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Group Insurance Plan of Benefits for General Electric (Control #724874) Administered by Aetna International® Effective Date: January 1, 2016

PPO			
Eligibility Provision			
Employee	**Active employees** GE employee recognized and accepted by Global Mobility Services as working outside of your designated home country. Eligible employees are: • **U.S. expatriates** - United States employees recognized and accepted by GE as expatriates assigned to work outside of the U.S.; and • **Non-U.S. expatriates** - employees from any country recognized and accepted by GE as expatriates assigned to work outside of their designated home country.		
Dependent	Wife or husband or eligible same-sex domestic partner; children up to age 26; regardless of student status.		
PLAN FEATURES	**OUTSIDE THE U.S.**	**In the U.S.**	
		Preferred Benefits (In-Network)	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	None	None	None
Annual Individual and/or Family Out-of-Pocket Payment Limit *(includes covered medical, pharmacy, dental and vision expenses)*	$1,800 per calendar year	$1,800 per calendar year	$1,800 per calendar year
Lifetime Maximum *(includes covered medical, pharmacy, dental and vision expenses)*	Unlimited		
Plan Payment Percentages			
Hospital Services			
Inpatient	80%	80%	80%
Outpatient	80%	80%	80%
Private Room Limit	The institution's semiprivate rate (or a private suite, if a semiprivate suite is not available)		
Centers of Excellence Facilties for Knee and Hip Surgery	Not Covered	100%	100%
Physician Services			
Periodic physical and gynecological exams and routine health screenings — routine checkups, including preventive immunizations, gynecological exams and Pap smears; and health screenings, including mammograms, prostate screenings and colon screenings. • **Well-child care** — checkups, including preventive immunizations. • **Doctors' services** — when provided by a licensed physician. Services may be provided in a doctor's office, a hospital, your home or elsewhere.	100%	100%	100%

Note: This is not evidence of coverage. You must enroll and be accepted for coverage with the Coverage Administrator before these documents will be effective. In the case of a discrepancy between the Plan Documents and this document, the Plan Documents will determine the Plan of Benefits. As used herein, the term "Plan Documents" includes, but is not limited to, the Booklet, Summary of Coverage and any Booklet Amendments/Riders including any state-specific variations, as applicable. For further details, refer to your Plan Documents.

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PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Alcoholism, Drug Abuse and Mental Health Disorders			
Inpatient Coverage *(Unlimited days per calendar year)*	80%	80%	80%
Outpatient Coverage *(Unlimited visits per calendar year)*	80%	80%	80%
Convalescent Facility *(120 days per calendar year)*	80%	80%	80%
Hospice Care Facility	80%	80%	80%
Home Health Care	80%	80%	80%
Nurses' Services	80%	80%	80%
Hearing Aids including exams, fitting, repairs, and adjustments. Hearing aids must be Medically Necessary and Cost Effective. Two (one per ear) every three years.	80%	80%	80%
Chiropractic Services	80%	80%	80%
Diagnostic Outpatient X-ray and Lab	80%	80%	80%
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply)*	80%	80% (includes Mail Order Drugs)	80%
Brand Name Drugs *(365 day maximum supply)*	80%	80% (includes Mail Order Drugs)	80%
Vision Care			
Exams Includes covered eye exams one per calendar year for Employees and Dependents regardless of age.	100%	100%	100%
Hardware/Supplies Includes one pair of glasses every other calendar year for Employees and Dependents age 19 and older, one pair of glasses every calendar year for dependents under age 19. Alternatively, covered participants may choose to receive up to a three month supply of disposable contact lenses each calendar year, regardless of age.	80%	80%	80%

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Dental Care	
GE Global Health Plan pays 80% of covered preventive care and necessary dental services. You pay the remaining 20% until you reach your annual out-of-pocket maximum. Then, the plan pays 100% for the rest of the calendar year.	
Calendar Year Maximum	There is a $2,500 limit on restorative and prosthodontic care per calendar year/per person. There is also a $2,500 lifetime maximum limit on orthodontia for each children under age 19. ***The services for preventative services are not included in the $2,500 limit.***
Covered services include: • **Preventive and diagnostic care** - *including routine exams, x-rays, cleanings, scaling and polishing; two checkups each calendar year.* • **Fillings** • **Crowns** • **Dentures** • **Bridgework** • **Root canal therapy** • **Gum treatment** • **Oral surgery** - *including extractions.* • **X-rays and medically necessary general anesthesia.** • **Treatment of accidental injury to healthy teeth or gums occurring while you're covered under the plan.** • **Orthodontics for dependent children up to age 19** - *including diagnosis and development of a treatment plan, braces, exams, appliances and appliance adjustments.*	80% *NOTE: Some limitations apply. Consult with plan administrator before commencing treatment.*
The following dental services are not covered under the GE Global Health Plan: • **Anesthesia or drugs, unless medically necessary** • **Adult orthodontics, unless due to accidental injury.** • **Myofunctional therapy** • **Plaque control programs** • **Broken appointments** • **Completion and filing of claim forms**	
Services and Programs	
Informed Health Line (24-hour nurse line) **International Employee Assistance Program** **On-Line Global Health and Travel Information through HTH Worldwide *(http//www.aetnainternational.com)***	

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Payment limits apply to subscribers and/or eligible dependents per individual on a calendar year basis for a maximum annual out-of-pocket maximum of $1,800. Dental benefits have a limits of $ 2,500/calendar year for restorative and prosthodontic care per calendar year. There is also a $ 2,500 lifetime maximum limit on orthodontia for children under age 19.The services for preventative services are not included in the $ 2,500 limit. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit.

Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and eligible female family members.

This is only a brief summary of the Medical, Dental and Vision benefits available. Some restrictions may apply.