fund
(00448)	Spartan Investment Grade Bond Fund

Code	Fund Name
	INTERNATIONAL EQUITY FUNDS
(00309)	Fidelity Canada Fund
(00325)	Fidelity Diversified International Fund
(00322)	Fidelity Emerging Markets Fund
(00301)	Fidelity Europe Fund
(00094)	Fidelity Overseas Fund
(00302)	Fidelity Pacific Basin Fund
(00318)	Fidelity Worldwide Fund
	INTERNATIONAL FIXED INCOME FUNDS
(00331)	Fidelity New Markets Income Fund
	SPECIALTY/SECTOR FUNDS
(00304)	Fidelity Balanced Fund
(00308)	Fidelity Convertible Securities Fund
(00334)	Fidelity Global Balanced Fund
(00004)	Fidelity Puritan Fund
(00303)	Fidelity Real Estate Investment Portfolio
(00368)	Fidelity Strategic Income Fund
(00311)	Fidelity Utilities Fund
(00794)	Fidelity Inflation-Protected Bond Fund
(01329)	Fidelity Strategic Dividend & Income Fund

Fund Exchanges

Except as provided below, you may exchange all, or part, of your assets from one investment fund to other investment funds on any business day of the year.

- An exchange may be made in 1% increments or dollar amounts. An exchange must consist of assets having a Current Market Value of $500, or if less, all the assets in the investment fund.

- Your contributions and earnings on your contributions required to be invested in the GM $1-2/3 Par Value Common Stock Fund) may not be exchanged until completion of the Required Retention Period.

- GM contributions, as well as earnings on such contributions, required to be invested in the GM $1-2/3 Par Value Common Stock Fund may not be exchanged until completion of the Required Retention Period.

- No exchanges of assets into the Delphi Common Stock Fund, EDS Common Stock Fund, DIRECTV Group Common Stock Fund, News Corporation Preferred ADS Fund or Raytheon Common Stock Fund are permitted.

GM reserves the right to modify or suspend subscriptions, redemptions or exchanges among any one or more of the Promark Funds or the GM $1-2/3 Par Value Common Stock Fund offered under the Program, at any time, in response to market conditions or otherwise. Furthermore, Fidelity and the other mutual fund providers reserve the right to modify or suspend exchanges among their mutual funds as described in their prospectuses. Fidelity and other mutual fund providers also reserve the right, under circumstances described in their prospectuses, to suspend or delay purchases and/or redemptions from their mutual funds, which might in turn delay your exchanges to or from the Promark Funds or the GM $1-2/3 Par Value Common Stock Fund. Neither GM, GMIMCO, GMTC or the other Fund Managers, the Investment Advisors nor the Trustee shall be responsible for any economic impact (including change in market value) resulting from any such suspension or modification.

Loans

Once each calendar year you may borrow from assets in your account. If you are a former employee or a surviving spouse of an employee and you have assets in the Program, you may also take a loan from your account. You may have up to five outstanding loans at any one time. The loan may be for any reason. No credit statement is required. Amounts borrowed are not subject to income tax, except in the case of a loan default. GM contributions subject to the Required Retention Period cannot be borrowed. The minimum loan amount is $1,000. You may not have at any time loans outstanding exceeding the maximum of $50,000. You may apply for a loan for an amount which is the lesser of:

- $50,000 less the highest amount of loans you had outstanding during the prior 12 months; or

- One-half of the current market value of your total vested assets.

Additionally, while you remain actively employed at GM the maximum amount available to you for a loan will be reduced by an amount equal to the outstanding principal, including accrued interest, of any loan defaulted after December 31, 2001, and deemed to be a distribution to you. However, while you remain an active employee of GM you may repay a loan after it has been declared a deemed distribution, thus eliminating the restriction on the amount available to you for any future loan.

The interest rate payable on a loan is the prime interest rate prevailing as of the last business day of the quarter immediately preceding the date that a loan is requested. The prime rate is the rate charged to a bank's best customers. The interest rate will remain fixed for the duration of a loan.

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

Amounts repaid are allocated to your account based on the investment options you elect for your current contributions. However, the portion of repaid amounts obtained from assets required to be invested in the GM $1-2/3 Par Value Common Stock Fund must be reinvested in the GM $1-2/3 Par Value Common Stock Fund if still subject to the Required Retention Period.

Repayment of a loan is made through after-tax payroll deductions. The minimum repayment is $50 per month, over a period of time you elect. Generally, the repayment period ranges from six months to five years. You have up to 10 years if the loan is to purchase or build your principal residence. If you are an active employee of GM, seeking to repay a defaulted loan after it has been declared a deemed distribution or if your are a former employee or the surviving spouse of an employee, your loan repayment will be through payments made directly by you to the GM Benefits & Services Center. There are no prepayment penalties if you repay the loan earlier than scheduled.

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

Withdrawals

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

During the Required Retention Period, you may withdraw part, or all, of your Regular Savings and earnings thereon, at any time, without restrictions. You may withdraw your Deferred Savings only as described below. You may not withdraw any GM contributions or earnings thereon that are subject to the Required Retention Period. No forfeiture of any GM contributions will occur as a result of your withdrawal.

After the Required Retention Period, you may, subject to certain limitations on the withdrawal of Deferred Savings, withdraw from your account part, or all, of your assets. This includes earnings on your contributions, as well as any GM contributions.

You may withdraw part, or all, of your Deferred Savings and earnings thereon for any reason after you attain age 59-1/2. Prior to age 59-1/2, the withdrawal of Deferred Savings may be made by you only in the event you have a "financial hardship" as defined by federal rules and the withdrawal is in order to:

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

Any withdrawal of Deferred Savings for a hardship will be limited to the amount of your contributions. Earnings on Deferred Savings are not available for a hardship withdrawal. If you request a hardship withdrawal, you may include in the withdrawal any amounts necessary to cover the anticipated taxes and early withdrawal penalties resulting from the withdrawal. Before Deferred Savings can be withdrawn for a hardship, you must take all available asset distributions, withdrawals, and loans under all applicable plans maintained by GM. ***If you withdraw Deferred Savings because of a hardship***, you will be suspended from making further contributions under this Program and certain other GM benefit and compensation plans for a period of 12 months following the withdrawal.

Flexible Dividend Payments
You may choose to have all, or 50%, of the dividends on your vested assets in the GM $1-2/3 Par Value Common Stock Fund reinvested in the Fund or have all, or 50%, of the cash dividends paid to you by check mailed to your address of record. Your choice applies to dividends paid on your vested assets in the GM $1-2/3 Par Value Common Stock Fund purchased by you and through GM's contributions. You may elect to have cash dividends paid to you by check by calling the GM Benefits & Services Center at 1-800-489-4646. Once you make your election it remains in effect until you change it. If you do not

choose to have cash dividends paid to you, the dividends will be reinvested in the GM $1-2/3 Par Value Common Stock Fund.

How Assets Are Distributed

At distribution, you will receive the Program assets to which you are entitled, in the following form:

- **GM $1-2/3 Par Value Common Stock, Delphi Common Stock, EDS Common Stock, DIRECTV Group Common Stock, News Corporation Preferred ADSs, and Raytheon Common Stock**
  In the case of a withdrawal, or upon receipt of a settlement at the termination of your employment, you may elect to receive (1) stock certificates registered in your name alone, or in your name with your spouse as a "joint tenant with right of survivorship," but not as "tenants in common," or (2) the current cash value of your stock fund(s).

- **Other Assets**
  Units to your credit in the Promark Funds always will be settled in cash. Shares to your credit in the Fidelity and other mutual funds also will be settled in cash.

Distribution Upon Termination of Employment or Retirement From GM

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

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

If, at the time of your termination, the value of your vested assets is not greater than $1,000, you will receive a distribution of the entire amount of such assets not later than 60 days following the month in which the termination occurs.

If you retire under the terms of the GM Salaried Retirement Program or terminate employment from GM for any other reason and the value of your vested S-SPP assets is greater than $1,000, you may continue to leave your assets in the Program. You may elect subsequently to receive your S-SPP assets in a lump sum at any time.

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

Furthermore, during the period your assets remain in the Program, you may elect to receive periodic installment payments from your account. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installments must be in whole dollar amounts and total at least $1,200 each year. You may, at any time, revise the amount and frequency of any such installments, or you may discontinue installment payments. ***Additionally, you may take a partial distribution of your assets at any time,*** either in addition to any installment payments you may elect or without installment payments.

Age 70-1/2 Minimum Distribution Requirement

If you are actively employed by GM and you attain age 70-1/2 on or after January 1, 1997, and you have not retired or terminated employment from GM, required minimum annual distributions will begin following your retirement or termination of employment from GM.

If you are actively employed by GM and you attained age 70-1/2 prior to January 1, 1997, the legally required minimum annual distribution of assets in your account began not later than April 1 of the year following your attaining age 70-1/2 and are made annually thereafter. However, you can choose to discontinue such minimum annual distributions while you continue employment at GM. If you choose to discontinue minimum annual distributions, such annual distributions will begin upon your retirement or termination of employment from GM and will be made according to federal regulations.

If you retire or terminate your employment from GM, and you (1) defer receipt of your

S-SPP assets and (2) later attain age 70-1/2 and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The amount of your annual minimum required distribution will be determined consistent with prevailing federal regulations and paid to you from your account beginning not later than April 1 of the year following your attaining age 70-1/2. You will be notified, in writing, prior to receipt of your first minimum required distribution. Thereafter, depending upon the amount you withdraw voluntarily during the calendar year from your S-SPP account, a minimum distribution payment will be made to you in December each year.

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

Restoration of Forfeited GM Contributions

If you terminate your employment from GM and are subsequently ***rehired and again become eligible to participate in the S-SPP*** before incurring five consecutive one-year breaks in service following termination, you may restore any previously forfeited GM contributions. This may be accomplished through the repayment of the full amount of the distribution you received upon termination, or if no distribution of your assets occurred, upon your request to the GM Benefits & Services Center for such restoration. All repayments must be made before the earlier of five years after you are re-employed, or when you incur five consecutive one-year breaks in service following the date of the distribution. You should contact the GM Benefits & Services Center for additional information.

Voting Rights

Through the Trustee, you will be extended the right to vote all shares equivalent to the current value of assets invested in the General Motors $1-2/3 par value common stock, Delphi common stock, EDS common stock, DIRECTV Group common stock, and Raytheon common stock in your account as of the record date for voting at each annual meeting of stockholders. Holders of News Corporation Preferred ADSs have no voting rights except in limited circumstances as described in the proxy statement of the News Corporation Limited dated August 21, 2003. Before each respective stockholder meeting, you will be contacted by mail or electronically via the Internet and asked for directions on how to vote shares equivalent to the current value of your investment in the above mentioned common stocks. You may specify your directions by telephone, the Internet, or by completing and returning the proxy/voting instruction card that will be provided to you by mail. The Trustee will vote by proxy, with proper precautions to preserve the complete confidentiality of your vote. Refer to the S-SPP prospectus for more voting information.

Account Statements and Tax Information

You will be furnished a statement four times per year reflecting assets credited in your account under the Program. In lieu of receiving your account statement by mail, you may create, at any time, your own online account statement covering any monthly, quarterly or specified time periods going back 24 months by accessing the Program's website through Socrates or at gmbenefits.com.

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

Tax Considerations

GM is required under current federal tax law to limit your annual pre-tax contributions. This limit will be $14,000 in 2005 and increases to $15,000 in 2006, and thereafter indexed for inflation in $500 increments. Other federal limits also apply and may result in a reduction of your after-tax and/or pre-tax contributions. If you are affected, your subsequent contributions until the end of the calendar year may be (1) recategorized from pre-tax to after-tax, (2) reduced, or (3) refunded to you.

In specific situations, if you are age 50 or over, or will attain age 50 by the end of the calendar year, you may be eligible to make additional pre-tax catch-up contributions of up to $4,000 in 2005, $5,000 in 2006, and thereafter indexed for inflation in $500 increments.

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

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

Under current tax law, a 10% additional early distribution tax will be imposed on the taxable portion of any Program withdrawal or distribution made when you are under age 59-1/2. The additional tax does not apply to (1) the non-taxable portion of a withdrawal or distribution, or (2) taxable monies you roll over, or elect to have directly rolled over, into an IRA or another eligible retirement plan.

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

- Made to you after you separate from service by retirement during or after the calendar year in which you attain age 55;
- Made to you because you have tax-deductible medical expenses (whether or not you itemize deductions);
- Paid to an alternate payee under a Qualified Domestic Relations Order;
- Made to you as a result of a federal tax levy after 1999;
- Paid to your beneficiary after you die;
- Made to you because you are totally and permanently disabled; or
- Made to you as part of a series of substantially equal periodic (at least annual) payments over your lifetime or the joint lives of you and your beneficiary and such payments begin after your separation from service and continue for five years or until age 59-1/2, whichever is later.

Furthermore, if you choose to receive cash dividend payments from the GM $1-1/2 Par Value Common Stock Fund, such dividends are taxable income when received. However, under current tax law, the cash dividend payments are not subject to the 10% additional early distribution tax. Cash dividend payments cannot be rolled over to an IRA or another eligible retirement plan.

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

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

If you retire or terminate your employment from GM you may continue to defer distribution of all your assets, provided the vested value of these assets is greater than $1,000, until April 1 of the year following the year you attain age 70-1/2 (the time minimum annual distributions must commence for retired and terminated participants).

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

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

- The maximum loan amount available to you will be reduced by an amount equal to the outstanding principal, including accrued interest, of any outstanding loans you may have at the time of application including any loans defaulted after December 31, 2001 and deemed to be a distribution to you;
- If at the time of your separation from service the value of your vested assets is not greater than $1,000, you will receive a distribution of the entire amount in your S-SPP account;
- If your GM employment ends and your have less than three years of credited service at the time of separation any GM contributions not vested will be forfeited;
- In the event the Program should be disqualified or GM makes a decision to terminate the Program, such disqualification or termination may result in tax consequences to your as a participant in the S-SPP.

Claims Review Procedure

If you make a claim for benefits under the Program and the claim has been denied, the Program Administrator will notify you or your beneficiary in writing of the specific reasons for the denial. You or your beneficiary will then be given an opportunity for a full and fair review of the decision to deny a claim for benefits by filing an appeal with the Employee Benefit Plans Committee (EBPC) of GM. The EBPC has been delegated final discretionary authority to construe, interpret, apply, and administer the Program. The written appeal must be filed within 60 days from the date of the Program Administrator's written decision denying a claim for benefits. The appeal must be sent to the Secretary of the EBPC, General Motors Corporation, 300 Renaissance Center, Mail Code 482-C26-A68, Detroit, MI 48265-3000. The written appeal should clearly state why you or your beneficiary believe the Program Administrator was wrong in denying your claim for benefits. **The EBPC is the final review authority with respect to appeals, and its decision is final and binding upon GM, you and your beneficiary.** A written decision on the request for review will be furnished to you or your beneficiary within 60 days (120 days if special circumstances required an extension of time) after the date the written request is received by the EBPC.

Enhanced Variable Pay Plan

The purpose of the Enhanced Variable Pay Plan (EVP) is to (1) recognize the importance and contributions of GM employees in the creation of stockholder value, (2) align compensation with business success, and (3) provide employees with the opportunity for capital accumulation through stock option grants to acquire shares of GM $1-2/3 Par Value Common Stock and/or payment of cash. EVP payouts are contingent on the Corporation's business conditions and the attainment of preestablished Corporate and Regional Performance measures.

Eligibility

Generally, you are eligible to participate in the EVP if you are an active U.S. classified employee under GM's North American Operations working in the United States or Canada, including individuals who are sent to work in a foreign operation by the Corporation on a temporary basis, as of December 31, and are:

- A regular active salaried employee (compensated fully or partly by salary and/or commission);
- A part-time employee;
- A flexible service employee;
- A cooperative student (hired prior to January 1, 1999); and/or
- A GM Fellow

Salaried employees of Electromotive Division, and GM Asset Management Company are not eligible to participate in the EVP.

How EVP Works

EVP is a variable pay opportunity that may be delivered to you in the form of cash and/or stock options. Cash represents the short-term component of variable pay. It provides a more immediate reward to you for your contributions during the performance year. Stock options represent the long-term component of variable pay.

Stock options have a 10-year life during which you along with other employees can contribute to the company's performance and potential stock price growth. Through the increase in GM's stock price and total stockholder return, you too may realize a personal financial gain from the exercise of these stock options.

The amount of cash and/or options you will receive is tied directly to your level of responsibility and annual base salary. The higher your annual base salary and level of responsibility, the greater your total payout opportunity.

The portion of your payout that is paid in cash and/or the portion which is delivered in stock options is determined at the end of the year once business performance results have been finalized. The mix between cash and stock options may vary by individual. It is determined at the aggregate level for all employees participating in EVP.

Cash EVP Payout Choices

Generally you will receive the cash portion of your EVP payout in a regularly scheduled March paycheck of the year following the performance year that generated the payout.

Alternatively, you may choose to contribute all or part of the cash portion (in 10% increments) of your EVP payout, on a pre-tax basis, into your S-SPP account up to the federal compliance limits. If you defer the cash portion of your EVP payout into your S-SPP account, it will be invested in the same investment options you have in effect for your current S-SPP "discretionary contributions" (those contributions not required to be invested in the GM $1-2/3 Par Value Common Stock Fund). If you do not have an S-SPP investment option election in effect, the cash portion of your EVP payout will be invested in the Promark Income Fund. General Motors does not match the cash portion of your EVP payout deferred into your S-SPP account.

If you elect to defer the cash portion of your EVP payout into your S-SPP account, this amount will be subject to Social Security taxes and such taxes will be withheld from your regular paycheck. However, under current tax law, federal income taxes and, in most cases, state and local income taxes will be deferred until you withdraw your money from your S-SPP account at a later date.

Personal Retirement Income Plan

The Personal Retirement Income Plan provides Individual Retirement Accounts (IRAs) through the Putnam IRA Program sponsored and administered by the Putnam Funds of Boston, Massachusetts. The Plan provides you the opportunity to invest in a number of options through (1) payroll deduction, or (2) lump-sum contributions. Participation in the Plan is completely voluntary.

Eligibility

All salaried employees are immediately eligible, upon their date of hire, to participate in the Personal Retirement Income Plan.

GM's Involvement

The sole involvement of General Motors is, without endorsing the Plan, to allow Putnam to publicize the features of the Plan to employees and to collect contributions through payroll deductions and remit them to Putnam. This Plan is not a GM employee benefit plan governed by ERISA. It is not sponsored, administered or reviewed by GM, and is not subject to GM's Plan appeal procedures. While GM does not endorse the Plan or any of the investment options, it provides you the convenience of payroll deduction. No contributions are made by GM.

Investing in the Plan

Putnam has informed GM that the Personal Retirement Income Plan allows for contributions up to $2,000 each year, either through payroll deductions or lump-sum investments. In addition to opening an IRA for yourself, you also can open an account for your spouse. This is true whether your spouse is employed or not. The Plan permits an annual investment of up to $4,000 for married couples.

If you participate, the minimum payroll deduction for Personal Retirement Income Plan contributions is $12.50 per payroll period, or $25 a month. The minimum lump-sum contribution is $500 ($250 per fund).

Putnam Fund prospectuses can provide you with details on each investment fund option.

Communications

Putnam has informed GM that it will provide you with a quarterly statement of information regarding your IRA account. In addition, Putnam will send you a report on fund performance for the Putnam family of funds semi-annually. This report offers updates on the funds and issues relating to the Putnam Program. Annual and semi-annual fund reports are sent to you for each of your Putnam mutual fund investments. These reports discuss recent market conditions and provide a listing of the funds' investment portfolios.

Questions or concerns regarding the Plan or taxes should be directed to Putnam. If you wish to enroll in the ***Personal Retirement Income Plan***, you may call Putnam using the toll free number ***1-800-343-0909***.

GMAC Demand Notes

GMAC Demand Notes is designed to offer eligible GM family members a convenient means of investing funds directly with GMAC. Demand Notes are unsecured debt obligations of GMAC; since Demand Notes is not a bank account, it is not FDIC insured.

Eligibility

All salaried employees are eligible to invest in Demand Notes. In addition, family members (spouse, children, siblings, parents and grandparents) are also eligible to invest in GMAC Demand Notes.

Here are some of the advantages of investing with GMAC:

- **Low minimum investment**
  You may open a GMAC Demand Notes account with as little as $1,000. Additional investments of $50 or more may be made at any time.

- **Payroll deduction**
  As a GM employee you can invest in Demand Notes through payroll deduction. Your deduction must total at least $50 per month. Current Demand Notes investors may process a payroll deduction by calling 1-800-684-8823. You may also invest your entire net paycheck through direct deposit (see the Services tab in 'My Socrates').

- **Easy and convenient access to your investment**
  You may access your Demand Notes investment at any time by using one of several convenient redemption options, including free check-writing privileges ($250 minimum), ACH redemptions and wire transfers.

- **Interest rate**
  The interest you earn on your Demand Notes is compounded daily and reinvested automatically in your Demand Notes at the end of each month. The Demand Notes interest rate is set on a weekly basis.
  For current interest rate information call 1-800-426-8323 or logon to www.demandnotes.com.

- **Investor services**
  As a Demand Notes investor, you will receive periodic statements showing a summary of your Demand Notes investments and redemptions, interest earned and the interest rates applicable during that period. You will also have 24-hour toll-free access to complete information about the status of your account and current interest rates by calling 1-800-684-8823. You can also access your account information online at www.demandnotes.com.

Additional Information

The money you invest in Demand Notes is principally used by GMAC to provide a wide variety of automotive financial services to automobile dealers and their customers.

Enrollment Information

GMAC Demand Notes are offered in the U.S. by prospectus only. You can obtain a prospectus by calling **1-888-271-4066** or by visiting the website at www.demandnotes.com.

Financial Planning

The Financial Planning Option provides you access to a personalized financial planning service. The Ayco Company of Albany, New York sponsors and administers the Financial Planning Option. Participation is completely voluntary.

Eligibility

The Financial Planning Option is available only to regular active employees who are either: (1) U.S. residents, (2) Puerto Rico residents, or (3) International Service Personnel (ISP U.S.).

GM's Involvement

The sole involvement of GM is, without endorsing the service, to allow the Ayco Company to publicize the features of their service to employees and to collect contributions through payroll deductions and remit them to the Ayco Company. The Financial Planning service provided is not a GM employee benefit plan governed by ERISA. It is not sponsored, administered, or reviewed by GM and is not subject to GM's Plan Appeal procedures. While GM does not endorse the service or any of the Financial Planning Options, it provides you the convenience of payroll deduction. No contributions are made by GM.

Features

Real-world personal guidance for all major life events plus analytical tools for the 'do-it-yourselfer'.

The Personal Finance Program provides access to an experienced, objective financial planner via the toll-free *Ayco-AnswerLine,* as well as the interactive power of the Ayco Financial Network (**www.aycofn.com**), a password-protected, member-only website that acts as your financial mentor and record keeper. Through *The Ayco-AnswerLine,* you can get personalized, professional advice on your planning issues, including your GM benefits and the financial implications of such life events as getting married, buying a home, preparing for a child's education, helping aging parents and preparing for retirement. Personalized, topic-specific reports provide an objective assessment of your current financial situation (including stock option planning).

Aycofn.com provides 'do-it-yourselfers' with the tools they need to assess their financial health and prioritize while guiding them through the steps they need to take. It allows users to keep a secure, easily updateable record of their progress and features a variety of financial modeling tools. You can model multiple scenarios as life events occur and access Ayco's online reference library for information on cash flow, debt management, investments, estate planning, insurance, tax planning and key life events.

Using **Aycofn.com** in conjunction with an *AnswerLine* planner can help you make better informed decisions and avoid costly mistakes in today's complex financial environment.

What the Personal Finance Program includes:

- 'Welcome Letter' and brief confidential questionnaire that helps Ayco understand your planning needs
- Personalized financial counseling via *The Ayco AnswerLine* service (up to 5 hours annually)
- Ayco *Updates* newsletters (10 issues)
- *The Ayco-Approved List of Mutual Funds*
- Access to personalized Focus Reports on retirement, asset allocation and education funding
- Unlimited access to the Ayco Financial Network
- The *Investing in your Future* guidebook, a comprehensive planning reference

Questions or concerns regarding these **Financial Planning** options should be directed to Ayco. You may call Ayco at the toll-free number **1-800-437-6383**, Monday through Friday, 9:00 a.m. to 5:00 p.m. Eastern time (1-518-464-2488 if calling from outside the United States). Visit Ayco's website at www.aycofinancialnetwork.com/clients/mim for more information on the Ayco Financial Network and other services available to GM employees

Your Flexible Compensation Payment

The Flexible Compensation Payment (FCP) is designed to provide you increased flexibility in managing your total compensation. With the FCP you have the opportunity to receive cash in several options and/or exchange a portion of it for additional days off. The availability, amount, and various options under the FCP may vary from year to year.

Eligibility

You are eligible for the FCP if you are (1) a regular active salaried employee, (2) a flexible service employee, (3) a part-time employee (greater than 20 hours), or (4) a graduate fellow. Your GM service date must be on or before January 1 of the plan year, and you must be on the active salaried payroll as of January 15 of the plan year.

How FCP Works

Currently, a full FCP equals $1,900 for each regular active salaried employee and $1,235 (or 65% FCP) for an eligible flexible service employee, part-time employee or graduate fellow who meets the eligibility requirements.*

The amount required to purchase additional days off and the number of days available for purchase will depend upon whether you qualify for a full FCP or a 65% FCP. If you are eligible for the full $1,900, you may purchase one, two, three, four or five paid days off at a cost of $175 per day (subtracted from the lump sum amount) However, if you are eligible for a 65% FCP, you may purchase one, two, or three paid days off at a cost of $175 per day (subtracted from the lump sum amount).

* *GMAC/MIC employees' FCP is determined by their length of service.*

** *GMAC/MIC employees do not qualify for additional days off.*

Cash Lump Sum Option

Under the cash lump sum option, payment of the (1) full FCP, (2) 65% FCP, or (3) amount remaining after purchasing the additional days off will be included in your March paycheck. It will be subject to all social security income taxes, based on your withholding elections on file.

Savings-Stock Purchase Program (S-SPP) Contribution Option

The FCP contribution option into your S-SPP account is made in a lump sum payment. Your S-SPP deduction will include both your regular payroll contribution and your FCP contribution. Your FCP contribution into your S-SPP account will be on a **pre-tax basis**, up to any Internal Revenue Code limits you may reach. Thereafter, any remaining FCP contributions to your S-SPP account will be made on an after-tax basis, to the extent permissible under federal tax law.

Once your FCP is contributed to your S-SPP account, it becomes subject to all the rules and conditions of that Program — including the tax law requirements. FCP contributions to your S-SPP account will ***not be eligible for GM matching contributions.*** FCP contributions will be invested consistent with your current S-SPP investment election for your "discretionary contributions" (those contributions not required to be invested in the GM Common Stock Funds).

If you do not participate in the S-SPP but are eligible to do so, you may decide that the FCP option is a good way to start. ***If you elect to deposit your FCP into the S-SPP but you do not have an S-SPP investment option election in effect,*** your FCP contributions will be invested in the S-SPP Promark Income Fund.
If, as of December 31 of the year preceding the year in which the FCP is paid, you are not eligible to contribute to the S-SPP due to a suspension resulting from a hardship withdrawal*, you* ***cannot*** elect the option to contribute your FCP to the S-SPP. Furthermore, if you request and receive a hardship withdrawal from your S-SPP account after you had elected a FCP contribution to your S-SPP account, the FCP contribution to your S-SPP account will not be made. Instead, the FCP will be paid to you as a cash lump sum.

Additional Days Off

The additional days off elected by you may be used (1) at any time during the year, ***including the July shutdown period,*** (2) after you have used your regular vacation entitlement, and (3) at a time that is mutually agreeable between you and your supervisor. Additional days off elected by you must be used during the calendar year**.** ***There will be no payment for days unused at year end.***

Employment Status Changes

A change in your employment status during the year may impact your FCP*.* ***If your status changes during the year***, you should keep the following points in mind.

- FCP will be paid as a part of your March paycheck — even if before that pay date you: (1) retire on February 1 or March 1, (2) are placed on an unpaid leave of absence, or (3) transfer to either hourly status or a GM subsidiary.

- ***No FCP will be paid*** if your employment ends on or before the mid-March pay date ***for reasons other than retirement****.* Moreover, if you retire effective January 1, you are not eligible for FCP.

- If you should die prior to the mid-March pay date, a cash lump sum payment will be paid to the beneficiary of your basic life insurance. This amount will be paid as soon as practicable.

Your Flexible Benefits

The purpose of the Flexible Benefits Program (Flex) is to increase your flexibility regarding your total compensation as a GM salaried employee. Flex is designed to provide you with the opportunity to elect the benefit coverages you feel make the most sense, to fit the needs of you and your family. Thus, you determine what value you will receive from your personal benefits package. You also have the opportunity to increase your benefits or increase your take home pay along with the potential to realize significant tax advantages when you use the Program.

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Eligibility

Generally, you are eligible to participate in the Flexible Benefits Program if you are:

- A regular active salaried employee (compensated on a monthly salary or salary plus commission basis);
- A Flexible Service employee (except GMAC/MIC);
- A part-time employee, qualifying for benefit plan coverage;
- Any of the above on certain leaves (for example, a disability leave of less than six months);
- An employee on a career transition leave as of (1) the beginning of the enrollment period and (2) the last day of the enrollment period. These dates are, generally, September 1 and December 31 of the year prior to the start of each Flex year.
- If you are newly eligible for Flex, you should expect to automatically receive a Flex enrollment packet within approximately six weeks after you are eligible. If you have not received your Flex enrollment packet by that time, you should contact the GM Benefits & Services Center at 1-800-489-4646.

Benefits Affected

- Flexible Spending Accounts
  - Health Care
  - Dependent Care
- Salaried Health Care Program
  - Medical
  - Dental
  - Vision
- Life and Personal Accident Insurance
  - Yourself
  - Your spouse
  - Your child(ren)
- Supplemental Extended Disability Benefit (SEDB)

Participation

Participation in Flex enables you to determine the type of benefit coverage you want based on your personal circumstances. Flex is an annual program. That means you will have an opportunity to enroll each fall for the following calendar year's coverage.

The choices you make generally become effective on January 1 and generally remain in effect through December 31 if you remain an eligible employee. Additionally, any life insurance, personal accident insurance, and supplemental extended disability benefit (SEDB) elections you make will become effective on the first day you are actively at work in the new Flex year. If proof of good health is required, your life insurance and SEDB elections will become effective on the first day of the month following approval by the carrier, provided you are actively at work.

You may change your elections, if you wish, during each annual enrollment period. However, you may change your elections during the Flex year ***only in the case of a "life event change."*** Additionally, any life insurance, personal accident insurance, and supplemental extended disability benefit (SEDB) elections you make will become effective on the first day of the month following the month of the receipt of your election by the GM Benefits & Services Center, provided you are actively at work on that day. If proof of good health is required, your life insurance and SEDB elections will become effective on the first day of the month following approval by the carrier, provided you are actively at work. "Life event changes" are those the IRS considers to be a major change in your family situation. Some of the major events that may entitle you to change certain of your benefit elections during the year include the following:

- Certain changes in employment status for you or your spouse or an eligible dependent;

- Marriage or divorce;
- Addition of a dependent;
- Loss of a spouse or dependent;
- Retirement; and
- Relocation.

If you have a "life event change" and wish to change your elections, it is <u>your</u> responsibility to notify the GM Benefits & Services Center within 31 days.

How the Program Works

Under the Program you are offered an array of options and each option is assigned a monthly price. You decide which options you want to elect based on your personal or family needs and simply total their prices.

Regarding health care contributions, cost increases will be evaluated annually considering our business conditions and our total compensation approach.

If you elect 1 times annual base salary for basic life insurance, you will receive a monthly credit under the Flexible Benefit Program for the other 1 times annual base salary.

The following chart illustrates the current choices that may be available to you under Flex.

Current Flex Options

Health Care and Dependent Care Spending Accounts (Refer to pages 31 and 32 for further details)	▪ Either account ▪ Both accounts or neither ▪ Annual contributions of $48 to $5,000, separate for each account

NOTE: Four different family statuses are available for each of the health care options described below. You may elect a different status for medical, dental, and vision. These categories are: you only; you and your spouse/same-sex domestic partner; you and children; you and family.

Medical (Refer to page 37 for further details)	▪ Basic Medical Plan (BMP) ▪ Enhanced Medical Plan (EMP) ▪ Preferred Provider Organizations (PPOs), where available ▪ Health Maintenance Organizations (HMOs), where available ▪ Opt out for non-GM coverage ▪ Waiver for other GM coverage
Extended Care Coverage (Refer to page 61 for further details)	▪ Coverage ▪ Waiver (Permanent Election)
Dental (Refer to page 63 for further details)	▪ Traditional Dental Plan ▪ Alternative Dental Plans, where available ▪ Waive
Vision (Refer to page 66 for further details)	▪ Vision Plan ▪ Waive
Supplemental Extended Disability Benefits (SEDB) (Refer to page 86 for further details)	▪ No coverage ▪ Coverage (If on January 1 of the Flex year your credited service is less than 10 years, this coverage may be elected.)
Basic Life Insurance Options — for you* (Refer to page 96 for further details)	▪ One times annual base salary ▪ Two times annual base salary

Optional Life Insurance Options— for you* (Refer to page 96 for further details)	▪ One through six times annual base salary
Dependent Life Insurance Options for your spouse/same-sex domestic partner (Refer to page 97 for further details)	No coverage $10,000 $25,000 $50,000 $75,000 $100,000 $150,000
Dependent Life Insurance Options — for eligible children* (Refer to page 97 for further details)	No coverage $5,000 $10,000 $15,000 $20,000 $25,000 $30,000
Personal Accident Insurance (PAI) Options — ▪ for you ▪ your spouse/same-sex domestic partner ▪ children (Refer to page 98 for further details)	**For you and your spouse/same-sex domestic partner***** No coverage $10,000 $25,000 $50,000 $100,000 $200,000 $250,000 $300,000 $400,000* $500,000**** $750,000**** $1,000,000**** **For child(ren)***** No coverage $10,000 $20,000 $30,000 $40,000 $50,000

* If you are a resident of Texas, the combined amount of basic and optional life insurance you may have on yourself is restricted by Texas state insurance laws and cannot exceed seven times your annual base salary.

** Texas state insurance law limits the amount of dependent life insurance a Texas resident may have. In addition, a signature is required from dependents age 18 or over who are enrolled for the first time for $10,000 or more of coverage. This also includes any increase that raises the amount to $10,000 or more.

*** Coverage for a spouse/same-sex domestic partner (as defined by the health care plan) or child(ren) may not exceed coverage for you.

**** May not be elected if exceeds 10 times annual base salary.

Spending Accounts

Spending Accounts can save you money by allowing you to reimburse yourself for eligible expenses with pre-tax dollars you set aside through payroll deduction.

As a part of the Flex enrollment process, you have the opportunity to establish health care and dependent care spending accounts:

- The health care spending account helps you pay certain health care expenses that are either not fully covered or not eligible for payment through your health care plans for you and/or your eligible dependents;
- The dependent care spending account enables you to reimburse yourself for eligible daycare and/or elder care expenses that may be necessary for you — and if you are married, your spouse — to be gainfully employed.

Spending Account Deposits

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

If you decide to establish a spending account, you may elect to contribute up to $5,000 each year in each spending account. Under current tax law, each year you must allocate a specific amount for each account. Each account has a separate maximum. And, federal regulations provide that you cannot switch amounts you have allocated to one spending account into the other.

Health Care Spending Account

Generally, almost any health care expense that is eligible for a deduction for federal income tax purposes may be eligible for reimbursement through your health care spending account. *But* ***a word of caution*** — you cannot do both. You may not deduct an eligible expense ***and*** receive reimbursement for that same expense. In addition, eligible expenses for reimbursement from your health care spending account include deductibles and copayments, but ***not the contribution or premium*** you pay for your health care coverage.

The entire amount you elect to contribute to your health care spending account is available at any time — even if your current expenses exceed the amount deposited to your account to date. However, upon termination of employment, remaining contributions necessary to fulfill your annual election for the health care spending account will be taken from your final check, and if necessary, from any other monies which may become payable to you in the form of salary or benefits, as discussed on page 35. You will still be able to file claims for services received after termination and through the end of the calendar year.

Your health care spending account may not be decreased or discontinued, even if you have a "life event change." Any monies that you do not use at the end of the year are forfeited.

Special Note: Remember, to receive reimbursement for your expenses the services must be (1) eligible for reimbursement, and (2) rendered during the year for which the spending account was established.

What Are Eligible Health Care Expenses for Reimbursement From the Spending Account?

Listed below are examples of eligible and non-eligible health care spending account expenses. **This is not intended to be a complete listing**. If you would like to receive additional information about eligible expenses, you should call the IRS at 1-800-TAX-FORM and request IRS publication #502 (Medical and Dental Expenses).

Eligible

- Medical, dental, and vision deductibles and copayments
- Prescription drug copayments
- Mental health and substance abuse copayments
- Allergy testing and treatment
- Noncovered orthodontic expenses
- Acupuncture
- Orthopedic shoes
- Organ donor expenses
- Special telephone equipment for the deaf
- Special equipment installed in your home or car for medical reasons
- Tutoring for certain learning disabilities
- Services of a Christian Science practitioner
- Special school costs for physically or mentally handicapped child(ren), including tutoring fees
- Corrective vision surgery
- Non-prescription drugs and medicines

Not Eligible

- Contributions and/or premiums for medical, dental or Long Term Care coverage
- Marriage/family counseling fees
- Health care treatments, medicine, or services that are not legal
- Expenses for weight reduction or smoking cessation programs for general health purposes and unrelated to specific ailments
- Bottled water
- Cosmetics, sundries, and toiletries
- Cosmetic surgery (non-reconstructive)
- Non-prescription dietary supplements, e.g., vitamins
- Health programs offered by resorts, health clubs, or gyms
- Scientology fees
- Maternity clothes
- Domestic help (apart from nursing services), even if recommended by a doctor
- Hair treatments and medication to prevent hair loss, even if prescribed by a physician (for example, Rogaine)

Dependent Care Spending Account

The dependent care spending account allows you to reimburse yourself for dependent care expenses necessary for you — or you and your spouse — to be gainfully employed. If your spouse is disabled or a full-time student, you may also use this account. If you are married and file federal income taxes separately, your deposit to the dependent care spending account is limited to $2,500. If you file jointly, your maximum deposit to the account cannot exceed $5,000 or the smaller of your income or your spouse's.

A word of caution:

- Your monies not used at the end of the year are forfeited.

- Your deposits to the dependent care spending account stop upon termination of employment. You will be able to file a claim for services received after that date up to your existing balance.

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

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

Eligible dependents for your dependent care spending account include:

- Any person under age 13 whom you claim as a dependent for income tax purposes; and
- Any other dependent who isn't able to care for himself or herself.

Eligible expenses for the dependent care spending account may include care provided:

- In or out of your home;
- In an elder care center or a child care center that complies with all state and local regulations; or
- By a housekeeper whose services include, in part, care of an eligible dependent.

Special Note: Remember, to receive reimbursement for your expenses the services must be rendered during the year for which the spending account was established.

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

Listed below are examples of eligible and non-eligible dependent care spending account expenses. ***This is not intended to be a complete listing.*** If you would like to review additional information about eligible expenses, you should call the IRS at 1-800-TAX-FORM and request IRS publication #503 (Child and Dependent Care Expenses).

Eligible

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

Not Eligible

- Care provided by someone you claim as a dependent on your federal income tax return
- Expenses claimed under the federal dependent care tax credit for the calendar year
- Expenses incurred before participation
- Overnight camp expenses
- Transportation to or from a dependent care provider
- Health care expenses for your dependents (may be eligible for health care spending account)

Requests for Reimbursement

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

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

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

Forfeitures

You should use the spending accounts ***only*** for eligible expenses that you can reasonably predict. That is because ***federal regulations require*** that **unused amounts** in each of your spending accounts **must be forfeited** at the end of each calendar year. Any forfeited amounts will be used by GM to defray part of the administrative costs of the Flex Program.

Planning to Use Spending Accounts

Getting the most out of your spending accounts takes some planning. Although there are tax advantages from using them, the tax laws — governing both personal taxes and benefits — may create confusion. The following chart summarizes the current tax rules as a reference tool for your use.

Summary of Flexible Spending Accounts (FSA) IRS Rules

Feature	Health Care Account	Dependent Care Account
Separate accounts	Accounts must be separate; you cannot move money from one account to another; you cannot receive reimbursement from one account for an expense covered by the other account.	
Tax-free	You do not pay Social Security, federal and most state or local income taxes on contributions and reimbursements.	
Alternative personal federal income tax treatment	FSA in lieu of health care itemized deductions	FSA in lieu of federal dependent care tax credit
Eligible expenses	Generally almost the same as those qualifying as itemized deductions, **except premiums and/or contributions**. Remember, services must be rendered within that Flex year.	Dependent care expenses necessary for you or your spouse to work (or your spouse to attend school full-time). Remember, services must be rendered within that Flex year.
Eligible dependent	Dependent claimed for federal income tax purposes.	Your child(ren) under age 13; a dependent parent; a dependent or spouse unable to care for himself/herself.
Pre-paid care ineligible	Services for eligible expenses must be received during the calendar year; pre-paid care or services to be received during the previous or following calendar year do not qualify for reimbursement. (e.g., orthodontia)	
Contribution maximums*	$5,000	$5,000 if you are a single parent or married filing jointly $2,500/person, if married and filing taxes separately The lesser of your income or your spouse's income
Sources of contributions	Flex credits or pre-tax deductions from your pay	
Reimbursement availability	Up to **annual contributions at any time**	Up to **amount accumulated** in your account
Unused balance	**Money not used for reimbursement of expenses will be forfeited after March 31 of the following Flex year.**	

** GM requires a $48 minimum annual contribution to establish a spending account.*

Other Flexible Benefit Considerations

Effect on Other Benefits

Although your pre-tax contributions will lower your pay for certain tax purposes, they will not lower your pay for determining pay-related GM benefits such as:

- Retirement benefits;
- S-SPP contributions;
- Basic and optional life insurance amounts; or
- Disability benefits.

Participation in the Flexible Benefits Program may have some effect on your Social Security benefit. Under the Flex Program, you do not pay Social Security taxes on any pre-tax contributions from your pay. That means if your taxable income is less than the maximum Social Security wage base, your future benefits, which are based on the Social Security taxes you pay, could be somewhat less than if you did not elect to authorize pre-tax contributions from your pay.

Participation in the Flexible Benefits Program will not affect contributions to your S-SPP account.

Flex Opt Outs

You may elect to forego any or all of medical, dental or vision plan coverages from GM. If you elect to opt out of only one or two of these coverages, you remain eligible for the other(s). Additionally, if you opt out of any coverage, certain restrictions may apply if you want that coverage later. If you opt out of medical coverages, this election will remain in effect for one calendar year. If you waive Extended Care Coverage (ECC), you are permanently excluded from future re-enrollment unless you waive medical coverage to be covered as a dependent of another GM salaried employee or retiree who has ECC. Because an opt-out is an election to receive dollars in lieu of coverage, for the period you opt-out you ***cannot be carried as a dependent on another person's GM coverage.*** The opt-out value will be established each Flex year.

You may not opt-out if you are ordered to provide coverage pursuant to a Qualified Medical Child Support Order.

Flex Health Care Waiver

When you and your spouse are both employed by GM and each of you can elect coverage in your own right, you may ***"waive"*** coverage to be covered as a dependent of your GM spouse. When ***you waive medical coverage you automatically waive dental and vision coverage*** although you may be enrolled for these coverages as your spouse's dependent. Because you will still receive medical coverage through GM, you will not receive opt-out dollars under the Flex Program. You will be eligible to elect medical, dental and vision coverages again depending on which GM plan covers you as a dependent during the waiver period.

You may not waive coverage if you are ordered to provide coverage pursuant to a Qualified Medical Child Support Order.

Proof of Good Health

If you experience a qualifying life event change and wish to modify your Flex elections, during the same year, contact the GM Benefits & Services Center within 31 days of the event. In some cases, you may be required to provide satisfactory proof of good health. In the event you have elected reduced basic life insurance and your most recent date of hire is prior to January 1, 1993, your insurance coverage will be restored to two times annual base salary without proof of good health at retirement subject to reduction under plan provisions.

Changes in Employment Status

If you (1) retire, (2) die, (3) become disabled, (4) are laid off, or (5) terminate employment, you will forfeit any unpaid cash payment due you for any unused credits. In addition, if you were contributing to a spending account prior to any such change in status, you may receive reimbursement (1) up to your elected annual account balance for eligible health care services rendered any time during the Flex year and/or (2) up to your year-to-date dependent care spending account balance for eligible dependent care expenses, as may be applicable.

Note: The amount necessary to contribute to your health care spending account to equal your elected annual amount will be deducted from your last check.

You will forfeit any amount remaining in one or more of your spending accounts after 90 days following the end of the Flex year.

Flex Administration

Any Flex election, status change, or questions in general pertaining to the Flexible Benefits Program should be directed to the GM Benefits & Services Center at the following toll-free number: ***1-800-489-4646.***

A Word About Taxes

Pre-tax, after-tax, tax free… what do they mean? Do they apply to you? How do they affect your Flex benefits? All are valid questions. Flex offers benefit options that are available on either a pre-tax or an after-tax basis. *Your* ***pre-tax options*** include medical, dental, and vision plans (except for coverage of non-dependent same-sex domestic partners), health and dependent care spending accounts, and supplemental extended disability benefits. ***Pre-tax options*** are purchased with credits or contributions taken from your pay ***before*** both income and Social Security withholding taxes are calculated.

Note: By paying for benefits with pre-tax dollars, you lower your taxable income and, as a result, lower your taxes.

Your ***after-tax options*** include the portion of any employee life insurance coverage in excess of two times your annual base salary, any dependent life insurance coverage for your spouse/same-sex domestic partner and child(ren) and all personal accident insurance, as well as medical, dental or vision coverage for a non-dependent same-sex domestic partner. ***After-tax options*** are paid for with contributions taken from your pay ***after*** taxes are calculated and withheld.

The following chart illustrates how contributions for both ***pre-tax*** and ***after-tax*** elections affect your monthly pay.

The Formula		Description
	Gross pay	**Gross pay** is your pay for the current pay period.
+	**Opt-out dollars**	Your **opt-out dollars** for waiving coverage.
-	**Pre-tax contributions**	Before taxes (Social Security, federal, state, and local income taxes) are calculated and deducted from your pay, the total of any of your **pre-tax contributions** are subtracted from your pay.
=	**Taxable Income**	The result — your **taxable income** — is a lower amount.
-	**Taxes**	The **taxes,** and
-	**After-tax contributions**	The total of any of your **after-tax contributions are** deducted from your **taxable income.**
=	**Net pay**	This gives you your take-home or **net pay.**

How It Works

- **Each pay period:**
  - — You receive a portion of your pre-tax **opt-out dollars**, and
  - — Contributions for certain **pre-tax** elections are deducted
    - Medical, dental, and vision coverage
    - Health and dependent care spending accounts

- **Mid-month pay period:**
  - — Contributions for certain **pre-tax** elections are deducted
    - Supplemental Extended Disability Benefits
  - — Contributions for your **after-tax** elections are deducted
    - Optional life insurance
    - Dependent life insurance
    - Personal accident insurance

If You Have Health Care Expenses

The General Motors Salaried Health Care Program (the Program) provides comprehensive coverage for you and your eligible dependents for a wide range of health care services and expenses including acute care services (such as surgery and hospitalizations) and preventive care (such as physicals and physician office visits). There also are components covering long-term and custodial care needs. The Program helps protect you from catastrophic medical costs while allowing flexibility in the way you plan for your health care expenses.

The specific provisions of the Salaried Health Care Program, the range of covered services, eligibility rules and so forth may be amended, modified, suspended, increased, decreased or terminated by General Motors from time to time through the years. Additionally, while coverages provided under this Program are very broad and comprehensive, the Program does not cover all health care services and expenses under all circumstances, nor is it intended to do so. You should seek guidance from your health care carrier (for example, Blue Cross & Blue Shield) if you have questions about whether a particular health care service or expense is covered under the Program. The following information is based upon the Program provisions as of January 2005, unless otherwise noted.

Basic hospital, surgical, medical, prescription drug, hearing aid, mental health, substance abuse and extended care coverages are known as “core coverages.” Dental and vision coverages also are provided and are known as “non-core coverages.”

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Eligibility for Coverage

You

Generally, you are eligible to participate in the Medical Plan if you are:

- A regular active salaried employee (compensated on a monthly salary);
- A Flexible Service employee;
- A part-time employee, qualifying for benefit plan coverage;
- Either of the above on certain leaves (for example, a disability leave of less than six months).

You are eligible for coverage on the first day of the third month following the month of hire, provided you are actively at work on that day. For example, an employee hired January 16 would be eligible for coverage April 1. If you are not in active service on the date your health care coverages otherwise would start, your coverages become effective upon your return to work. For the purpose of initial eligibility for coverage, if you are on an approved disability leave of absence, you will be deemed to be actively at work.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may in the future be able to enroll yourself or your dependents in the Salaried Health Care Program, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent (e.g., 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 31 days after the event.

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

Generally, your eligibility for coverage ceases at the end of the month you are last in active service. Any continuation beyond that point is based upon your employment status. For information about continuation opportunities when your status is retirement, see page 120, "Other Benefit Program Coverages After Retirement." For information about continuation during periods of leave, see page 92, "Other Benefit Program Coverages While on Disability Leave," and pages 141 and 142, "Benefit Program Coverages While on Non-disability Leave." For information about continuation during periods when your status is layoff, see page 105, "Other Benefit Program Coverages While on Layoff."

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

For services that require predetermination, benefit payments may be reduced if you fail to call and receive authorization.

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

If a Medicare-eligible surviving spouse fails to enroll in Medicare Part B, the surviving spouse will not be eligible for corporation contributions for health care coverage.

If Your Status Is...

- **International Service Personnel**
  You are eligible for the coverage provided under the International Health Care Plan which consists of hospital, surgical, medical, prescription drug, hearing aid, mental health and substance abuse, dental, and vision coverages. ***This excludes Extended Care Coverage (ECC).***

- **Flexible Service Employee (GMAC/MIC)**
  You are eligible for the ***core coverages under the Basic Medical Plan**** as outlined on page 139, dental (except Alternative Dental Plans) and vision.

- **A Flexible Service Employee (except GMAC/MIC)**
  You may select options other than the Basic

Medical Plan, but you will be required to pay an additional $50 per month employee contribution. You will also be eligible for Extended Care Coverage (ECC).

- **Cooperative Student**
  If your service date is prior to January 1, 1999, you are eligible for the ***core coverages only under the Basic Medical Plan**** as outlined on page 141. You are **not** eligible for dental, vision and Extended Care Coverage (ECC). If your service date is on or after January 1, 1999, you are not eligible for coverage.

  **As a Flexible Service Employee (GMAC/MIC) or Cooperative Student, you will automatically be enrolled in the coverages as outlined above, unless you contact the GM Benefits & Services Center to request a waiver of coverages.*

Your Dependents

Some of your dependent family members may be enrolled for coverage with Corporation contributions while for others you must pay the full cost of coverage.

Eligible family members that may be enrolled for coverage with Corporation contributions may include:

- Your spouse;
- Your natural or adopted children; and
- Your current spouse's natural or adopted children;
- Your same-sex domestic partner (see below);
- Your same-sex domestic partner's children — if they qualify as your dependents.

You should note that a spouse or child acquired after retirement can be enrolled only as a sponsored dependent, as described later in this section. Same-sex domestic partners and their children acquired after retirement are not eligible for coverage.

To be eligible for Program coverage with Corporation contributions, children must meet certain tests. These tests include:

- ***Relationship:*** The children must be yours or your current spouse's by birth or legal adoption.
- ***Age:*** The children must not have reached the end of the calendar year in which they turn age 19, except for two cases.

  The first is if the children are ***full-time students*** for at least one full school term during the calendar year, in which case they remain eligible for such year(s), ***but not beyond the end of the calendar year in which they turn age 25***. Such children, age 24 or older, must qualify as your dependents under Section 152 of the Internal Revenue Code.

  The second exception is the case of ***totally and permanently disabled (T&PD)* child(ren)**. T&PD children may have coverage continued if they continuously meet the Salaried Health Care Program's definition of T&PD status (i.e., having any medically determinable physical or mental condition that prevents a child from engaging in substantial gainful activity and that can be expected to result in death or be of long-continued or indefinite duration) and continue to meet all other applicable eligibility requirements.
- ***Marital status:*** The children must not be married.
- ***Residency:*** The children must reside with ***you*** (children temporarily away from home while attending school full time meet this test) or ***you*** must have legal responsibility for the provision of health care coverage. If you are ordered to provide coverage for your children pursuant to a divorce decree, court order, paternity order or a Qualified Medical Child Support Order (QMCSO) as defined by the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), you may be able to satisfy the residency test for children that do not reside with you.

QMCSO Procedures

Additional information regarding enrollment pursuant to a QMCSO can be obtained, without charge, by writing to the Plan Administrator at the GM Benefits & Services Center, Attn: QMCSO Processing MZ-TS4P, One Spartan Way, Merrimack, NH 03054 or calling the GM Benefits & Services Center at 1-800-489-4646.

Same-Sex Domestic Partners and Their Children

Effective August 1, 2000 the eligibility provisions of the GM Salaried Health Care Program were expanded to permit enrollment of qualified same-sex domestic partners and their eligible children.

To qualify for coverage, you and your same-sex domestic partner must:

- Be the same sex;
- Have shared a continuous committed relationship for at least six months, intend to do so indefinitely and have no such same-sex domestic partner relationship with any other person;
- Reside in the same household;
- Share responsibility for each other's welfare and financial obligations;
- Not be related by blood to a degree of kinship that would prevent marriage from being recognized under law;
- Be over age 18, of legal age and legally competent to enter a contract;
- Reside in a state where marriage between two persons of the same sex is not recognized as valid under law; and
- Not be married to any other person.

In areas where marriage is legal for same-sex couples, marriage is required for eligibility. Similarly, if a state has some formal recognition of a same-sex domestic partner relationship (for example, the "Civil Union" in Vermont), recognition under such state law is required.

Your same-sex domestic partner's children are eligible for enrollment only if ***you***, as primary enrollee, are eligible to claim exemptions for them on your federal income tax return. The same-sex domestic partner's children must also satisfy the general eligibility rules for children.

Generally, employees enrolling same-sex domestic partners have the standard plan options. However, certain insured managed care entities may not accept same-sex domestic partners. If the plan in which you are enrolled at the time you add a same-sex domestic partner does not accept them, you may change options, subject to Flex Plan administrative rules.

Although retirees may not add new same-sex domestic partners or their children to coverage after retirement, they may continue coverage for eligible same-sex domestic partners or their children who are enrolled at the time of retirement.

Under current federal and most state tax laws, unless your same-sex domestic partner qualifies as your dependent under Section 152 of the Internal Revenue Code, the same-sex domestic partner is not entitled to the same tax treatment as if you were adding a spouse. Consequently, the value of the health care coverage represents imputed income to you. In addition, any contributions required for the same-sex domestic partner's coverage are to be made on a post-tax basis.

Under current federal law, a same-sex domestic partner does not qualify for COBRA continuation. However, if you and your same-sex domestic partner terminate the relationship, an opportunity to continue coverage, on a basis comparable to COBRA, will be provided. In the event of your death, a surviving same-sex domestic partner will be provided continuation opportunities comparable to a similarly situated surviving spouse.

Sponsored Dependents

You also may be able to enroll certain individuals for limited GM medical coverage as sponsored dependents if you are ***able to, and do, legally claim exemptions for them on your federal income tax return.*** You pay the full cost of such coverage. The following individuals may be enrolled for sponsored dependent coverage:

- Your child or your current spouse's child who:
  - — is single,
  - — lives with you, and
  - — does not satisfy the age test;
- A minor child living with you and for whom either you or your current spouse is the court-appointed guardian because both natural parents of the minor child are deceased;

- A minor child living with you and who is the child of your enrolled dependent child;
- One or both of your parents or your current spouse's parents; or
- A spouse and/or child acquired after retirement.

Before becoming eligible for coverage, sponsored dependents who are not citizens of the United States must reside in the United States for one full year and must be legally entitled to remain in the United States indefinitely. The medical coverage available to sponsored dependents is the same option you choose for yourself. Each sponsored dependent has his or her own set of contributions, deductibles, copayments, and out-of-pocket maximums, if applicable. Coverage is effective the first of the month following receipt of a completed application and any necessary supporting documentation.

You may not purchase dental, vision or Extended Care Coverage (ECC) for sponsored dependents.

Medical Plan

Periodically, U.S.-based regular salaried employees will be provided an opportunity to elect coverages through the medical plan options available under the Program. Such elections also may include a choice among dental options. (Separate provisions summarized on page 77 apply to U.S. regular salaried employees residing in Canada, Hawaii or Puerto Rico or salaried employees classified as International Service Personnel. Separate provisions also apply to Flexible Service employees (see page 139).

The specific choices available will depend on your status, the availability of approved options in your geographic area, and your and/or your eligible dependents' Medicare status. Additionally, you may be required to make monthly contributions for coverages, as determined annually, according to your status, enrollment classification, option elected, the type and number of dependents enrolled, and Medicare status.

You may elect from among four medical plan options and certain alternative dental plan options to the extent such options are available in your area. From time to time, the types of available options may change. The current Medical Plan options are as follows:

- The Basic Medical Plan (BMP) option;
- The Enhanced Medical Plan (EMP) option;
- The Preferred Provider Organization (PPO) option; and
- The Health Maintenance Organization (HMO) option.

Descriptive materials concerning benefits provided under each option are available from the GM Benefits & Services Center. In general, covered expenses and major limitations and exclusions are summarized below. ***This is a general description only and the provisions of the Salaried Health Care Program control your eligibility for coverage and specific benefits.*** Furthermore, each HMO has its own rules that are provided in the certificate you receive from the HMO. A glossary of terms is provided at the end of the handbook. Also provided on page 45 is a chart intended as an at-a-glance resource.

Under the Basic Medical Plan, the Enhanced Medical Plan and the Preferred Provider Organization, selected carriers handle certain administration and claims processing for the GM programs. Under the Health Maintenance Organization option, coverages are provided by HMOs for which General Motors contributes for the premiums. The individual HMOs are solely responsible for financing, administration, medical policy, claims processing, and appeal procedures.

Three features – Care Management, Disease Management and Centers of Excellence – are applicable for salaried employees, non-Medicare retirees and eligible dependents in the Basic Medical Plan, the Enhanced Medical Plan and Preferred Provider Organization options.

The ***Care Management*** feature requires advance review of any hospital stay (except emergency or maternity), surgery, skilled nursing facility admission or home health care visit. Emergency admissions must be reported within 48 hours of inpatient admission. Keep in mind that certain

invasive tests and injections are considered surgery. If in doubt about the nature of the proposed treatment, you should call SHPS (formerly Health International). Nurses and board-certified physicians from our Care Management administrator, SHPS, advise, educate and present alternatives that help enable patients to make informed decisions about the treatment that's best for them. ***Enrollees are responsible for assuring that SHPS is called regarding procedures that require predetermination.*** If a procedure is determined not to be covered under the Program, the provider and enrollee will receive communication regarding its non-covered status.

If you do not call, or if you proceed with services that are considered medically inappropriate, you will be responsible for up to an additional $200 per occurrence for services provided. These amounts (up to $600 per year) are in addition to any normal deductibles and copayments, and will not be applied to your out-of-pocket maximum.

Services determined not to be medically necessary are not covered. Predetermination is not a guarantee of benefit payment. To be covered, the service must meet all terms and conditions of the Program.

The ***Disease Management*** feature is a confidential, voluntary resource if you have a serious, chronic condition, such as asthma, diabetes or heart disease. Medical professionals who specialize in these conditions work with you and your doctor to develop a personalized, coordinated plan of care with the goal of increasing the likelihood you receive appropriate, evidence-based, high-quality care.

Centers of Excellence is a confidential, voluntary resource that provides you with information about and access to doctors, hospitals and health centers that are nationally recognized for improved outcomes in treating specific conditions. Financial assistance may also be provided if you and a family member need to travel to a Center over 100 miles from your home. When travel to a Center of Excellence is approved by SHPS, certain travel expenses of up to $7,500 may be reimbursed through procedures that have been established by the administrator.

Questions regarding the Care Management, Disease Management and Centers of Excellence features may be directed to SHPS (formerly Health International) at 1-877-299-4635.

Basic Medical Plan (BMP)

If you enroll in the BMP option for core coverages, currently you will not be required to make a monthly contribution. However, you will be required to share a part of the expense of covered services.

- An annual $900 individual or $1,800 family deductible will be applied to covered services (other than certain screening tests/examinations, durable medical equipment and prosthetic and orthotic appliances, prescription drugs, mental health, substance abuse, and extended care services, as discussed in a later section). Only the reasonable and customary charges for covered services can be counted toward meeting the deductible. Each covered individual can contribute only a maximum of $900 toward satisfying the family deductible.

- After the annual deductible is met, you will be responsible for a 25% copayment for most covered services, until your annual out-of-pocket expense for such copayment equals a maximum of $1,600 for an individual or $3,200 for a family. Your maximum annual out-of-pocket expense for the deductible and copayment for covered services is limited to $2,500 ($900 individual deductible plus $1,600 copayment) for an individual and $5,000 ($1,800 family deductible plus $3,200 copayment) for a family.

  After your maximum annual out-of-pocket expense is reached, charges for any remaining covered services will be paid at 100% of the reasonable and customary amount for the rest of the year.

- Prescription drug, mental health, substance abuse, and extended care coverages are not subject to the deductibles and copayments noted above. Charges incurred for prescription drug, mental health, substance abuse treatment, and extended care services will not be counted toward satisfying the deductible or out-of-pocket maximum.

Care Management, Disease Management and Centers of Excellence features apply to the BMP option.

Enhanced Medical Plan (EMP)

The features of the EMP option are the same as those of the BMP option previously described except:

- A monthly contribution is required for core coverages;
- The annual deductible amounts are $450 and $900 for an individual and a family, respectively;
- The copayment rate for expenses incurred above the deductible is 20% for a maximum annual amount of $1,050 for an individual and $2,100 for a family; and
- The total annual out-of-pocket maximum for deductible and copayments for covered services is $1,500 and $3,000 for an individual and a family, respectively.

Care Management, Disease Management and Centers of Excellence features apply to the EMP option.

The Preferred Provider Organization (PPO)

Under this health care arrangement, selected physicians, hospitals, and other health care providers in a geographic area are pooled together as a network to provide services to you and your family. PPOs are offered based on your address of record. Provider directories are available, without charge, from your local carrier on-line and/or by calling their toll-free number. Care Management, Disease Management and Centers of Excellence features apply to the PPO option. You may be required to pay a monthly contribution for enrollment in the PPO option.

The features of the PPO option are the same as those of the BMP option previously described except:

- The annual deductible amounts are $300 and $600 for an individual and a family, respectively; and
- When PPO network providers are used and all PPO network rules (e.g., required referrals) are followed, core coverages, (other than certain screening tests/examinations, prescription drugs, mental health, substance abuse, and extended care services) are subject to a 10% copayment, up to a calendar year maximum out-of-pocket cost for covered services of $1,300 for an individual and $2,600 for a family.
- If you choose to go to a non-PPO network provider (unless referred by a PPO panel provider or in the event of an emergency), payment for covered services will be 70% of the PPO's level of payment for the same service or, if less, 70% of the actual charge. You will be responsible for the difference between the PPO's payment and the non-panel provider's charge. The amount of your liability will **not** be applied to the $1,300 individual or $2,600 family out-of-pocket maximum.

The Health Maintenance Organization (HMO)

Health Maintenance Organizations (HMOs) are local health care delivery systems. HMO coverage differs from the BMP and EMP options in that you must receive services from HMO providers for the services to be covered. Unlike the PPO option, non-emergency services obtained from providers outside of the HMO panel are **not** covered at all unless the primary care physician makes the referral or the HMO authorizes treatment.

HMOs have monitoring systems to assess quality of care, necessity of treatment, and appropriateness of inpatient hospital stays. The coverage varies among individual HMOs, but all HMOs include certain preventive and routine care services such as physical exams, office visits and immunizations. Generally, such care is provided at lower or no cost to you. A summary of the coverages provided by each HMO is located at gmbenefits.com.

If you are enrolled in the HMO option, all of your core coverages are provided by the HMO except Extended Care Coverage. ***Coverage for services may vary from that provided under the BMP, EMP, and PPO options.*** The applicable information in the certificate you receive from the HMO is incorporated in this Summary Plan Description handbook by reference. It contains specific information about any cost-sharing provisions, including deductibles, coinsurance, and copayment amounts for which the participant will be

responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits for selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. Provider directories are available, without charge, at the HMO's website, or by calling their toll-free number. It is important to review the HMO certificate carefully to become familiar with the scope and level of benefits that are available through a particular HMO.

HMOs are offered based on your address of record. You should contact the GM Benefits & Services Center to obtain information regarding any HMO available to you. Additional literature can be obtained by contacting an HMO and requesting the membership handbook that describes its benefits and the provider directory which lists the doctors, hospitals, laboratories, and pharmacies that participate in that HMO. If you are considering enrollment in an HMO, you should carefully review the HMO's provider directory or contact the HMO to understand provider availability in your area.

The individual HMOs are solely responsible for administration, claims processing and appeal procedures.

BMP, EMP, PPO and HMO At-a-Glance

	BMP (1)	**EMP(1)**	**PPO**		**HMO**
			In-Network (1)	**Out-Of-Network (2)**	
Monthly contributions	None	Yes	Varies	Varies	Varies
Annual deductible:			$300		
Individual	$900	$450	$600		None
Family	$1,800	$900	(Combined in and out of Network)		None
Copayment:					
Plan pays	75%	80%	90%	70% PPO Fee	Varies
You pay	25%	20%	10%	The Balance	
Out-of-pocket maximum: (3)					
Individual	$2,500	$1, 500	$1,300	Not applied to maximum	None
Family	$5,000	$3,000	$2,600		None

(1) Annual deductibles, copayments, and out-of-pocket maximums are calculated on the basis of "Reasonable and Customary" (R&C) charges as determined by the carrier. For PPOs, and for BMP and EMP in the case of those carriers with "participating" or approved provider arrangements, it is the amount the participating/approved provider has agreed to accept for covered services.

(2) Except in the case of a bona fide medical emergency, if you use a non-PPO provider without the proper preauthorization, the plan will pay 70% of the lesser of the charge or the PPO's fee schedule, and you will pay the rest.

*(3) Deductibles, copayments, and out-of-pocket maximums apply only to covered hospital, surgical, and medical services. They do not include mental health/substance abuse coverage or prescription drug coverage. Out-of-network copayments and Care Management sanctions will **not** be applied to out-of-pocket maximums. Certain screening procedures are covered before deductible and without copayment.*

Medical Plan Coverages

The various medical plan coverages described in this section apply to the BMP, EMP, and PPO. As previously noted, medical coverages available under HMO options may vary from those described below.

Hospital

What Is Covered

In general, for an inpatient stay to be eligible for full plan coverage, it must be: (1) medically necessary, (2) prescribed by your doctor, and (3) "predetermined" by the utilization review organization, SHPS (formerly Health International), as to the setting and length of stay. ***(Note: Predetermination is not a guarantee of payment. In addition, benefit payment can be severely limited for Blue Cross & Blue Shield enrollees who receive non-emergency services at a non-participating hospital. You should call your medical carrier to verify your eligibility for benefit payment.)***

Your doctor may order surgery, tests, or treatment not requiring an overnight stay. When you or a dependent receive covered services from an outpatient department of a hospital, the hospital's facility charges are generally covered on the same basis as inpatient care. Facility charges also may be covered for services performed in an ***approved*** free-standing ambulatory surgery center (FASC). Predetermination is required for outpatient surgery before the procedure is performed. You should consult your medical plan carrier to determine the approval status of any particular FASC.

Facility charges covered under hospital coverage (maximum of 365 days per "benefit period," 45 days in the case of tuberculosis) include, but are not necessarily limited to:

- Semiprivate room, general nursing services, meals and special diets, and service in a special care unit;
- Private room accommodations, if medically necessary;
- Use of operating rooms;
- Anesthesia when administered by an employee of the hospital and anesthesia supplies, gases, and use of equipment;
- Laboratory and pathology examinations under the direction of the hospital's pathologist;
- Chemotherapy (chemotherapeutics, antineoplastic agents, and select ancillary drugs and administration) for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is (1) research, (2) investigational, or (3) experimental in nature;
- Physical, functional occupational, and speech therapy;
- Drugs, biologicals, solutions, oxygen, and other supplies and equipment used in treatment while in the hospital;
- Blood services, including transfusions of whole blood and packed red blood cells (if not replaced);
- Maternity care and routine nursery care; (Generally, under federal law, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of the above periods);
- Hemodialysis when provided by a hospital qualified to provide hemodialysis treatment and which has a hemodialysis program approved by the carrier;
- Necessary and appropriate x-rays;
- Pulmonary function evaluation;
- Hyperbaric oxygenation provided in the hospital outpatient setting for patients with

emergent conditions. Such as cyanide poisoning, acute carbon monoxide intoxication and decompression illness;

- Tissue storage bank costs (e.g., skin banks and bone banks) for inpatients only; and
- Outpatient emergency room services and observation care (see the glossary for definition and further description of terms and conditions).

What Is Not Covered — Limitations and Exclusions

Limitations and exclusions to the hospital coverage include, but are not necessarily limited to, the items listed below:

- Drugs, biologicals and solutions — beyond the extent they are used in connection with the inpatient or outpatient service;
- Chemotherapy done on a research, investigational or experimental basis (as determined by the carrier);
- Outpatient treatment of chronic conditions that require repeated hospital visits (except hemodialysis and IV infusion therapy services);
- Follow-up care in an emergency room for treatment received initially in an emergency room (follow-up should be done in a physician's office to avoid facility charges);
- Skin bank, bone bank, and other tissue bank services for outpatients, (except for certain specified procedures);
- Hospital admissions and services beyond the period which is medically necessary for the proper care and treatment of the patient, or in excess of the maximum benefit period (see glossary for definition) or inconsistent with other applicable Program provisions;
- Hospital services related to domiciliary, custodial, convalescent, nursing home, or rest care;
- Hospital services consisting principally of dental treatment or extraction of teeth (except when either multiple extractions or the removal of one or more unerupted teeth is performed under general anesthesia and a concurrent hazardous medical condition exists);
- Inpatient hospital services when the care received consists principally of observation or diagnostic evaluations, inpatient physical, functional occupational, or speech therapy, x-ray examinations, laboratory examinations, electrocardiography or basal metabolism tests, ultrasound studies, nuclear medicine studies, weight reduction by diet control with or without medication or environmental control;
- Facility charges for care received in an urgent care center;
- Facility charges for care received in a freestanding ambulatory surgery center, unless such center meets Program standards and is approved by the carrier;
- Facility charges related to refractive eye surgery (e.g., radial keratotomy, lasik corneal sculpting, or similar surgical procedures to correct vision), sterilization reversals, or non-covered plastic, cosmetic, or reconstructive surgery;
- Reimbursement limits of:
  - up to $250 per day for room, board, and all covered inpatient services in a **non-participating** non-psychiatric hospital, and full coverage for the first five days of emergency admissions;
  - up to **$35 per condition** for covered **outpatient services** received **at a non-participating** non-psychiatric **hospital** (services may be covered at a participating hospital rate in some cases of emergency.

Skilled Nursing Facility

Services received from skilled nursing facilities licensed to provide such care may be covered under your GM medical plan. ***When such services are recommended, they must be predetermined prior to the admission, to determine if such services are covered by the Program and to ensure that the intended provider of such services is approved by the carrier. You should call or ask your doctor, the hospital and/or discharge planning staff or the skilled nursing facility staff to make the call to predetermine these services. (Note: Predetermination is not a guarantee of payment.)***

The Care Management Administrator can also determine whether the patient is a candidate for case management and work with the Extended Care Coverage (ECC) carrier and the DME and P&O Network in appropriate cases.

What Is Covered

Two days of inpatient skilled nursing facility care are available for each remaining day of inpatient hospital care within the benefit period (see glossary for definition), up to a maximum of 730 days for each continuous period of confinement. Each day of inpatient hospital care within a benefit period reduces by two the number of days of care available for skilled nursing facility services. The use of skilled nursing facility days does not reduce the number of days of inpatient hospital care available.

For skilled nursing facility care to be covered it must be:

- Prescribed by a physician;
- Medically necessary based on the severity of illness/injury and intensity of the service;
- Received from a carrier-approved skilled nursing care facility; and
- Provided and billed by the facility.

Services provided under skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Semiprivate room and board and general nursing services;
- Meals and special diets;
- Use of special treatment rooms;
- Routine laboratory exams;
- Physical, functional occupational, and speech therapy, when medically necessary;
- Drugs, biologicals, solutions, oxygen and other supplies used while in the facility; and
- Durable medical equipment.

What Is Not Covered

Services not covered under the skilled nursing facility coverage include, but are not necessarily limited to, the items listed below:

- Care that is principally custodial or domiciliary in nature (although coverage may be available under Extended Care Coverage); and
- Treatment for tuberculosis or substance abuse.

Physical, Functional Occupational and Speech Therapy, and Cardiac Rehabilitation

When you or a family member require certain therapy to restore or improve musculoskeletal, speech, or cardiac performance, your health care program may provide coverage to help you meet these needs.

Outpatient services must be (1) approved by the carrier, (2) prescribed by the physician in charge of the case, (3) provided or supervised by a physician (other than a limited-practice physician) or by a registered and licensed physical, occupational, or speech therapist for the specific therapy prescribed, and (4) billed by a physician (other than a limited-practice physician) or a hospital, or a freestanding outpatient physical therapy facility, home health care agency, skilled nursing facility, or independent therapist approved by the carrier.

What Is Covered

Services provided under physical, functional occupational, speech therapy, and cardiac rehabilitation coverage include, but are not necessarily limited to, the items below:

- Medically necessary physical, functional occupational, speech therapy, and cardiac rehabilitation:
  - During a covered admission to a hospital or skilled nursing facility for the treatment of the condition for which the patient is admitted. These services normally are billed by the hospital or skilled nursing facility;
  - Care prescribed and received through an approved rehabilitation center that meets Program standards;

- Physical, functional occupational, and speech therapy provided through an approved home health care agency;

- Outpatient physical and functional occupational therapy to restore or improve musculoskeletal function;

- Restorative speech therapy on an outpatient basis when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the enrollee's illness, subject to certain limitations; and

- Cardiac rehabilitation on an outpatient basis provided through a hospital or performed or supervised and billed by a physician (limited to services provided during the six-month period immediately following acute myocardial infarction, initial diagnosis of angina pectoris, or certain heart surgeries).

What Is Not Covered

Services not covered under the physical, functional occupational, and speech therapy and cardiac rehabilitation provisions include, but are not necessarily limited to, the following:

- Speech therapy for:
  - — Educational learning disabilities;
  - — Deviant swallow or tongue thrust;
  - — Mild developmental speech or language disorders;
  - — Congenital deafness;
  - — Elimination of a lisp, or similar defect in articulation;
  - — Improving speech that is not fully developed; or
  - — Long-standing, chronic conditions or inherited speech abnormalities except:
    - When the patient is diagnosed as having a severe communication deficit as defined by Program standards; and when speech therapy is not available through other public agencies (e.g., state or school);

- Physical and functional occupational therapy when:
  - — The condition is not expected to improve in a reasonable and generally predictable period of time;
  - — Improvement does not occur, as documented in the patient's record on a periodic basis; or
  - — Progress is no longer being made or the previous level of function has been restored;

- Physical and/or functional occupational therapy provided solely to maintain musculoskeletal function;

- Inpatient admissions which are principally for physical, functional occupational, and/or speech therapy or cardiac rehabilitation;

- Manipulation, adjustment, or massage of the musculoskeletal system;

- Vision therapy or training;

- Cognitive rehabilitation, (including but not limited to, vocational rehabilitation, recreational therapy, or learning exercises);

- Day, night, or residential rehabilitation programs;

- Services which could be performed by an untrained, unlicensed person, by the enrollee, or by a member of the enrollee's family; and

- Physical and/or functional occupational therapy for first and second degree burns.

Home Health Care

When a patient no longer requires constant care, home health care services of a part-time or intermittent nature may be prescribed by the doctor.

- ***When home health care services are recommended they must be predetermined prior to incurring expenses, to determine if such services are covered by the Program and to ensure that the intended provider of such services is approved by the carrier.*** SHPS (formerly Health International) can also determine whether the patient is a candidate for special Program components (such as case management) and interface with the Extended Care Coverage (ECC) carrier and the DME/P&O Network in appropriate cases (Note: Predetermination is not a guarantee of payment);

- Coverage for home health care services is available only when the patient is essentially homebound, and the services are medically necessary.

What Is Covered

When home health care is medically necessary and appropriate, the following services are ***covered, if they are provided on a part-time or intermittent basis*** during a home health care visit and billed by a home health care agency approved by the carrier. Services provided under home health care coverage include, but are not necessarily limited to, the items below:

- General nursing services;
- Physical therapy and speech therapy;
- Social service guidance, dietary guidance, and functional occupational therapy;
- Home health aide services (if provided in conjunction with general nursing services, or physical or speech therapy services) by an approved health care agency.

The following are covered when provided and billed by an approved provider:

- Laboratory tests;
- Drugs, biologicals, solutions; and
- Medical supplies ordered by the physician and necessary for the home medical regimen.

What Is Not Covered

Services not covered under the home health care provisions include, but are not necessarily limited to, the following:

- Supplies such as elastic stockings, personal comfort or personal hygiene items or equipment, or supplies and appliances that may be covered under Durable Medical Equipment (DME) or Prosthetic and Orthotic Appliance (P&O) provisions;
- Physician services, private duty nursing, or housekeeping services;
- Skilled nursing services and home health aide visits when the care exceeds the part-time or intermittent levels;
- Home uterine monitoring;
- Travel time; and
- Services for which the cost would exceed the daily cost for similar care in a skilled nursing facility.

Surgical and Medical

You are eligible for benefits for expenses incurred for covered surgical and medical services when such services are approved by the carrier and are medically necessary. Your carrier will pay benefits for covered services based on a fee schedule, capitation schedule or its determination of reasonable and customary charges.

Surgical procedures, including certain tests, injections, and other services classified by the American Medical Association as surgery, must be predetermined. If you have questions concerning whether a procedure is considered surgery, you should contact SHPS (formerly Health International). (Note: Predetermination is not a guarantee of payment.)

What Is Covered

Services covered under surgical and medical provisions include, but are not necessarily limited to, the items below.

- Certain surgical services consisting of generally accepted operating and cutting procedures for the necessary diagnosis and treatment of disease, injuries, fractures, or dislocations, including medically recognized human organ transplants, laser surgery if the alternative cutting procedure is covered, and voluntary sterilizations (but not reversals);
- Certain plastic and reconstructive surgery, such as correction of deformities following cancer surgery or accidental injuries;

  In the case of a participant or beneficiary who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, under federal law, coverage must include:
  - reconstruction of the breast on which the mastectomy has been performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications of all stages of mastectomy, including lymphedemas

  in a manner determined in consultation with the attending physician and the patient;

- Certain dental surgery (e.g., multiple extractions or removal of one or more unerupted teeth) is covered **when performed in the hospital (inpatient or outpatient setting) or at a freestanding ambulatory surgical center, but only when a concurrent hazardous condition requiring such hospitalization exists;**

- Hemodialysis;

- Anesthesia (by other than the operating physician), including the administration of anesthesia by a lay or nurse anesthetist in the employ of the physician who authorizes the services and who is available for immediate attendance;

- Medically necessary technical surgical assistance, (i.e., services of a physician or a physician assistant who actively assists the operating physician) when the services of interns, residents, or house officers are not available. In order for technical surgical assistance performed by a physician assistant to be covered, the physician assistant must be legally qualified and registered, certified and/or licensed, as applicable, to perform these health care services. The physician assistant must meet Program standards and be approved by the carrier. Reimbursement for technical surgical assistance services performed by a physician assistant will be made to the employer of the physician assistant;

- Maternity care, including prenatal and postnatal care;

- Obstetrical services (received in a hospital or birthing center affiliated with a hospital) provided by a certified nurse midwife. Coverage is limited to basic antepartum care, normal vaginal deliveries, and postpartum care;

- Consultations when requested by the physician in charge;

- Chemotherapy for malignant conditions, both inpatient and outpatient — excluding research, investigational or experimental services;

- Therapeutic radiology and certain diagnostic radiology services;

- Laboratory services;

- Certain services related to contraception;

- Physician medical visits in the home, doctor's office, hospital or skilled nursing facility for:
  - — Inpatient medical care when provided by the physician in charge of the case;
  - — Treatment rendered in or at a hospital when provided by a physician who is not an employee of the hospital;
  - — Well child(ren) care for enrollees six years of age or younger; and
  - — One physical examination per calendar year for enrollees over six years of age;

- Certain immunizations and injections;

- Foot care for treatment of injuries and/or infections; and

- Screening examinations. (Note: Certain screening exams will not be subject to the deductible or copayment requirements.)

What Is Not Covered

Services not covered under the surgical and medical provisions include, but are not necessarily limited to:

- Physician medical visits for the types of care listed below (although some may be covered under other provisions of the Program):
  - — Mental health or substance abuse treatment;
  - — Routine eye examinations;
  - — Insurance, employment, and premarital examinations;
  - — Manipulation, adjustment, or massage of the musculoskeletal system;
  - — Allergy testing, treatment, or injections;
  - — Weight control;
  - — Acupuncture; or
  - — Services provided by non-physician practitioners (e.g., physician assistants (except as provided above), Christian Science practitioners);

- Dental services including extraction of teeth except as provided for earlier;

- Examinations and tests in connection with research studies, paternity determinations, weight control, autopsies, etc.;

- Charges for stand-by physicians or similar charges where no service is actually performed;

- Services relating to refractive eye surgery (e.g., radial keratotomy, corneal sculpting, or similar surgical procedures to correct vision);
- Growth factor treatment for wound care; and
- Thermography.

Ambulance Service

GM's medical plan provides you with ambulance service coverage when the following three conditions are met:

- Ambulance services must be medically necessary (ambulance services are not medically necessary if any other means of transportation could be used without endangering the patient's health);
- Services are provided by an approved, licensed ambulance operation; and
- A physician prescribes the services that necessitate use of an ambulance.

What Is Covered

Services covered under the ambulance service provisions include, but are not necessarily limited to, the following:

- Basic life support services that consist of services which provide for the initial stabilization and transport of a patient;
- Advanced life support services (defined as acute emergency treatment procedures with physician involvement);
- Mileage charges while the patient occupies the ambulance;
- Waiting time involved in round-trip transport of an enrollee from a hospital to another treatment site and return to the same hospital;
- Transportation to the nearest medical facility qualified to provide treatment; transportation to other than the nearest, qualified treatment facility will only be covered in an amount equal to that for transportation to the nearest facility; and
- Air and boat ambulance transportation is subject to individual review and, unless the services of the air or boat ambulance are determined to be medically necessary, will only be covered in an amount equal to that for ground transportation, assuming ground ambulance services were medically necessary.

What Is Not Covered

Services not covered under the ambulance provisions include, but are not necessarily limited to, the following:

- Transportation in a vehicle not qualified as an ambulance;
- Transportation for the convenience of you, your family, or your physician;
- Services rendered by providers whose fee is in the form of voluntary donation, for example, fire departments or rescue squads;
- Transfers not medically necessary;
- Services billed by physicians or other independent health care providers for care rendered to enrollees transported by ambulance;
- Services when you are not actually transported while under care;
- Services payable through an existing arrangement to transfer patients where no additional charge is usually made, whether or not such services were immediately available; and
- Services that are covered as a component of the basic or advanced life support services such as:
  - Use of specific equipment or devices;
  - Gases, fluids, medications, dressings, or other supplies;
  - First aid, splinting, or any emergency medical services or personal service procedures; and
  - Vehicle operators, attendants, or other personnel.

Prescription Drugs

Prescription drug coverage is delivered through retail pharmacies participating in the National Managed Pharmacy Network. The National Managed Pharmacy Network pharmacies provide prescription drug services that meet high quality standards. Generally, a participating pharmacy will

be located within three miles of your residence. Medco Health is the carrier for this coverage.

When you use a network pharmacy, the copayment for generic drugs is $5. For preferred brand-name drugs, the copayment is 25% per prescription or refill with a minimum of $15 and a maximum of $25. For non-preferred brand-name drugs, the copayment is $50. For drugs that cost less than the applicable copayment, you will be charged the network cost of the drug. A listing of preferred brand-name drugs can be obtained by calling Medco Health customer service at 1-800-464-4679 or accessing the Medco website www.medco.com.

Locating a Network Pharmacy

There are over 40,000 network pharmacies nationwide. You may call 1-800-464-4679 to locate a network pharmacy anywhere in the country. When you are traveling out of your home area, or if you have dependents living away from home, the customer service representative on the toll-free line will assist you in locating the nearest network pharmacy.

Using a Non-Network Pharmacy

If you have a prescription filled at a non-network pharmacy, you will pay the pharmacist the full cost of the prescription. When you submit a claim form to Medco Health, you will be reimbursed for 75% of the reasonable and customary charge after your copayment has been deducted. Claim forms may be obtained on-line at www.medco.com or by calling Customer Service: 1-800-464-4679.

In the event of any emergency, or if you are traveling and cannot locate or access a network pharmacy, your non-network claim for covered prescriptions will be reimbursed at 100% of the reasonable and customary charge after your copayment has been deducted.

Mail Order Prescription Drug (MOPD) Option

If you are taking any medications on a regular basis, you may be able to save money by purchasing your prescription through the mail order option, sometimes referred to as home delivery.

When you order your prescriptions by mail, you will not have to submit claim forms or wait for reimbursement. Your medication is delivered to your home, postage-paid, within 14 days from the date you mail your prescription. You can receive up to a 90-day supply of medication, which saves you money because you currently pay only $10 for generic drugs. $30 for preferred brand-name drugs, and $75 for non-preferred brand-name drugs. If your prescription costs less than the applicable copayment, you will be charged the network cost of the drug.

How to Use the Mail Order Option

1. Your doctor may prescribe ongoing medications for up to a 90-day supply, plus refills. If you are now taking medication on a long-term basis, and are **not** currently using the mail order option, ask your doctor for a new prescription written for a 90-day supply. A year's worth of medication would include 3 refills covering up to 90 days each.

2. To begin using mail order or to obtain envelopes, call 1-877-START MAIL. Your physician can also fax in the prescription.

3. Send the completed patient profile you receive and your original prescription(s) in the order envelope provided. Make sure you sign and complete all the information on the order envelope. Additional mailing envelopes can be ordered on the Internet at www.medco.com.

4. The mail order pharmacy will promptly process your order and send your medications to you via U.S. mail or UPS, along with instructions for future refills. You should receive your medication and an explanation of your cost-sharing within 14 days from the date you mail your prescription.

5. Refills can be ordered via the Internet at www.medco.com or by calling 1-800-464-4679.

What Is Covered

Items covered under prescription drug coverage include, but are not necessarily limited to:

- Federal legend drugs that are medically necessary to treat an illness or injury and are prescribed by a doctor. This includes most recognized pharmaceuticals and generic substitutions for federal legend drugs;

- Contraceptive pills and diaphragms;
- Up to a 21-day supply of a covered drug (covered drug means insulin or any prescription legend drug, except as excluded by the Program, that is dispensed according to a prescription). Certain exceptions to the 21-day supply limit will be allowed for medications pre-packed in 30-day units (e.g., contraceptives) or for residents living in institutional settings;
- Up to a 90-day supply if purchased through mail order;
- An appropriate supply of disposable syringes and needles when prescribed for self-injection only when ordered **with a supply of insulin or an antineoplastic or chemotherapeutic agent**;
- Transdermal nicotine patches, covered medications or prescription legend drugs used for or in connection with the control or cessation of smoking.

For the Basic, Enhanced, and PPO options of the Salaried Health Care Program, the prescription drug carrier administers several processes that promote the appropriate prescribing of prescription medications*. These processes may include requiring prior authorization of certain medications or specifying quantity limits in line with a medically appropriate 34-day supply. The specific medications included may be modified from time to time.* Physicians can obtain prior authorization by calling 1-800-458-8001. You can obtain additional information by calling 1-800-464-4679.

What Is Not Covered

Items not covered under the prescription drug component include, but are not necessarily limited to:

- Any research or experimental agent;
- Any medication being used for a cosmetic purpose;
- Any medication for the purpose of attempting to induce pregnancy;
- Drugs prescribed for weight control or appetite suppression;
- Devices or appliances (e.g., orthotics);
- Any vaccine administered for the prevention of infectious diseases;
- Any charge for the administration of covered drugs;
- A covered drug in excess of the quantity specified by the physician;
- More than a medically appropriate 21-day supply of a covered drug provided by a retail pharmacy (except as provided for above), or for more than a 90-day supply of a covered drug supplied through the Mail Order Prescription Drug option; or
- Drugs received prior to the effective date of the enrollee's health care coverage.

The Maximum Allowable Cost Feature

Your prescription drug coverage includes a Maximum Allowable Cost (MAC) feature that is a generic substitution program. Generic drugs are required to: (1) have the same active ingredients in the same dosage, (2) meet the same quality standards, and (3) have the same medical effect as brand-name drugs, though generic drugs generally cost substantially less. The MAC feature is designed to encourage use of generic drugs by *limiting the amount that will be paid for certain drugs.* **When a generic equivalent is available, you're responsible for the generic copayment and the difference in cost between the generic and brand-name drug.**

If you have a question about your GM ***prescription drug coverage***, call a Customer Service Representative at: ***1-800-464-4679***.

Hearing Aid

GM provides coverage to address hearing deficiencies or loss once you have been examined by an ear specialist (otologist or otolaryngologist).

What Is Covered

If the examination by an ear specialist determines that your hearing problem may be corrected by use of a hearing aid, benefits may be provided. Following this examination, payment will be made for the following services ***when obtained from a participating provider*** and when provided in the order below, once during any period of 36 consecutive months:

- Audiometric examination (up to the reasonable and customary charge);
- Hearing aid evaluation test (up to $126, subject to periodic review and adjustment); and
- One standard hearing aid of the following designs (up to the acquisition cost plus dispensing fee):
  - In-the-ear;
  - Behind-the-ear (including air and bone conduction types); or
  - On-the-body.
- Hearing aid ear molds for children. Children under 3 years of age are eligible for four (4) molds per year. Children between 3 and 7 years of age are eligible for two (2) molds per year.

If an enrollee is 18 years of age or older, he or she will be required to have a medical examination of the ear only prior to receiving the initial hearing aid. However, enrollees under age 18, he or she will be required to have a medical examination of the ear each time a hearing aid is dispensed.

What Is Not Covered

Services not covered under hearing aid provisions include, but are not necessarily limited to, the following:

- Audiometric examinations by an audiologist that are not ordered by a physician;
- Medical or surgical treatment;
- Drugs or other medication;
- Audiometric examinations, hearing aid evaluation tests, and hearing aids:
  - Ordered: (1) prior to the enrollee's eligibility for coverage; (2) after termination of the enrollee's coverage; or (3) while covered but delivered more than 60 days after termination of coverage;
  - For which no charge is made to the enrollee or for which no charge would be made in the absence of hearing aid coverage;
  - Which are not recommended or approved by a physician;
  - Which do not meet professionally accepted standards of practice, including any service or supplies that are experimental in nature;
  - Received as a result of ear disease, defect, or injury due to an act of war;
  - Provided by any governmental agency that are obtained by the enrollee without cost;
  - Provided under any applicable workers' compensation law;
- Replacement of hearing aids that are lost or broken;
- Replacement parts for and repairs of hearing aids;
- Charges incurred by enrollees of an HMO option;
- Eyeglass-type hearing aids, to the extent the charge exceeds the expense for one standard hearing aid;
- Binaural hearing aids except as provided to correct or prevent speech impairment, for ***children under age 19*** who have hearing loss in both ears; and
- Digital-controlled/programmable hearing devices, to the extent the charge for such device exceeds the covered expense for a standard, conventional hearing aid.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliance

When a patient needs to use equipment or appliances that are prescribed by a doctor, they may be covered— whether used in a hospital or skilled nursing facility or after discharge. Coverage is provided when the attending physician prescribes such equipment, and it is approved by the carrier. Durable medical equipment and prosthetic and orthotic appliances should be obtained through the National DME/P&O network.

When covered services are received from **non-network** providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount charged by the **non-network** provider in excess of the network fee schedule. Additionally, benefit payments toward the Medicare deductible or coinsurance for those individuals enrolled in Medicare will **only** be made when services are received from a Network Provider. You or your provider may contact the network administrator, **Northwood National Provider Network at 1-800-936-9314** for preauthorization, claims processing, assistance in locating participating providers, and for other questions or concerns.

Durable Medical Equipment (DME) — What Is Covered

Equipment and services covered under DME provisions include, but are not necessarily limited to:

- Equipment that meets Program standards which include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;
- Equipment used in a hospital or skilled nursing facility or used outside the hospital or skilled nursing facility and rented or purchased from such hospital or facility;
- Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);
- Neuromuscular stimulators;
- Positioning transportation chairs as alternatives to traditional wheelchairs for child(ren) under 14 years of age, who suffer from neuromuscular disorders, closed head injuries, spinal cord disorders, or congenital abnormalities;
- External electromagnetic bone growth stimulators, in certain cases;
- Portable insulin infusion pumps and home glucose monitors for certain diabetics;
- Pressure gradient supports for certain patients; and
- Pronged and standard canes (when purchased).

Durable Medical Equipment (DME) — What Is Not Covered

Equipment not covered under these provisions includes, but is not necessarily limited to, the following:

- Rented equipment which extends beyond the expiration of the original prescription, unless the physician recertifies with another prescription that the equipment continues to be reasonable and medically necessary;
- Deluxe equipment such as motor-driven wheelchairs and beds unless medically necessary;
- Comfort, convenience, self-help, and environmental items not primarily medical in nature, such as adjust-a-beds, elevators, air conditioners, sauna baths, and non-medical supplies such as paging systems;
- Physician's equipment;
- Exercise and hygienic equipment; and
- Experimental, investigational or research equipment.

Prosthetic and Orthotic (P&O) Appliances — What Is Covered

Appliances and services covered under the P&O provisions include, but are not necessarily limited to:

- P&O appliances that are furnished by an accredited facility and meet Program standards, including being approved for reimbursement under Medicare Part B;
- Orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace;
- Appliances or devices that are surgically implanted permanently within the body (except for experimental or research appliances or devices) or those which are used externally while in the hospital as part of regular hospital equipment or when prescribed by a physician for use outside the hospital;
- Replacement, repair, fitting and adjustments of the appliance;
- Wigs and appropriate related supplies for hair loss caused by chemotherapy or radiation therapy, up to $200 for the first purchase and up to $125 for subsequent purchases after each period of 12 months has elapsed; and
- Through your medical plan carrier, the first set of prescription lenses (eyeglasses or contact lenses) following a cataract operation for any disease of the eye or to replace the organic lens missing because of congenital absence; (after that, eyeglass or contact lenses are covered under the vision plan).

Failure to use the network may result in out-of-pocket cost to you.

Prosthetic and Orthotic (P&O) Appliances — What Is Not Covered

Items not covered under this coverage include, but are not necessarily limited to:

- Dental appliances, hearing aids, eyeglasses, elastic stockings, or corrective footwear;
- Foot orthotics; or
- Experimental, investigational or research devices.

Hospice

The GM medical plan's hospice coverage addresses the needs of terminally ill patients who do not require the continuous level of care provided in a hospital or skilled nursing facility. For terminally ill patients to be eligible for covered hospice expenses:

- The services must be provided and billed by a hospice program which meets Program standards and is approved by the carrier;
- The enrollee must be admitted to the hospice program by order of a physician who certifies that the patient requires this type of care and has a life expectancy of six months or less; and
- The enrollee must voluntarily elect to participate in the hospice program and agree to accept the services provided as treatment of the terminal condition.

An approved hospice program is limited to a lifetime maximum of up to 210 days.

What Is Covered

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

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a social worker under the direction of a physician;
- Physician services;
- Counseling services provided to the patient, family members, and/or other persons caring for the patient at home;
- General inpatient care provided in a hospice inpatient unit;
- Medical appliances and supplies;
- Physical, occupational, and speech therapies;

- Continuous home care provided during periods of crisis, as necessary to maintain the patient at home;
- Respite care;
- Bereavement counseling;
- Care rendered in a nursing home with hospice support; and
- Home health aide services.

Mental Health and Substance Abuse

The provisions of this section apply to enrollees of the Basic Medical Plan (BMP), Enhanced Medical Plan (EMP), and Preferred Provider Organization (PPO) options of the Program. As a BMP, EMP, or PPO enrollee, you receive such services through a managed care arrangement with a network of providers that helps you and your covered family members receive quality, appropriate care.

Participating providers are authorized by CIGNA Behavioral Health (CBH) to deliver care for you and your family members. You may be directed to the appropriate panel provider by CBH. ***All non-emergency inpatient services must be delivered by a participating provider to be eligible for maximum coverage.*** Emergency detoxification is the only substance abuse treatment service that may be delivered by a non-participating provider.

CBH has a toll-free telephone number that is available 24 hours a day. If you have questions regarding your mental health/substance abuse coverages or need services, call 1-888-865-2960. ***Remember, you must use panel providers to receive full benefits.***

Treatment Options

Mental health and/or substance abuse treatment is generally delivered in one of two ways:

- Inpatient — with an admission to a panel facility; or
- Outpatient — by periodic visits to a participating provider or facility.

A continuing care treatment plan is designed to facilitate effective delivery of services for substance abuse patients. A patient entering detoxification, residential, or halfway house facilities is required to receive a treatment plan as part of his or her assessment. Completion of the plan as prescribed is necessary. If you are an employee and the plan is not completed, you may be responsible for reimbursing the plan up to $1,000 per occurrence toward the cost of treatment.

Inpatient Care — What Is Covered

Note: Inpatient treatment can be delivered as hospital care or in one of several alternative treatment facilities. To be covered, your stay at an inpatient treatment facility must be approved by CBH within 24 hours of your admission. Treatment at a residential facility must always be approved prior to treatment.

Services covered under the mental health and substance abuse treatment provisions include, but are not necessarily limited to:

- Up to 45 days of approved hospital care or up to 90 days of treatment in an approved partial hospitalization facility during the benefit period, including:
  - Semiprivate room with general nursing services, meals and special diets;
  - Laboratory and pathology (hospital care only) examinations;
  - Drugs, biologicals, solutions, use of equipment and supplies related to the treatment;
  - Professional and ancillary services;
  - Individual and group therapy;
  - Counseling for family members;
  - Electroshock therapy; and
  - Supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients (hospital care only);
- Psychological testing when administered by a panel psychologist and approved by CBH;
- Treatment of mental disorders, limited to individual and group psychotherapeutic treatment, family counseling, psychological testing prescribed or performed by a physician, and electroshock therapy;
- ***Up to 90 days of approved*** skilled nursing facility care for ***mental health services only*;**

- ***Up to a 90-day lifetime*** treatment in an approved halfway house for ***substance abuse treatment*** including:
  - Bed and board;
  - Intake evaluation;
  - Up to one routine drug screen per week;
  - Individual and group therapy or counseling; and
  - Counseling for family members.

When both inpatient hospital services and treatment in a partial hospitalization or skilled nursing facility are required, coverage limits take into account the combined treatment. Each day of inpatient hospital care for any condition (including non-mental health or substance abuse conditions) is equivalent to two days of partial hospitalization facility treatment or skilled nursing care.

For example, if an enrollee is admitted to the hospital for one day of inpatient care, coverage may be provided for up to 88 days (90 minus 2) of partial hospitalization or skilled nursing care. Or, after two days of skilled nursing care, an enrollee may be covered for up to 44 days (45 minus 1) in the hospital. One day of inpatient care uses two days of partial hospitalization or skilled nursing care.

Outpatient Care — What Is Covered

*Note: Outpatient treatment does **not** require a hospital stay or admission to a treatment facility. It is delivered during visits to a participating provider. Emergency outpatient treatment requires authorization through CBH within 24 hours of your first visit.*

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

- Outpatient services provided and billed by a facility:
  - Professional staff and ancillary services to ambulatory patients;
  - Prescribed drugs and medications dispensed by a facility in connection with treatments;
  - Electroshock therapy for a mental health patient;

- Outpatient services provided and billed by facilities or professional providers including:
  - Individual psychotherapeutic treatments, group mental health and substance abuse treatment, and family counseling to members of patient's family:
    - 20 mental health visits per year at 100% coverage;
    - Additional 15 mental health visits per year at 75%; and
    - 35 substance abuse visits per year at 100% coverage.

- Panel providers are required to verify eligibility and receive prior authorization for all non-emergency substance abuse treatment;

- Coverage will be limited to the following when rendered by or through non-panel providers:
  - Emergency services. Providers must contact CBH within 24 hours of the inpatient admission or outpatient treatment for authorization of such services;
  - Non-emergency services. Benefits for mental health services provided by non-panel providers without referral by a panel provider are limited to 50% of the panel reimbursement amount. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee;
  - Outpatient services. Services provided by non-panel physicians (e.g., internists or general practitioners) must be registered with CBH after the first visit and are limited to a maximum of one (1) visit.

What Is Not Covered

Certain health care services and charges described in the mental health and substance abuse coverage are excluded or limited, as set forth below:

- Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification;

- Coverage is not available for:
  - Services for treatment of mental disorders which are not amenable to favorable modification, except for the period necessary to determine that the disorder is not amenable to favorable modification;
  - Substance abuse treatment professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations unless therapy, counseling, or psychological testing are provided on the same day;

- Family counseling rendered by a provider other than the provider for the family member in the course of treatment;
- Diversional therapy;
- Psychological testing in connection with vocational guidance, training or counseling; or
- Tobacco use disorder.

General Limitations and Exclusions

Certain health care services and charges described in the previous sections are excluded or limited. The following are some but not necessarily all of these services:

- Services provided after an enrollee's coverage under this Program is terminated, except for physician and hospital, skilled nursing facility, or residential substance abuse facility services for continuous predetermined and approved inpatient admissions which commence prior to the termination date of the coverage;
- Private duty nursing services;
- Upgraded room accommodations;
- Dental services;
- Treatment for temporomandibular joint (TMJ) dysfunction;
- Chemotherapy services or supplies when the treatment is research, investigational, or experimental in nature;
- Services, care, treatment, or supplies which are not medically necessary according to accepted standards of medical practice;
- Care, services, supplies, or devices which are experimental, research, or investigational in nature;
- Personal or convenience items;
- Services for premarital or pre-employment examinations;
- Charges determined by the carrier to be unreasonable;
- Services related to any condition, disease, ailment, or injury arising out of or in the course of employment for which the employer pays or provides reimbursement under the provisions of any law of the U.S.;
- Services for which a charge would not have been made if no coverage existed;
- Services available through other programs (e.g., Medicare);
- Services provided to the enrollee by members of the enrollee's household or immediate relatives of the enrollee;
- Care, services, supplies, or devices related to custodial or domiciliary care provided in an institutional setting;
- Care, services, supplies, drugs, or devices for the purpose of inducing pregnancy;
- Travel time or expenses;
- Special education facilities and tutoring for learning disabilities or correction of behavioral problems;
- Food, dietary supplements, or vitamins;
- Services, supplies, or equipment not performed by, prescribed by, or rendered by a physician;
- Charges for miscellaneous services, such as acupuncture, massage, hypnotherapy, etc.;
- Charges for missed appointments, room or facility reservations, completion of any claim forms, or record processing; and
- Bone marrow transplant services under certain conditions.

Extended Care Coverage

When long-term hospital, skilled nursing or custodial care is required, Extended Care Coverage (ECC) provides for certain services not covered by your medical plan. The maximum benefit payable under this coverage for services incurred during any one calendar year is $50,000 for each enrollee. You are eligible for ECC regardless of whether you have elected BMP, EMP, PPO or HMO, unless you have previously waived ECC for a reason other than being a dependent under the coverage of a salaried employee or retiree with ECC.

What Is Covered

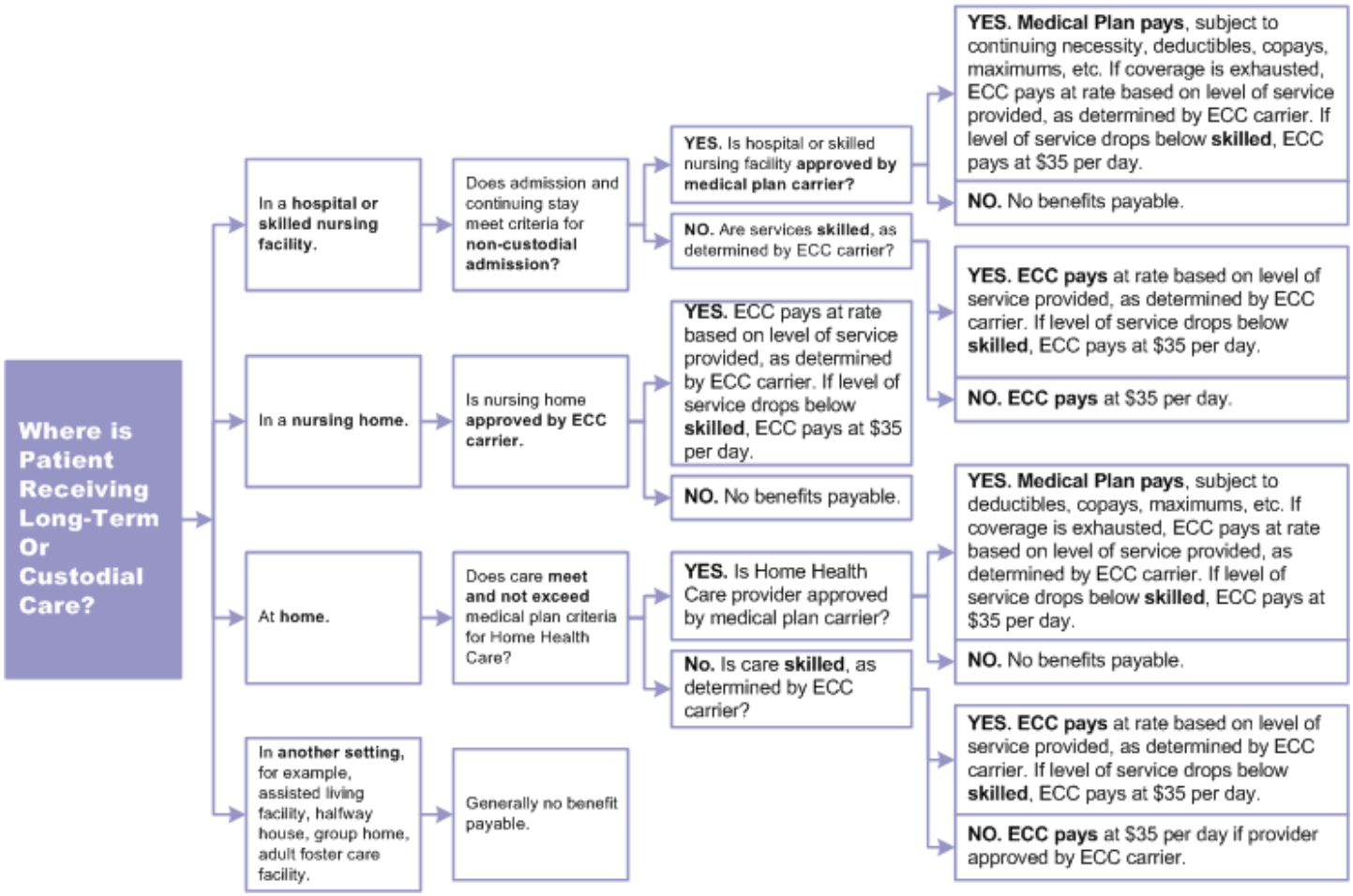
Services covered under Extended Care Coverage (ECC) provisions include, but are not necessarily limited to, the following:

- Medically necessary non-custodial hospital or skilled nursing facility admissions which exceed the medical plan limits;
- Skilled hospital or skilled nursing facility admissions which are not covered under the medical plan due to the medical plan carrier's determination that the admissions are custodial in nature;
- Admissions to ***nursing homes approved by the ECC carrier,*** for services considered by the ECC carrier to be skilled in nature;
- Skilled care being provided in the home by a qualified home health care agency or by a qualified nurse professional but which does not meet the criteria for coverage under the medical plan provisions;
- Unskilled care delivered in a hospital, skilled nursing facility, nursing home, or in the patient's home by nurse professionals approved by the ECC carrier (up to $35 per day); and
- Medical supplies not covered under other Program provisions (e.g., prescription drugs, durable medical equipment) for an enrollee admitted to a hospital or skilled nursing facility for unskilled custodial care.

Limitations and exclusions to the ECC coverage include, but are not necessarily limited to, the items below:

- Services in the home in connection with routine nursing care of newborn child(ren);
- Services not prescribed by a physician;
- Education or training (including such services when directed toward learning, behavioral, or developmental deficiencies);
- Amounts covered by public programs providing benefits (such as those under laws pertaining to workers' compensation, non-occupational disability, old age assistance, veteran's assistance, and any federal or state health insurance act providing nursing benefits);
- Amounts reimbursed by Medicare;
- Amounts in excess of the reasonable and customary charge or which are not considered to be necessary as determined by the carrier;
- Charges which duplicate benefits paid under another section of the Program;
- Services provided by a person related to you by blood or marriage;
- Services provided by an assisted living facility, a halfway house, group home, adult foster care facility, and the like;
- Services provided by a non-licensed facility;
- Non-medical supplies including, but not limited to, personal hygiene products, over-the-counter medications, and personal items (including disposable briefs and diapers);
- Private duty nursing services for patients admitted to hospitals, skilled nursing facilities, or nursing homes;
- Mental health/substance abuse care exceeding the medical plan coverage; and
- Charges for services rendered prior to the effective date of, or after termination of coverage under the Program.

Extended Care Coverage



Dental Coverage

GM provides dental care coverage for services and supplies necessary for the treatment of many dental conditions but only to the extent that related charges are reasonable and customary as determined by the carrier and only if such services are rendered in accordance with accepted standards of dental practice.

Dental coverage is provided through either a traditional option or a managed dental care plan, known as an Alternative Dental Plan (ADP). GM's dental coverage has cost-sharing components for participation and for certain services. It also includes limits on the benefits you may receive. ***If a course of treatment is expected to involve covered dental expenses of $200 or more, carrier predetermination is required. The carrier for GM's traditional dental coverage is MetLife.***

Under ADPs, to receive full coverage, you must use a dentist who is a member of the plan's network. Benefits may not be provided or may be reduced, if you receive services from a non-network dentist.

Coverage under available ADPs varies from plan to plan and may differ from GM's traditional dental coverage. The certificate you receive from the ADP contains specific information about cost-sharing provisions, including lifetime caps or limitations, services requiring preauthorization and/or utilization review, and rules for selection of providers. Provider directories are available, without charge, at the ADP's website, or by calling their toll-free number.

Traditional Dental Benefits

If your dentist recommends treatment with an expected cost of $200 or more, a description of the procedure and estimate of the charges should be filed with MetLife prior to commencing the course of treatment. After considering alternate procedures, services, and courses of treatment, your carrier will inform you and your dentist of the charges to be covered for the course of treatment in question. The predetermination process is not necessary for courses of treatment under $200 or for emergency treatment, routine oral examinations, x-rays, prophylaxes, and fluoride treatments.

Failure to file a description and estimate of your course of treatment prior to treatment could result in your being faced with higher than anticipated out-of-pocket expenses.

What Is Covered

Services covered under dental provisions include, but are not necessarily limited to, the following:

- ***Preventive*** dental services at 100% of the reasonable and customary charge:
  - Two routine oral examinations and cleanings (scaling and cleaning of teeth) within a calendar year; up to three cleanings per calendar year will be allowed if you have a documented history of periodontal disease. Up to four cleanings per calendar year will be covered for two full calendar years following periodontal surgery;
  - Fluoride treatments, only if under 20 years of age (unless specific dental condition makes such treatment necessary);
  - Space maintainers to replace prematurely lost teeth for child(ren) under 19 years of age;
  - Emergency palliative treatment;

- ***Minor restorative*** services at 90% of the reasonable and customary charge:
  - Dental x-rays, including: full mouth x-rays once in any five consecutive calendar year period; bitewing x-rays once per calendar year; other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment;
  - Extractions;
  - Oral surgery;
  - Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations;
  - General anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
  - Treatment of periodontal and other diseases of the gums and tissues of the mouth;
  - Endodontic treatment, including root canal therapy;
  - Injection of antibiotic drugs by the attending dentist;
  - Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or

relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any three-year period;
  - — Inlays, onlays, gold fillings, or crown restorations, only when the tooth cannot be restored with other filling restoration;
  - — Cosmetic bonding of eight front teeth for child(ren) 8 through 19 years of age, under certain conditions, but not more frequently than once in any three year period.

- ***Major Restorative*** services at 50% of the reasonable and customary charge:
  - — Initial installation of fixed bridgework (including inlays and crowns as abutments);
  - — Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation);
  - — Replacement of an existing partial or full removable denture or fixed bridgework under certain circumstances. (Note: Dentures will be customarily replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be covered);

- ***Orthodontic*** procedures and treatment at 50% of R&C (including related oral examinations), for a covered individual ***under 19 years of age when treatment commences up to a lifetime maximum of $2,000 per enrollee;***

- ***Treatment of the temporomandibular joint (TMJ)*** including, but not limited to, related oral examinations, consultations, x-rays, occlusal equilibration, diagnostic models, and casts, temporary splints, and orthotic appliances, limited to $2,000 during the lifetime of the enrollee (it does not include orthodontic treatment, except as in the above); and

- ***Accidental dental injury*** services for repair and/or care of ***natural teeth***. For this component to apply,
  - — The annual maximum benefit must be exhausted;
  - — The accident must be documented;
  - — The services must be a direct result of the accident and are provided within one year of the accident;
  - — Benefits are subject to a reasonable and customary charge, a 20% copayment, and a maximum benefit payment of $12,000 per qualified occurrence and per lifetime.

The ***maximum benefit*** payable for ***all*** covered dental expenses during any calendar year is $1,700 per covered person. For expenses in connection with orthodontics, including related oral examinations, the maximum ***lifetime*** benefit per eligible covered individual is $2,000. For expenses for treatment of TMJ, the maximum ***lifetime*** benefit equals $2,000 per covered individual. For accidental injury the ***lifetime*** maximum is $12,000.

Certain dental care services and charges are limited. Please consult with MetLife concerning these limitations.

What Is Not Covered

Services not covered under dental provisions include, but are not necessarily limited to, the following:

- Charges for services covered under other health care coverages;

- Charges for:
  - — Treatment by someone other than a dentist;
  - — Veneers or similar properties of crowns and pontics for certain teeth;
  - — Services or supplies that are cosmetic in nature;
  - — Prosthetic devices, crowns, inlays, and onlays and their fitting ordered while you were not covered;
  - — Replacement of a lost, stolen or missing prosthetic device;
  - — Failure to keep a scheduled visit with a dentist;
  - — Replacement or repair of an orthodontic appliance;
  - — Services or supplies compensable under workers' compensation or employer's liability law;
  - — Services rendered through a facility provided or maintained by GM;
  - — Services or supplies that the enrollee is not legally obligated to pay or for which no charge would be made in the absence of dental coverage;

- Services or supplies that are not necessary, recommended, or approved by the attending dentist;
- Services or supplies that are experimental in nature;
- Any duplicate prosthetic device or appliance;
- Completion of any insurance forms;
- Sealants, oral hygiene and dietary instruction;
- A plaque control program;
- Dental implants and/or implantology; or
- Services or supplies related to periodontal splinting.

A Closer Look at Your Dental Options

<table>
<tr><th></th><th colspan="2">Traditional Dental Coverage</th><th>Alternative Dental Plan (ADP) (where available)</th></tr>
<tr><td>Monthly contributions</td><td colspan="2">Yes</td><td>Yes</td></tr>
<tr><td>Deductible</td><td colspan="2">None</td><td>None</td></tr>
<tr><td>Copayment
▪ Preventive
▪ Minor restorative
▪ Major restorative
▪ Orthodontics
▪ TMJ dysfunction</td><td>Plan Pays
100%
90%
50%
50%
50%</td><td>You Pay
0%
10%
50%
50%
50%</td><td rowspan="5">Copayments, benefit maximums, and covered services vary from plan to plan and may differ from the Traditional dental coverage. (Contact the ADPs available in your area for more information.)</td></tr>
<tr><td>Maximum annual benefit</td><td colspan="2">$1,700 per covered person</td></tr>
<tr><td>Maximum lifetime orthodontic benefit</td><td colspan="2">$2,000 per covered person under age 19</td></tr>
<tr><td>Maximum lifetime TMJ benefit</td><td colspan="2">$2,000 per covered person</td></tr>
<tr><td>Maximum lifetime accidental dental injury benefit</td><td colspan="2">$12,000 per covered person</td></tr>
</table>

Vision Coverage

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

The carrier for GM's vision coverage is Cole Managed Vision.

What Is Covered

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

- One vision examination per calendar year including refraction, case history, coordinating measurements, and tests;
- Prescription of glasses where indicated;
- Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist;
- Materials and professional services connected with the order, preparation, fitting, and adjusting of:
  - — Normal size lenses (single vision, bifocals, trifocals, lenticular) once per calendar year;
  - — Number 1 or 2 tint for lenses;
  - — Contact lenses in lieu of regular lenses:
    - Following cataract surgery;
    - When visual acuity cannot be corrected to 20/70 in the better eye;
    - When medically necessary due to keratoconus, irregular astigmatism, or irregular corneal curvature; or
    - Up to $80 if prescribed for any other reason than those listed above;
  - — Frames once during two consecutive calendar years.
- Limited coverage for corrective eye surgery (e.g., LASIK, PRK, RK). The maximum benefit for corrective eye surgery will be $295 in any four (4) year period. If you receive benefits for corrective eye surgery, you will be ineligible for material benefits (frames, lenses) for that year and three (3) subsequent years. You will still be eligible for an annual vision exam. Further, Enrollees will retain access to material discounts should they need material items during the time of any "lock-out" period.

What Is Not Covered

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

- Any lenses that do not require a prescription;
- Medical or surgical treatment of the eye;
- Drugs or any other medication;
- Procedures determined by the carrier to be special or unusual (e.g., orthoptics, vision training);
- Vision examinations, lenses, or frames obtained without cost to you; and
- Vision examinations performed and lenses and frames ordered before you become eligible for coverage or after the termination of your coverage.

Vision Network

The National Vision network is made up of vision providers who have agreed to accept reimbursement based on a fee schedule, to meet certain contractual standards for quality, and to provide a selection of frames available to GM enrollees at no cost.

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

In addition, participating providers can check on your eligibility, file your claim and be authorized by you to receive the reimbursement for covered services directly from the carrier. Information about participating providers in your area is available, without charge, by calling 1-800-638-0166.

Out of Network

Generally, if you choose to receive covered vision services from a non-participating provider, you will be required to reimburse the provider and file your own claim with Cole Managed Vision. Cole Managed Vision will reimburse you directly based on a fee schedule. There is one exception. Your reimbursement for a vision exam provided by a non-participating ophthalmologist will be based on the reasonable and customary charge as established by the carrier, minus a $7 copay.

Out of Area

If you live more than 25 miles from a participating provider and choose to receive covered services from a non-participating provider, then your reimbursement will be based on reasonable and customary charges as determined by the carrier, minus a $7 copayment for exams and a $10 combined copayment for lenses and frames.

Summary

This chart summarizes the benefit frequency and the level of reimbursement for covered vision services when received In Network, Out of Network, or Out of Area.

BENEFIT	FREQUENCY	NETWORK PROVIDER	OUT OF NETWORK	OUT OF AREA*
VISION EXAM	Once each calendar year.			
Optometrist		Covered in full.	Enrollee reimbursed $37.	Enrollee reimbursed based on R&C** minus $7 copay.
Ophthalmologist		Covered in full.	Enrollee reimbursed based on R&C** minus $7 copay.	Enrollee reimbursed based on R&C** minus $7 copay.
FRAMES	Once every two consecutive calendar years.	Covered in full if selected from designated display (all other frames: covered to $24 after 30% discount).	Enrollee reimbursed $24.	Enrollee reimbursed $24 minus a $10 copay, if applicable.***
LENSES	Once each calendar year.	Covered lenses available at no cost. (Additional lens options are not covered).	Enrollee reimbursed based on fee schedule.	Enrollee reimbursed based on R&C** minus $10 copay.
CONTACT LENSES	Once each calendar year in place of regular lenses.	Enrollee pays difference between provider's charge and $80.	Enrollee reimbursed $70.	Enrollee reimbursed $80 minus $10 copay.
CORRECTIVE EYE SURGERY	Once every four consecutive years.	Enrollee reimbursed $295.****	Enrollee reimbursed $295.****	Enrollee reimbursed $295.****

* *Out of Area occurs when there is no network provider within 25 miles of the enrollee's residence.*
** *R&C stands for reasonable and customary charges.*
*** *There is a combined annual copayment of $10 for lenses and frames.*
**** *An enrollee receiving benefits for corrective eye surgery will be ineligible for material benefits (frames, lenses and contact lenses) for three (3) subsequent years. A corrective eye surgery claim form is necessary for reimbursement.*

Coordination of Benefits

If you or your dependents are covered by another employer's medical, dental or vision plan, the benefits/coverages will be coordinated between the two plans. To determine how to coordinate the coverage under the two plans, it is first necessary to determine which plan pays first.

The primary plan will pay first, without consideration to any other plan, according to the guidelines of its coverage. The secondary plan does not consider a claim for benefits until the primary plan pays or denies the claim. The secondary plan then follows its procedure to determine its payment, coordinated with the payment already made by the primary plan.

Because you are an employee, your GM plan will be primary for most of **your** health care claims. If you are also covered as a dependent under your spouse's plan, you should submit your claim to the carrier of your spouse's plan after your claim has been processed under the GM plan.

If your spouse is covered by your GM Salaried Health Care Program coverage and if your spouse is employed and covered under his or her employer's plan, then that employer's plan is the primary coverage for your spouse's claims.

Your spouse's claim should be submitted to the GM plan after being processed under the spouse's plan.

If your dependent child(ren) is covered by both your plan and your spouse's plan, the "Birthday Rule" applies.

The Birthday Rule

The primary plan for your child(ren)'s coverage is the plan of the parent whose birthday comes first in the calendar year.

If you and your spouse have the same birthday, then the plan that has covered your child(ren) for the longer period of time is primary.

A different guideline applies for your dependent child(ren) if you are ***divorced or legally separated.*** In this situation:

- The plan of the parent who has legal custody of the dependent child(ren) is that child(ren)'s primary plan unless an appropriate court order states otherwise; and the plan of a step-parent with whom the child(ren) resides will pay before the plan of the parent without custody.

If none of these rules establish which plan is primary, the plan that has covered the person for the longer time becomes the primary plan.

When the GM Salaried Health Care Program Is Secondary for a Claim

The GM Salaried Health Care Program calculates the amount it would pay as if there were no other coverage. The amount of benefits actually payable by the other plan for services covered by the GM plan is then subtracted from the amount the GM plan would have paid. The GM plan pays the difference, if any. In other words, if the primary plan's payment meets or exceeds the amount the GM plan would have paid alone, no further payment is made. ***Through the COB process, you cannot receive any more than the total amount of the charge.***

When there are multiple coverages, you must first file the claim with the primary health care plan. After you have received written notification of payment or denial from the primary carrier, you should make a copy of it and submit it to the carrier of the secondary plan.

Under the GM Program, you will receive credit toward satisfying deductibles and out-of-pocket maximums ***even though the primary plan,*** rather than you, ***is making the payment.*** GM uses a similar arrangement to coordinate payments from its plan with those paid by Medicare Part B, for individuals who have Medicare coverage that is primary.

Coordination of Benefits Example #1

John is married to Mary, a GM salaried employee who elected the Basic Medical Plan for herself and her spouse. John has other coverage through his employer, and it pays 70% of covered expenses with no deductibles. That coverage is primary for John. The GM coverage he has through Mary is secondary.

Assume that John submits a bill for $200 in covered expenses and that the deductibles applicable to Mary's GM coverage have already been satisfied for the year. Here's how benefits would be paid:

John submits the expense to his plan which is primary:

Expense	$200
His plan pays 70%	$140
Remainder	$ 60

After payment from his primary plan, John submits the total expense to the GM Basic Medical Plan, along with a statement of payment action by his plan.

Expense	$200

What the Basic Medical Plan would have paid:

At 75% if it were John's only coverage	$150
What John's primary plan paid	$140
What the Basic Medical Plan will pay	$ 10

Credit applied to the out-of-pocket limit for John under the GM Basic Medical Plan ($200 - $150)	$ 50

Coordination of Benefits Example #2

Bob is a GM salaried employee who elected traditional dental coverage. Bob's spouse, Sue, has dental coverage through her employer which covers most procedures at 80% of reasonable and customary charges as determined by the carrier. Assume that Sue recently had covered expenses of $200 and that the charges were not greater than either carrier's determination of reasonable and customary.

Since her plan is primary these expenses were first sent to her dental plan administrator for consideration.

Expense	$200
Primary pays 80%	$160

After the payment from her primary plan is received, Bob can submit the dental services received by his spouse for additional consideration under GM dental coverage, along with a statement of payment action from the primary plan. Assume in this case that the procedures performed are payable at 90% of reasonable and customary charges as determined by the carrier under GM dental coverage.

If GM dental coverage had been primary:

Expense	$200
GM dental pays 90%	$180

What GM dental coverage will pay as the secondary payer

GM dental plan would have paid	$180
Primary plan paid	$160
What GM coverage will pay	$ 20

The amount applied toward Sue's annual maximum at GM will be what GM would have paid or $180. Sue's remaining calendar year maximum is $1,320 ($1,500 - $180).

How to File a Claim

Claims should be filed with the appropriate carrier as services are rendered and expenses are incurred. However, ***claims for all health care services must be submitted not later than the end of the calendar year following the year in which services are rendered.*** Claim forms are available on-line, through Socrates.

Your Social Security number (or an alternative identification number issued to you by your carrier) is always needed when you communicate with any of the carriers. If you are a dependent, the Social Security number (or alternative identification number) of the employee, retiree, or surviving spouse through whom you have the coverage is needed.

Preauthorization of Services

If you are enrolled in the BMP, the EMP or the PPO, you must predetermine any hospital stay (except emergency or maternity), surgery, skilled nursing facility admission or home health care visit. Emergency hospital admissions must be reported within 48 hours of inpatient admission. See page 42 for information on this predetermination requirement for medical services.

In addition, if you are enrolled in the BMP, the EMP or the PPO, certain mental health or substance abuse services will require the use of panel providers to be eligible for maximum coverage. See page 58 for information on the use of panel providers for mental health or substance abuse services.

Basic Hospital, Medical and Surgical Claims

If your carrier is a Blue Cross or Blue Shield plan, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Usually, a hospital or other facility is paid directly by Blue Cross for covered services. Blue Shield generally pays physicians directly for covered services. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office. **You should always check with your provider or with Blue Cross-Blue Shield, before you receive services, to make sure you use "participating" providers for your medical care needs.** Participating providers generally have agreed to accept a negotiated fee from Blue Cross-Blue Shield for covered services which can reduce the your out-of-pocket costs. If you seek care from a non-participating provider, benefit reimbursement may be severely limited and you may be required to pay the bulk of the non-participating provider's fee for services rendered.

If your carrier is United HealthCare, show your health care identification card when you go to the hospital, residential or outpatient treatment facility, physician, or other provider of covered services anywhere in the country. Payment will be made directly to providers who participate in United Health Care's network. Providers who do not participate in United Health Care's network may require you to pay their bills directly and file a claim for reimbursement. In that case, United HealthCare will pay you the appropriate amount.

Prescription Drug Claims

When you use a network provider, your claims for services will be filed electronically with Medco Health by the provider. If you obtain services from a non-network provider, you will be required to pay the full charge and file a claim. Claim forms may be obtained by calling Medco Health. You and/or the provider may complete all the required information on the form. You may then mail the claim to the address noted on the form. You will be reimbursed the appropriate amount after your copayment has been deducted.

Mental Health and Substance Abuse Claims

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

Claim forms also may be obtained from the office that administers your health care benefits.

If it becomes necessary for you, instead of the facility or provider, to submit a claim form to Connecticut General Life Insurance Company (CG) (e.g., you receive outpatient mental health treatment from a non-panel physician provider to whom you must make payment before you may seek reimbursement from CG), you are required to send the originals of either (1) itemized bills, (2) statements, or (3) receipts for each of the medical expenses for which you are claiming payment.

Hearing Aid Claims

Because only approved or participating providers are eligible for reimbursement, such providers generally will have the necessary hearing aid claim forms. Benefits will be paid directly to the provider by the carrier. ***Benefits are payable only if you obtain hearing aid services from a participating provider, and only if they are obtained in the appropriate sequence.*** Ask the provider if he or she is participating ***before*** you receive services. Information about participating providers is available, without charge, from your medical plan carrier.

Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Claims

Durable medical equipment and prosthetic and orthotic appliances should only be obtained from the National DME/P&O network. By using network providers, you will not have to file claim forms, nor will you receive balance due billings from providers.

When covered items or services are received from non-network providers, you will be responsible for paying the provider and submitting the claim and supporting documentation to the carrier. The carrier will then send payment to you based upon the amount applicable to network providers. You may be required to pay the amount due to the provider that is in excess of network fee schedules.

Contact the network administrator, Northwood National Provider Network, at 1-800-936-9314 with any questions pertaining to the network.

Dental Claims

Dental claim forms and instructions generally are available from dentists in areas where there are GM employees and retirees. Also, claim forms are available from MetLife.

If a course of treatment is expected to involve dental expenses amounting to $200 or more, prior to the commencement of treatment, you should have your dentist submit a description of the procedures to be performed and an estimate of the charges to MetLife. They will notify the dentist and you of estimated benefits payable, with consideration given to alternate procedures that may be performed to accomplish the desired results.

Vision Claims

Cole Managed Vision is the vision coverage carrier. A claim form may be obtained from a participating provider, by contacting the GM Benefits & Services Center, by accessing the web (gmbenefits.com), or calling Cole Managed Vision. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to Cole Managed Vision. Payment will be made directly to a participating provider, unless you have paid all, or part, of the charges for covered services. In that case, the carrier will pay you the appropriate amount. Payment for covered services received from a non-participating provider will be sent to you.

Extended Care Coverage (ECC)

You should obtain the necessary forms from Connecticut General by calling 1-800-523-4626. ***There are things you should do routinely to prepare for filing the claim:***

- Obtain all bills and receipts for medical services incurred by you and your covered dependents;
- Be sure bills and receipts are properly identified, separated by individual, and in chronological order;
- Ensure that the bills or receipts are itemized and include the patient's name, description of service or medical supply, date of service or purchase, and charges incurred;
- Submit "Explanation of Benefit" statements from your medical coverage carrier and, if applicable, "Medicare Explanation of Medicare Benefit" statements, with appropriate bills or receipts;
- Be sure that receipts for medical supplies, equipment, private duty nursing, physical

therapy, or other services not performed by a physician are supported by certification of the attending physician and that such supplies, equipment, or services are medically necessary; and

- Be sure that claims are filed not later than the end of the calendar year following the year in which services are rendered.

Appealing a Pre-Service or a Post-Service Claim Determination

Mandatory Appeal Procedure

If you wish to appeal an adverse claim determination, you must submit your appeal in writing within 180 days from the initial claim determination. Follow the instructions provided on the Explanation of Benefits (EOB) you receive from the carrier and send your written appeal to the address of the appropriate carrier. In the case of a claim involving urgent care, when the services in question require pre-authorization, you may initiate the appeal by a telephone call to the appropriate carrier.

For an appeal regarding eligibility under the Program, you must direct your written appeal to the GM Benefits & Services Center, P. O. Box 770003, Cincinnati, OH 45277-1060.

Health Maintenance Organizations (HMOs) and Alternative Dental Plans (ADPs) each have their own appeal process which must be followed in all circumstances, other than questions regarding eligibility for participation in the GM Salaried Health Care Program. If you wish to appeal a claim determination, write directly to the HMO or ADP at the address given on the initial claim determination or in your certificate. HMOs and ADPs are responsible for formulating their own medical policy. Decisions resulting from their appeal process are final.

If you are enrolled in the Basic Medical Plan, Enhanced Medical Plan, Preferred Provider Organizations or Traditional Dental Plan, and you wish to appeal the denial of a health care claim, write to your local carrier and include in your correspondence the following:

- A copy of the Explanation of Benefits (EOB) you received from the carrier;
- Any additional information/documentation to be considered;
- The reason why you believe the denial was incorrect.

If a claim meets the definition for urgent care under applicable federal regulations, the request may be submitted by telephone. As part of the review, you may submit any written comments that may support the claim. A written decision on the request for review will be furnished to you as follows:

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

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

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

Under the mandatory procedure, the carrier has discretionary authority to construe, interpret, apply and administer the Program.

Once you have completed the appeal process offered by the carrier, you may bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 or you may continue to pursue your appeal under the Voluntary Review Process.

Voluntary Review Process

Your decision to submit an adverse claim determination for review under the GM Voluntary Review Process will not have an effect on your rights to any other benefits under the GM Salaried Health Care Program.

You can elect to submit an adverse claim determination for review under the Voluntary Review Process only after exhaustion of the mandatory appeal procedure described above. The carrier's final determination completes the mandatory appeal procedure.

Any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary review is pending. The Program waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a claim determination for review under the voluntary process.

You have a right to legal representation. However, representation is not required under the Voluntary Review Process. The Program will impose no fees or cost for review.

To utilize the voluntary process, submit your written appeal to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-1060 including with your correspondence the following:

- A copy of the initial EOB;
- Copies of any information you sent to the carrier when you appealed;
- The carrier's decision on the appeal;
- All previous responses;
- The basis for requesting a redetermination; and
- Other pertinent documentation.

The following is a summary of the GM Voluntary Review Process.

Step one is a review by a Benefits Administrator at the GM Benefits & Services Center.

Step two is a review by the Assistant Director of the GM Benefits & Services Center.

Step three is a review by the Plan Administrator whose role is to determine whether the Program provisions have been applied properly. For services determined to be research, experimental or investigational in nature, an additional review step may be made available. The Plan Administrator is required to follow the terms of the Program and has discretionary authority to construe, interpret, apply and administer the Program.

The Plan Administrator will respond in writing by either approving or denying your claim.

For step four, you will then have 60 days to appeal your denied claim by writing to the Secretary of the Employee Benefit Plans Committee (EBPC), Mail Code 482- C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. As part of this appeal, you must provide any written documentation to support your position that the Program provisions have not been properly applied. Requests for exceptions to the Program provisions may not be appealed to the EBPC.

Under the voluntary process, the EBPC of the Corporation has been delegated authority to construe, interpret, apply and administer the Program, and is the final review authority with respect to the appeal.

Effect of Medicare

You become eligible for Medicare at age 65, whether or not you choose to continue working. However, if you continue to work after age 65, Social Security will not notify you of your eligibility to enroll for Medicare. ***It is your responsibility to contact the local Social Security Administration office to apply for Medicare***, whether or not you are working when you attain age 65. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment.

If you or one of your dependents have a severe long-term disability, end-stage renal disease, or

undergo a kidney transplant, you may be eligible for Medicare coverage prior to age 65. If you or one of your dependents fit one of these categories, you should contact your nearest Social Security Administration office to have your case evaluated.

Generally, you or your dependents will want to enroll for Medicare when you first are eligible to do so. This is true not only because of penalties which may be incurred in Medicare premiums, but also because Medicare may cover services not covered by the GM Program. ***Moreover, eligibility for Corporation contributions for coverage may depend on Medicare enrollment.*** For example, in the event of your death, your surviving spouse will not be eligible for Corporation contributions for any GM health care coverages if your spouse is eligible, but is not enrolled, for Medicare Part B at or after age 65.

If you are working, and you (1) are over age 65, or (2) have a dependent who is eligible for Medicare, you may elect to have coverage under both the GM Program and Medicare. Generally, if you do so, the GM Program will be the primary source of benefits (the first to pay for any covered services). Usually, it is in your interest to apply for Medicare hospital insurance (Part A). No premium is required if you have enough work credits under Social Security, and Part A can supplement the GM Program. Enrollment in Medicare medical insurance (Part B) is required for your age 65 or older surviving spouse to receive Corporation contributions for coverage in the event of your death (see preceding paragraph).

If you retire and are enrolled in Medicare, Medicare will become the primary source of benefits for you and your dependents who also are enrolled for Medicare. Benefits otherwise payable under the GM Program will be adjusted to reflect the amount of benefits payable by Medicare for the same covered services. The GM Program will supplement Medicare, to the extent the GM Program covers services Medicare does not cover. Your health care claim first must be filed with Medicare. After Medicare pays its portion, the claim should be sent to the appropriate GM carrier. In some areas arrangements have been made for Medicare to electronically submit claims to your GM carrier, after Medicare has paid its portion.

This arrangement is called “Medicare Crossover” and may minimize your involvement in the claims handling process. You should contact your carrier to determine if Medicare Crossover is available in your area.

Most health maintenance organizations (HMOs) accept Medicare enrollees; however, those plans generally require enrollment in both Part A and Part B, if eligible.

If you are enrolled in an HMO, you must follow the guidelines of the HMO regarding Medicare claims processing.

The Balanced Budget Act of 1997 made some changes in the Medicare program. The law includes a section called Medicare+Choice that creates new health plan options. All Medicare beneficiaries will receive annual mailings and information from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicare.

You should keep in mind that these mailings are not connected in any way with the GM Salaried Health Care Program. The Medicare materials will not explain how the changes apply to you and your Program coverage.

To continue your GM coverage, you will not need to do anything in response to the Medicare mailings. In fact, if you do join an HMO not offered by GM, or if you elect a plan outside of the annual GM enrollment process, you may be putting your GM-sponsored coverage at risk.

Special Benefit

If you are enrolled in Medicare Part B and are a ***(1) retiree or surviving spouse receiving a GM monthly Part A retirement benefit,*** *or* ***(2) disabled employee eligible to receive extended disability benefits,*** you may be eligible to receive a monthly Special Benefit for each month you maintain Medicare Part B enrollment. The amount is equal to the lesser of the Medicare Part B premium or $76.20, and will be included in your monthly GM retirement check or extended Disability Benefit check. Also, under current federal income tax law, because receipt of the Special Benefit is conditioned on your Medicare Part B enrollment as verified by GM, the Special Benefit will be non-taxable.

This Special Benefit also is payable, upon application, to an eligible retiree or eligible surviving spouse who is (1) receiving GM monthly Part A retirement benefits, (2) under age 65, and (3) enrolled in Medicare Part B.

Evidence satisfactory to GM of your enrollment in Medicare Part B is required for you to receive a Special Benefit. If evidence of enrollment is not provided in a timely manner, retroactive payment of the Special Benefit will be limited to 12 months. Any recipient who is enrolled in Medicare Part B coverage will have the Special Benefit discontinued for periods during which Medicare Part B enrollment is not maintained.

The Special Benefit is ***not*** payable to any: (1) former employee receiving a deferred vested retirement benefit, or (2) surviving spouse receiving a survivor benefit resulting from a deferred vested retirement benefit.

No more than one Special Benefit is payable to any individual for any one month.

Reimbursement for Third-Party Liability

Occasionally a person may sustain an injury and incur health care expenses because of another party's wrongdoing. While GM does not suspend coverage while liability is being determined, GM should not bear the financial burden if another party is responsible. Consequently, if (1) GM pays benefits on behalf of you or one of your dependents, and (2) you recover any monies from a third party for the same expenses, you are expected to reimburse the Program.

You must provide notice to the Corporation (or to your health care carriers on behalf of the Corporation) of any such recovery (or effort to recover) from a third party. You are required to assist in the recovery effort. In this regard, you should note:

- The Corporation assumes your right to recover payment from any third party, up to the extent of such third party's liability;
- If you recover any monies through lawsuit, settlement, or other means, you must reimburse the Corporation for benefits paid;
- You grant the Corporation a lien on any monies you or your beneficiaries may recover, either through settlement or otherwise, whether the recovery is designated economic or non-economic damages;
- You grant the Corporation the right to intervene in a lawsuit for the purpose of enforcing the Corporation's lien;
- You grant the Corporation the right to recover its legal fees and costs that exceed the Corporation's payment of benefits from any recovery;
- You agree to inform the Corporation when you engage an attorney to pursue a claim, and to inform your attorney of the Corporation's rights under this Program; and
- You agree not to settle any claim or take any action that would prejudice the Corporation's rights or interests.

Comparison of GM Health Care Program Coverages for U.S. Regular Salaried Employees

Medical Plan Coverages	Basic Medical Plan (BMP)	Enhanced Medical Plan (EMP)	Preferred Provider Organization (PPO) (where available)	Health Maintenance Organization (HMO) (where available)
▪ Hospital ▪ Skilled nursing facility ▪ Physical, functional occupational and speech therapy/cardiac rehabilitation coverage ▪ Home health care coverage ▪ Surgical and medical coverage ▪ Ambulance service coverage	For the services listed, scope and level of coverage are identical for BMP, EMP, and PPO, subject to various plan limits.			Varies by HMO
▪ Prescription drug coverage (per prescription)	Retail: generic $5, preferred brand-name 25% with $15 minimum/$25 maximum, non-preferred brand-name $50 Mail order: generic $10, preferred brand-name $30, non-preferred brand name $75 Must use the National Managed Pharmacy Network for full reimbursement.			
▪ Hearing aid coverage ▪ Durable Medical Equipment/ Prosthetic and Orthotic appliance coverage (DME/P&O) ▪ Hospice coverage	For the services listed, scope and level of coverage are identical for BMP, EMP, and PPO, subject to various plan limits.			
▪ Mental health and substance abuse coverage	Scope and level of coverage are identical for BMP, EMP, and PPO and are subject to separate copayment provisions and limitations. Coverage is through the CIGNA Behavioral Health.			
Extended Care Coverage (ECC) ▪ Hospital ▪ Skilled nursing facility ▪ Nursing home ▪ Home nursing ▪ Custodial	Available with BMP, EMP, PPO, and HMO medical options • Provides for certain long-term and/or custodial care needs, either not covered or that exceed medical plan limits • $50,000 maximum benefit per individual payable during any one calendar year			

Dental Coverages	Traditional Dental Plan Coverage	Alternative Dental Plans (where available)
▪ Preventive ▪ Minor restorative ▪ Major restorative	100% 90% 50% (Combined annual maximum benefit per individual of $1,700)	Varies by Plan
▪ Orthodontics (under age 19)	50% ($2,000 lifetime maximum per covered person)	
▪ Temporomandibular joint dysfunctions (TMJ)	50% ($2,000 lifetime maximum per covered person)	
▪ Accidental Dental Injury	80% ($12,000 per qualified occurrence and per lifetime)	

Vision Coverage	Vision examinations — Once during a calendar year Lenses — Once during a calendar year Frames — Once during two consecutive calendar years National Vision Network — There is no out-of-pocket expense for covered services when received from a participating provider. (Out-of-pocket expenses will be incurred if certain frames or lens features are selected.)

Special Provisions

If You Reside In...

- ***Canada***
  Regular U.S. employees who are residents of Canada may elect to enroll for Optional Canadian Health Care Coverages (OCHCC). This is a ***permanent election as long as you remain a resident of Canada***. You may re-enroll in the GM Salaried Health Care Program if you move from Canada.

  The OCHCC includes coverage for medical, dental, and vision services that supplements the Canadian National/Provincial coverage. It also includes an optional Comprehensive Medical Expense Insurance Program (CMEIP) component.

- ***Puerto Rico***
  Employees working and residing in Puerto Rico have health care provisions similar to U.S. employees to the extent that such enrollment options are available.

- ***Hawaii***
  Because of special provisions of federal and state laws, health care eligibility, coverages, and enrollment options for ***employees*** working and residing in Hawaii will be ***different from those that apply to employees in other states***.

More detailed information regarding the above provisions is available from the GM Benefits & Services Center.

If You Are Classified As...

International Service Personnel or Permanently Internationally Mobile…

You are eligible for enrollment in the International Health Care Plan, including medical, dental and vision coverages. Extended Care Coverage is not available (however, it may be available upon repatriation).

You can obtain additional information by calling CIGNA International at 800-441-2668 inside the U.S. or 302-797-3100 (outside the U.S.), or sending an e-mail to cieb@cigna.com.

Long-Term Care Insurance

The Long-Term Care (LTC) Insurance Plan is a welfare benefit plan that, if elected, provides long-term care insurance to salaried employees, their eligible spouses, parents, and parents-in-law. LTC is designed to provide a degree of protection against the cost of care you might need if you were to require assistance from another person in caring for yourself as a result of an accident, illness, or effects of aging. It could provide benefits for a variety of services, including care in an assisted living facility, a nursing home, or adult day care setting as well as assistance with activities of daily living. The John Hancock Life Insurance Company of Boston, Massachusetts offers and underwrites the LTC Insurance. You are provided the opportunity to apply for coverage and remit payments to John Hancock through payroll deduction. Participation is completely voluntary.

Eligibility

All salaried employees are eligible to apply for LTC Insurance after the first day of the third month following date of hire. Additionally, your spouse or qualified same-sex domestic partner (issue age 18 or older), your parents, and your parents-in-law (under issue age 80) may apply separately for LTC Insurance by contacting John Hancock directly. John Hancock will notify you whether your application is approved or declined. Monthly LTC Insurance premium payments for you and/or your spouse or same-sex domestic partner are on an after-tax basis through payroll deduction. Monthly LTC Insurance premium payments for your parents and parents-in-law are on a self-pay basis directly to John Hancock.

GM's Involvement

The involvement of General Motors is, without promoting the services, to allow the John Hancock Life Insurance Company to communicate features of their services to all salaried employees and to collect monthly premiums for employee-elected coverages through payroll deduction and remit them to John Hancock. The LTC Plan is governed by ERISA. While GM is the sponsoring employer of the LTC Insurance, John Hancock is the claims fiduciary and:

- Is responsible for all payment of benefits;
- Is responsible for decisions regarding the payment of benefits;
- Is responsible for all decisions regarding the appeal of denied claims; and
- Has discretionary authority to interpret, apply, and construe the provisions of the plan with regard to claims issues.

GM does not guarantee and is not responsible for payment of any LTC benefits. The decision to purchase LTC Insurance is solely your responsibility. You should not interpret the availability of this option as a recommendation by GM for the purchase of it.

Types of Services

LTC Insurance covers an assortment of services, as follows:

- All levels of nursing home care — skilled, intermediate, and custodial — provided in a licensed nursing home or skilled nursing facility.
- Care provided in an assisted living facility to individuals with organically-based brain disorders. An assisted living facility must be licensed to provide residential care specifically to people who have Alzheimer's disease or other forms of dementia.
- A temporary bed-holding benefit. This holds a bed in a nursing home or assisted living facility for up to 10 days if the insured should have to go into a hospital while receiving plan benefits.
- An alternate plan of care if it is recommended and approved by a Care Manager at John Hancock and it appears to be more cost effective and appropriate. For example, payment could be approved to have a doorway to the bathroom widened to improve wheelchair access so that an insured person could remain at home instead of having to go into a nursing home.
- The following home health care services:
  - Care provided by a registered nurse, licensed practical nurse, or licensed vocational nurse;

- Services provided by a qualified home health aide for the purpose of assisting in activities of daily living;
- Physical, respiratory, occupational, or speech therapy provided by a licensed therapist;
- Nutrition counseling provided by or under the supervision of a registered dietitian; and
- Services provided by a registered nurse, physician's assistant, or medical social worker in evaluating the need for and development of a home health care plan upon request of an attending physician.

Home health care services provided by a family member or by a person who ordinarily lives in the insured's home are not covered.

- Adult day care, including a range of medical and support services provided by a qualified adult day care center.

- Informal care by a licensed or unlicensed caregiver, including a family member who does not ordinarily live in the insured's home. Covered services include:
  - Assistance with activities of daily living such as bathing or dressing;
  - Maintenance of the home environment through the following services: shopping, menu planning, meal preparation, and light housekeeping;
  - Personal supervision for the protection of a cognitively impaired person.

Informal care services provided by a person who ordinarily resides in the insured's home are not covered.

The plan also pays benefits when nursing home care, skilled nursing care, home health care, adult day care, or informal care is needed for respite care. Respite care is short-term care that provides temporary relief to a family member or other informal caregiver.

Coverage Options

Three levels of Daily Maximum Benefit amounts will be available. These options represent the maximum daily amount and the corresponding Lifetime Maximum Benefit amount the plan will pay for covered care in a nursing home, skilled nursing facility, or assisted living facility.

Home health care, adult day care, and informal care also are covered under the plan. The maximum benefit for each covered day of home health care and/or adult day care is 60% of the nursing home Daily Maximum Benefit. The maximum benefit for each covered day of informal care is 25% of the nursing home Daily Maximum Benefit. The total of benefits payable for all informal care received in any calendar year is 30 times the informal care daily maximum benefit.

The Lifetime Maximum Benefit is the most the plan may pay for all covered expenses incurred while you are insured. Think of it as a pool of money against which benefits may be drawn according to the schedule of benefits for the option elected.

For individuals whose coverage begins on or after January 1, 2005, the available options are as follows:

	Nursing Home/ Assisted Living Facility Daily Maximum Benefit*	Home Health Care/ Adult Day Care Daily Maximum Benefit*	Lifetime Maximum Benefit*
Option 1	$ 85	$51	$160,000
Option 2	$115	$69	$210,000
Option 3	$170	$102	$315,000

* *Due to differences in state regulations, the options for residents of Connecticut, Delaware and Kansas are slightly different and can be obtained by calling John Hancock directly at 1-800-200-6773.*

When Benefits Are Needed

When an insured person needs long-term care services, the GM Medical Plan and Extended Care Coverage should be reviewed in addition to calling the John Hancock Long-Term Care Customer Service Center. The John Hancock Care Manager, a registered nurse with extensive knowledge in the long-term care field, will determine whether the insured qualifies for Long-Term Care benefits.

The insured person will be certified for benefits when a Care Manager determines him/her to be cognitively impaired or dependent in at least two of five Significant Activities of Daily Living (SADLs) due to a covered condition. The insured person will be eligible for benefits after completing a 90-day qualification period. Kansas residents

must meet slightly different requirements; call John Hancock at 1-800-200-6773 for details.

Cognitively Impaired

A person is cognitively impaired if he/she has a deterioration or loss of intellectual capacity due to an organic brain disorder that requires continual supervision for the protection of the person or others. Alzheimer's disease is an example of an organic brain disorder.

Dependent in a Significant Activity of Daily Living (SADL)

For purposes of LTC a person is dependent in a SADL if he/she needs help or supervision from another person to perform a major part of a SADL a majority of the time. The five SADLs are:

- Bathing or dressing;
- Eating;
- Maintaining continence;
- Toileting; and
- Transferring from bed to chair.

The Care Manager considers the person's cognitive and physical ability to perform these activities independently, safely, and appropriately without supervision or help from another person. For example, if the insured can't bathe or eat without help or supervision from another person, he/she will be certified as a dependent in these activities.

The Care Manager Will:

- Assess long-term care needs;
- Determine level of cognitive impairment or dependence in the SADL for certification to receive benefits;
- Suggest types of facilities or care providers suited to the situation; and
- Research and provide a list of long-term care resources for you and your family.

Qualification Period

A claimant must complete a 90-day qualification period before being eligible for benefits. The qualification period starts on the date the person is determined to be SADL-dependent or cognitively impaired and ends 90 days later as long as the person stays certified during this time. The person doesn't have to receive long-term care services or be hospitalized at any time during this period. The plan will pay benefits for covered charges incurred after the qualification period is met as long as the person remains certified. Benefit payments are determined by John Hancock in accordance with the terms of the policy.

Waiver of Premium

Once a person becomes certified for plan benefits and has satisfied the qualification period, premium payments are suspended. The claimant will not need to make any further premium payments until he/she is no longer certified. This payment "break" is known as a waiver of premium.

Exclusions

To keep your coverage more affordable, some exclusions apply. No benefits will be payable for services received due to the following conditions and circumstances:

- Mental or emotional disorders without demonstrable organic disease. This includes, but is not limited to, neurosis, psychoneurosis, psychopathy, and psychosis. This exclusion does not apply to Alzheimer's disease or other organically caused brain disorders;
- Intentionally self-inflicted injury;
- Treatment specifically provided for detoxification or rehabilitation of alcoholism or drug abuse;
- Conditions caused by:
  - Committing or attempting to commit a felony,
  - Engaging in an illegal occupation,
  - Participating in an insurrection or riot;
- Conditions caused by war, declared or not, or any act of war, or service in any armed forces or auxiliary units;

- Care or treatment provided outside the United States or Puerto Rico. (The United States includes only the 50 states and the District of Columbia.);

- A service or supply furnished primarily to beautify;

- A service or supply furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except:
  - A program established by the federal government for its civilian employees,
  - Medicare, and
  - Medicaid (any state medical assistance program under Title XIX of the Social Security Act as amended from time to time); and

- A service or supply for which a charge would not have been made in the absence of insurance.

These exclusions may not apply in all states, and may vary depending on the state in which you live. The Certificate of Insurance you receive once you are insured will outline the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

Continuation of Coverage

As long as premiums are paid when due and the Lifetime Maximum Benefit amount has not been used up, Long-Term Care Insurance coverage will be continued by John Hancock, or a successor carrier, even though the insured employee's employment or affiliation with GM is broken. In such a case, if premiums were being paid through payroll deduction, John Hancock will bill directly.

Important Information

Notice

This is only a summary of the Long-Term Care Insurance available; it does not cover all the details. The Certificate of Insurance that is issued to you when you become insured contains the detailed statement of the terms and conditions of your insurance coverage. If there is any conflict between the information contained herein and the Certificate of Insurance, the terms of the Certificate will control.

LTC is offered through an insured policy issued by John Hancock to GM. John Hancock is solely responsible for payment of benefits in accordance with the terms of the policy. GM does not guarantee and is not responsible for payment of any LTC benefits.

Please note that plan provisions may be changed or deleted in order to satisfy state requirements or other legal requirements. General Motors reserves the right to discontinue or change these benefits at any time. In the event that benefits are changed, except to comply with legal requirements, John Hancock will allow existing insureds to continue their coverage. In the event the group policy is terminated or the LTC plan is discontinued, existing insureds may continue their coverage under a replacement policy or under a conversion policy issued by John Hancock.

Coverage is provided under Policy #28201-LTC issued on form GPB-COV-0002 to General Motors Corporation and underwritten by John Hancock Life Insurance Company.

Review of Denied Claims

If your claim for benefits under your Long Term Care Insurance Policy is denied, in whole or in part, you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to a review of that claim denial if:

- You make written request for such review; and
- You send such request to John Hancock within 60 days after receipt of the denial.

In your request for a claim review, you should:

- state why you disagree with John Hancock's determination;
- state what other factors (if any) John Hancock should take into consideration; and
- identify whom John Hancock could contact (including names, addresses, and phone numbers) to gather any additional pertinent information regarding your condition or your care.

John Hancock will make a full and fair review of the claim and may require additional information to objectively evaluate your appeal. John

Hancock may use one or more of the following resources for its review:

- a Physician who will assess your condition and report it to John Hancock;
- an on-site geriatric assessment; or
- medical records from your physician(s) and/or provider(s) of care.

John Hancock will then review and make a final decision with respect to the claim appeal for benefits under the Policy. In reviewing your claim John Hancock will have discretionary authority to interpret, construe and apply the terms of the Long-Term Care insurance. The decision will be in writing and, if a denial, will include specific reasons for the denial. John Hancock will make its decision regarding your claim promptly, and usually not later than 60 days after receiving the request for review.

Questions regarding Long-Term Care Insurance should be directed to John Hancock at 1-800-200-6773. Additional numbers: Hearing impaired employees: 1-800-255-1808 (TTY), Outside the United States: 1-617-572-0023

While You Are Disabled

If you become disabled and are unable to work, you may be approved for a disability leave of absence. To be granted a disability leave, you must furnish medical evidence satisfactory to GM that you are unable to perform your job responsibilities as a result of disability.

In the usual case, you will continue to receive your regular salary for the first week of your disability. Thereafter, while you remain disabled and furnish medical evidence satisfactory to GM, you may receive (1) salary continuation and sickness and accident benefits combined for up to six months (refer to table on page 88) and (2) continuing sickness and accident benefits for up to 12 months. Extended disability benefits may be payable thereafter. Social Security Disability Insurance Benefits (SSDIB) also may become payable.

If you are totally and permanently disabled, monthly benefits also may be payable to you from the Salaried Retirement Program, and if total and permanent disability was caused by an accident, and you elected personal accident insurance, monthly benefits also may be payable from that plan. In addition, you may be eligible to receive a distribution of your account, if any, under the Savings-Stock Purchase Program.

If you lose a body member through accidental means, additional benefits may be payable under the personal accident insurance plan if you have elected such coverage.

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If You Are in a Classified Salaried Position

You are covered for sickness and accident benefits on the first day of the sixth month following the month in which you commence working with GM. If you are not actively at work on the day your coverage otherwise would start, coverage commences on the day you return to active work.

While you are unable to work because of sickness or injury and you are being treated by a physician legally licensed to practice medicine, sickness and accident benefits may be payable for as long as 12 months. Treatment may also be provided by a physician assistant, however **certification of disability must be provided by a physician legally licensed to practice medicine.** Sickness and accident benefits also may be payable if you are (1) disabled from surgery for sterilization, or (2) hospitalized for testing to determine your suitability to be a donor for an organ or tissue transplant.

To receive sickness and accident benefits, you must be totally disabled, thereby preventing you from performing the duties of your occupation and must give written notice of any sickness or injury within 20 days after the onset of disability. Sickness and accident benefits may begin after a seven-day waiting period or the first day of treatment by a physician legally licensed to practice medicine (or a physician's assistant where certification of disability is provided by a physician legally licensed to practice medicine), if later. Your salary may be continued during the seven day waiting period. Also, you must provide proof of your injury or sickness to the carrier within 90 days after the termination of the period for which monthly benefits are payable.

Monthly benefit amounts are determined by your monthly base salary. Base salary, for purposes of sickness and accident benefits, includes the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium, or any other payments.

Benefits generally are payable on your regular payday. These benefits may be supplemented by salary continuation, as shown in the table on page 88.

Your monthly benefit amount is equal to 75% of your monthly base salary for periods of disability commencing after you attain one year's length of service. Your monthly benefit amount is equal to 60% of your monthly base salary for periods of disability commencing prior to your attainment of one year's length of service.

Sickness and accident benefits are payable for a period based on your (1) GM length of service, or (2) years of participation under the Life and Disability Benefits Program, if greater (see page 170).

For each month of service, you may receive one monthly benefit, up to a total of 12 monthly benefits. If your GM service is less than 12 months, benefits may continue up to 12 months while you are hospitalized, or receiving workers' compensation payments from GM.

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

Sickness and accident benefits are reduced by:

- Primary Social Security Disability Insurance Benefits (SSDIB) or unreduced Social Security Retirement Insurance Benefits (including retroactive amounts paid for the same period of disability);
- Certain workers' compensation payments;
- Any unemployment compensation payments to which you are entitled for the same period you receive sickness and accident benefits;

- Any payments made under the Corporation's salary continuation policy;

- Any salary payments that may be made in connection with any Corporation incentive separation plan.

You may be required to apply for SSDIB if your disability is expected to continue for a year or longer. You will be required to repay any overpayment incurred due to receipt of an SSDIB award (see page 89).

You may be required to be examined by a doctor, clinic, or other medical authority for the purpose of verifying disability, at any time you may be eligible to receive sickness and accident benefits (see page 89).

How to File a Claim

To apply for ***Sickness and Accident Benefits***, you must complete a claim form provided by the ***GM Benefits & Services Center***.

You may contact the center, toll-free, at ***1-800-489-4646 or 1-877-347-5225 for the hearing or speech impaired.***

In certain states, employees in either classified or executive salaried positions may be eligible under a statutory disability benefits law for disability benefits for time lost from work. ***If you are an employee working in California, Hawaii, New Jersey, New York, Puerto Rico, or Rhode Island,*** certain modifications in your sickness and accident benefits, or salary continuation payments during disability, are explained in a special insert.

Extended Disability Benefits and Supplemental Extended Disability Benefits

If you continue to be disabled after you receive sickness and accident benefits and/or salary continuation payments for the maximum period of 12 months, or if you become disabled while on layoff and continue to be disabled after you receive layoff benefits for the maximum period and you continue to be a GM employee, you may be eligible to receive monthly extended disability benefits.

You are covered for extended disability benefits on the first day of the sixth month following the month in which you commence working with GM. If you are not actively at work on the day your coverage otherwise would start, coverage commences on the day you return to active work.

To receive extended disability benefits, you must (1) be totally disabled so as to be unable to engage in any regular employment with GM at the location where you last worked, and (2) not be working elsewhere. If your employment terminates for any reason while covered for sickness and accident, you will not be eligible to receive extended disability benefits.

Monthly benefit amounts are determined by your monthly base salary. Base salary, for purposes of extended disability benefits, includes the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium, or any other payments.

Your monthly benefit amount is equal to 60% of your monthly base salary.

Extended disability benefits are payable for a period based on your GM years of participation under the Life and Disability Benefits Program (see page 170).

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

* *However, if you become disabled at or after age 63, you may receive extended disability benefits for a period of time beyond age 65.*

In addition, if you are covered for extended disability benefits, but have less than 10 years of participation in the Life and Disability Benefits Program, you may elect to purchase **supplemental extended disability benefits** coverage under the Flexible Benefits Program.

As the name implies, supplemental extended disability benefits coverage is intended to supplement the extended disability benefits for shorter service employees. You may elect supplemental extended disability benefits during the Flexible Benefits enrollment period, ***only*** if on January 1 of the following year, you have ***less than 10 years of participation***. If eligible, supplemental extended disability benefits would be available to you on a pre-tax, self-paid basis. Contributions and coverage for supplemental extended disability benefits would not commence until you have acquired 13 months of credited service under the Retirement Program for salaried employees.

To be eligible for a supplemental extended disability benefit payment, you must have (1) elected supplemental extended disability benefits under the flexible benefits program, (2) made at least one monthly contribution, and (3) exhausted maximum extended disability benefits.

If you are eligible, supplemental extended disability benefits provides you with disability benefits equal to 60% of your monthly base salary in effect as of September 1 of the year prior to your first day of disability. Supplemental extended disability benefits will begin when your extended disability benefits are exhausted. The length of time the benefit is paid may continue until the earliest of recovery from your qualifying disability, age 65, or death. This additional coverage will provide you with the maximum duration of extended disability benefits available to employees with 10 or more years of credited service. Receipt of supplemental extended disability benefits does not extend eligibility for health care and life and disability coverages.

Extended disability benefits and supplemental extended disability benefits are reduced by:

- Any monthly Part A benefits and Part B supplementary benefits (see page 109 for which you may be eligible under the GM Salaried Retirement Program;
- Any benefit for which you are eligible under any other GM retirement or pension plan;
- Any salary payments that may be made in connection with any Corporation incentive separation plan;
- Governmental benefits, such as workers' compensation;
- Certain Social Security benefits; and
- Any federal or state lost-time disability benefits.

Increases in any of these benefits payable after extended disability benefits or supplemental extended disability benefits commence will not be deducted, unless the increase represents an adjustment in the original determination of the amount of such benefit. ***A retroactive award of any of these benefits will create an overpayment of extended or supplemental extended disability benefits that were paid for the same period of disability.***

If you have at least 10 years of credited service, you will be required to apply for total & permanent disability retirement benefits. If you do not apply by the end of the 12th month of receiving extended disability benefits, your extended disability benefits will be reduced by a presumed amount of total & permanent disability retirement benefits commencing with the 13th month. If extended disability benefits are reduced by a presumed amount, you will not be reimbursed for the presumed reduction if you are awarded such benefits at a later date.

For both extended disability benefits and supplemental extended disability benefits, you will be required to apply for Social Security Disability Insurance Benefits (SSDIB) under a special procedure designed to handle the offset of SSDIB against extended disability benefits. You will be required to repay any overpayment incurred due to receipt of an SSDIB award (see page 89).

You may be required to be examined by a doctor, clinic, or other medical authority for the purpose of verifying disability, at any time you may be eligible to receive extended disability benefits or supplemental extended disability benefits (see page 89).

How to File a Claim

To apply for ***Extended Disability Benefits or Supplemental Extended Disability Benefits***, you must complete a claim form provided by the ***GM Benefits & Services Center***. You may contact the center, toll-free, at ***1-800-489-4646 or 1-877-347-5225 for the hearing or speech impaired***.

Illustration of Salary Continuation, Sickness and Accident Benefits (S&A), and Extended Disability Benefits (EDB) for Eligible Salaried Employees

Types of Disability Payments for Periods Shown Below				
Length of Service[1]	**Full Salary[2]**	**S&A and Salary Combined Equal to Full Salary[3]**	**Maximum S&A Benefits Payable**	**Maximum EDB Payable**
Less than 1 year	1st week	—	Up to 12 months	None[4]
1 year but less than 5 years	1st week	Next 7 weeks	12 months	For a period equal to years of participation (if under 10) less the period S&A and/or salary continuation paid[5] but not beyond age 65[6]
5 years but less than 10 years	1st week	Next 12 weeks	12 months	
10 or more years	1st week	Next 25 weeks	12 months	To age 65[6] (if years of participation are 10 or more)

(1) At commencement of disability.
(2) For this purpose, full salary includes base salary and the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium, or any other payment.
(3) The combined payments equal 25% salary continuation and 75% sickness and accident benefits. For this purpose, full salary includes base salary and the premium for necessary continuous seven-day operations, but does not include overtime, night-shift premium, or any other payment.
(4) If you elected supplemental extended disability benefits, employee contributions and coverage will not begin until you have acquired 13 months of credited service under the Retirement Program for salaried employees.
(5) If you are covered for extended disability benefits, but have less than 10 years of participation in the Life and Disability Benefits Program, you may elect to purchase supplemental extended disability benefits coverage under the Flexible Benefits Program.
(6) If you become disabled at or after age 63, you may receive extended disability benefits for a period of time beyond age 65.

General Provisions Applicable to Sickness and Accident, Extended Disability Benefits and Supplemental Extended Disability Benefits

Example of GM Disability Income Benefits

A GM employee with more than 10 years of service becomes totally disabled in February 2003. The following table illustrates the monthly benefits an eligible employee may receive assuming a final monthly base salary of $4,100.

Period Payable	Type of Disability Income Benefit	Monthly Benefit Amount
1st 6 months	Salary continuation (25%) Sickness and accident (75%) **Total**	$1,025.00 $3,075.00 $4,100.00
2nd 6 months	Sickness and accident (75%)	$3,075.00
After 12 months	Extended disability (60%)	$2,460.00

This employee also may be eligible to receive:

- Monthly total and permanent disability benefits under the Retirement Program (see page 113).
- His/her entire account balance under the Savings-Stock Purchase Program after one year of disability.

Social Security Disability Insurance Benefits

If you become disabled before age 65, you may be eligible for disability insurance benefits from Social Security. Your nearest Social Security office can tell you if you qualify. Benefits may be payable after you have been disabled for five full calendar months.

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

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

- Failure to obtain an SSDIB award may result in a lesser Social Security Retirement Insurance Benefit.
- Your dependents also may qualify for Social Security benefits.
- Your Social Security benefits may be increased annually to reflect cost-of-living increases.
- You become eligible for Medicare after receiving 24 months of SSDIB. If you become enrolled in Medicare Part B, you may become eligible for payment of a monthly Special Benefit under the Salaried Health Care Program (see page 74).
- If you are receiving SSDIB and return to work, you may be eligible to continue these benefits, in addition to your salary, up to 12 months. You should contact your nearest Social Security office for additional information.
- SSDIB awards are given favorable federal tax treatment, under current tax laws.

If you are receiving sickness and accident, extended disability or supplemental extended disability benefits, you may be required to complete an authorization form that allows the Social Security Administration to inform GM of the status of your claim for Social Security Disability Insurance Benefits. If you fail to complete this authorization, your sickness and accident, extended disability benefits or supplemental extended disability benefits will be suspended until the authorization is received.

You may be required to be examined by a doctor, clinic, or other medical authority for the purpose of verifying disability, at any time you may be eligible to receive sickness and accident benefits, extended disability benefits or

supplemental extended disability benefits, or personal accident insurance benefits. Generally, if you are found able to work, your benefits will be discontinued. Failure to report for the examination may also result in suspension of benefits. You will be reimbursed, upon request, at .36¢ per mile for travel to and from the examination, if your residence is more than 40 miles (one-way) from the examiner's office.

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

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, forfeiture, suspension, reduction or recovery of benefits. The circumstances include but are not limited to: insufficient length of service; insufficient credited service; gainful employment, Impartial Medical Opinion Examinations; offset due to Social Security, Workers' Compensation, and retirement benefits; failure to comply with program eligibility rules; falsification of disability claim forms; discharge; termination of the plan; any benefit plan overpayment due to any reason; quit; discharge; and end of continuation period.

Disability Claims Review Procedure

Applies to disabilities <u>including</u> accelerated benefits option and total and permanent disability under personal accident insurance.

To receive benefits under the Plan, you will need to file an application. Appropriate forms are available by contacting the GM Benefits & Services Center.

Initial Determination

After your application is received, your eligibility for benefits will be determined, and you will be advised accordingly.

If your application for benefits is denied in whole or in part, written notice will be made to you as soon as practicable but generally no later than 45 days (unless special circumstances require an extension) after receipt of your application.

This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted. An explanation of the procedure by which you may have your denied claim reviewed also will be included in the notice.

Appealing the Initial Determination

Within 180 days following receipt of the formal notification letter from the carrier that a disability claim has been denied, you may request in writing to have the claim reviewed. The request for review should be submitted in writing to the carrier and must include at least the following information:

- Name of employee;
- Name of plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

As part of the review, you may submit any data or written comments to support the claim. A written decision will be furnished within a reasonable time, but not later than 45 days (90 days if special circumstances require an extension of time) after the request for review is received. The written decision will include specific reasons for the decision and will set forth specific reference to plan provisions upon which the decision is based. The carrier has discretionary authority to construe, interpret, apply and administer the Program.

Voluntary Appeal Process

Applies to disabilities <u>except</u> accelerated benefits option and total and permanent disability under personal accident insurance.

If you are not satisfied with the decision of the carrier, the Corporation provides for an additional voluntary level of review as follows: You may appeal within 60 days to the Plan Administrator. You may initiate such an appeal by writing the Plan Administrator, at Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. As part of the review, you may submit any data or written comments to support the claim. The Plan Administrator has discretionary authority to construe, interpret, apply and administer the Program.

If you are still not satisfied with the decision, you may appeal within sixty (60) days to the Employee Benefit Plans Committee (EBPC) which has been delegated authority to construe, interpret, and administer General Motors' employee benefit plans. *The decision of the Employee Benefit Plans Committee is final and binding.* You may initiate such an appeal by writing the Secretary, EBPC, at Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000.

Other Benefit Program Coverages While on Disability Leave

Health Care Coverages

If your length of service date with the Corporation is prior to January 1, 2001, GM will continue contributions towards your health care coverages while you remain totally and continuously disabled and you remain on an approved disability leave. If your disability leave is canceled because the period of leave equals your length of service, health care coverage may be continued while you remain an employee and are receiving sickness and accident or extended disability benefits. However, receipt of supplemental extended disability benefits does not extend the continuation period. Note also that for this coverage to remain in effect you must continue to pay the applicable monthly employee contribution, if any.

Savings-Stock Purchase Program

You may continue to contribute to the S-SPP while you are on an approved disability leave and while you continue to receive salary continuation payments. If you are eligible, you may contribute for a period of up to six months, and such contributions will be based on salary continuation payments of 25% of your monthly base salary.

GM contributions continue to vest while you remain on disability leave. You retain the usual withdrawal, fund exchange and loan privileges. You must, however, continue to make your loan repayments to the Program.

Life and Disability Benefits Coverages

Corporation contributions for basic life insurance, sickness and accident, and extended disability benefits coverages will be continued:

- For any period you are entitled to receive sickness and accident benefits or salary continuation payments while you are totally disabled;
- And thereafter, while you are totally and continuously disabled and remain on an approved disability leave, but not to exceed a period equal to your years of participation (see page 170) as of the first day of disability.

Also, in the event your disability leave is canceled because the period of the leave equaled your length of service, life and disability benefits coverages may be continued while you continue to receive monthly extended disability benefits. However, receipt of supplemental extended disability benefits does not extend the continuation period. GM will make contributions for these coverages during these periods.

If your disability leave is canceled because you recovered, and you again become totally disabled within three working days of the date your leave was canceled, so as to be unable to work, life and disability benefits coverages to which you were entitled will be continued under these circumstances. If you are returned to an approved disability leave, GM will make contributions for these coverages while you remain totally disabled. However, coverage cannot continue beyond the period equal to your years of participation as of your first day of disability.

If at the end of the above periods you are receiving payment from Workers Compensation due to employment with the Corporation, your basic life insurance will be continued while you are receiving those payments. GM will make contributions for this coverage during this period.

You will need to pay the required monthly contributions to continue optional life, dependent life and personal accident insurance while your basic life insurance remains in force.

If you have 10 or more years of participation at the commencement of your disability, your basic life insurance will be continued at no cost to you while you are totally disabled prior to age 65.

For employees hired prior to January 1, 1993: If you have less than 10 years of participation at the commencement of your disability, and you are at least age 60 with 5 or more years of participation when your disability continuance period expires, you may be eligible to continue your life insurance coverage to age

65 by making the required contributions. Contributions will not be required after you retire.

Accelerated Benefits Option

If you are diagnosed as having a terminal illness with a life expectancy not to exceed 12 months, you may be eligible to receive an accelerated benefits option payment of up to 50%, but not less than $1,000, of your basic life insurance. However, if your basic life insurance will be reduced within 12 months of the date the accelerated benefits option payment is approved, such payment will be limited to 50% of the fully reduced amount of basic life insurance.

The total of an accelerated benefits option payment and the amount of basic life insurance payable at your death may never exceed the amount of basic life insurance which would otherwise have been payable without the accelerated benefits option payment.

An accelerated benefits option payment will be made (1) as of the date the insurance company certifies all eligibility requirements are met, (2) only once, regardless of the amount elected, (3) only in one lump sum and (4) only if you are living when payment is made.

An accelerated benefits option payment will be reduced by any benefits paid to you under any GM benefit plan which should not have been paid or should have been paid in a lesser amount.

An accelerated benefits option payment will not be made if (1) your basic life insurance is not in force, (2) you are making contributions for basic life insurance, (3) all or a portion of your basic life insurance is to be paid to a former spouse and/or child(ren) as part of a divorce agreement, (4) the amount of payment would be less than $1,000, (5) you previously received payment of basic life insurance as an accelerated benefits option, regardless of the amount paid, (6) you are not living as of the date the insurance company certifies all eligibility requirements are met or (7) you have assigned all or a portion of your basic life insurance to another party.

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

Upon your death basic life insurance proceeds payable to your beneficiary will be reduced by the amount of any accelerated benefits option payment.

How to File a Claim

To apply for an accelerated benefits option payment you will be required to complete a claim form provided by the ***GM Benefits & Services Center***. A form may be obtained by calling the GM Benefits 7 Services Center toll-free at, ***1-800-489-4646*** or, for the hearing/speech impaired, ***1-877-347-5225***.

Personal Accident Insurance

If you become totally and permanently disabled, as defined below, as a result of an accidental injury while you are an active employee, you may be paid the full benefit amount of any personal accident insurance you elected. The benefit will be paid in monthly installments of 2% of the full amount payable, less any amount paid for losses previously sustained. For benefits to become payable, you must become totally and permanently disabled within 12 months of the accident, remain so disabled for 12 months thereafter and you must submit evidence satisfactory to the insurance company of such disability. Total and permanent disability benefits, under personal accident insurance, begin on the later of: (a) the first day of the month the insurance company receives satisfactory proof you are totally and permanently disabled, or (b) the first day of the month you have been totally and permanently disabled for a period of 12 months following an accident.

"Total and permanent disability" under personal accident insurance means the total and permanent inability, as caused by an accidental injury, to engage in any employment or occupation for remuneration or profit, for which you are suited by reason of education, training or experience as based on medical evidence satisfactory to the insurance company. Spouses/same-sex domestic partners and dependent child(ren) are not eligible for this benefit.

Personal accident insurance also may provide payment for loss of body members, hearing, speech, or eyesight.

You may be required to be examined by a doctor, clinic, or other medical authority for the purpose of verifying disability; at any time you may be eligible to receive personal accident insurance benefits. Generally, if you are found able to work, your benefits will be discontinued. Failure to report for the examination may affect any eligibility you may have for benefits.

Additional information is contained in the section "In the Event of Death or Dismemberment" on page 122.

How to File a Claim

To apply for **total and permanent disability benefits under personal accident insurance**, you must complete a claim form provided by the **GM Benefits & Services Center**. A form may be obtained by calling the GM Benefits & Services Center, toll-free, at **1-800-489-4646 or 1-877-347-5225 for the hearing or speech impaired**.

Retirement Program

You may continue to make regular monthly contributions to Part B while you remain on an approved disability leave and you receive salary continuation payments.

You may continue to accrue credited service for up to 11 months while you remain on an approved disability leave, as explained on page 110.

Salaried Retirement Program benefits may be payable if you have 10 or more years of credited service (see page 110).

Your Life Insurance Coverages

The basic life, optional life and dependent life insurance plans will be administered in compliance with applicable state laws to the extent legally required and to the extent such laws are not pre-empted by federal law. For example, Texas insurance law limits the amount of dependent life insurance an employee residing in Texas may have. This amount may not exceed the combined amount of basic life insurance and optional life insurance.

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Protection Available Under the Life Benefits Program

Your Basic Life Insurance

When Coverage Starts

Basic life insurance coverage starts on the first day of the third month following the month in which your employment commences. If you are not actively at work on the day your coverage otherwise would start, coverage starts on the day you return to active work.

Amount of Coverage

Your basic life insurance is equal to a maximum of two times your annual base salary.*

If you are eligible to participate in the Flexible Benefits Program, your annual base salary will be based upon your monthly base salary in effect on September 1, of the year preceding the Flexible Benefits Plan year.

* If you elect "1 x annual base salary" for basic life insurance, you will receive a monthly credit under the Flexible Benefit Program. A separate brochure describing this program is available on line.

If death should occur as the result of an accident while you are on company business, your beneficiary will receive an additional benefit, equal to 50% of your basic life insurance in force, up to one times your annual base salary.

For the work-related accidental death benefit to be payable, your death must occur within one year following the accident and must not be due to disease, self-inflicted injury, or any act of war or other causes stipulated in the Plan.

Beneficiaries

You may name any individual or individuals you wish as your beneficiary (or beneficiaries). You may change your beneficiary designation at any time. If you die from any cause, your beneficiary will receive a benefit equal to the amount of your basic life insurance in effect, less any accelerated benefits option payment you may have received.

If your beneficiary (or beneficiaries) is entitled to a benefit of $5,000 or more, the benefit will be payable automatically under the Total Control Account Program® (TCA).

Your beneficiary (or beneficiaries) may receive this benefit under one of several options available. The TCA Program provides your beneficiary with total control of the proceeds from your life insurance. A personalized checkbook allows your beneficiary ready access to all, or a portion, of the money. Funds left with the insurance company earn interest at rates set by the insurance company. Several investment options also are available under the TCA.

Your Optional Life Insurance

When Coverage Starts

Optional life insurance is available to regular employees on the first day of the third month following your month of hire provided basic life insurance is in force.

Amount of Coverage

You may enroll for optional life insurance in amounts of one, two, three, four, five, or six times your annual base salary.

If you are eligible to participate in the Flexible Benefits Program, your annual base salary will be based upon your monthly base salary in effect on September 1 of the year preceding the Flexible Benefits Plan year.

If you have elected an amount of basic life insurance equal to one times annual base salary in accordance with the Flexible Benefits Program, you are not eligible for optional life insurance.

The amount of your optional life insurance will immediately reduce upon retirement by 10% for every year you are over age 65. If you retire prior to age 66, your optional life insurance will reduce 10% on the first day of the month following your 66th birthday. Optional life insurance will continue to reduce by 10% each year on the first of the month following your birth date until age 75.

Effective Date

The date your coverage becomes effective depends upon when your completed election is received by the GM Benefits & Services Center. If your election is received:

- on or before your eligibility date, coverage becomes effective on your eligibility date, provided you are actively at work;
- within 31 days following your eligibility date, coverage becomes effective on the first day of the month next following the receipt of your election, provided you are actively at work;
- more than 31 days following your eligibility date, your election will not be processed. Your elections will default to no coverage and you will not be allowed to make any changes except during the annual enrollment period, or by furnishing evidence of a qualifying life event change.

If you have a qualifying life event change, you may increase your coverage provided, you have notified the GM Benefits & Services Center within 31 days following the qualifying life event. However, you must furnish proof of good health before your optional life insurance will become effective. Proof of good health may be waived if you notify the GM Benefits & Services Center within 31 days of an increase in your family status (marriage, birth or adoption). If proof of good health is required, your coverage will become effective on the first day of the month following approval by the insurance company.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

Beneficiaries

You may name any individual or individuals you wish as your beneficiary or beneficiaries. The beneficiary need not be the same as you designate for your basic life insurance. However, if you do not name a beneficiary, any proceeds will be paid to the beneficiary or beneficiaries designated for your basic life insurance.

Cost of Coverage

You contribute the full cost of optional life insurance based on your age as of the end of the calendar year. The GM Benefits & Services Center can inform you of the current monthly contribution rate for your age group. Rates are subject to change by the insurance company.

Refer to page 121 for an explanation of optional life insurance in retirement.

Your Dependent Life Insurance

When Coverage Starts

You are eligible for dependent life insurance on the first day of the third month following your month of hire, provided you are insured for basic life insurance and you have an eligible dependent.

Amount of Coverage

You may enroll for dependent life insurance in amounts of $10,000, $25,000, $50,000, $75,000, $100,000, or $150,000 on your spouse/same-sex domestic partner and in amounts of $5,000, $10,000, $15,000, $20,000, $25,000, or $30,000 on each eligible dependent child.

A signature is required from dependents age 18 or over who are enrolled for the first time in $10,000 or more of coverage. This also includes any increase in coverage that raises the amount to $10,000 or more.

Effective Date

The date your coverage becomes effective depends upon when your completed election is received by the GM Benefits & Services Center. If your election is received:

- on or before your eligibility date, coverage becomes effective on your eligibility date, provided you are actively at work;
- within 31 days following your eligibility date, coverage becomes effective on the first day of the month next following the receipt of your election, provided you are actively at work;
- more than 31 days following your eligibility date, your election will not be processed. Your elections will default to no coverage and you will not be allowed to make any changes except during the annual enrollment period, or by furnishing evidence of a qualifying life event change.

If you have a qualifying life event change, you may increase your coverage provided, you have notified the GM Benefits & Services Center within 31 days following the qualifying life event. However, you must furnish proof of good health before your dependent life insurance will become effective. Proof of good health may be waived if you notify the GM Benefits & Services Center within 31 days of your marriage or birth of your first child. If proof of good health is required, your coverage will become effective on the first day of the month following approval by the insurance company.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

Definition of Dependent

An eligible dependent for dependent life insurance is the same as defined under the Salaried Health Care Program (see page 40), except a sponsored dependent and dependents acquired after the employee's retirement date are not eligible for coverage. A dependent child(ren) is covered from the moment of "live birth" if coverage is then in effect. ***If you are not actively at work on the day your dependent life insurance otherwise would start*****,** coverage would start on the day you return to active work. Additionally, coverage on any dependent whose signature is required will not take effect unless the signed form is received by the GM Benefits & Services Center.

Beneficiaries

You are always the beneficiary for dependent life insurance.

A special death benefit for your first-born child(ren) is available, if your spouse/same-sex domestic partner is insured for dependent life insurance. This special benefit of $2,000 will cover your first-born from the moment of live birth until the child(ren) can first be covered under child(ren) coverage or 60 days. Additional child(ren) are automatically covered from the moment of live birth, if you then have child(ren) coverage in effect. If you elect coverage for your child(ren), you will pay the same rate whether you cover one or more than one child.

Cost of Coverage

You contribute the full cost of dependent life insurance based on your age as of the end of the calendar year. The GM Benefits & Services Center can inform you of the current monthly contribution rate for your age group. Rates are subject to change by the insurance company. Refer to page 121 for an explanation of dependent life insurance in retirement.

Your Personal Accident Insurance

When Coverage Starts

You are eligible for personal accident insurance for yourself on the first day of the third month following your month of hire, provided you are insured for basic life insurance.

Amount of Coverage

You may enroll for personal accident insurance in amounts ranging from $10,000 to $1,000,000. You may not elect coverage amounts in excess of $500,000 if the amount elected exceeds 10 times your base salary. ***If you are not actively at work on the day personal accident insurance coverage otherwise would start*****,** coverage would start on the day you return to active work. In retirement, after attainment of age 70, insurance for any person may not exceed $150,000.

The coverage amounts *of* ***personal accident insurance available for your spouse/same-sex domestic partner*** are identical to the amounts available for yourself. You must purchase personal accident insurance coverage for yourself in order to purchase it for your spouse/same-sex domestic partner. The amount of spouse/same-sex domestic partner personal accident insurance coverage may differ from, but not exceed the amount of, your own personal accident insurance coverage.

For your child(ren), available coverage levels range from $10,000 to $50,000 (in increments of $10,000). You must purchase personal accident insurance coverage for yourself in order to purchase it for your child(ren). Any amount of child(ren)'s coverage may not exceed the amount of your own coverage. No additional dependents may be added under child(ren)'s coverage in retirement.

Definition of Dependent

An eligible dependent child for purposes of personal accident insurance is the same as defined under dependent life insurance.

Effective Date

The date your coverage becomes effective depends upon when your completed election is received by the GM Benefits & Services Center. If your election is received:

- on or before your eligibility date, coverage becomes effective on your eligibility date, provided you are actively at work;
- within 31 days following your eligibility date, coverage becomes effective on the first day of the month next following the receipt of your election, provided you are actively at work;
- more than 31 days following your eligibility date, your election will not be processed. Your elections will default to no coverage and you will not be allowed to make any changes except during the annual enrollment period, or by furnishing evidence of a qualifying life event change.

If you have a qualifying life event change, you may increase your coverage provided, you have notified the GM Benefits & Services Center within 31 days following the qualifying life event. Proof of good health is not required for personal accident insurance.

If you are not actively at work on the date that coverage would otherwise start, coverage will start on the date you return to active work.

Beneficiaries

You may name any individual (or individuals) you wish as your beneficiary (or beneficiaries) for personal accident insurance on yourself. The beneficiary need not be the same as you designate for your basic life insurance. However, if you do not name a beneficiary, any proceeds will be paid to the beneficiary (or beneficiaries) designated for your basic life insurance. Additionally, you are the beneficiary for personal accident insurance coverage on your spouse/same-sex domestic partner and/or child(ren).

A special death benefit (an amount equal to the lowest level of child coverage) may be payable in the event of the death of your first born child, provided that spouse coverage is in effect. This special benefit will cover your first born child from the moment of live birth for a period up to 31 days, provided you are not then covered for personal accident insurance on such child.

Cost of Coverage

You contribute the full cost of personal accident insurance. The GM Benefits & Services Center can inform you of the current monthly contribution rates for this coverage. If you elect coverage for your child(ren), you will pay the same rate whether you cover one or more than one child(ren).

Losses, Exclusions and Limitations

See page 124 “In the event of death or dismemberment” for a complete description of losses and benefits including exclusions and limitations.

Refer to page 121 for an explanation of personal accident insurance in retirement.

General Information

How to Change Your Beneficiary

You may name anyone you wish as your beneficiary (or beneficiaries). You may change or view your beneficiary designation at any time by accessing the Beneficiaries link at gmbenefits.com. This life insurance beneficiary application provides the capability for you to designate and submit your life insurance beneficiary online and receive immediate confirmation on its acceptance.
You may still obtain a beneficiary change form by contacting the GM Benefits & Services Center at 1-800-489-4646 or for the hearing/speech impaired at 1-877-347-5225.

If you have assigned your basic life insurance to someone else, only the assignee has the right to designate the beneficiary.

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

In regards to basic life, optional life, dependent life and personal accident insurance, the following circumstances may result in disqualification, ineligibility, denial, loss, offset, forfeiture, suspension, reduction or recovery of benefits. The circumstances include but are not limited to: failure to comply with program

eligibility rules, non-payment of premium, any benefit plan overpayment due to any reason, end of continuation period, termination of the plan, quit, discharge, proof of good health denial, insufficient years of participation, insufficient length of service, and state of residence.

Life and Accidental Death or Dismemberment Claims Review Procedures

Initial Determination

After the carrier receives your claim for benefits, the carrier will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date received, unless the carrier notifies you within that period that there are special circumstances requiring an extension of time.

If the carrier denies your claim in whole or in part, the notification of the claim decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the carrier did not receive sufficient information the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by the carrier. This request for review should be sent in writing to Group Insurance Claims Review at the address of the carrier's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, the carrier will provide you free of charge with copies of relevant documents, records and other information.

The carrier will evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date the carrier received your request for review, unless the carrier notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the carrier denies the claim on appeal, the carrier will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references, any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, the carrier will provide you free of charge with copies of documents, records and other information relevant to your claim. The carrier has discretionary authority to construe, interpret, apply and administer the Program and their decision is final and binding.

Life Insurance and Personal Accident Insurance Certificates

Detailed provisions of the insured benefit coverages you have under the policies issued to General Motors Corporation by its insurance carrier can be made available to you by contacting the GM Benefits & Services Center toll-free at 1-800-489-4646, or for the hearing/speech impaired, at 1-877-347-5225.

If You Are Laid Off

If you are a regular classified salaried employee with length of service of one or more years, and you are placed on Layoff status, as described in Section 3 of the U.S. HR Policies and Procedure website (http://policymanual.hr.gm.com), you may be eligible for semi-monthly payments under the Layoff Benefit Plan (LBP).

Executives are covered by the Separation Allowance Plan, as discussed in Section 311 of the U.S. HR Policies and Procedure website.

(Note: GMAC/MIC employees are not eligible for the Layoff Benefit Plan.)

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Layoff Benefit Plan (LBP)

In the event of layoff, if you are eligible, your LBP benefits will be based on your highest base salary during the three months prior to layoff (12 months in a defined "plant closing" situation).

If you do not execute a release of claims form approved by the Plan Administrator or its delegate ("Release") the monthly total of your semi-monthly LBP benefits will equal 100% of your monthly pay for the first 2 months of layoff.

If you sign the Release, the monthly total of your semi-monthly LBP benefit will equal:

- 100% of your monthly pay for the first six months of layoff for which benefits are payable; and
- 80% of your monthly pay for up to the next 6 months (18 months if you had 10 or more years' length of service as of your last day worked prior to layoff) of the continuing layoff for which benefits are payable.

The following amounts, if any, will be deducted from the amount of your LBP benefits:

- Any state or federal unemployment compensation (UC) received, or to which you would be entitled if you appropriately applied, and any state disability benefits received; plus
- Any GM pay received or receivable, and any pay applicable to GM work made available but not worked; plus
- 75% of any Income from Other Sources including earnings received or receivable from another employer, or from self-employment (for example, wages, tips, commission, bonuses, vacation pay, disability pay, supplemental unemployment compensation pay, termination pay, value of employer provided meals, board, transportation or housing); plus
- Any unemployment payments to which you are entitled under any GM plan or program to which General Motors has contributed.
- Any outstanding amounts owed to GM, or trustees of any GM benefit plan or program, for overpayments made by GM or under any GM benefit plan or program.

Example 1...

Assume your length of service is one or more years. You live and work in Detroit, Michigan, and are laid off August 1, 2004, with a monthly base salary of $5,500.

Base salary	$5,500.00
100% of base salary *	$5,500.00
First Semi-Monthly Period (1st-15th):	
Benefit level (1/2 of $5,500)	$2,750.00
Less: state UC for period**	$ 724.00
Less: earnings and other benefits	- 0 -
LBP benefit payable	$2,026.00
Second Semi-Monthly Period (16th-31st):	
Benefit level (1/2 of $5,500)	$2,750.00
Less: state UC for period**	$ 879.14
Less: earnings and other benefits	- 0 -
LBP benefit payable	$1,870.86
Total LBP benefits payable for month	$3,896.86
Total UC payable for month	$1,603.14
Total layoff income for June	$5,500.00

* *LBP benefit calculation would be based on 80% of monthly base salary, starting with the seventh month of continuing layoff for which LBP benefits are payable.*

** *Michigan Unemployment Compensation (UC) amount based upon weekly benefit rate of $362.00. The $724.00 UC amount for the first semi-monthly period is based on 14 days of UC. The $879.14 for the second semi-monthly period is based on 17 days of UC.*

Example 2...

A classified salaried employee is laid off with a monthly base salary of $5,500. The employee qualified for and received benefits for 8 months before being hired by a non-GM employer earning $25.00 per hour. During a semi-monthly period, the employee has earnings of $2,200. The employee's pre-tax LBP income benefit for the semi-monthly period is calculated as follows:

LBP Benefit Level:	
Monthly base salary	$5,500.00
LBP benefit level for month (80%)	$4,400.00
LBP semi-monthly income benefit level (÷ 2)	$2,200.00
Earnings Offset:	
Semi-monthly income from other sources	$2,200.00
Semi-monthly LBP benefit offset (75%)	$1,650.00
LBP Semi-Monthly Income Benefit Payment:	
LBP income benefit level	$2,200.00
Earnings offset	-$1,650.00
Gross LBP income benefit payment	$ 550.00
Total LBP benefits payable	$ 550.00
Total non-GM earnings	$2,200.00
Total layoff income for Semi-monthly period	**2,750.00**

Application Requirements

To receive LBP benefits, you are required to file a completed application with the GM Benefits & Services Center for each semi-monthly period of layoff. In order for benefits to be payable, your application must be filed within 60 days after the end of the semi-monthly period.

Layoff Benefit Plan application forms are available from the ***GM Benefits & Services Center at 1-800-489-4646***.

The duration of LBP benefit payments is based on your length of service as of your last day worked as a regular active employee prior to being placed on Layoff status under this Plan.

If you do not sign a Release form and have one or more years of service as of your last day worked prior to a qualified layoff, you may receive LBP benefits for up to 2 months.

If you sign the Release form and have one or more years but less than 10 years length of service as of your last day worked prior to a qualified layoff, you may receive LBP benefits for up to 12 months.

If you sign the Release form and your length of service is 10 or more years, you may receive LBP benefits for up to 24 months.

To receive your full entitlement to LBP benefits, you must remain on Layoff status. If your status changes for any reason, (for example, you refuse a GM job or training offer that results in your status being changed to a "quit"), you no longer will be eligible for LBP benefits.

Appeal Process

If you disagree with a determination that you are not entitled to a Layoff Benefit for any semi-monthly period(s), you must make a written request for review within 60 days after receipt of the determination. You may submit any written comments that may support a reversal of the determination. A written decision on your request for review will be furnished to you within a reasonable time not longer than 60 days, unless special circumstances require an extension after the receipt of your request.

If you are not satisfied with the written decision, you may appeal the decision by writing within 60 days to the Secretary of the Employee Benefit Plans Committee (EBPC) at:

GM Employee Benefit Plans Committee
Mail Code 482-C26-A68
300 Renaissance Center
P.O. Box 300
Detroit, MI 48265-3000
Attn: Secretary, EBPC

The EBPC, which has been delegated authority to construe, interpret, apply, and administer the General Motors Layoff Benefits Plan for Salaried Employees, is the final review authority with respect to any appeal. The decision of the EBPC is final and binding.

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

The following circumstances may result in disqualification, ineligibility, denial, loss, offset, forfeiture, suspension, reduction or recovery of benefits. The circumstances include but are not limited to: insufficient length of service; wages offset due to unemployment compensation or income from other sources; Workers' Compensation, disability benefits, and retirement benefits; failure to comply with program eligibility rules; discharge; termination of the plan; or willful misrepresentation of material facts.

Termination of Your LBP Benefits

Your eligibility for all LBP benefits will terminate permanently (even though you may not have applied for, or have not yet become eligible to receive, LBP benefits) upon the earliest of your:

- Death;
- Retirement, except for a disability retirement wherein GM determines you have recovered, retirement benefits are no longer payable, and GM does not offer you employment;
- Loss of length of service for any reason;
- Refusal to apply for statutory benefits that could or would be offset from LBP benefits;
- Failure to file an application for Corporation employment, in accordance with the applicable provisions of Corporation policy;
- Failure to report, within 60 days, required information that would result in the offset of LBP benefits; or
- Refusal of, or failure to appear for, a GM employment interview (except for good cause as defined under the LBP), or refusal to accept any offer of employment or training assignment at any GM facility, provided you also are offered reimbursement for relocation or interview expenses, as provided under GM policy.

Suspension of LBP Benefits

Your eligibility for LBP benefits will be suspended (even though you may not have applied for, or have not yet become eligible to receive, LBP benefits) if, with respect to "non-GM" employment, you:

- Refuse, or fail to appear for, an employment interview (except for good cause as defined under the LBP), or fail to accept an offer of "suitable employment," as defined in the Plan, if referred by GM, an agent of GM, or a Public Employment Service, unless the new job is expected to result in pay of less than 120% of your existing average semi-monthly income from any current employment;
- Terminate "suitable employment" arranged for by GM, its agent, or Public Employment Service, for any reason over which you have some degree of control;
- Cease to work for any reason prior to working full-time for 90 consecutive calendar days as a regular employee for any employer, if such employment resulted in the reinstatement of suspended LBP benefits;
- Cease to work because of a strike or personal leave for one week or more.

LBP Benefit Overpayments

Any LBP benefit overpayment must be repaid upon receipt of written notice describing the overpayment. If you fail to repay any LBP overpayment within 30 days, your future LBP benefits will be reduced. If LBP benefits are not payable, and the overpayment is not repaid, the amount of overpayment shall be deducted from any present or future monies payable by the Corporation in the form of wages or benefits under other GM benefit plans. General Motors maintains the right to pursue collection, to the extent allowed by applicable law.

Other Benefit Program Coverages While on Layoff

Health Care Coverages

If you are laid off, your coverage as an active employee ceases at the end of the month in which you are last in active service, as defined under the Salaried Health Care Program.

As set forth in the following chart, health care coverages may be continued subject to all applicable contributions, copays and deductibles during periods of layoff status (as defined by salaried policy) for up to 25 consecutive months following the last month you are in active service. Health care layoff coverages cease as of the earlier of the cessation of layoff status or the time limits set forth in the chart below.

Length of Service	Number of Months With Corporation Contributions	Maximum Months of Coverage Self-Paid 50%
4 months	—	4
5 months	—	5
6 months	—	6
7 months	—	7
8 months	—	8
9 months	—	9
10 months	—	10
11 months	—	11
12 months	12	—
13 months, but less than 10 years	13	—
10 years or more	25	—

If you return to work as a regular employee, discontinued coverages will be reinstated as of the date you return to work. If you are scheduled to return to work, but are prevented from doing so by disability, and are consequently placed on an approved disability leave of absence, you will be deemed to have returned to work for the purpose of reinstatement of coverages.

If you return to work from layoff as a regular employee-temporary assignment (RETA), coverages as an active employee will be reinstated as of the date you return to work. Your coverages will be continued until the end of the month you are last in active service on your RETA assignment. Upon returning to layoff, you will be entitled to the balance, if any, of your original layoff continuation entitlement, measured from the end of the month prior to your return to work.

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

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

Retirement Program

You may continue to accrue credited service for up to 11 months while on layoff. If you had 10 or more years of credited service on your date of layoff, you may accrue additional credited service of up to 12 months, or a total of 23 months, for the period of the layoff. However, you cannot make contributions while on layoff.

If your layoff continues for longer than 12 months (24 months in the case of an employee with 10 or more years of credited service), you may have your Part B contributions returned to you with interest. In lieu of a return of contributions, you may elect to receive an annuity. If, after you elect an annuity, you are rehired in a GM salaried position and you immediately resume contributing under Part B, your previous Part B benefit entitlement would be reinstated.

If, after 12 months (24 months in the case of an employee with 10 or more years of credited service) of layoff you have 10 or more years of credited service that would remain unbroken upon your attaining age 55, you may leave your contributions in the Program until you retire.

Savings-Stock Purchase Program

Although no additional contributions to your S-SPP account are permitted while you are on layoff the following S-SPP provisions apply:

- During the period you remain on layoff status and are eligible to receive LBP benefits, you may leave your assets in the S-SPP and continue to vest in GM contributions. You retain the usual withdrawal, fund exchange, and loan privileges. If you have an outstanding loan at the time you are laid off, you may suspend loan repayments for up to 12 months of layoff. Upon completion of the suspension period you must commence repayment of your loan. This suspension may extend the original period of your loan but not beyond the maximum period of five years (10 years if the loan is for the purchase or construction of your principal residence) at which time the loan is due and payable in full.

- Upon separation following layoff:
  - If you have three or more years of credited service, at time of separation, you will be entitled to receive a full distribution of all assets in your account including all GM contributions.
  - If you have less than three years of credited service, at time of separation, you will be entitled to receive a full distribution of all assets attributable to your contributions and related earnings. Any GM contributions not vested will be forfeited.
  - If, at the time of separation, your available account balance is greater than $1,000, you may continue to leave your assets in the Program. You may elect subsequently to receive your S-SPP assets in a lump sum at any time. While your assets remain in the Program, you may continue to exchange assets among the various investment funds, initiate loans, elect installment payments and take partial distributions as permitted under Program provisions. Any assets remaining in your S-SPP account beyond age 70-1/2 will be subject to federal minimum annual distribution requirements.

Life and Disability Benefits Coverages

Coverages may be continued for the following periods:

- For the first month following the month in which you last worked prior to layoff, basic life insurance, sickness and accident benefits, and extended disability benefit coverages will be continued with GM contributions.

- Thereafter, you may continue basic life insurance for the next 12 months (24 months if you have 10 or more years of length of service on your last day worked prior to layoff).

  If you had one but less than 10 years of recognized length of service when your layoff commenced, GM will make contributions for your coverages (excluding optional life, dependent life and personal accident insurances) for 12 months.

  If you had 10 or more years of recognized length of service when your layoff commenced, GM will make contributions for your coverages (excluding optional life, dependent life and personal accident insurances) for 24 months.

- Thereafter, while your GM length of service remains unbroken, you may continue basic life insurance up to an additional 12 months of layoff.

To continue this coverage for any month in which GM does not contribute, you must contribute $0.50 per $1,000 of basic life insurance. Also, to continue optional life, dependent life, and personal accident insurance while basic life insurance remains in force, you must pay the required monthly contributions.

If you return to work as a regular employee, coverages discontinued while on layoff will be reinstated as of the date you return to work.

If you return to work from layoff as a regular employee-temporary assignment (RETA), coverages as an active employee will be reinstated as of the date you return to work. Your coverages will be continued until the end of the month following the month you are last in active service on your RETA assignment. Upon returning to layoff, you will be entitled to the balance, if any, of your original layoff continuation entitlement, measured from the end of the month prior to your return to work.

However, only those life and disability benefit coverages in force on your last day at work prior to your leave can be continued.

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

If you were hired prior to January 1, 1993, and you are at least age 60 with 5 or more years of participation at the end of the above period, you may be eligible to continue your life insurance coverage to age 65 by making the required contributions. Under current plan terms contributions are not required after you retire.

If you become disabled while on Layoff status, and sickness and accident coverage is not in force, benefits under the Layoff Benefit Plan may be continued, up to your maximum entitlement. If you continue to be disabled after you have received layoff benefits, or separation allowance, for your maximum entitlement, you may be eligible for monthly extended disability benefits (see page 86).

At the time of layoff, you will be given a notice explaining (1) your Life and Disability Benefits Program continuance privileges and (2) any monthly contributions you may be required to make.

When You Retire

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Your GM Retirement Program Is Made Up of Two Parts

Part A is non-contributory. General Motors pays the entire cost. Part A provides monthly benefits for employees who were hired prior to January 1, 2001 and have five or more years of credited service and retire or receive deferred vested benefits under the Program. Monthly retirement benefits also are payable when you retire at age 65, or older, based on your credited service. Part A consists of:

- Basic benefits;
- Temporary benefits; and
- Supplements.

Part B is contributory. To receive full Part B benefits, you must (1) contribute at all times while eligible, and (2) leave your contributions in the Program. Part B provides you with an opportunity to build up substantial additional monthly benefits, consisting of:

- Supplementary benefits, which are based on your (1) years of Part B credited service, and (2) average monthly base salary over the highest 60 months during the 120 months immediately preceding retirement; and
- Primary benefits, which are based on the amount you contribute.

While you are required to contribute to participate in Part B of the Program, GM also contributes, in the aggregate, about 85% of the cost of this part of the Program.

Eligibility

- **To Participate**
  Participation is automatic for regular GM salaried employees who have a length of service date prior to January 1, 2001.

- **Part B**
  You are eligible to contribute under Part B when you have attained (1) age 21, and (2) six months of continuous service.

  Effective January 1, 2003, your Part B contribution is 1.25% of your eligible monthly base salary in excess of $3,400. When you elect to participate in Part B, your contribution is deducted from your salary each month, at the end of the month. Your Part B contributions are limited to 35 years.

- **To Retire**
  You are eligible to retire under normal retirement provisions when you attain age 65.

  You may retire voluntarily at (1) any age if you have 30 or more years of credited service*, or (2) age 55 with 10 or more years of credited service.

  If you have 10 or more years of credited service, you may retire at any age prior to age 65 if totally and permanently disabled.

  * *This provision is not applicable to a salaried employee whose length of service date is on or after January 1, 1988.*

Credited Service

Your credited service is used in determining your Part A benefits.

Your Part A credited service also is used in determining your Part B supplementary benefit, provided you (1) contribute to Part B at all times while eligible, and (2) do not withdraw your contributions.

If you contribute to Part B only part of the time while eligible, your credited service used in determining your Part B supplementary benefit generally would not include any period when you did not contribute.

If you never contribute to Part B while eligible, you will not have any credited service to be used in determining any Part B benefits. ***If you withdraw your contributions to Part B immediately prior to retirement,*** you will not have any credited service to be used in determining any Part B benefits.

Your credited service includes all periods of regular employment for which you are paid.

If you are on (1) an approved military leave, or (2) a disability leave and receive workers' compensation, you may receive credited service for such absence.

If you were on layoff at any time during the years (1) 1951 through 1967, (2) 1974 through 1976, or (3) 1979 through 1985, upon application, you may receive credited service for all, or part, of such layoff. The amount of credited service you will receive will depend on your years of credited service as of December 31, 1967; December 31, 1973; October 1, 1979; October 1, 1984; October 1, 1993; October 1, 1996; or October 1, 1999, as applicable.

Your credited service prior to January 1, 1973 will equal the greater of your (1) length of service, or (2) credited service, on December 31, 1972.

Commencing with calendar year 1968, you are eligible for credited service for each calendar month of disability leave or layoff in a year during which you receive pay for periods totaling at least one month. After 1970, up to 11 months may be credited for a disability leave or layoff that continues into the following year. An employee placed on layoff on or after March 1, 1982, with 10 or more years of credited service may be credited with up to 12 additional months for the period of continuous absence due to the layoff.

- **Foundry/Asbestos Service**
  An employee with credited service on or after October 1, 1999, who at retirement has more than 10 years of credited service accrued on certain salaried positions in foundry or asbestos operations, at designated GM locations, will receive additional credited service.

- **Flexible Service**
  A salaried employee, other than a regular salaried employee, who is classified as Flexible Service, may accumulate credited service. Flexible Service employees will receive credited service in any year in which they are paid by GM for working 750 or more hours.

- **Annual Statement**
  Each year you will be given a statement showing your (1) total credited service, and (2) contributions, up to the end of the preceding calendar year.

  If you have any questions concerning the amount of your credited service or contributions, as shown on the statement, you should contact the GM Benefits & Services Center at 1-800-489-4646.

- **Loss of Credited Service**
  You will lose all credited service under the Retirement Program if you quit, are discharged, or are separated for any reason. However, if you have five or more years of credited service, or "service," your retirement benefits are vested (see page 143). If you are re-employed by GM, your credited service will be reinstated, upon proper application. If you have prior credited service that has not been reinstated, you should make application for its reinstatement. Application forms are available at the GM Benefits & Services Center.

  You also will lose Part B credited service if you withdraw your contributions.

Alternative "Service" to Determine Vested Benefit

If you lose credited service before age 65 and have less than five years of credited service, but have five or more years of "service," you would be eligible for vested benefit(s). For example, if you have only four years and six months of credited service, but have five years of "service," the five years of "service" would provide you a vested Part A basic benefit. However, the monthly benefit amount would be based on four years and six months of credited service.

You first become eligible to be covered for this "service" provision when you (1) attain age 21, or (2) complete one year of "service," whichever is later. You receive one year of "service" when you complete 750 hours of "service" in a 12 consecutive month period, beginning with your employment date. You complete an hour of "service" for each hour for which you are paid by GM for working, or for having been entitled to work. No "service" is granted for any (1) period of employment prior to age 18, or (2) year in which you are paid by GM for working less than 750 hours.

A one-year break in "service" will occur if you do not complete 375 hours of "service" in any 12 consecutive months period. Hours paid for vacation and sickness or disability, which are not worked, may be counted to prevent a break in "service." In addition, certain periods of absence because of pregnancy, childbirth, adoption, or child care immediately following birth or placement of a child related to adoption, may be counted to prevent a break in "service." Any absence from work commencing on or after October 1, 1993, for which an employee is entitled to a leave of absence under the ***Family and Medical Leave Act of 1993***, also may be counted to prevent a "break" in service. You will lose your years of "service" if the number of consecutive one-year breaks equals, or exceeds, the greater of (1) the aggregate years of "service" you had before such break, or (2) five years.

Retirement at Age 62 or Later

If you retire at, or after, age 62, you may receive the following benefits:

Part A Basic Benefit

Your monthly Part A basic benefit is determined by your basic benefit rate times your years and months of credited service.

Your basic benefit rate depends on your (1) benefit class code (which is based on your salaried position level), and (2) retirement date, as follows:

		Basic Benefit Rate Per Year of Credited Service for Months Commencing			
Salaried Position Level	**Benefit Class Code**	**10-1-03 through 9-1-04**	**10-1-04 through 9-1-05**	**10-1-05 through 9-1-06**	**10-1-06 and After**
1 and 2	A	$47.75	$48.80	$49.85	$50.90
3	B	$48.00	$49.05	$50.10	$51.15
4	C	$48.25	$49.30	$50.35	$51.40
5 & above	D	$48.50	$49.55	$50.60	$51.65

For example, if you retired October 1, 2003, at age 65 with a "D" benefit class code, your basic rate will be $48.50. If you had 30 years of credited service, your monthly Part A basic benefit would be $1,455.00 ($48.50 X 30 = $1,455.00). Employees retiring October 1, 2003 and after will receive increases to their Part A basic benefit up to October 1, 2006 as shown in the table above.

Part B Primary Benefit

Your Part B primary benefit will be based on your contributions to the Program. This monthly benefit will equal the sum of 5% of your contributions made before July 1, 1977, plus 6-1/4% of your contributions made between July 1, 1977, and October 1, 1979, plus 8-1/3% of your contributions made thereafter.

For example, if you retired October 1, 2002, and you had contributed $1,500 before July 1, 1977; $1,000 between July 1, 1977, and October 1, 1979; and $7,000 through May 31, 2002, your monthly Part B primary benefit would be:

Contributions				**Benefit**
$ 1,500	x	5%	=	$75.00
$ 1,000	x	6-1/4%	=	$ 62.50
$ 7,000	x	8-1/3%	=	$583.33
Monthly Part B primary benefit:				$720.83

Part B Supplementary Benefit

You also may receive a monthly Part B supplementary benefit, ***if you have contributed to Part B at all times while eligible and have not withdrawn your contributions***. This benefit will equal 1% of the amount by which your average monthly base salary exceeds the applicable amount, shown in the following table, multiplied by your years and months of Part B credited service. Average monthly base salary is calculated over the highest 60 months during the 120 months preceding your date of retirement.

Retirement Date	**Applicable Amount**
10-1-03 through 9-1-04	$4,850
10-1-04 through 9-1-05	$4,955
10-1-05 through 9-1-06	$5,060
10-1-06 and thereafter	$5,165

For example, if you retired October 1, 2003, at age 65 with an average monthly base salary of $5,900 and had 30 years of Part B credited service, your monthly Part B supplementary benefit would be $315.00.

60 month average base salary	$5,900.00
Less applicable amount	-$4,850.00
	$1,050.00
Times 1%	x 1%
	$ 10.50
Times years of Part B credited service	x 30
Monthly Part B supplementary benefit $	$ 315.00

Special Benefit

In addition, at age 65, or earlier while you are enrolled in Medicare Part B, you may receive a monthly Special Benefit, as described on page 74.

Summarizing the examples shown for an employee who retired October 1, 2003, at age 65 with 30 years of credited service, the total monthly benefits at retirement would be:

Part A basic benefit	$1,445.00
Part B primary benefit	$ 720.83
Part B supplementary benefit	$ 315.00
Special benefit	$ 66.60
Total monthly benefit	$2,557.43

Retirement Prior to Age 62 With Unreduced Benefits

Your benefits will not be reduced if you retire prior to age 62 under a:

- Total and Permanent Disability (T&PD) retirement — at any age with 10 or more years of credited service. Retirement can commence if you are an employee, after you are disabled for at least 5 months, (may apply immediately in the case of an occupational injury or disease or in the case of a terminal condition). See page 118 for appeal procedures if you are denied a T&PD retirement and you wish to appeal.

- "Grandfather" provision — available to certain employees laid off, prior to October 1, 1987, and not currently working for GM.

Part A Basic Benefit

If you retire under any of the retirement provisions shown above, your monthly Part A basic benefit, as shown on page 112, will be determined as if you had retired at age 62, but based on your credited service at the time you retire.

Part A Temporary Benefit

In addition, you may receive a monthly Part A temporary benefit until you reach age 62 and one month or, if earlier, until you become eligible for a Social Security Disability Insurance Benefit (SSDIB).

The amount of your monthly temporary benefit will be based on your years and months of credited service, up to 30, and your retirement date, as follows:

Monthly Temporary Benefit		
Retirement Date	**Rate***	**Maximum**
10-1-03 through 9-1-04	$45.75	$1,372.50
10-1-04 through 9-1-05	$47.05	$1,411.50
10-1-05 through 9-1-06	$48.50	$1,455.00
10-1-06 and thereafter	$49.80	$1,494.00

**Rate per year of credited service*

***If you retire because of total and permanent disability*,** the temporary benefit will be paid only if you submit evidence satisfactory to GM that you are not eligible for SSDIB. A retroactive SSDIB award creates an overpayment of any temporary benefit that was paid for the same period of disability.

Part A Supplements

You also may receive a monthly Part A supplement. Part A supplements are described on pages 114 and 115.

Part B Primary Benefit

If you have contributed to the Program, you also will receive a monthly Part B primary benefit, determined as if you had retired at age 62, but based upon the actual amount of contributions you made. An example of this benefit is shown on page 112.

Part B Supplementary Benefit

Any monthly Part B supplementary benefit will be based on your (1) average monthly base salary over the highest 60 months during the 120 months immediately preceding retirement, and (2) your Part B credited service at the time you retire. An example of this benefit is shown on page 112.

Special Benefit

In addition, at age 65, or earlier while you are enrolled in Medicare Part B, you may receive a monthly Special Benefit, as described on page 74.

Retirement Prior to Age 62 With Age-Reduced Benefits

You may retire voluntarily with reduced benefits:

- At any age if you have 30 or more years of credited service;
- As early as age 55 and prior to age 62 if you have 10 or more years of credited service.

Part A Basic Benefit

Your monthly Part A basic benefit, as shown on page 112, will be determined as if you had retired at age 62, but based on your credited service at the time you retire. This benefit will be reduced, based on your age at retirement, if you elect to have it commence before you attain age 62 (age 65 if retired between ages 55 - 59 with less than 85 points). However, **if your length of service date is prior to January 1, 1988 and you have 30 or more years of credited service, or your years of age and credited service total 85 or more,** such reduction will apply only until you attain age 62 and one month.

Part A Supplements

You also may receive monthly Part A early retirement or interim supplements. Part A supplements are described on pages 115 – 116.

This provision is not applicable to a salaried employee whose length of service date is on or after January 1, 1988.

Part B Benefits

Any monthly Part B primary and supplementary benefits, as described on page 112, will be determined just as for other types of retirement. ***Monthly Part B benefits will be reduced permanently, if you elect to have them commence prior to age 62 (age 65 if retired between ages 55 - 59 with less than 85 points).***

Important Note

If you retire voluntarily as early as age 55 and prior to age 60, when your combined years of age and credited service total less than 85, and you have less than 30 years of credited service, or if your length of service date is on or after January 1, 1988, even if you have 30 years or 85 points, your benefits under the Retirement Program, will be affected. For example:

- **Your retirement benefits will be reduced from age 65.**
  (This note does not apply to 30-year retirements at any age, retirements where age and credited service total 85 or more for employees whose length of service date is prior to before January 1, 1988, or retirements after age 60 with 10 or more years of credited service.)

Part A Supplements for Retirement With 30 or More Years of Credited Service

Early Retirement Supplement

An "early retirement supplement" may be payable to you each month ***if your length of service date is prior January 1, 1988, and if you retire before age 62 and one month with 30 or more years of credited service***. This supplement is an amount which, when added to the sum of all other Part A and any Part B supplementary benefits payable to you, prior to reduction for any survivor coverage, will raise the total of these benefits payable prior to your attaining age 62 and one month, to the amount shown in the following table:

Retirement Date and Total Monthly Benefit Amount for Determining Early Retirement Supplement Prior to Age 62 and One Month			
10-1-03 through 9-1-04	**10-1-04 through 9-1-05**	**10-1-05 through 9-1-06**	**10-1-06 and after**
$2,805	$2,875	$2,950	$3,020

For example, if you retired October 1, 2003, at age 53 years and 2 months and you had contributed $500 before July 1, 1977; $500 between July 1, 1977, and October 1, 1979; and $7,000 from October 1, 1979 through September 30, 2003, your average monthly base salary totaled $5,900 and you were a 6th level employee electing no survivor coverage, your retirement benefit would be as follows:

Part B Primary Benefit

Contribution			**Benefit**
$500	X	5%	$ 25.00
$500	X	6-1/4%	$ 31.25
$7,000	X	8-1/3%	$583.33
Part B Primary Benefit			$639.58
(Age Reduction Factor)	X	49.6%	$317.23

Part B Supplementary Benefit

60-month average base salary	$5,900.00
Less applicable amount	-$4,850.00
	$1,050.00
Times 1%	$ 10.50
Times years of Part B credited service	X 30
	$ 315.00
(Age Reduction Factor) X 49.6%	$ 156.24

Part A Basic Benefit

Basic Benefit (Class Code D)	$48.50
Times year of Part A credited service	X 30
	$1,455.00
(Credited Service) X 49.6% Age Reduction Factor	$ 721.68

Part A Early Retirement Supplement

"30 and Out" Supplement Level	$2,805.00
Part A Basic Benefit	-$721.68
	$2,083.32
Part B Supplementary Benefit (see above)	-$156.24
	$1,927.08

Total Benefit at Retirement

Part A Basic Benefit	$721.68
Part A Early Retirement Supplement Benefit	$1,927.08
Part B Primary Benefit	$317.23
Part B Supplementary Benefit	$156.24
Total Benefit	$3,122.23

Part A Supplements for Retirement With Less Than 30 Years of Credited Service

Interim Supplement

An "interim" supplement may be payable to you each month until you attain age 62 and one *month* ***if you retire voluntarily with less than 30 years of credited service***. If you retire as early as age 55 and prior to age 60, your age plus credited service must total 85 or more, ***and you must have a length of service date prior to January 1, 1988, to be eligible for this supplement.*** This supplement also may be payable if you retire between ages 60 and 62 with less than 30 years of credited service.

The following table shows the amount of this supplement, which is based on your age at retirement. The amount of this supplement is reduced by the amount of any monthly Part B supplementary benefit payable to you, prior to reduction for any survivor coverage.

Age at Retirement	Monthly Amount * and Effective Date of Interim Supplement Payable Prior to Age 62 and One Month for Each Year of Credited Service for Retirements			
	10-1-03 through 9-1-04	10-1-04 through 9-1-05	10-1-05 through 9-1-06	10-1-06 and After
	$	$	$	$
55	20.10	20.70	21.35	21.90
56	23.75	24.45	25.20	25.85
57	28.70	29.50	30.45	31.25
58	33.65	34.60	35.70	36.60
59	37.55	38.60	39.85	40.85
60	43.45	44.70	46.10	47.30
61	43.45	44.70	46.10	47.30

* *NOTE: The interim supplement is prorated for intermediate ages and is computed on the basis of the number of complete calendar months by which you are under the age you will attain on your next birthday.*

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

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

- Insufficient credited service; Impartial Total & Permanent Disability Retirement Examinations; offsets due to Social Security, workers' compensation; failure to comply with program eligibility rules; gainful employment if receiving total and permanent disability related benefits; termination of the plan; tax levy; any benefit plan overpayments due to any reason.
- Supplements are not payable to you if you (1) retire voluntarily as early as age 55 and prior to age 60 and the sum of your age and years of credited service is less than 85, or (2) are discharged (even if you are discharged and you are treated as retired due to your credited service or age).
- If the total of monthly benefits under Part A and the Part B supplementary benefit exceed 70% of your final monthly base salary, the monthly Part A early retirement or interim supplement will be reduced to the extent required so that such benefits would equal 70% of the final base salary.
- Supplements are not applicable to you if you were hired on or after January 1, 1988.
- If you retire voluntarily and become eligible for Social Security Disability Insurance Benefits (SSDIB), your monthly supplement will be reduced by the temporary benefit amount in effect at the date of your SSDIB award.
- Supplements are only payable if you retire within five years of your last day worked for General Motors.

Survivor Benefits

In the event of your death, either before or after you retire, monthly benefits may be provided for the lifetime of your survivor.

Refer to pages 128 through 130 for an explanation of these important benefits, including the pre-retirement surviving spouse benefit provided at no cost to you.

To waive any surviving spouse coverage available after retirement under this Program, it will be necessary for you to obtain the written consent of your spouse, witnessed by a notary public.

If survivor coverage is rejected, it will not be available in the future and, if you predecease your spouse, your spouse will not receive any surviving spouse benefits.

Special Benefit

In addition, at age 65, or earlier while you are enrolled in Medicare Part B, and if you are eligible to participate in the GM Salaried Health Care Program, you may receive a monthly Special Benefit, as described on page 74.

Workers' Compensation Offset

Workers' compensation benefits paid to retired employees will be deducted from GM retirement benefits otherwise payable.

Additional information about Salaried Retirement Program benefits appears elsewhere in this booklet under applicable headings.

For more information about your retirement, or to apply for retirement benefits, you should contact the **GM Benefits & Services Center** at **1-800-489-4646** or, for the hearing/speech impaired, **1-877-347-5225**.

Social Security

Social Security benefits are in addition to your GM retirement benefits. You and GM contribute to the cost of your Social Security benefits by paying Social Security taxes. Your share of Social Security taxes are deducted from your pay. Social Security retirement benefits may begin as early as age 62 in a permanently reduced amount. For employees who attain age 65 prior to the year 2003, benefits are payable in full if they begin at, or after, age 65.

Social Security Disability Insurance Benefits may begin at any age.

Your spouse's Social Security benefit at age 65 generally will be equal to one-half of your Social Security benefit, unless your spouse is eligible for a higher benefit based on your spouse's earnings. Your spouse may receive a permanently reduced benefit commencing as early as (1) age 62, or (2) age 60 if a widow or widower.

You can contact the Social Security Administration at 1-800-772-1213 or www.socialsecurity.gov.

Salaried Retirement Program Application And Claims Review Process

How To Apply for Retirement If You Meet Eligibility

At least 60 days prior to your retirement, contact the GM Benefits & Services Center at 1-800-489-4646 to request a retirement forms package. GM Benefits & Services Center will send you a packet of material, which should be completed and mailed backed to the Center at least 30 days prior to your retirement date.

In addition, you must submit photocopies of the following documents:

- Birth Certificate
- Marriage Certificate
- Spouse's Birth Certificate
- Spouse's Social Security Card

Retirement Appeal Process

General Motors Corporation is the Plan Administrator and has full authority to construe, interpret and administer the Program. The Administrator will provide adequate and timely notice in writing to any participant or beneficiary whose claim for benefits under the Program is denied, setting forth the specific reasons for such denial. Any denied claim may be appealed to the Plan Administrator at GM Employee Benefit Plans Committee, Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000. The request must be made in writing.

If a participant or beneficiary is not satisfied with the decision of the Plan Administrator, an appeal may be filed with the Employee Benefit Plans Committee (EBPC), which has been delegated authority necessary to construe, interpret, and administer the Program. Such an appeal must be filed in writing within sixty (60) days from the date of the notice from the Plan Administrator denying a claim for benefits under the Program the Secretary of the Employee Benefit Plans Committee (EBPC) at the following address: GM Employee Benefit Plans Committee, Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000, Attn: Secretary, EBPC.

The decision of the EBPC shall be final and binding upon the Corporation and the participant or beneficiary.

How to Apply for Total and Permanent Disability Retirement

Contact the GM Benefits & Services Center at 1-800-489-4646.

Denial of Total and Permanent Disability (T&PD) Retirement Appeal Process

Determination

If your application for T&PD Retirement is denied in whole or in part, written notice will be made to you as soon as practicable but generally no later than 45 days after receipt of your application. This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted. An explanation of the procedure by which you may have your denied application reviewed also will be included in the notice.

Appealing the Determination

In the event your application for T&PD retirement is denied, you may appeal in writing the decision within 180 days of receipt of the denial. The appeal may be sent, to the attention of the Plan Administrator at: GM Benefits & Services Center, P.O. Box 5014, Southfield, Michigan, 48086-5014.

The Plan Administrator has discretionary authority to construe, interpret, apply and administer the Salaried Retirement Program. You should include with your appeal the reason(s) you believe your application was improperly denied, and submit any additional comments, documents and medical records relating to your claim. In the event that your application was denied based on medical evidence, your appeal will be forwarded by the Plan Administrator to the GM Medical

Director who has discretionary authority in this process to construe, interpret, and make medical evaluation on behalf of General Motors regarding your total and permanent disability status.

The Plan Administrator will advise you of the determination of your appeal within a reasonable time, but no longer than 45 days after receipt of appeal, unless special circumstances require additional time to complete the review. Upon written request, you may receive free of charge copies of relevant documents, records and other pertinent information pertaining to your claim.

Other Benefit Program Coverages After Retirement

Savings-Stock Purchase Program

Lump-Sum Distribution: You may elect to receive, in a lump sum, all assets in your S-SPP account, including GM's contributions.

Deferral of Distribution: At retirement, if the value of your S-SPP assets is greater than $1,000, you may continue to leave your assets in the Program. You may elect subsequently to receive your S-SPP assets in a lump sum at any time.

During the period your assets remain in the Program they may continue to grow on a tax-deferred basis. Moreover, you may continue to "manage" the assets in your account. You may (1) exchange assets among the various investment funds and (2) borrow from your assets, as permitted under Program provisions. Any outstanding S-SPP loans you have at the time of retirement, or any new loans you may take thereafter, must be repaid, by making monthly cash payments. No loan repayments will be deducted from your GM retirement checks. Rather, the GM Benefits & Services Center will send you loan repayment coupons for use when submitting your cash payment.

- **Installment Payments and Partial Distributions:**
  During the period your assets remain in the Program you may elect to receive periodic installment payments from your account. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installments must be in whole dollar amounts and total at least $1,200 each year.

  You may, at any time, revise the amount and frequency of any such installments, or you may discontinue installment payments. Additionally, you may take a partial distribution of your assets at any time, either in addition to any installment payments you may elect or without installment payments.

- **Age 70-1/2 Minimum Distribution Requirement:**
  If you (1) defer receipt of your S-SPP assets and (2) later attain age 70-1/2 and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The amount of your annual minimum required distribution will be determined consistent with prevailing federal regulations and paid to you from your account beginning not later than April 1 of the year following your attaining age 70-1/2. You will be notified, in writing, prior to receipt of your first minimum required distribution. Thereafter, depending upon the amount you withdraw voluntarily during the calendar year from your S-SPP account, a minimum distribution payment will be made to you in December each year.

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

Individual Retirement Account

Another alternative available at retirement, is the "rollover" of the taxable and non-taxable amount of a S-SPP distribution to an Individual Retirement Account (IRA). Similar to the S-SPP, during the period your assets remain in an IRA they may continue to grow on a tax deferred basis. Any rollover of assets would be arranged between you and a bank or investment company of your choice.

Health Care Program

Generally, under current provisions, your participation in the Salaried Health Care Program can be continued in retirement if your length of service date with the Corporation commenced prior to January 1, 2001. However, you will be required to pay the full monthly cost of any continuing coverage if you:

- Are an employee whose continuous service with the Corporation commenced on or after January 1, 1993 (or have an adjusted service date on or after that date);
- Retire with less than 10 years of credited service under the General Motors Retirement Program for Salaried Employees; or
- Retire voluntarily at or after age 55 and prior to age 60 when your combined years of age and credited service total less than 85.

  Note: If you are eligible to retire with 30 or more years of credited service ***at any age*** (and your most recent date of hire is prior to January 1, 1988), you are eligible for corporation contributions for health care in retirement.

In addition, at age 65, or earlier while you are enrolled in Medicare part B, and if you are eligible to participate in the GM Salaried Health Care Program, you may receive a monthly Special Benefit, as described on page 74.

As a retiree, any dependent you acquire after you retire will be limited to sponsored dependent coverage for which you pay the full cost.

Former employees eligible only for a deferred retirement benefit are NOT entitled to any General Motors Salaried Health Care Program coverage. Former employees who are discharged from employment are not eligible for health care in retirement even if their discharge is treated under the Salaried Retirement Program as a retirement.

Life Insurance

In retirement, your life insurance coverage may be continued as stated below.

Basic Life Insurance

If Your Most Recent Date Of Hire (Or Length Of Service Date) With GM Is Prior To January 1, 1993, and you:

- retire (for reasons other than total and permanent disability) with 10 or more years of participation, your basic life insurance will immediately reduce upon retirement to an amount equal to 1-1/2% for each year of participation times the amount of life insurance in force at retirement.

Example...

If you have 30 years of participation with $80,000 of basic life insurance in force at retirement, you will have an amount of continuing life insurance equal to $36,000 immediately upon retiring.

1-1/2% x 30 = 45%
45% x $80,000 = $36,000

The minimum amount of continuing life insurance is $5,000.

- retire under the total and permanent disability provisions of the retirement program, your life insurance will reduce when you attain age 65, as shown in the example above.

  Note: If you elected one times your annual base salary, your life insurance will be restored to two times your annual base salary at retirement and then reduced in accordance with the example above.

  — Your basic life insurance will be continued during retirement with GM contributions (except for voluntary retirement as early as age 55 and prior to age 60 when your combined years of age and credited service total less than 85). If you retire voluntarily as early as age 55 and prior to age 60 and your combined age and years of service total less than 85, you may continue your life insurance to age 65 by making the required

contributions of $.50 per month per $1,000 of basic life insurance in force. After age 65 your coverage will be continued without cost to you. If you are eligible to retire with 30 or more years of credited service at any age your life insurance will be continued without cost to you during your retirement.

If you have at least five years of participation at age 60 and cease active work, you may continue basic life insurance to the end of the month in which you attain age 65. ***If you are eligible for retirement benefits***, General Motors will make contributions for such insurance.

- If you retire from a layoff or leave of absence prior to age 65 for reasons other than total and permanent disability, and your basic life insurance ceased while you were on leave or layoff, the coverage will be reinstated upon your retirement. The plan provisions to be reinstated will be the plan in effect as of your retirement effective date.

- If you are eligible for continuing life insurance in retirement and you become terminally ill, with a life expectancy not to exceed 12 months, you may be eligible for an accelerated benefits option payment as discussed on page 93.

If Your Most Recent Date Of Hire (Or Length of Service Date) With GM Is On Or After January 1, 1993,

Your basic life insurance may not be continued in retirement. However, you may convert to a personal insurance policy without providing proof of good health provided you make written application to the insurance company within 31 days from the cessation of such coverage.

Note-regardless of your date of hire former employees who are discharged from employment are not eligible for life insurance in retirement even if their discharge is treated under the Salaried Retirement Program as a retirement.

Optional Life Insurance

Optional life insurance in force when you retire may be continued to age 75, provided (1) your basic life insurance remains in force, unless your most recent date of hire (or length of service date) is on or after January 1, 1993, and you have 10 or more years of credited service, and (2) you make the required monthly contributions.

The amount of your optional life insurance will immediately reduce upon retirement by 10% for every year you are over age 65. If you retire prior to age 66, your optional life insurance will reduce 10% on the first day of the month following your 66th birthday. Optional life insurance will continue to reduce by 10% each year on the first of the month following your birth date until age 75.

Dependent Life Insurance

Dependent life insurance in force when you retire may be continued to age 70, provided (1) your basic life insurance remains in force, unless your most recent date of hire (or length of service date) is on or after January 1, 1993, and you have 10 or more years of credited service, and (2) you make the required monthly contributions.

Personal Accident Insurance

In retirement, you may continue personal accident insurance on yourself and any eligible dependents for your lifetime, provided:

1. Your basic life insurance remains in force and you have 10 or more years of credited service. (Note: If your service date is on or after January 1, 1993, it is not required that your basic life insurance remain in force to continue Personal Accident Insurance).

2. You pay the required contribution

After attainment of age 70, insurance in force on any person may not exceed $150.000.

Former employees eligible only for a deferred retirement benefit are NOT entitled to any coverage under the General Motors Life and Disability Benefits Program.

In the event a dependent loses eligibility, you are responsible for contacting the GM Benefits & Services Center at 1-800-489-4646 to cancel the ineligible dependent from your life insurance coverage.

In the Event of Death or Dismemberment

In the event of your death, your surviving spouse and dependents may be eligible for benefits under both the GM Life and Disability Benefits and Salaried Health Care Programs. In addition, benefits may be available for your survivors under the GM Retirement Program for Salaried Employees and the GM Savings-Stock Purchase Program.

You may also be eligible for benefits in the event you, your spouse/same-sex domestic partner or dependents suffer an accidental dismemberment or other loss.

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Your Basic Life Insurance

If you die from any cause while you are employed, your beneficiary will receive a benefit equal to the amount of your basic life insurance in effect, less any accelerated benefits option payment you may have received.

If death should occur as the result of an accident while you are on company business, your beneficiary will receive an additional benefit, equal to 50% of your basic life insurance in force, up to one times your annual base salary.

For the work-related accidental death benefit to be payable, your death must occur within one year following the accident and must not be due wholly or partly, directly or indirectly, by:

- disease or bodily or mental infirmity, medical or surgical treatment or diagnosis thereof; or
- any infection, except infection caused by an external visible wound accidentally sustained; or
- hernia, no matter how or when sustained; or
- war or any act of war; or
- intentional self-destruction or intentionally self-inflected injury, while sane or insane.

If your beneficiary (or beneficiaries) is entitled to a benefit of $5,000 or more, the benefit will be payable automatically under the Total Control Account Program® (TCA).

Your beneficiary (or beneficiaries) may receive this benefit under one of several options available under the beneficiary's TCA. The TCA Program provides your beneficiary with total control of the proceeds from your life insurance. A personalized checkbook allows your beneficiary ready access to all, or a portion, of the money. Funds left with the insurance company earn interest at rates set by the insurance company. Several investment options also are available under the TCA.

A separate brochure describing ***TCA options*** is available upon request by contacting the ***GM Benefits & Services Center***, toll-free at ***1-800-489-4646*** or, for the hearing/speech impaired, ***1-877-347-5225.***

Your Optional Life Insurance

If you die from any cause while optional life insurance is in effect, your beneficiary will receive a benefit equal to the amount of your optional life insurance in effect.

If your beneficiary (or beneficiaries) is entitled to a benefit of $5,000 or more, the benefit will be payable automatically under the Total Control Account Program® (TCA).

Your beneficiary (or beneficiaries) may receive this benefit under one of several options available under the Beneficiary's TCA. The TCA Program provides your beneficiary with total control of the proceeds from your life insurance. A personalized checkbook allows your beneficiary ready access to all, or a portion, of the money. Funds left with the insurance company earn interest at rates set by the insurance company. Several investment options also are available under the TCA.

Your Dependent Life Insurance

If you die while dependent life insurance is in effect, your surviving spouse/same-sex domestic partner may continue this coverage if your spouse/same-sex domestic partner pays the required monthly contribution. Your surviving spouse/same-sex domestic partner may continue this coverage until the earliest of (1) remarriage, (2) age 70, or (3) death.

The monthly contribution for the entire year will be based on the surviving spouse's/same-sex domestic partner's age as of December 31 of the plan year. Your surviving spouse/same-sex domestic partner may name any individual or individuals as beneficiary (or beneficiaries).

If an eligible dependent should die from any cause while you are insured for dependent life

insurance, benefits are payable to you in a lump sum or, if the benefit from a single claim is $2,500 but less than $5,000 you may request payment under the Total Control Account Program® (TCA), or if the payment from a single claim is $5,000, or more, benefits will be payable automatically under the beneficiary's TCA.

Your Personal Accident Insurance

Benefits are payable to your beneficiary (or beneficiaries) if you should die as a result of a covered accident while insured for personal accident insurance. If you do not name a beneficiary (or beneficiaries), any proceeds will be paid to the beneficiary (or beneficiaries) designated for your basic life insurance.

Benefits will be payable to you in the event of your accidental dismemberment or because of any covered accidental loss or losses sustained by your eligible spouse/same-sex domestic partner or dependent child(ren). Benefits are only payable if you, your spouse/same-sex domestic partner or dependent child(ren) sustain an accidental bodily injury and suffer a loss within one year of the accident; provided the loss was not the result partly or wholly due to causes stipulated in the plan. Certain exclusions are listed below:

- suicide, attempted suicide or intentionally self-inflicted injury while sane or insane;
- flight in an aircraft (including boarding and alighting there from) which is being used for (a) any test or experimental purpose, except while performing YOUR duties as an EMPLOYEE of the CORPORATION, or (b) operated by or under the direction of any military authority, other than transport type aircraft operated by the Military Airlift Command (MAC) of the United States of America or similar air transport service of any other country;
- flight in an aircraft (including boarding and alighting there from) while YOU are a pilot, student pilot, or member of the crew, which is being used for (a) flights requiring a special permit from the appropriate civil aviation authority, even if granted, except while performing YOUR duties as an EMPLOYEE of the CORPORATION; or (b) racing or exhibition stunt flying; or (c) skywriting or banner towing; (d) crop dusting, spraying, seeding, or firefighting; or (e) exploration, pipe or power line inspection; or (f) any form of hunting;
- war, or any act of war whether or not during a time of peace;
- physical or mental illness, diagnosis of or treatment for the illness;
- any infection unless it is caused by an external wound that can be seen and which was sustained in an accident;
- the use of any drugs or medicine unless taken on the advice of and in accordance with the direction of a licensed physician;
- service on full-time active duty in the armed forces of any country or international authority at war (any contributions made by YOU for coverage during such period of active duty will be returned to YOU); or
- committing or attempting to commit an assault or felony.

The loss schedule provides benefits if injury results in death or dismemberment within one year after the date of the accident as indicated below:

Loss	Benefit
Life	Full amount
Speech and hearing	Full amount (two times the full amount for child)
Total and permanent disability*	Full amount
Paralysis**	Full amount (two times the full amount for child)
Two or more members***	Full amount (two times the full amount for child)
One member	One-half the full amount (full amount for child)
Speech	One-half the full amount (full amount for child)
Hearing in both ears	One-half the full amount (full amount for child)
Thumb and index finger of the same hand	One-quarter the full amount (one-half the full amount for child)

* *"Total and permanent disability" coverage does not apply to your spouse/same-sex domestic partner or dependent children and ceases at retirement.*

** *"Paralysis" coverage is applicable only to your spouse and dependent child(ren).*

*** *"Member" as used in the above schedule means hand, foot, sight of eye, speech or hearing in both ears.*

Note: The full amount payable will not exceed $100,000 while the insured is flying as a pilot, student pilot, or member of the crew. This limitation does not apply to commercial air travel.

Only one amount, the largest to which you are entitled, is paid for all losses sustained by one covered individual resulting from one accident.

For example: You suffer an accidental bodily injury resulting in one of the losses described in the table on page 124, entitling you to a payment of one-half the full amount of your coverage (e.g. loss of one hand). In the same accident, you suffer another bodily injury resulting in one of the losses described in the table on page 124, entitling you to a payment of the full amount of your coverage (e.g. loss of sight in both eyes). The amount paid to you will only equal the full amount (i.e. the greater amount) because the total amount paid to you for losses resulting from the same accident cannot exceed the total amount of personal accident insurance in force.

If you or your beneficiary are entitled to a benefit of $5,000 or more, benefits will be payable automatically under the Beneficiary's Total *Control Account Program® (TCA)*.

Special Benefits

Coma Benefit

One percent of the full amount of personal accident insurance in force shall be payable, on behalf of an insured employee, covered spouse/same-sex domestic partner or covered child who becomes comatose within 365 days of an accident. Such benefit will be payable on the 32nd day of the coma and each month thereafter for a maximum of 100 months, until the date the comatose person regains consciousness or until death, if earlier, at which time any balance would be paid.

Special Child Care Center

If you elected coverage for yourself, spouse/same-sex domestic partner and dependent child(ren), an additional benefit of five percent of the employee's full amount of personal accident insurance or the actual amount of child care costs, whichever is less, (subject to a maximum of $6,000 per year) will be paid to the beneficiary for up to four years for each eligible child, under the age of 13, enrolled (or who becomes enrolled within 90 days of the covered accident) in a qualified child care center, when the insured employee or insured spouse/same-sex domestic partner suffers a loss of life as a result of a covered accident.

If there is no dependent child who qualifies, an additional benefit of $1,000 will be paid to the beneficiary.

Spousal Occupational Training

If you elected coverage for yourself and your spouse/same-sex domestic partner, a benefit up to five percent of the personal accident insurance or the actual amount of expenses incurred, whichever is less, but not to exceed $6,000 per year, will be reimbursed to a surviving spouse/same-sex domestic partner, as a Spousal Occupational Training benefit, when the insured employee suffers a loss of life as a result of a covered accident. The benefit is paid to the surviving spouse/same-sex domestic partner as reimbursement for attending a formal occupational training program in order to become specifically qualified for active employment in an occupation for which the spouse/same-sex domestic partner would not otherwise qualify. The benefit is provided for reasonable and necessary expenses incurred within three years of the date of the employee's death. No payment will be made for room, board, or other living, traveling, or clothing expenses.

Special Education

If you elected coverage for yourself and your dependent child(ren), an additional benefit of up to five percent of the employee's full amount of personal accident insurance or the actual amount of tuition, whichever is less, (subject to a maximum of $6,000 per year) will be paid as a Special Education benefit for each eligible dependent child when the insured employee suffers a loss of life as a result of a covered accident. Each eligible dependent child must be enrolled as a full-time student in an accredited college or university within 365 days of the death of the employee.

The benefit will be payable annually for up to four consecutive years providing the eligible child

consecutively continues education as a full-time student. Benefits payable beyond the first year require evidence that the child has successfully completed all academic requirements of the prior school year.

No payment will be made for room, board, or other living, traveling or clothing expenses. If there is no dependent child who qualifies, an additional benefit of $1,000 will be paid to the beneficiary.

No benefit amount is payable following the employee's retirement for Coma Benefit, Special Child Care Center, Spousal Occupational Training, or Special Education.

Seat Belt and Air Bag Benefit

An additional benefit of up to ten percent (10%) of the full amount in force may be payable for you, your spouse/same-sex domestic partner, or your child, as applicable, (up to a maximum of $25,000) if you, your covered spouse/same-sex domestic partner or covered child suffer a loss of life as a result of a covered accident which occurs on or after January 1, 2001 in a private passenger car and the covered person's seat belt was properly used. An additional benefit of ten percent (10%) of the covered person's full amount in force (up to a maximum of $25,000) will also be payable if an air bag is deployed for the seat which the covered person occupied and while properly using a seat belt.

Repatriation Expense Benefit

If you, your covered spouse/same-sex domestic partner, or covered child suffer a loss of life as a result of a covered accident and the death occurs 100 miles or more away from the covered person's principal residence, an additional benefit of $5,000 is payable for the preparation and transportation of the covered person's body to the city of the person's principal residence.

How to File a Claim

To ***apply for life insurance or personal accident insurance benefits***, you or your beneficiary will be required to complete a claim form provided by the ***GM Benefits & Services Center***. A form may be obtained by calling the GM Benefits & Services Center, toll-free at, ***1-800-489-4646*** or, for the hearing/speech impaired, ***1-877-347-5225***. In addition, a certified copy of the death certificate will be required.

Life and Accidental Death or Dismemberment Claims Review Procedures

Initial Determination

After the carrier receives your claim for benefits, the carrier will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date received, unless the carrier notifies you within that period that there are special circumstances requiring an extension of time.

If the carrier denies your claim in whole or in part, the notification of the claim decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the carrier did not receive sufficient information the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by the carrier. This request for review should be sent in writing to Group Insurance Claims Review at the address of the carrier's office which processed the claim

within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, the carrier will provide you free of charge with copies of relevant documents, records and other information.

The carrier will evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date the carrier received your request for review, unless the carrier notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the carrier denies the claim on appeal, the carrier will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references, any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, the carrier will provide you free of charge with copies of documents, records and other information relevant to your claim. The carrier has discretionary, authority, to construe, interpret, apply and administer the Program and their decision is final and binding.

Retirement Program Survivor Benefits

In addition to benefits under the GM Life and Disability Benefits Program, your survivor may receive benefits under Part A and/or Part B of the Retirement Program for Salaried Employees.

If You Die Before Retirement (and Were Otherwise Eligible to Retire Voluntarily)

- **Part A benefit for your surviving spouse:** If you (1) die after attaining eligibility to retire voluntarily, and (2) have been married at least one year, a lifetime monthly Part A basic benefit may be payable to your surviving spouse.

  Your spouse's monthly benefit would be 65% of the reduced monthly Part A basic benefit you would have received had you retired voluntarily with the survivor coverage in effect.

- **Part B benefit for your surviving spouse:** The surviving spouse of an employee who is participating in Part B of the Retirement Program will be provided a monthly income for life, based on the employee's accrued primary and supplementary benefits under Part B. If you marry after you first become eligible to participate in Part B, the survivor coverage becomes effective on the one-year anniversary of the marriage.

  If you (1) are eligible to retire voluntarily on the date of your death, and (2) have this coverage in effect, your surviving spouse would receive 65% of your accrued Part B primary and supplementary benefits plus the Part A basic survivor benefit.

  This coverage generally remains in effect until the earliest of the date:

  — You are eligible for the survivor coverage after retirement;
  — Your employment terminates;
  — You become divorced;
  — You are transferred to the hourly rolls for one year (two years with 10 or more years of credited service); or
  — You withdraw your contributions from Part B of the Retirement Program.

If You Die Before Retirement (and Were Not Otherwise Eligible to Retire Voluntarily)

If you die prior to attaining eligibility to retire voluntarily, Part A pre-retirement survivor coverage may provide a monthly income to your surviving spouse if:

- You have at least five years of credited service, as explained on page 110; and

- You have been married to your spouse for at least one year immediately prior to your death.

The monthly Part A basic benefit payable to your surviving spouse is 50% of the deferred vested amount that otherwise would have been payable at age 65 to you. The spouse benefit is payable commencing (1) when you would have attained age 65, or (2) at the earliest age you could have retired voluntarily, reduced for the deceased employee's age at such date.

Part B benefits would be payable to your surviving spouse, as described earlier on this page (65% of the accrued Part B primary and supplementary benefit), provided (1) you are participating in Part B of the Program, and (2) the Part B surviving spouse coverage is in effect.

Example...

Assume you have Part B survivor coverage in effect and you die in August 2004 at age 50, before you are eligible to retire voluntarily. You and your spouse are the same age, your average monthly salary is $5,480, you have contributed $11,500 to Part B of the Retirement Program, and you have 25 years of credited service.

Your surviving spouse would immediately receive monthly benefits equal to 65% of your accrued Part B benefits or, in this case, an estimated $689 a month for life.

Your surviving spouse also would be eligible to receive an automatic Part A pre-retirement surviving spouse benefit on what would have been your 65th birthday. In this example, the added benefit would be approximately $576. This payment could start, on a reduced basis, as early as the first of the month after the date you would have attained age 55. The Part A pre-retirement surviving spouse benefit, reduced for commencement at age 55, would be $247.

If You Die After Retirement

- **Part A basic and Part B surviving spouse benefits:**
  When you retire, lifetime monthly benefits will be payable to your eligible surviving spouse after your death, unless waived (requires your spouse's approval). This coverage is effective on the one year anniversary of the marriage. ***If you do not waive the surviving spouse coverage***, your benefits generally will be reduced by 5%. If the age difference between you and your spouse exceeds five years, however, your benefits will be further adjusted. Your surviving spouse's monthly benefit would be 65% of the reduced monthly Part A basic and/or Part B benefits payable to you.

Generally, this survivor coverage becomes effective on the date you retire. However, if you retire due to disability (1) before age 55, and (2) with less than 30 years of credited service, this coverage becomes effective at age 55. Prior to age 55, the following would apply:

- Under Part A, you may provide your spouse an actuarially determined 50% joint and survivor coverage (described later); and
- Any pre-retirement Part B survivor coverage for your spouse would continue in effect until you attain age 55 as described on page 129.

If you should outlive your spouse, you may cancel the Part A survivor coverage. After retirement, you may revoke Part A and Part B survivor coverage. GM approval is necessary for any revocation while your spouse is alive. Additionally, you must obtain the written consent of your spouse to revoke one or both survivor coverages. If, however, you should become divorced after retirement, the terms of your Qualified Domestic Relations Order (QDRO) will determine whether you may revoke survivor coverages.

If you marry or remarry after you retire, you may elect prior to 18 months of marriage the surviving spouse coverage under Part A of the Retirement Program for your new spouse. Surviving spouse coverage is available only if you had not rejected such coverage for a previous spouse when it first was made available to you. The marriage or remarriage provision is not applicable to Part B benefits.

You must obtain the written consent of your spouse, witnessed by a notary public, to waive the automatic survivor coverage at retirement.

If you cancel or revoke the coverage, your future benefits will be restored to the amount payable without the coverage upon making application on a form available from the ***GM Benefits & Services Center*** at ***1-800-489-4646*** or ***1-877-347-5225*** for the hearing or speech impaired. In such event, your previously designated survivor no longer would be eligible for any benefit.

Special Benefit

When your surviving spouse is receiving a monthly Part A retirement benefit, excluding deferred vested benefit recipients, the Special Benefit described on page 74 also can become payable upon your spouse's attainment of age 65. To be eligible, your surviving spouse is required to provide proof of enrollment in Medicare Part B. This benefit can become payable prior to age 65, upon application, if your surviving spouse (1) is receiving a monthly Part A retirement benefit, and (2) provides proof of enrollment in Medicare Part B.

Part A Basic and Part B Contingent Annuitant

As an alternative to the surviving spouse coverage, you may elect a contingent annuitant option. Under this option, all, or any part of, your reduced monthly Part A basic and Part B benefits may be continued to any beneficiary you designate. For further information on this option, contact the GM Benefits & Services Center.

Part A Joint and Survivor Coverage (Disability Retirement)

If you retire due to total and permanent disability before age 55 with less than 30 years of credited service, joint and survivor (J&S) coverage will be provided automatically for your spouse. The J&S coverage would pay your spouse 50% of your actuarially reduced monthly Part A basic benefit in the event you die before your spouse.

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

You can revoke the J&S coverage before you are age 55 if (1) your spouse should die, or (2) you become divorced, and a Qualified Domestic Relations Order so provides or with written spousal consent acknowledging the effect of the revocation, witnessed by a notary public. Restoration of your Part A basic benefit would be effective the first of the month following the date of the death of your spouse upon receipt by GM, of evidence satisfactory to GM of your spouse's death, or the first of the month after written revocation of the election because of divorce on a form approved by GM and accompanied by satisfactory evidence of the final divorce decree. Otherwise, this coverage cannot be canceled until you attain age 55.

The regular survivor coverage, described on pages 128 and 129, becomes available on the first of the month following your attainment of age 55 whether or not you reject the J&S coverage. This means that you may reject the J&S coverage prior to age 55 and still have the regular survivor coverage at age 55. However, any rejection of surviving spouse coverage by a married employee requires the written consent of the spouse, witnessed by a notary public, during the 90 days prior to its effective date.

Social Security

Social Security benefits maybe payable. Contact Social Security Administration at 1-800-772-1213 or www.socialsecurity.gov.

Savings-Stock Purchase Program Beneficiary Payout

In the event of your death, all assets in your Savings-Stock Purchase Program (S-SPP) account, including all of GM's contributions, are distributed to the beneficiary(ies) designated by you. However, ***if you are married*****,** assets will be distributed to your spouse unless your spouse had agreed earlier, in writing, on forms satisfactory to the Administrator to the designation of some other person(s) as beneficiary(ies) to receive your S-SPP assets. ***If you are not married and have not designated a beneficiary(ies),*** assets in your account will be distributed to the beneficiary(ies) designated to receive the proceeds of your ***basic life insurance*** under the GM Life and Disability Benefits Program.

If your spouse is your beneficiary, your spouse may elect to keep your account assets in the S-SPP after your death. Your surviving spouse may elect subsequently to receive the assets in a lump sum at any time. While the assets remain in the S-SPP your surviving spouse may initiate loans, fund exchanges, elect partial distributions and request to receive installment payments. Your surviving spouse may not contribute to the S-SPP. Also, if your surviving spouse elects to keep the assets in the S-SPP, your surviving spouse will be deemed to have attained age 70-1/2 on the date you would have attained such age. If your surviving spouse has not withdrawn all the account assets by the date you would have attained age 70-1/2, legally required minimum annual distributions will begin to be paid to your surviving spouse from the account.

A non-spousal beneficiary may not keep your account assets in the S-SPP after your death.

Health Care Coverage for Survivors

Health care coverages are **not** available to:

- A surviving spouse of a former employee eligible only for deferred vested retirement benefits;
- A surviving spouse of an employee or former employee whose length of service date with the Corporation commenced on or after January 1, 2001;
- A spouse or former spouse receiving, or eligible to receive, only a pre-retirement survivor benefit under the Retirement Plan; or
- A retiree's surviving spouse who is eligible only for sponsored dependent coverage but is not so enrolled as of the date of the retiree's death. If the surviving spouse is enrolled as a sponsored dependent as of the retiree's death, a conversion contract may be available.

The eligibility of other surviving spouses is summarized in the chart on pages 131 and 132. To use the chart, identify the category in the left column that best describes the decedent's status at the time of death. Then move to the right to determine the coverages available, the periods of time they are available and whether or not there are Corporation contributions. In some cases eligibility varies depending on whether or not the employee's/retiree's continuous employment commenced prior to January 1, 1993. In those cases the provisions applicable to the pre-1993 service dates are in the middle column and those applicable to the 1993 or later service dates prior to 2001 are in the right-hand column.

If your surviving spouse is eligible to continue coverage, he/she may continue coverage for dependent child(ren) enrolled at your death, provided they continue to meet the eligibility criteria applicable to dependent child(ren).

Health care coverages for a retiree's surviving spouse and/or eligible dependent child(ren) acquired after retirement, who are carried as sponsored dependents, cease at the end of the month in which the retiree dies. A conversion opportunity with current health care carriers may be available.

A surviving spouse age 65 or older who is eligible, but is not enrolled for Medicare Part B coverage, is not eligible for GM contributions for any health care coverages. Coverages may be continued on a self-paid basis until Medicare Part B coverage is obtained. After enrollment in Part B is obtained, contributions may be reinstated and continued while Medicare Part B enrollment is maintained.

SURVIVING SPOUSE ELIGIBILITY*

Salaried Health Care Program

Surviving Spouse of:	Primary Enrollee Service Date** Prior to January 1, 1993, and Dies On or After January 1, 1993	Service Date** On or After January 1, 1993 and prior to January 1, 2001
#1. Employee who dies prior to eligibility for health care	If married to the employee for at least one year prior to the employee's death, the surviving spouse may enroll for core Program coverages on a self-paid basis as follows: ▪ For 24 months, or ▪ Until the earlier of remarriage, age 62 or death, if the surviving spouse is age 45 as of the date of the employee's death or if the surviving spouse's age and the employee's years of credited service totals 55 or more. ▪ Conversion may be available after Program coverage exhausted.	
#2. Employee who dies after eligibility for health care coverage with less than 10 years of credited service	▪ If married to the employee for at least one year prior to employee's death, the surviving spouse may enroll in and/or continue core Program coverages as follows: —— For up to 24 months at 12 months with Corporation contributions and 12 months at 100% self-paid, or —— Self-paid beyond the 24-month period above until the earlier of remarriage, age 62 or death, if the surviving spouse is age 45 as of the date of the employee's death or if the surviving spouse's age and the employee's years of credited service totals 55 or more. ▪ COBRA available as an alternative to Program coverage. ▪ Conversion may be available after Program or COBRA coverage is exhausted.	
#3. Employee who dies with 10 or more years of credited service and not eligible to retire voluntarily	▪ If surviving spouse ***is receiving a Part B survivor benefit*** under the Salaried Retirement Program, the Corporation shall make contributions to continue core and non-core coverages until the later of 24 months, or remarriage. Conversion may be available after continuance exhausted. ▪ If surviving spouse is married to the employee for at least one year prior to employee's death and ***is not receiving a Part B survivor benefit,*** core coverages will be available as detailed in #2 above. ▪ COBRA available as an alternative to Program coverage. ▪ Conversion may be available after Program or COBRA coverage is exhausted.	▪ If surviving spouse ***is receiving a Part B survivor benefit*** under the Salaried Retirement Program, the Corporation shall make contributions to continue core and non-core coverages for 12 months. Following this period the surviving spouse may continue coverages on a self-paid basis for an additional 12 months or remarriage. Conversion may be available after continuance exhausted.
#4. Employee who dies after becoming eligible to retire voluntarily	Core and non-core coverages may be continued with Corporation contributions if: (1) The employee was hired prior to 1-1-88 and had 30 or more years of credited service; (2) The employee's age and credited service as of date of death totaled 85 or more and the employee had at least 10 years of credited service; or (3) The deceased employee was age 60 or more and had 10 or more years of credited service as of the date of death and the surviving spouse is receiving a Part B survivor benefit under the Salaried Retirement Program. ▪ If employee does not meet (1), or (3) above, the Corporation shall make contributions to continue core and non-core coverages for 12 months after which coverage may be continued on a self-paid basis. ▪ If employee has at least 10 years of credited service and the employee's age, when added to the employee's years of credited service as of the date of death does not equal 85 points, coverage will be available as detailed in #3 above. ▪ COBRA available as an alternative to Program coverage. ▪ Conversion may be available after Program or COBRA coverage is exhausted.	▪ Core and non-core coverage may be continued for 12 months with Corporation contributions. Thereafter, coverage may be continued on a self-paid basis.
#5. Employee who dies from accidental injury caused by employment with GM	Corporation will make contributions for the surviving spouse to enroll in and/or continue core and non-core coverages until remarriage. Coverages and Corporation contributions may continue beyond remarriage if eligible in accordance with #1 through #4 above. ▪ COBRA available as an alternative to Program coverage. ▪ Conversion may be available after Program or COBRA coverage is exhausted.	

#6.Retiree	▪ If surviving spouse was eligible for coverage only as a sponsored dependent and was not enrolled as of date of retiree's death, no coverage is available. ▪ If surviving spouse was enrolled as a sponsored dependent as of the retiree's date of death, only conversion is available. ▪ If the retiree's coverage was self-paid in retirement and the surviving spouse was eligible for coverage as a spouse, the surviving spouse may enroll in and/or continue core and non-core coverages on a self-paid basis. Elections and required payment must be made promptly. Conversion also is available. ▪ If the retiree was receiving Corporation contributions for coverage in retirement and if the surviving spouse is eligible for coverage as a spouse as of the date of the retiree's death, the surviving spouse is eligible to continue coverages with Corporation contributions for core and non-core coverages.

** Eligibility for Corporation contributions for a surviving spouse age 65 or older is conditioned on participation in Medicare Part B, if eligible.*

*** Service Date (Length of Service) represents your current continuous period of employment or adjusted service date with General Motors. This service is used to determine participation in certain Programs or Plans.*

General Motors reserves the right to amend, change or terminate these provisions.

Work Life Plus

Eligibility

Work Life Plus services are available to all GM employees.

If you have personal or family problems…

Work Life Plus is a resource available to assist employees and family members in identifying and resolving personal problems. These may include marital or family issues, mental health, substance abuse, financial or legal difficulties, stress or changes in your work or family life.

Services are provided by trained counselors and include problem assessment, counseling, referral to community resources, ongoing support and follow-up. Assistance is provided to link employees with helpful resources within GM as well. Work Life Plus also conducts employee education and management training programs on health promotion, work and family life issues.

Cost

There is no cost to use Work Life Plus. There may be costs, however, related to services provided by resources you are referred to. If you are referred to a community resource or treatment program, efforts are made to refer you to a service covered under your health care program.

Confidentiality

Confidentiality is the cornerstone of Work Life Plus. Confidentiality guidelines are in compliance with federal and state regulations and are reviewed with you by your counselor.

To obtain additional information call
1-800-280-6507

General Motors University

General Motors University (GMU) provides employees with an opportunity to enhance and develop skills designed to lead to business and professional growth.

Eligibility

All GM salaried employees are eligible to attend GMU. Employees are encouraged to discuss learning needs and opportunities with their supervisors. Together, a decision can be made as to which courses would be most helpful to individual development as well as achieving department goals.

What is General Motors University (GMU)?

GMU is a global network of learning resources designed to help GM salaried employees improve their competitive performance to conduct and grow the business of General Motors. The university helps facilitate better coordination of learning activities globally under one “virtual” roof.

GMU’s learning efforts are aligned with GM’s global business processes and functions. Each of GMU’s colleges focuses on its own area of expertise. A dean is responsible to each global process leader for development and delivery of the courses/learning that develop capability and drive process and business performance.

How was GMU developed?

A global group of GM managers and employees worked together to design a university concept to help meet the ongoing business and personal growth needs of employees and others, such as dealers and suppliers.

Since 1997, GMU has been focusing on improving the effectiveness of its offerings. Initially, these efforts eliminated course redundancies and, more recently, have focused on enhancing the effectiveness of courses and finding ways to make learning faster and more global.

How can employees benefit from GMU?

Overall, employees need learning to stay contemporary, competitive and energized in an increasingly competitive global automotive market. Specifically, the university provides an opportunity for employees to develop skills designed to lead to business and personal growth. GMU also enables employees to take an active role in their own career development. Lastly, targeted coursework through GMU helps supervisors and employees enhance work performance, and increase knowledge and understanding of GM businesses.

What methods of learning are available through GMU and where will classes be held?

Employees can experience new and innovative ways of learning. In addition to traditional classroom work, the latest technology is used to accelerate and leverage learning. For example web-based learning and interactive distance learning (video satellite transmission) provide fast and efficient ways to spread the same learning to many locations. The emphasis is to provide learning opportunities that are learner centered and allow employees to get the knowledge they need when and where they need it.

How can employees find a listing of classes?

A list of GMU courses can be found through GMU On-Line on GM’s Intranet. In addition, several of the colleges provide course listings specifically for their respective functional team members.

What is GMU On-Line?

The GMU On-Line website is the virtual doorway to the General Motors University colleges and resources through which employees can receive information and access learning opportunities.

Employees with access to the Intranet can find the GMU site at http://gmu.gm.com. The intent of GMU On-Line is to bring the concept of continuous learning to every employee's desktop.

How can employees enroll?

Employees can enroll through the GMU On-Line website on GM's Intranet by selecting the Employee Enrollment Catalog.

If you have a question about **General Motors University**, you may call the **GMU General Information number at 1-888-468-4784.**

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GM Contributions

GM makes contributions for Part A of the Salaried Retirement Program, most of the cost of Part B of the Salaried Retirement Program, basic life insurance, disability benefit coverages, the Layoff Benefit Plan, and the Enhanced Variable Pay Plan after you become eligible and while you are in active service. GM also makes contributions for health care coverages, with the exception of contributions that may be required for sponsored dependent coverage, or self-paid continuation, or for deductibles, copayments, or sanctions required under the rules of the Salaried Health Care Program. The Enhanced Medical Plan (EMP), certain HMOs or PPOs, Extended Care Coverage, dental and vision coverage, if elected, may require an enrollee contribution. Under the Savings-Stock Purchase Program (S-SPP), effective January 1, 2003, GM contributes $0.50 for each $1.00 an employee contributes up to 6% of eligible salary.

The contributions to the Retirement Program are actuarially determined. The contribution amounts under the Life and Disability Benefits Program are determined by the carrier and GM based on claim experience. The contribution amounts for the self-insured Salaried Health Care Program also are based on claim experience. GM makes contributions to the Layoff Benefit Plan sufficient to pay benefits to laid-off employees.

Benefits made available by GM, the full costs of which are borne by employees, are optional life insurance, dependent life insurance, personal accident insurance, flexible spending accounts, supplemental extended disability benefit, sponsored dependent medical coverage and long term care insurance.

Recovery of Benefit Overpayments

If any benefit paid to you should not have been paid, or should have been paid in a lesser amount, your prompt voluntary repayment will be requested. If necessary, to the extent allowed by applicable law, overpayments may be recovered from any monies then payable, or which may become payable, to you in the form of salary or benefits payable under a GM benefit plan (excluding the GM Retirement Program and S-SPP, except with respect to overpayments by the respective plans).

If you wish, you may direct GM to withhold an amount up to 10% of your monthly retirement benefit to repay a benefit overpayment. S-SPP distributions also may be reduced to repay an overpayment.

Cessation of Coverages

Health care coverages cease at the end of the month in which you quit or are terminated, or immediately if you do not make required contributions. COBRA and conversion privileges are described on pages 143 and 154 – 156.

All Life and Disability Benefits Program coverages cease on the day you quit voluntarily or are discharged. If your employment is terminated for any other reason, except retirement, all coverages continue until the end of the month in which your length of service is broken, provided you make all required contributions.

Optional life, dependent life and personal accident insurance cease when basic life insurance ceases (the requirement to have basic life insurance is waived during retirement if your length of service date is on or after January 1, 1993 and prior to January 1, 2001 and you retire with 10 or more years of participation). If you fail to make a required monthly contribution, optional life, dependent life, and personal accident insurance will cease at the end of the month preceding the month for which the contribution was due.

Optional life insurance also ceases at the end of the month in which you attain age 75. However, if you continue to work beyond age 75, this insurance ceases at the end of the month preceding your retirement date.

Dependent life insurance also ceases at the end of the month in which you attain age 70. If you continue to work beyond age 70, this insurance ceases at the end of the month preceding your retirement date.

Dependent life insurance and personal accident insurance spouse and child(ren) coverages also cease for any person when that person no longer is an eligible dependent. You are responsible for notifying the GM Benefits & Services Center at 1-800-489-4646 in the event your dependent loses eligibility.

Conversion privileges are described on page 143.

Benefits for Part-Time Employees

Part-time salaried employees who regularly work at least half their employing unit's base work week and who are eligible to accumulate length of service in accordance with Corporation policy, may be eligible to participate in certain GM benefit programs for salaried employees.

Benefits for Flexible Service Employees

(Note: These provisions do not apply to GMAC/MIC Flexible Service employees unless specifically noted.)

- **Sickness and accident benefits (S&A)** are paid according to S&A Plan provisions except that Flexible Service employees are compensated at a rate proportional to their work schedule.
  - Flexible Service employees are not eligible for extended disability benefits or supplemental extended disability benefits.

- **Basic life insurance** is provided at no cost to Flexible Service employees in the amount of $15,000.

- **Optional life and dependent life and personal accident insurance** are offered on the same basis as a regular active employee.

- **Layoff benefits** are provided on the same basis as regular employees, except that for a Flexible Service employee the Monthly Base Salary is their proportional regular salary as of the last day worked prior to layoff.

- **Enhanced Variable Pay Plan (EVP) —** The EVP payouts to employees who are classified as flexible service will be determined based on the annual "payout opportunity percent" for the employees' level and the final "weighted average percent." With regard to the stock option provisions under EVP, employees who are classified as flexible service may be eligible to receive a lesser number of options than their full time counterparts. The number of options awarded as well as the "payout opportunity percent" used to determine the cash payout is based on the employee's level of responsibility as of December 31.

- **Medical Plan** — Flexible Service employees are eligible for the same health care options as regular active employees and are assessed an additional monthly contribution for all coverages other than Basic Medical Plan. Selection of health care options will occur during the annual open enrollment period. Extended Care Coverage also is available as a separate election for Flexible Service Employees.

- **Flexible Spending Accounts** — Flexible Service employees are eligible to contribute, on the same basis as regular active employees, pre-tax dollars to Health Care and/or Dependent Care Spending Accounts during the annual open enrollment period. Flexible Service employees are subject to the same account maximums and proof of expenses provisions as regular active employees.

- **Flexible Compensation Payment (FCP)** — Subject to all terms and conditions of the payment, Flexible Service employees are eligible for 65% of the first $1,900 of the FCP provided to regular active employees, or $1,235. Flexible Service employees may purchase one, two or three paid days off at a

cost of $175 per day (subtracted from the lump sum amount).

- **(Note: GMAC/MIC Flexible Service Employees' FCP is determined by their length of service and GMAC/MIC Flexible Services employees do not qualify for additional days off.)**

- **Financial Planning** — Flexible Service employees are eligible to elect the Financial Planning Option and have the added convenience of payroll deduction by enrolling through the annual Flexible Benefit enrollment process. Please visit www.aycofinancialnetwork.com/clients/mim for more information or call 1-800-437-6383.

Flexible Service employees continue to be eligible to participate in the Savings-Stock Purchase Program, the Personal Retirement Income Plan, the Salaried Retirement Program, the Dental and Vision Plans, and Long-Term Care Insurance, in accordance with specific provisions set forth in each plan.

Flexible Service employees are not eligible to participate in the Layoff Benefit Plan, work related death benefits, supplemental life benefits and the personal umbrella liability insurance.

The following life and disability benefits continuance provisions apply to Flexible Services employees who are not actively at work:

- **Disability Leave of Absence** — Basic life insurance and sickness and accident coverage are continued for up to 12 months without cost to a Flexible Service employee. Optional life, dependent life and personal accident insurance may be continued while basic life insurance remains in force, provided the required contributions are paid by the employee.

- **Separations (for reasons other than quit or discharge)** — Basic life insurance and sickness and accident coverage are continued for the balance of the month last worked and for the first full calendar month thereafter at no cost to the employee. Following this period, basic life insurance may be continued for the next 11 months or on a time-for-time basis, whichever is less, provided the required contributions are made. Optional life, dependent life and personal accident insurance may be continued while basic life insurance remains in force provided the required contributions are paid by the employee.

- **Retirement — If a Flexible Service employee is hired prior to January 1, 1993, and:**
  - — Retires from active service, basic life insurance may be continued for the balance of the month in which the employee last works and for the first full month thereafter at no cost to the employee. Following this period basic life insurance may be continued for the next 11 months provided the required contributions are paid (subject to reduction upon retirement).
  - — Retires from a disability leave of absence, basic life insurance may be continued for the balance if any of the 12-month period remaining from the disability leave, provided the required contributions are paid.
  - — Retires with benefits under the GM Retirement Program and was eligible for such benefits on the date of transfer to Flexible Service employment, the basic life coverage in force as of the date of transfer may be continued on the same basis as for any other regular active salaried employee, provided the Flexible Service employee was hired as a regular salaried employee prior to January 1, 1993.
  - — Optional life, dependent life and personal accident insurance may be continued while basic life insurance remains in force, provided the required contributions are paid.

- **Retirement , if a flexible service employee is hired on or after to January 1, 1993:**
  - — On the date employee retires the amount of basic life insurance shall be discontinued.
  - — Optional life, dependent life and personal accident insurance may be continued for up to 12 months following the month the employee last worked provided the employee makes the required contribution and remains otherwise eligible.

Benefits for GMAC/MIC Flexible Service Employees

GMAC/MIC Flexible Service employees may be eligible to participate in the Savings-Stock Purchase Program, the Personal Retirement Income Plan, the Salaried Retirement Program, Salaried Health Care Program, Life and Disability Benefits Program, and the Enhanced Variable Pay Plan, in accordance with specific provisions set forth in each plan. GMAC/MIC Flexible Service employees are not eligible to participate in the Layoff Benefit Plan. Information on life and disability coverages for such employees is described in a separate insert.

Benefits for Cooperative Students

College-level cooperative students employed by GM prior to January 1, 1999, are provided certain benefit coverages in relation to the amount of time for which they receive pay.

Cooperative students hired on or after January 1, 1999, are not eligible for health care and life and disability benefit coverages. Furthermore, such cooperative students are not eligible to participate in the Savings-Stock Purchase Program.

Benefit Program Coverages While on Non-Disability Leave

As an alternative to continuation rights under federal law, if you are granted a leave of absence for a reason other than disability, you may continue your benefit coverages as follows:

The Family and Medical Leave Act (FMLA) of 1993

Under the FMLA, you may be eligible to receive health care coverages on the same basis as an active employee for up to 12 weeks in a year, if such leave is related to:

- The birth of a child or the placement of a child by adoption or foster care;
- The need to provide care for a family member (child(ren), spouse, parent) with a serious health condition; or
- A serious health condition that makes you unable to do your job.

If you do not return to work immediately following an FMLA leave, your eligibility and the basis for continuation of health care coverages, if any, will be governed by the GM Salaried Health Care Program provisions applicable to your status as of and following the date you do not return to work. If appropriate, GM can recover the cost for the continuation of health care coverage during the FMLA leave unless your continued absence is caused by a serious health condition or another reason beyond your control.

Health Care Coverage

From time to time the Corporation may establish certain leave or separation programs under which you may be offered limited continuation privileges provided specified monthly contributions are made. These programs may vary in percentage of the full cost of coverage that you may be required to pay and in the length of the continuation period as stipulated by the leave program.

Your health care coverage as an active employee will cease at the end of the month in which you are last in active service. If you wish to continue coverages (other than dental) beyond this time you may do so provided you make the necessary contributions as described in the following:

- **Dependent care leave:** Coverage may be continued for up to 24 months, provided you pay 50% of the full monthly cost for the first

12 months and 100% thereafter. If a dependent care leave (or portion of such leave) is also covered by provisions of the FMLA you may continue the health care coverages with Corporation contributions for that portion of the leave covered by FMLA.

- **Educational leave:** Coverage may be continued for the duration of the leave, provided you pay 50% of the full monthly cost.

- **All other non-disability leaves:** Coverage may be continued for up to 12 months, provided you pay 50% of the full monthly cost.

Retirement Program

Generally, you continue to be covered by the provisions of the Retirement Program while on a non-disability leave. However, you cannot make contributions, and no credited service can accrue except in the case of an approved military leave of absence.

Savings-Stock Purchase Program (S-SPP)

Although no additional contributions are permitted, you may leave your assets in the S-SPP and continue to vest any non-vested GM contributions. You retain withdrawal, fund exchange, and loan privileges. If you have an outstanding loan at the time you go on an unpaid leave of absence, you may suspend loan payments for up to 12 months of your leave. Upon completion of the suspension period you must commence repayment of your loan. This suspension may extend the original period of your loan, but not beyond the maximum period of five years (10 years if the loan is for the purchase or construction of your principal residence) at which time the loan is due and payable in full.

Life and Disability Benefits Coverages

For the first month following the month you last work prior to an approved non-disability leave of absence, basic life, any sickness and accident, and extended disability benefit coverages will be continued with GM making contributions. Thereafter, you may continue basic life insurance coverage for the next 11 months (or for the duration of an educational leave or 24 months for a dependent care leave), provided you contribute $0.50 per month per $1,000 of basic life insurance.

If you were granted a non-disability leave of absence because of a medical condition that may be expected to result in total disability in the future (e.g., anticipated surgery or termination of pregnancy), sickness and accident and extended disability benefit coverages may be reinstated when you become totally disabled. For disability coverages to be reinstated, you must (1) have been making contributions to continue your basic life insurance and (2) present medical evidence satisfactory to GM that you are totally disabled. GM will contribute the cost of your basic life and reinstate disability coverages. Such GM contributions will start the first of the month in which you present evidence of total disability satisfactory to GM. While you continue to be disabled, GM will contribute the cost of your coverages, on the same basis as provided for an employee on a disability leave, as described on page 92.

If you were hired prior to January 1, 1993, and you are at least age 60 with 5 or more years of participation at the end of the above period, you may be eligible to continue your life insurance coverage to age 65 by making the required contributions. Under the current plan terms contributions are not required after you retire.

You must make the required monthly contributions to continue any optional life, dependent life, and personal accident insurance in effect while your basic life insurance remains in force.

When you go on a non-disability leave, you will be given a notice explaining (1) your basic life and disability benefit continuance privileges and (2) any monthly contributions you may have to make.

If You Leave General Motors

If you leave GM prior to retirement, you will have certain rights and be required to make certain decisions relative to your benefit program coverages, as described below.

Program Conversion Privileges

During the 31 days following cancellation of your life insurance and/or health care coverages, you may do the following:

- Convert, at your expense, to whatever "direct pay" individual contract for health care coverage is available. (Corporation contributions for health care coverage cease at the end of the month you are last in active service.) Application may be made in accordance with a notice that you may receive from your applicable carriers.

- Convert, at your expense, all or part of your Basic and Optional Life Insurance to an individual policy without proof of good health. Dependent Life Insurance may be converted to an individual policy only by a covered dependent or the dependent's legal guardian. Optional and Dependent Life Insurance may not be converted if the insurance ceases due to failure to pay the required contributions. Term insurance is not available for conversion policies.

  To convert Basic, Optional, or Dependent Life Insurance, you should contact the GM Benefits & Services Center immediately by calling 1-800-489-4646 to request a detailed conversion notice. You should also immediately contact MetLife by calling 1-877-ASK-MET7 (275-6387), or you may contact them on the Internet at solutions@metlife.com, to notify them you would like to convert your coverage. MetLife will arrange for a Financial Services Representative to follow up with you and assist you and/or your dependent(s) in the application process.

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

Retirement Program

Part A Basic and Part B Supplementary Benefits

If you leave GM before retirement, have five or more years of credited service, (accrued on or after January 1, 1989), or "service" as defined on page 110, you will be eligible at age 65 for deferred Part A basic and Part B supplementary benefits, if any. You may elect to have these benefit payments start prior to age 65 on a reduced basis. Benefit payments would commence only after you have contacted the GM Benefits & Services Center at 1-800-489-4646 or 1-877-347-5225 (TTY) and requested commencement of your benefit.

Your monthly Part A deferred vested retirement benefit, commencing at age 65, would be based on the vested basic benefit rate in effect for your salaried position level on the date your credited service is broken, as shown on page 110, times your years of credited service. If you were participating in Part B of the Program, any monthly Part B supplementary benefit payable at age 65 would be determined as of the date your credited service is broken, see page 110.

Part B Primary Benefits

If you leave GM before retirement, you may leave your Part B contributions in the Program or withdraw your contributions, plus interest.

If you leave your Part B contributions in the Program and have five or more years of credited service, you may be entitled to unreduced monthly Part B primary benefits commencing (1) at age 65, or (2) prior to age 65 on a reduced basis. If you have less than five years of credited service, you will receive benefits based only on your contributions.

Under the pre-retirement surviving spouse coverage, see page 128, your spouse is provided a benefit in the event of your death. The pre-retirement coverage will provide a 50% benefit to your spouse, based on your benefit amount, and could be payable at the earliest age you could have commenced payment of your monthly benefits.

Single-Sum Payment

If the present value of the accrued deferred retirement benefit for a former employee is $5,000 or less under Part A and Part B, it will be paid to you in a single sum. In accordance with the Internal Revenue Code, in the event the former employee fails to make a distribution election, mandatory distributions in excess of $1,000 will be automatically rolled over to an IRA chosen by the Plan administrator.

A former employee, or the surviving spouse of a former employee, entitled to a monthly deferred retirement benefit(s) **may** elect to receive benefit(s) in a single-sum payment. To request such a lump sum payment, they should contact the GM Benefits & Services Center.

Savings-Stock Purchase Program (S-SPP)

If you leave GM and have three or more years of credited service at time of separation, you will be entitled to receive a full distribution of all assets in your account, including all GM contributions, regardless of the reason for termination of employment.

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

If at the time of termination, the value of your vested assets is not greater than $1,000, you will receive a distribution of the entire amount of such assets not later than 60 days following the month in which the termination occurs.

Deferral of Distribution: Upon termination, if the value of your S-SPP assets is greater than $1,000, you may continue to leave your assets in the Program. You may elect subsequently to receive your S-SPP assets in a lump sum at any time.

During the period your assets remain in the Program they may continue to grow on a tax-deferred basis. Moreover, you may continue to "manage" the assets in your account. You may (1) exchange assets among the various investment funds and (2) borrow from your assets as permitted under Program provisions. Any outstanding S-SPP loans you have at the time of termination, or any new loans you may take thereafter, must be repaid by making monthly cash payments. The GM Benefits & Services Center will send you loan repayment coupons for use when submitting your cash payments.

- **Installment Payments and Partial Distributions:** During the period your assets remain in the Program you may elect to receive periodic installment payments from your account. Installment payments may be made on a monthly, quarterly, semi-annual or annual basis. Installments must be in whole dollar amounts and total at least $1,200 each year. You may, at any time, revise the amount and frequency of any such installments, or you may discontinue installment payments. Additionally, you may take a partial distribution of your assets at any time, either in addition to any installment payments you may elect or without installment payments.

- **Age 70-1/2 Minimum Distribution Requirement:** If you (1) defer receipt of your S-SPP assets and (2) later attain age 70-1/2 and continue to have an account balance, federal law requires that you must receive annually a minimum required distribution from your account. The amount of your annual minimum required distribution will be determined consistent with prevailing federal regulations and paid to you from your account beginning not later than April 1 of the year following your attaining age 70-1/2. You will be notified, in writing, prior to receipt of you first minimum required distribution. Thereafter, depending upon the amount you withdraw voluntarily during the calendar year from your S-SPP account, a minimum distribution payment will be made to you in December each year.

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

Qualified Domestic Relations Order (QDRO)

Following is the address and phone number where an individual can obtain information, without charge, about General Motors QDRO and QMCSO procedures:

Savings-Stock Purchase Program

GM Benefits & Services Center
QDRO Administration Group
P.O. Box 770003
Cincinnati, Ohio 45277-0066

Telephone number: 1-800-489-4646

Salaried Retirement Program

Information about obtaining procedures relating to Qualified Domestic Relations Orders (QDRO) is available at gmbenefits.com or may be obtained by calling the GM Benefits & Services Center at *1-800-489-4646.*

Qualified Medical Child Support Order (QMCSO) Procedures

Additional information regarding enrollment pursuant to a QMCSO can be obtained, without charge, by writing to the Plan Administrator at the GM Benefits & Services Center, Attn: QMCSO Processing, MZ-TS4P, One Spartan Way, Merrimack, NH 03054 or call the GM Benefits & Services Center at 1-800-489-4646.

Separation Allowance

A Separation Allowance Plan has been established for the benefit of salaried employees separated from the payroll under certain circumstances. The Separation Allowance Plan is not applicable in the event of (1) transfers between General Motors and any of its wholly-owned or substantially wholly-owned domestic and foreign subsidiaries or (2) separation from any GM wholly-owned or substantially wholly-owned domestic or foreign subsidiary or for separation arising out of the sale of a GM unit where the employee continues, or is offered the opportunity to continue, employment with the buyer.

Additionally, separation allowance will not be paid in the case whereby an employee refuses to accept another GM assignment as determined by leadership and is subsequently separated from GM employment.

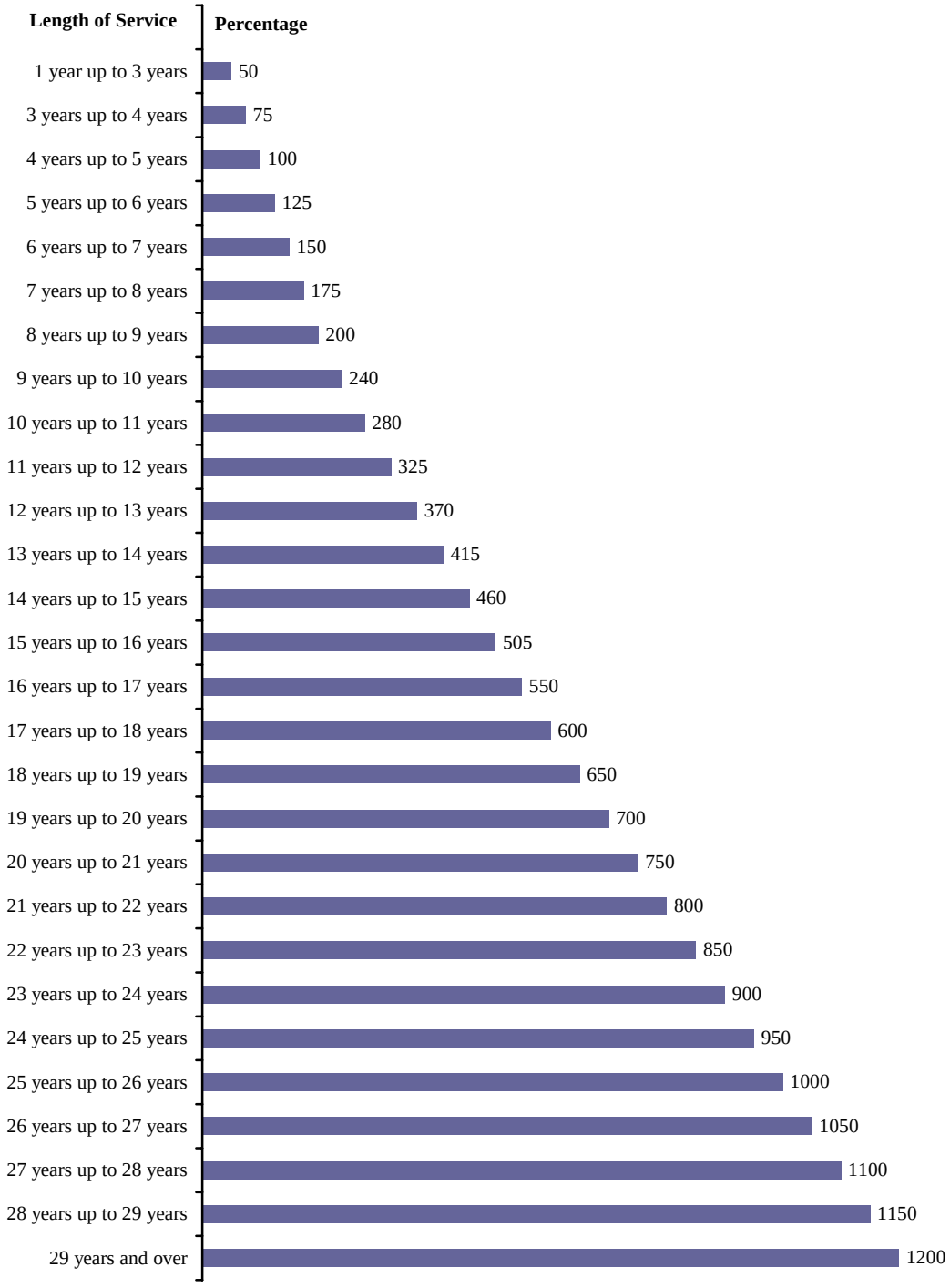
A separation allowance is payable only to employees with at least 12 months of salaried service. Classifications for which a separation allowance may be payable are:

- Final release;
- Mutually satisfactory release;
- Certain special separations; and
- Layoff, if the employee is an executive.

Payment of a separation allowance is normally made in monthly installments. Payment is limited to 200% of average monthly base salary unless the separated employee executes a release of claims satisfactory to the Corporation. The amount of separation allowance is based on “average monthly base salary” and length of service, as shown in the following table, except in situations in which the employee is separated as a final release due to poor performance or fails to execute a release of claims satisfactory to the Corporation. In such cases, the separation allowance may not exceed 200% of average monthly base salary. “Average monthly base salary” means the average base salary during the last 12 or 36 months worked, whichever produces the higher amount.

Executives do not receive benefits under the Layoff Benefit Plan, but do, however, receive monthly layoff payments pursuant to the Separation Allowance Plan. These payments will be reduced by the amount of any unemployment compensation, or other income, as defined under the Layoff Benefit Plan for classified employees.

Separation Allowance as % of Average Monthly Base Salary*



* *The inclusion of a schedule of separation allowances in this handbook, together with the conditions governing their payment, is not intended nor is it to be interpreted to establish a contractual relationship with the employee.* Payment is limited to 200% of average monthly base salary unless the separated employee executes a release of claims satisfactory to the Corporation.

Employee Retirement Income Security Act of 1974 (ERISA)

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

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Types of Plans

The GM Salaried Retirement Program is a defined benefit plan providing trusteed and/or insured retirement benefits to employees who retire and to their eligible survivors. The GM Life and Disability Benefits Program is a welfare benefit plan providing life, personal accident and disability coverages to employees. The GM Salaried Health Care Program is a welfare benefit plan that provides insured and/or self-insured benefits to employees and their eligible dependents. The GM Layoff Benefit Plan is a welfare benefit plan that provides benefits while employees are absent from work due to layoff. The GM Savings-Stock Purchase Program is a defined contribution plan with an employee stock ownership plan feature that provides trusteed benefits to employees who elect to participate in this program. The Separation Allowance Plan is a welfare benefit plan that provides benefits to salaried employees for separation under certain circumstances. Work Life Plus is a welfare benefit plan that provides assistance to salaried employees with personal problems.

GM Salaried Retirement Program trusteed benefits are provided through the payor bank, Deutsche Bank & Trust Company. Savings-Stock Purchase Program trusteed benefits are provided through State Street Bank and Trust Company. Life insurance, personal accident and Retirement Program insured benefits are provided through the Metropolitan Life Insurance Company. Health care benefits for employees are provided through carriers such as United HealthCare, Blue Cross/Blue Shield, a number of plans providing dental and vision coverages, and health maintenance organizations. Layoff Benefit Plan benefits are provided through the payor bank, BankOne. Long-term care insurance benefits are provided through John Hancock Life Insurance Company. Work Life Plus services are provided by CIGNA Behavioral Health. GM is responsible for administration of the plans described in this booklet.

Plan Year

December 31 is the end of the plan year for all plans and programs except the Retirement Program. Records of these plans are kept on a calendar year basis. The GM Salaried Retirement Program plan year ends on September 30.

Named Fiduciary

Except as described below, the Investment Funds Committee of General Motors Corporation is the Named Fiduciary of the benefit plans described in this booklet which are governed by ERISA. The Investment Funds Committee may delegate authority to carry out such responsibilities as it deems proper, to the extent permitted by ERISA. Except as provided below, General Motors Investment Management Corporation (GMIMCo) is the Named Fiduciary of the Savings-Stock Purchase Program (S-SPP), the Salaried Retirement Program (SRP) and the Salaried Health Care Program (SHCP), for purposes of investment of Program/Plan assets. GMIMCo may delegate authority to carry out such responsibilities as it deems proper, to the extent permitted by ERISA. For purposes of the S-SPP, any Participant or beneficiary, who makes an investment election permitted under the Program or otherwise exercises control permitted under the Program over the assets in the account, shall be deemed the Named Fiduciary under ERISA responsible for such decisions to the extent that such designation is permissible under applicable law and that the investment election or other exercise of control is not protected by Section 404(c) of ERISA, as amended.

It is intended that the S-SPP constitutes a plan described in Section 404(c) of ERISA, and pursuant to such Section 404(c), the fiduciaries of the Program may be relieved of liability for losses resulting from investment instructions given by any Participant or beneficiary.

The various plans have named fiduciaries for the purposes of deciding appeals.

Administrator

General Motors Corporation is the sponsoring employer and administrator of the employee benefit plans described in this booklet which are governed by ERISA. The administrator's address is Mail Code 482-C26-A68, 300 Renaissance Center, P.O. Box 300, Detroit, MI 48265-3000.

Identification Numbers

General Motors' employer identification number is 38-0572515. Plan numbers are as follows:

Program/Plan Name	Number
GM Salaried Retirement Program	001
Savings-Stock Purchase Program	002
Life & Disability Benefits Program	501
Layoff Benefit Plan	502
Dependent Care Spending Account	517
Health Care Spending Account	518
Separation Allowance Plan	522
Salaried Health Care Program	524
Work Life Plus	527
Long-Term Care Insurance	529

Legal Process

Service of legal process on General Motors Corporation may be made at any office of the CT Corporation. CT Corporation, which maintains offices in all 50 states, is the statutory agent for services of legal process on GM. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon GM at the Service of Process Office, GM Legal Staff, 400 Renaissance Center, Mail Code 482-038-210, Detroit, Michigan 48265-4000.

For long-term care insurance, service of legal process on John Hancock Life Insurance Company may be made to the Group Long-Term Care Division, 200 Clarendon Street, C7, P.O. Box 111, Boston, MA 02117.

Participant Rights

As a participant in the GM benefit plans which are governed by ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan And Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a retirement benefit at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get a right to a retirement benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without

evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the persons who are responsible for the operation of employee benefit plans.

The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Benefit Guaranty

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay the pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit

at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects form employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number) TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the internet at http://www.pbgc.gov.

Right to Amend, Modify, Suspend or Terminate

General Motors reserves the right to amend, modify, suspend, increase, decrease or terminate any of its employee benefit plans or programs by action of its Board of Directors (Board) or other committee or individual expressly authorized by the Board to take such action.

Such amendments, modifications, increases, decreases or termination may occur whenever the entities described above deem it to be appropriate.

If an amendment, modification, increase, or decrease occurs, the plans will implement the change consistent with the action of the entities described above.

If a plan or program is terminated, that plan or program will no longer exist and no further benefits are payable from that plan or program unless otherwise specified under federal law or the Plan or Programs. (i.e. Retirement Program)

The benefits to which an employee is entitled are determined solely by the provisions of the applicable benefit program. Absent an express delegation of authority from the Board of Directors, no one has the authority to commit the Corporation to any benefit or benefit provisions not provided for under the applicable benefit program, or to change the eligibility criteria or any other provisions of such program.

Salaried Retirement Program

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

- Mandatory employee contributions;
- In the case of benefits payable as an annuity:
  - In the case of benefits in pay status three years prior to termination (at the lowest pay level in that period and at the lowest benefit level under the Program during the three years prior to termination); and
  - In the case of benefits that would have been in pay status three years prior to termination had the participant been retired (and had the participant's benefits commenced then, at the lowest benefit level under the Program during the three years prior to termination).
- All other benefits of individuals under the Program that are guaranteed under the plan termination insurance provisions of ERISA, determined without regard to Section 4022 of ERISA;
- All other non-forfeitable benefits under the Program; and
- All other benefits under the Program.

In the event of termination or partial termination of the Program, the rights of all affected employees to benefits accrued to the date of such termination, partial termination, or discontinuance, to the extent funded as of such date, is nonforfeitable.

Life and Disability Benefits Program, Health Care Program and Layoff Benefit Plan

Upon termination or partial termination of either Program, coverage will cease as of the effective date of termination or partial termination.

Long-Term Care Insurance

Upon termination of the plan, coverage will cease as of the effective date of termination. John Hancock has represented to GM that all insured persons may continue coverage in effect under a replacement policy or a conversion policy issued by John Hancock.

Savings-Stock Purchase Program (S-SPP)

Upon termination, or partial termination, of the S-SPP, no further contributions will be made to the accounts of participants. Participants will maintain entitlement to vested benefits held in their account.

Trustees

Trustees of the Retirement Program, who accumulate assets through which trusteed retirement benefits (Part A and Part B supplementary) are provided, are as follows:

State Street Bank and Trust
One Lincoln Street
State Street Financial Center
Boston, Massachusetts 02111-2900

J.P. Morgan Chase Bank
3 Chase Metrotech Center
Brooklyn, NY 11245

General Motors Trust Bank, N.A.
767 5th Avenue, 15th Floor
New York, NY 10153

General Motors Trust Company
767 5th Avenue, 15th Floor
New York, New York 10153

Some retirement benefits (Part B primary) are provided through the following insurance companies:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06115

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010-3690

Prudential Life Insurance Company
Prudential Plaza
Newark, New Jersey 07101

The Trustee of the Savings-Stock Purchase Program, who accumulates assets through which benefits are provided, is:

State Street Bank and Trust Company
Master Trust Division
One Lincoln Street
State Street Financial Center
Boston, Massachusetts 02111-2900

Consolidated Omnibus Budget Reconciliation Act (COBRA)

This notice applies to you if you are covered under the GM Salaried Health Care Program (the Program). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Program. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Program when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Program and under federal law, you can request a copy of the Plan Document from the Plan Administrator by calling the GM Benefits & Services Center at 1-800-489-4646.

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What is COBRA Continuation Coverage?

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

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Program because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Program because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Program because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Program as a "dependent child."

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Program is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the GM Benefits & Services Center, P.O. Box 770001, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Program. This extension may be available to the spouse and any dependent children

receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Program as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Program had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646.

If You Have Questions

Questions concerning your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Contact Information

You should contact the GM Benefits & Services Center, P.O. Box 770003, Cincinnati, OH 45277-0020 or call the Benefits & Services Center at 1-800-489-4646, Monday through Friday between 7:30 a.m. and 6:00 p.m. Eastern Time zone, to speak with a Customer Service Associate.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to improve the availability and portability of health care coverage for workers and their families when they change or lose jobs, and employers are required to provide a certificate of prior health care coverage when enrollees lose coverage.

In addition, HIPAA established federal requirements as to how the General Motors Health Care Programs and Health Care Spending Account, collectively referred to in this Notice as the "Plans," may use and disclose protected health information about you for purposes of payment of health care claims and health care operations.

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Portability

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to improve the availability and portability of health care coverage for workers and their families when they change or lose jobs, and employers are required to provide a certificate of prior health care coverage when enrollees lose coverage.

A certificate is to be provided to: (1) an individual who is entitled to elect COBRA continuation coverage when a notice is provided for a qualifying event under COBRA; (2) an individual who loses coverage but is not entitled to elect COBRA continuation coverage; and (3) an individual who has elected COBRA continuation coverage when COBRA continuation ceases. The certificate is also provided upon request of the enrollee within 24 months after coverage ceases.

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

Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the General Motors Health Care Programs and Health Care Spending Account, collectively referred to in this Notice as the "Plans," may use and disclose protected health information about you for purposes of payment of health care claims and health care operations. The Plans may also use and disclose protected health information for other purposes that are permitted or required by law as described below. Although HIPAA also allows the Plans to use and disclose protected health information for treatment purposes, the Plans generally do not engage in treatment.

Protected health information (or "PHI") is individually identifiable health information collected from you that is created or received by a health care provider, a health plan, or a health care clearinghouse, and that relates to (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you.

Access to PHI is restricted to persons who need it to carry out their job duties in administering the Plans. Use and disclosure is limited to the minimum necessary to accomplish the intended purpose.

This Notice applies to covered dependents as well as primary enrollees.

Our Responsibilities

In accordance with the law, the Plans are required to implement reasonable measures to preserve the privacy of your PHI and to provide notice to you regarding:

(1) Uses and disclosures of PHI;

(2) The Plans' obligations relating to the privacy of your PHI;

(3) Your health information rights concerning your PHI;

(4) Your right to file a complaint with either the Plans or the Secretary of the U.S. Department of Health and Human Services; and

(5) Contact information for use in obtaining additional information with respect to the Plans' policies and procedures for handling PHI. The Plans are required to abide by the terms of this Notice until a revised notice is issued in accordance with HIPAA.

Your Rights with Respect to PHI

You have the following individual rights with respect to your PHI:

(1) You have a right to access your PHI. You have a right to inspect and copy your PHI. Generally, the Plans' records containing your PHI are claims payment records and associated documents.

(2) If you believe that your PHI is incorrect or incomplete, you may request an amendment to the information. The Plans are not required to agree to the amendment, but if it is denied, you have a right to submit a statement of disagreement to be kept with the disputed record.

(3) You have the right to request restrictions on certain uses and disclosures of PHI. For example, you may request that the Plans refrain from disclosing your PHI to other persons, such as family members, even for permitted uses. Under certain circumstances, the Plans are not required to agree to a requested restriction.

(4) If you believe that a disclosure of your PHI may endanger you, you may request that the Plans communicate with you regarding your PHI in an alternative manner or at an alternative location.

(5) You have a right to an accounting of certain disclosures of your PHI if your PHI has been disclosed for reasons other than treatment, payment for health care, or health care operations.

(6) You have a right to a paper copy of this notice.

To exercise these rights you may write to the address listed in the Contact Information section of this notice. To request claim payment records containing your PHI, you may also contact the customer service department of your health care carrier directly. You may be asked to submit your request in writing.

How Your Protected Health Information May Be Used

Treatment: While the Plans generally do not engage in treatment, the Plans are permitted to use or disclose your PHI for that purpose.

Payment: The Plans may use and disclose your PHI to pay claims associated with treatment and services that you receive by virtue of your enrollment in the Plans. Such purposes include, but are not limited to, eligibility determinations, claims processing, precertification or pre-authorization, billing, coordination of benefits, and subrogation. For example, PHI may be used to pay a doctor's bill for covered services rendered by that doctor while treating you.

Health Care Operations: The Plans may use and disclose PHI about you for day-to-day plan operations. Such purposes include, but are not limited to, business management and administration, customer service, enrollment, audit functions, fraud and abuse detection, quality assurance, and disease management. For example, the Plans may use claims information to respond to claims appeals or audit the accuracy of claims processing. If you have a Health Care Spending Account, your PHI may be used to process reimbursements.

Business Associates: The Plans contract with Business Associates to provide certain types of administrative services. To perform these functions or to provide the services, the Business Associates may receive, create, maintain, use, or disclose PHI. For example, the Plans may disclose your PHI to a Business Associate to administer claims or to provide customer service. The Business Associates will be required to agree in writing to appropriately safeguard your PHI. Examples of our Business Associates are Blue Cross Blue Shield of Michigan, United HealthCare and Medco Health. In some cases, Business Associates may also contract with third parties to perform certain functions or to provide services.

Plan Sponsor: The Plans may disclose PHI to General Motors Corporation in its capacity as plan sponsor for purposes associated with sponsorship of the Plans. For example, the Plans may disclose PHI to General Motors Corporation in its capacity as plan sponsor for the purpose of considering plan enhancements. Generally, the information disclosed is summarized data and does not identify individuals personally.

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

federal law. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws. The Plans are required to disclose your PHI to the Secretary of the U. S. Department of Health and Human Services when the Secretary is investigating or determining the Plans' compliance with HIPAA.

Legal Proceedings: The Plan may disclose your PHI: (1) as required by law in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal; and (2) in response to a subpoena, discovery request, or other lawful process, under the conditions required by applicable law.

Workers' Compensation: The Plans may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries.

Other Permitted Uses and Disclosures: The law permits the Plans to make the following types of uses and disclosures under certain circumstances. While the Plans generally do not use or disclose PHI for these purposes, they may disclose PHI to: a health oversight agency (such as Medicare or Medicaid); for government functions (for reasons of national security); to avert serious health or safety threat; or for post-mortem identification.

Other Uses: Other uses and disclosures require your written authorization. For example, an authorization is required for any use or disclosure of psychotherapy notes, except in connection with a legal action or other proceeding brought by the Individual who is the subject of the notes. If you provide an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI requiring authorization.

Complaints and Inquiries

You may file a complaint with the Plans or the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plans, you may write to the address below. You will not be retaliated against for filing such a complaint.

Future Changes in the Notice

The Plans reserve the right to change their privacy practices and the terms of this Notice, making the new notice provisions effective for all PHI maintained by the Plans. The revised Notice will be provided by mail. In the future, you may have the option of receiving the Notice electronically.

Contact Information

For your convenience, this Notice is also available at: privacy.gm.com/gpc/index.shtml. identified as "HIPAA Privacy Notice." For assistance, or to obtain a copy of this notice, you may contact the GM Benefits & Services Center at gmbenefits.com, call 1-800-489-4646 or write to:

GM Health Care Privacy Office
Mail Code 483-520-092
2000 Centerpoint Parkway
Pontiac, MI 48341-3146.

Glossary of Key Terms

Sometimes, in order to accurately describe a benefit plan, it is necessary to utilize technical terms. To help you better understand them, the following are brief definitions of some of the most commonly used terms. They are not meant to be all-inclusive as each Plan or Program may have specific use which may vary.

Programs for GM salaried employees referenced here are:

- Savings-Stock Purchase Program (S-SPP),
- Salaried Retirement Program (SRP),
- Salaried Health Care Program (SHCP),
- Layoff Benefit Plan, and
- Life and Disability Benefits Program.

Account — Assets credited to the participant in the trust fund established under the S-SPP.

Actively at Work — You are considered actively at work whenever you are performing the regular duties of your assignment, as determined by the Corporation, on a scheduled work day at one of the Corporation's places of business or at any other location to which the Corporation's business may require you to travel. Assignment includes both your regular assignment as well as any given on a temporary basis. If you are on an approved vacation as determined by the Corporation, or excused with pay, you shall be considered "actively at work" while on such approved vacation. For purposes of initial eligibility for health care coverage, an employee on approved disability leave of absence will be deemed to be "actively at work."

Alternative Dental Plan (ADP) — A dental plan that provides services on pre-paid or fee-for-service basis to participants in a designated geographic area.

Ambulance Services — Medically necessary transportation and life support services furnished within the SHCP provisions to sick, injured, or incapacitated patients by a licensed ambulance provider meeting program standards, utilizing ambulance vehicles, and personnel recognized as qualified to perform such services at the time and place where rendered.

Annual Base Salary — For the purposes of determining the amounts of various coverages, annual base salary means: 12 times your monthly base salary including any premium for necessary continuous seven-day operations.

If you are eligible to participate in the election of coverage amounts under the Flexible Benefits Program, your annual base salary for life and disability benefit coverages shall be defined as your annual base salary as of September 1 of the year immediately preceding the Flex plan year.

Approved Facility or Treatment Program — a facility or a treatment program that has met criteria established by the carrier to provide certain services covered by the GM Health Care Program. The following are examples of facilities and treatment programs which must be approved by the applicable carrier for full benefits to be paid:

- hospitals
- skilled nursing facilities
- outpatient mental health facilities
- substance abuse treatment facilities
- outlets for prosthetic or orthotic appliances
- freestanding physical therapy facilities
- home health care programs

- hospice programs
- freestanding ambulatory surgical centers (FASCs)
- hemodialysis programs

In addition, certain services are not payable under the GM Health Care Program unless rendered by approved facilities or on approved equipment. Some services also must meet certain medical criteria. The following are examples of services which must be rendered by approved providers:

- magnetic resonance imaging (MRI)
- extracorporeal shock wave lithotripsy (ESWL)
- positron emission tomography (PET scans)

In addition, Computerized Axial Tomography (CAT) scan services must be rendered on approved equipment. If you have any doubts about the approved status of a facility or treatment program, you should contact the appropriate health care carrier.

Assets — Securities and cash in the participant's S-SPP account.

Beneficiary — The person, persons, or entity named by you, a plan participant, to receive the plan's benefits when you die — or if you die prior to receiving a benefit due you.

Benefit Period — A period of time during which an enrollee is entitled to receive certain covered services which are subject to Salaried Health Care Program maximums.

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

Capital Appreciation — Growth of a S-SPP participant's initial investment.

Carrier — Any entity by which the various benefit program coverages are administered or benefits paid. The term includes, but is not limited to, the following:

- General Motors Corporation;
- An insurance company; and/or
- Non-governmental administrative services organizations.

COBRA — **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985 — federal legislation providing continuation rights to certain employees or dependents whose coverage under company-sponsored programs is lost due to certain "qualifying events."

Conversion — An opportunity to obtain other available individual coverage on a self-paid basis, from the carrier with which the employee was enrolled at the time eligibility terminated.

Core Coverage — Hospital, surgical, medical, prescription drug, hearing aid, mental health, substance abuse, and Extended Care Coverages.

Covered Expenses — The reasonable and customary, preestablished, or contracted charges incurred for covered materials and services provided or rendered to or for an enrollee for treatment of illness or injury, and performed by a provider or prescribed by a physician in accordance with the provisions of the Salaried Health Care Program.

Covered Service — A service that is included within the range of services identified in the Program, and that meets all Salaried Health Care Program requirements to be eligible for payment of benefits. A service within the range of those identified in the Salaried Health Care Program (e.g., a diagnostic radiology service) but which does not meet all of the specifications to be eligible for benefit payment (e.g., medically necessary) is considered a non-covered service.

Credited Service — Includes all periods of regular employment for which you are paid. This period of time is used to determine eligibility for and amount of benefits under the Retirement Program. It also may be used for eligibility purposes by other Programs and/or Plans.

Current Market Value — The value of your assets invested in the S-SPP's Promark Funds, GM $1-2/3 Par Value Common Stock Fund, GM Class H Common Stock Fund, Delphi Common Stock Fund, EDS Common Stock Fund, and Raytheon Common Stock Fund, as may be applicable, based on the unit values as determined each business day by the Trustee. Also, the value of assets invested in the Fidelity and other mutual funds based on the share values as determined each business day by the mutual fund provider.

Custodial or Domiciliary Care or Services — The type of care or service which, even if ordered by a physician, is primarily for the purpose of meeting personal needs of the patient or maintaining a level of function (as opposed to specific medical, surgical, or psychiatric care, or services designed to reduce the disability to the extent necessary to enable the patient to live without such care or services).

Custodial or domiciliary care generally does not require the continuing attention of medically skilled personnel, and usually can be provided by aides or other persons without special skills or training, operating without direct medical supervision. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, toileting, meal preparation and eating, taking of medications, ostomy care, bed baths, hygiene or incontinence care, checking of routine vital signs, routine dressing changes, and routine skin care.

The determination as to the nature of the care is not a function of the setting (e.g., hospital, skilled nursing facility, nursing home, another institutional setting, or the patient's home) or of the professional status of the person (e.g., physician, nurse, therapist, or aide) rendering the service, but of the severity of the patient's illness and the intensity of services being performed. The carriers, or Utilization Review Organization, as appropriate shall have discretionary authority to interpret, apply, and construe this provision of the SHCP. The carrier's determination as to the nature of the care being provided shall be given full force and effect unless it is determined by the Plan Administrator that the determination was inconsistent with the Program provisions or arbitrary and capricious.

Deferred Vested Benefits — Vested benefits that become payable at a future date from the retirement program which vested employees or vested former employees are entitled to receive.

Deferred Savings — S-SPP contributions deducted from an employee's eligible salary before federal income taxes and other taxes (if applicable) are determined (i.e., pre-tax employee contributions).

Dividend — A payment by a corporation to its stockholders, usually representing a share in the company's earnings.

Durable Medical Equipment — Equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to an enrollee in the absence of illness or injury.

Eligible Salary — Regular monthly base salary payable under Corporation policy to employees during such period or periods as the employee is eligible to contribute to the salaried retirement program or accumulate savings in the S-SPP. The term excludes commissions, drawing accounts, bonuses, incentive payments, overtime, and night-shift premiums, seven-day operation premiums, or any other special payments, fees, awards, and allowance, and in no event may exceed $210,000 per year, as adjusted under the IRS Code. The term also excludes any amounts that are deducted from the base salary and paid for other than working (i.e., sickness and accident benefits while on leave).

Emergency Room Services — Services in the emergency room of a hospital are covered for the initial examination and treatment of conditions resulting from accidental injury or medical emergencies. A medical emergency is a permanent health-threatening or disabling condition, other than an accidental injury, which requires immediate medical attention. The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the patient's health, or place the patient's life in jeopardy. The patient's signs and symptoms verified by the treating physician at the time of treatment, and not the final diagnosis, must confirm the existence of a

threat to the patient's life or bodily functions. A medical emergency will be considered to exist only if medical treatment is secured within 72 hours of the onset of the condition.

If services are not in an emergency room and the carrier determines the condition is not the result of an accidental injury or was not a medical emergency, the facility charges are not covered even though the professional charges of the physician may be covered (i.e., the charges comparable to an office visit).

Covered facility services and expenses are reimbursed based on charges or consistent with "reasonable and customary" levels and/or the contractual arrangements that may exist between the carrier and the hospital. If Blue Cross and Blue Shield (or any other carrier that has participating agreements with hospitals) is your BMP, EMP, or PPO carrier, coverage for services obtained from other facilities may be reduced.

ERISA — The **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974, as it may be amended from time to time.

Exchange — An exchange is a transfer of S-SPP assets from one investment fund to another.

Extended Care Coverage (ECC) — Coverage for certain hospital, skilled nursing facility, or home health care and other services that last beyond the base plan coverage limits, or that are not covered under the base plan because they are generally custodial in nature.

Flexible Compensation Payment — An annual compensation payment, in an amount determined by and at the discretion of the Corporation, which salaried employees may elect to either receive as a cash lump-sum amount or deferral payment into their S-SPP account.

Freestanding Ambulatory Surgical Center — A facility, separate from a hospital, in which outpatient surgical services are provided. Such facilities must meet SHCP standards and be approved by the local carrier.

Freestanding Outpatient Physical Therapy Facility — A facility, separate from a hospital, that provides outpatient physical therapy services. Such facilities must meet SHCP standards and be approved by the local carrier.

GM Benefits & Services Center — A service center through which GM employees, retirees, and surviving spouses may obtain services regarding their benefits. The Center processes various benefit-related transactions, provides general benefit-related information, and assists with problem resolution. The Center also provides services regarding account information and transactions under the S-SPP Program, benefits under the Salaried Retirement Program, and benefits under Layoff Benefit Plan. The Center maintains an Internet website at gmbenefits.com.

gmbenefits.com — The GM Benefits & Services Center Internet website which provides information and online services regarding benefits for GM employees.

1% GM Benefit Contribution — The Corporation's contribution amount to an employee's S-SPP account equal to 1% of the employee's eligible salary. This Corporation contribution is provided to employees hired on or after January 1, 1993, upon (1) completing six months of service, and (2) becoming eligible to participate in the S-SPP.

Health Maintenance Organization (HMO) — An organization that provides health care services on a pre-paid basis for participants in a designated geographic area. Enrollees generally must use HMO physicians and facilities in order to receive benefits.

HIPAA — Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 — Federal legislation intended to improve the availability and portability of health care coverage, which requires employers to provide a certificate of prior health care coverage when an enrollee loses coverage.

Home Health Care (HHC) — Care or services provided in the home for a patient who is essentially homebound, but whose condition does not warrant care in an institutional setting (such as a hospital or skilled nursing facility). The care/service is generally skilled, part-time and intermittent in nature.

Hospice Program — Medical and non-medical services provided for terminally ill enrollees and their families through agencies which administer and coordinate the services. A hospice program must meet SHCP standards and be approved by the local carrier.

Intermittent Care — Part-time care which is provided on less than a daily basis or up to eight hours per day of skilled nursing and home health aide services combined, delivered on a daily basis, but for a temporary period not to exceed one month.

Length of Service (Service Date) — Represents your current continuous period of employment or adjusted service date as determined under salaried policy with General Motors. This service is used to determine participation in certain Programs or Plans.

Live Birth – A child born with spontaneous respiration or a heartbeat. Live birth does not include a stillbirth, miscarriage, spontaneous abortion or induced abortion.

Monthly Base Salary — For purposes of determining amounts of coverage, "monthly base salary" means your current regular rate of pay each month, including the premium for necessary seven-day operation, but without overtime, night-shift premium or any other payment.

If you are eligible to participate in the election of coverage amounts under the Flexible Benefits Program your annual base salary shall be defined under that Program.

Mutual Fund — An investment company whose business is to invest in the securities (stocks, bonds, and money market instruments) of other companies, banks, governments, or municipalities. All mutual funds have a stated investment goal. The investment company buys securities it believes will help to meet the defined investment objective.

Non-Core Coverages — Dental and vision coverages.

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

Out-of-Pocket Maximum — The most enrollees in a health care plan will pay in deductibles and most copayments for covered expenses during a calendar year.

Part A (Retirement Program) — The non-contributory part of the Retirement Program.

Part B (Retirement Program) — The part of the Retirement Program that offers additional monthly benefits and requires eligible employees to make contributions. General Motors also contributes to Part B of the Retirement Program.

Part B Credited Service — The period of time you contribute to Part B of the Retirement Program, providing contributions remain in the Program. This service is used in calculation of supplementary benefits available under Part B of the Retirement Program.

Participating or Approved Provider — Any hospital, skilled nursing facility, outpatient physical therapy facility, home health care agency, physician, dentist, or other provider of health care services which, at the time an enrollee receives services included under SHCP, meets Program standards and has entered into a contract or agreement with a carrier to provide those health care services in accordance with this Program. Such contract or agreement shall include a provision that the provider accepts the amount of covered expenses, as determined by the carrier, as payment in full (unless otherwise provided). Providers who are not participating providers may or may not participate for individual claims and accept the amount determined by the carrier as payment in full. Use of a non-participating hospital for non-emergency inpatient or outpatient treatment may result in the application

of benefit payment maximums which could leave an enrollee with responsibility for a substantial portion of the reimbursement required by the non-participating provider for such treatment.

Part-Time Care — Up to and including 28 hours per week of skilled nursing and home health aide services combined, for less than eight hours per day; or up to 35 hours per week for less than eight hours per day, subject to individual review and approval by the carrier.

Physical Therapy and/or Functional Occupational Therapy — Therapy directed toward improving or restoring the level of musculoskeletal function lost due to illness or injury, the development of new function attainable following surgery, or, if for a chronic or congenital condition, significantly improving the condition in a reasonable and predictable period of time. Physical therapy generally pertains to large muscle use and functional occupational therapy to fine motor activities.

Physician — A doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, physician shall also include the following categories of limited-practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services they are legally qualified to perform:

- "Dentist" means doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention, and treatment of disease of the teeth and related structures.
- "Podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the foot (including the ankle), may be covered under the surgical and medical coverages. A podiatrist also may prescribe medications that may be covered under the prescription drug coverage.
- "Chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxation or misalignments of the spinal column and related bones and tissues that produce nerve interference. Services of chiropractors that may be covered are limited to diagnostic radiological services and emergency first-aid (as set forth in an administration manual published by the Control Plan), both pertaining to the spine and related bones and tissues. Under the SHCP, a chiropractor may not prescribe medications or perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, nor perform physical examinations not related to the spine and related bones and tissues.

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

Portfolio — A collection of investment holdings either in a fund or one's personal account.

Predetermination — A review process performed by a carrier or Utilization Review Organization prior to treatment to determine if proposed treatments, services, or facilities may be appropriate.

Preferred Provider Organization (PPO) — An arrangement with selected doctors, hospitals and other providers within a geographic area to provide care on a fee-for-service basis. PPO enrollees must use PPO physicians and facilities in order to receive the maximum benefit under the plan.

Principal — The initial amount invested not including earnings.

Prime Rate — The interest rate banks charge to their most credit-worthy customers.

Private Duty Nursing — Care or services provided by a nurse pursuant to a contract with a patient and/or a patient's family/personal representative. The services may be skilled or unskilled, therapeutic or custodial in nature and may be provided in any setting. Generally, the care contracted for is in excess of the care provided by an institution (such as a hospital or skilled nursing facility) or the part-time/intermittent/skilled care provided by a home health care agency.

Prospectus — A thorough, written description of a new security issue, a savings plan, or mutual fund.

Prosthetic Appliance — An artificial device that replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part.

Reasonable and Customary Charge — As it relates to covered health care expenses, unless otherwise specified, means the actual amount a provider charges for such services rendered or materials furnished, but only to the extent that the amount is reasonable, as determined by the carrier, taking into consideration, among other factors, the following:

- The usual amount that the individual provider most frequently charges the majority of patients or customers for a similar service rendered or materials furnished;
- The prevailing range of charges made in the same geographic area by providers with similar training and experience for the service rendered or materials furnished; and
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with the particular service rendered or materials furnished.

The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider, service, or material. The carrier shall have discretionary authority to interpret, apply, and construe this provision of the SHCP. The determination by the carrier as to the reasonable and customary charge shall be final and conclusive, and shall be given full force and effect unless it is determined by the Program Administrator to have been contrary to the SHCP provisions or it is proven that the determination was arbitrary and capricious.

As used in the SHCP, reasonable and customary also refers to the forms and/or amount of payment used by carriers and preferred provider or similar organizations to reimburse participating or contracted providers for covered services.

Regular Savings — Contributions made by a participant to the S-SPP after federal income taxes and other taxes (if applicable) are deducted from an employee's eligible salary (i.e., after-tax employee contributions).

Required Retention Period — The calendar year period from January 1 through December 31 in which employee and Corporation contributions are made to the S-SPP. During this period, (1) one-half of an employee's contributions, up to 6% of eligible salary, must be invested in either one or both of the GM Common Stock Funds and (2) Corporation contributions must be invested in the GM $1-2/3 Par Value Common Stock Fund.

Return — Profit or loss made on an investment in the form of capital appreciation or depreciation, interest, dividends, or other income.

Rollover — A transfer of assets attributable to the taxable amount of an S-SPP or Part B Retirement Program distribution that would be taxable to the participant if not moved directly from one eligible retirement plan to another eligible retirement plan or to an Individual Retirement Account (IRA).

Same Sex Domestic Partner — To qualify for coverage as a same-sex domestic partner, you and your same-sex domestic partner must:

- Be the same sex;
- Have shared a continuous committed relationship for at least six months, intend to do so indefinitely and have no such same-sex domestic partner relationship with any other person;
- Reside in the same household;
- Share responsibility for each other's welfare and financial obligations;
- Not be related by blood to a degree of kinship that would prevent marriage from being recognized under law;
- Be over age 18, of legal age and legally competent to enter a contract;
- Reside in a state where marriage between two persons of the same sex is not recognized as valid under law; and
- Not be married to any other person.

In areas where marriage is legal for same-sex couples, marriage is required for eligibility. Similarly, if a state has some formal recognition of a same-sex domestic partner relationship (for example, the "Civil Union" in Vermont), recognition under such state law is required.

Secondary Plan — Refers to the health care plan that has the secondary obligation to pay benefits when more than one health care plan covers an individual.

Service Date (Length of Service) – Represents your current continuous period of employment or adjusted service date as determined under salaried policy with General Motors. This service is used to determine participation in certain Program or Plans.

Share — The measure of a participant's interest in a mutual fund.

Skilled Nursing Care — Care or services that are prescribed by a physician and furnished by a licensed registered nurse (RN) or licensed practical nurse (LPN). The services may be provided on a continuous (as in a hospital or skilled nursing facility) or on an intermittent/part-time basis. The patient must be under treatment and/or convalescing from an illness or injury that requires ongoing evaluation and adjustment of care. The nature of the service and skills required for safe and effective delivery, rather than the patient's medical condition, determines whether the service is skilled.

Skilled Nursing Facility (SNF) — A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a physician and a registered nurse. The facility may be operated either independently or as part of an accredited general hospital. A skilled nursing facility must meet SHCP standards and be approved by the local carrier.

Surviving Spouse Coverage — Where applicable, provides benefits for your eligible spouse in the event that you die before your spouse.

Therapeutic Care — Specific and definitive surgical, medical, psychiatric, or other care provided to a patient whose condition continues to improve due to the treatment being received. It is provided with the expectation that the patient's level of disability will be reduced, within a reasonably predictable period of time, to enable the patient to function without such care. The improvement must be observable and documented by objective measurement. If a patient's condition stabilizes and further improvement is not reasonably predictable, continuing care will be considered maintenance care in nature.

Total and Permanent Disability Retirement (T&PD) — Where based on medical evidence satisfactory to General Motors, the employee is found to be wholly and permanently prevented from engaging in regular employment at the location last employed. (This definition does not apply to Personal Accident Insurance.)

Total Control Account Program® — Provides a beneficiary with control of the proceeds from GM life insurances, including ready access to the money and earnings/interest on money remaining in their account.

Trustee — The entity responsible for holding the benefits or assets of a Program or Plan. GM's current Trustees are listed on page 152.

Unit — The measure of a participant's interests in the S-SPP's Promark Funds, GM $1-2/3 Par Value Common Stock Fund, GM Class H Common Stock Fund, Delphi Common Stock Fund, EDS Common Stock Fund, and Raytheon Common Stock Fund.

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

Work Life Plus — A resource which provides employees and dependents with trained counselors who assist in resolving personal problems through counseling and/or referral to community services. Education and consultation services are also provided to management to assist in helping troubled employees or resolving problematic situations.

Years of Participation — under the Life and Disability Benefits Program is defined as follows:

- **Prior to September 1, 1950,** years of participation, in general, equal your recognized length of service as of September 1, 1950.

- **From September 1, 1950 through December 31, 1973,** you receive credit while insured for life insurance, plus any period while (1) on military leave or (2) receiving your life insurance in installments because of total and permanent disability. If you are not insured for a period in excess of 24 consecutive months and your recognized length of service is broken, you lose credit for prior years of participation.

- If your credited service under the GM Retirement Program is greater than your years of participation, credited service may be used instead of years of participation.

- **On and After January 1, 1974,** for Life and Disability Benefits Program purposes, your credited service accrued on and after January 1, 1974, under the Retirement Program will be added to your years of participation under the Life and Disability Benefits Program (or credited service, if greater) as of December 31, 1973.