

**2022 Legal Notices Inside**

**Baker Hughes**  TM

# 2022 Legal Notices

Included in this booklet are the following documents:

## Health & Welfare Benefits

- Medicaid and Children's Health Insurance Program Employer Notice
- Notice of Privacy Practices
- Notice of Special Enrollment Rights
- Coverage for Maternity Hospital Stay
- The Women's Health and Cancer Rights Act
- Summary of Benefits and Coverage - Standard Plan
- Summary of Benefits and Coverage - Standard Out-of-Area Plan
- Summary of Benefits and Coverage - Premium HSA Plan
- Summary of Benefits and Coverage - Premium HSA Out-of-Area Plan
- Summary of Benefits and Coverage - Basic HSA Plan
- Summary of Benefits and Coverage - Basic HSA Out-of-Area Plan



## Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –**

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
ALASKA Medicaid	COLORADO Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a>	Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	FLORIDA Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Website: <a href="https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html">https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html</a> Phone: 1-877-357-3268

<p align="center"><b>GEORGIA Medicaid</b></p> <p>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162 ext 2131</p>	<p align="center"><b>MASSACHUSETTS Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a>  Phone: 1-800-862-4840</p>
<p align="center"><b>INDIANA Medicaid</b></p> <p>Healthy Indiana Plan for low-income adults 19-64  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>  Phone: 1-877-438-4479  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  Phone 1-800-457-4584</p>	<p align="center"><b>MINNESOTA Medicaid</b></p> <p>Website:  <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>  Phone: 1-800-657-3739</p>
<p align="center"><b>IOWA Medicaid and CHIP (Hawki)</b></p> <p>Medicaid Website:  <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>  Hawki Phone: 1-800-257-8563  HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-auto-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-auto-z/hipp</a>  HIPP Phone: 1-888-346-9562</p>	<p align="center"><b>MISSOURI Medicaid</b></p> <p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>
<p align="center"><b>KANSAS Medicaid</b></p> <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884</p>	<p align="center"><b>MONTANA Medicaid</b></p> <p>Website:  <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084</p>
<p align="center"><b>KENTUCKY Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a></p> <p>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>  Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p align="center"><b>NEBRASKA Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178</p>
<p align="center"><b>LOUISIANA Medicaid</b></p> <p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center"><b>NEVADA Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>
<p align="center"><b>MAINE Medicaid</b></p> <p>Enrollment Website:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-442-6003  TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: -800-977-6740.  TTY: Maine relay 711</p>	<p align="center"><b>NEW HAMPSHIRE Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/oi/hipp.htm">https://www.dhhs.nh.gov/oi/hipp.htm</a>  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

<p align="center"><b>NEW JERSEY Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>	<p align="center"><b>SOUTH DAKOTA Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
<p align="center"><b>NEW YORK Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>	<p align="center"><b>TEXAS Medicaid</b></p> <p>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a>  Phone: 1-800-440-0493</p>
<p align="center"><b>NORTH CAROLINA Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>	<p align="center"><b>UTAH Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a>  CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a>  Phone: 1-877-543-7669</p>
<p align="center"><b>NORTH DAKOTA Medicaid</b></p> <p>Website:  <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-844-854-4825</p>	<p align="center"><b>VERMONT Medicaid</b></p> <p>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</p>
<p align="center"><b>OKLAHOMA Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>VIRGINIA Medicaid and CHIP</b></p> <p>Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a>  <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a>  Medicaid Phone: 1-800-432-5924  CHIP Phone: 1-800-432-5924</p>
<p align="center"><b>OREGON Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a>  Phone: 1-800-699-9075</p>	<p align="center"><b>WASHINGTON Medicaid</b></p> <p>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>  Phone: 1-800-562-3022</p>
<p align="center"><b>PENNSYLVANIA Medicaid</b></p> <p>Website:  <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HI_PP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HI_PP-Program.aspx</a>  Phone: 1-800-692-7462</p>	<p align="center"><b>WEST VIRGINIA Medicaid</b></p> <p>Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a>  Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center"><b>RHODE ISLAND Medicaid and CHIP</b></p> <p>Website: <a href="http://www.cohhs.ri.gov/">http://www.cohhs.ri.gov/</a>  Phone: 1-855-697-4347, or 401-462-0311  (Direct RIte Share Line)</p>	<p align="center"><b>WISCONSIN Medicaid and CHIP</b></p> <p>Website:  <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>  Phone: 1-800-362-3002</p>
<p align="center"><b>SOUTH CAROLINA Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p align="center"><b>WYOMING Medicaid</b></p> <p>Website:  <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>  Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

## Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

## **NOTICE OF PRIVACY PRACTICES BAKER HUGHES**

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

Baker Hughes is committed to protecting the privacy and security of all private health information created or received in relation to our employees and their families under our group health plans. This Notice covers the privacy practices of the following self-funded group health programs sponsored by Baker Hughes:

- The Baker Hughes Medical Plan;
- The Baker Hughes Medical Plan for Expatriates;
- The Baker Hughes Prescription Drug Plan;
- The Baker Hughes Dental Plan;
- The Baker Hughes Dental Plan for Expatriates; and
- The Baker Hughes Health Care Flexible Spending Account Plan.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by the group health programs listed above (the "Plans") to carry out treatment, payment and health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

*If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: The Corporate Health and Welfare Benefits Department of Baker Hughes, 12645 W Airport Blvd, Sugar Land, Texas, 77478, 1-866-244-3539 or 1-847-883-0945 (worldwide).*

### **EFFECTIVE DATE**

This Notice of Privacy Practices is revised from time to time. The effective date of this most current notice is September 1, 2018. This revised notice supersedes all previous notices.

### **OUR RESPONSIBILITIES**

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must take steps to protect the privacy of your "protected health information." Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group 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. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will mail a revised Notice to your address that we have on record or provide you with a copy of the revised Notice at a designated location at your workplace or we may provide you with information about the change to the Notice with instructions for accessing the revised Notice.

## **Primary Uses and Disclosures of Protected Health Information**

The following is a description of how we are most likely to use and/or disclose your PHI.

- ***Treatment, Payment and Health Care Operations***

We have the right to use and disclose your PHI for all activities that are included within the definitions of "treatment," "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule).

- **Treatment**

We may use or disclose your PHI for purposes of providing, coordinating, or managing health care and its related services by one or more of your providers. For example, we may use information about your claims to refer you to a disease management program. We may also provide you with information about alternative medical treatments and programs or about health-related products and services that may be of interest to you, such as smoking cessation programs or weight-loss programs.

- **Payment**

We may use or disclose your PHI to pay claims for services provided to you or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may use or disclose your PHI to determine whether reimbursement is appropriate under the Plans.

- **Health Care Operations**

We may use or disclose your PHI to support our business and administrative functions. These functions include, but are not limited to: quality assessment and improvement, business planning, and business development. For example, we may use or disclose your PHI: (1) to respond to an inquiry from you; or (2) in connection with fraud and abuse detection and compliance programs.

- ***Business Associates***

We may contract with individuals and entities (called Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management or subrogation functions. An example of a Business Associate would be a third party administrator, who handles many plan administrative functions.

- ***Other Covered Entities***

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and *improvement* activities, or accreditation, certification, licensing or credentialing.

- ***Plan Sponsor***

PHI may be disclosed to the plan sponsor of the Plans, Baker Hughes for purposes of plan administration or pursuant to an authorization request signed by you. The Plans may share enrollment information with the plan sponsor without your authorization.

- ***Security Breaches***

We may use or disclose your PHI when determining whether a security breach has occurred for purposes of the HIPAA Breach Notification Rules as set forth in 45 C.F.R. § 164, subpart D. We may also use or disclose your PHI in responding to a breach, as required under the HIPAA Breach Notification Rules. For example, if an individual hacks into our computer network, we would investigate the incident to determine the extent of the breach and if PHI had been accessed, used or disclosed in violation of the HIPAA Privacy Rule. If a breach for purposes of HIPAA has occurred, you have a legal right to be notified of the breach. Therefore, we would notify you of any HIPAA breach affecting your PHI. We are also required to notify the U.S. Department of Health and Human Services and the media (in some cases) of the breach but your PHI will not be disclosed when such entities are notified of the breach.

- **Genetic Information**

The Plans will not use or disclose PHI that is genetic information for underwriting purposes, as required by the Genetic Information Nondiscrimination Act of 2008.

### **Potential Impact of State Law**

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a more stringent privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

### **Other Possible Uses and Disclosures of Protected Health Information**

The following is a description of other possible ways in which we may, and are permitted to, use and/or disclose your PHI.

- **Required by Law**

We may use or disclose your PHI to the extent that other laws require the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- **Public Health Activities**

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Health Oversight Activities**

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.

- **Abuse or Neglect**

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose your PHI to a governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect, or domestic violence.

- **Legal Proceedings**

We may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a court order for such information, but limited to the minimum amount of PHI necessary to comply with the terms of the order.

- **Law Enforcement**

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (3) it is necessary to provide evidence of a crime that occurred on our premises.

- **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**  
We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- **Research**  
We may disclose your PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.
- **To Prevent a Serious Threat to Health or Safety**  
Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Military Activity and National Security, Protective Services**  
Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
- **Workers' Compensation**  
We may disclose your PHI to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- **Others Involved in Your Health Care**  
Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents, guardians, and other personal representatives if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to disclosures of your PHI to a family member or close friend, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

#### **Required Disclosures of Your Protected Health Information**

The following is a description of disclosures that we are required by law to make.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services**  
We 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 our compliance with the HIPAA Privacy Rule.
- **Disclosures to You**  
We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law.

*Even if you designate a personal representative*, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

### **Other Uses and Disclosures of Your Protected Health Information**

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

The HIPAA Privacy Rule requires an authorization for most uses and disclosures relating to (i) psychotherapy notes, (ii) marketing activities and (iii) the sale of PHI. In accordance with the HIPAA Privacy Rule requirements, we will not use or disclose your PHI for these purposes without obtaining your specific authorization.

### **Your Rights With Respect to Your PHI**

**Confidential Communication by Alternative Means:** If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

**Request Restriction on Certain Uses and Disclosures:** You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

**Right to Be Notified of a Breach:** You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

**Electronic Health Records:** You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

**Paper Copy of This Notice:** You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

**Right to Access Your PHI:** You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request. However, if you, or a third party requests a copy of your PHI, the fee limitations set out in the rules will apply only to your individual request for access to your own records but these fee limitations will not apply to an individual's request to transmit records to a third party.

**Right to Amend:** You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

**Accounting:** You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**Personal Representatives:** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

## **COMPLAINTS**

You may file a complaint in writing to us if you believe that we have violated your privacy rights. You may file a complaint with us by contacting:

The HIPAA Privacy Officer/Executive Counsel - Labor & Employment  
Baker Hughes  
17021 Aldine Westfield  
Houston, Texas 77073

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. Complaints to the Secretary of Health and Human Services should be filed in writing to:

U.S. Department of Health and Human Services  
Office for Civil Rights  
1301 Young Street, Suite 1169  
Dallas, Texas 75202  
214-767-4056

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

## **Special Enrollment Rights**

When certain events occur, as described in more detail below, you may have a special right to enroll yourself and/or your eligible dependents in the group health plans described in this SPD at a time other than an Annual Enrollment period. If you have any questions about special enrollment rights or would like to request special enrollment in one of the plans, you should contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

### **Special Enrollment Due to Loss of Other Medical Coverage**

If you or your eligible dependents have other group health plan coverage in place when you are initially eligible to enroll in the group health plans described in this SPD, you may decide not to enroll yourself or your eligible dependents in the Baker Hughes plan at that time. If you or your eligible dependents later lose that other coverage, you or your eligible dependents may become eligible for a special enrollment right.

If your other coverage was group health plan continuation coverage mandated by COBRA, you will become eligible for special enrollment when your COBRA rights are exhausted. However, you will not become eligible if you lose COBRA coverage without exhausting your rights (for example, if you stop paying premiums). If your other group health plan coverage was non-COBRA coverage, you will become eligible for special enrollment if an employer that had been contributing to the cost of coverage stopped making those contributions or if your coverage terminated when you ceased to be eligible (for example, through legal separation, divorce or loss of dependent status). However, you must request special enrollment within 30 days after you or your qualifying dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

### **Special Enrollment Due to Acquisition of a Dependent**

If you are enrolled in one of the group health plans described in this SPD and during the year you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, your dependent will be eligible for special enrollment in the plan.

If you are not enrolled, but you are eligible for coverage under the group health plans described in this SPD, and during the year you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you and your eligible dependents will be eligible for special enrollment in the plans. In such instances, you can enroll without enrolling your dependents, or you and some or all of your qualifying dependents can enroll. However, your dependents may not enroll in the plan unless you also enroll (or are already enrolled) in the plan.

You must request special enrollment within 30 days after the applicable marriage, birth, adoption or placement for adoption. Enrollments following a marriage, birth, adoption or placement for adoption will be effective as of the date of the marriage, birth, adoption or placement for adoption.

## Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a 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 from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical plan and the option offered under the Medical plan are in compliance with this law. Under the Act, the Medical plan and the Claim Administrators that offer mastectomy coverage under the options offered under the plan must for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provision consistent with those established for other benefits under the applicable option offered under the Medical plan that describes the benefits under such plan.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Standard Plan, deductible of \$750 individual/\$1,500 family with 20% coinsurance; Premium HSA, deductible of \$1,500 individual/\$3,000 family with 20% coinsurance; Basic HSA, deductible of \$3,250 individual/\$6,500 family with 20% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator 1-866-743-6549.



## Standard Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall deductible?</b></p>	<p>Network*: \$750 Individual / \$1,500 Family                      Non-Network*: \$750 Individual / \$1,500 Family                      Per calendar year. *Deductibles cross-apply</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p><b>Are there services covered before you meet your deductible?</b></p>	<p>Yes. Preventive Care and primary care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p><b>Are there other deductibles for specific services?</b></p>	<p>No, there are no other deductibles.</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p><b>What is the out-of-pocket limit for this plan?</b></p>	<p>For network provider: \$4,000 Individual / \$8,000 Family                      For out-of-network providers: \$0 Individual / \$0 Family per calendar year</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p><b>What is not included in the out-of-pocket limit?</b></p>	<p>Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></p>	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	Out-of- <u>network</u> may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 25% <u>coinsurance deductible</u> does not apply Mail Order: 25% <u>coinsurance deductible</u> does not apply	Retail: 25% <u>coinsurance deductible</u> does not apply	Retail: \$30 min/\$60 max. Mail: \$75 min/\$150 max. Out-of- <u>network</u> may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Retail: 30% <u>coinsurance deductible</u> does not apply	Retail: \$60 min/\$100 max. Mail: \$150 min/\$250 max. Out-of- <u>network</u> may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Retail: 30% <u>coinsurance deductible</u> does not apply	30% (30 day supply only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$100 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> . If admitted pre-authorization required within 2 days out-of- <u>network</u> or \$300 penalty.
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain outpatient services or \$300 penalty. Pre-authorization is also required out-of- <u>network</u> for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Routine prenatal care is covered at no charge. Pre-Authorization required out-of- <u>network</u> for stay over 48/96 hours c-section or \$300 penalty.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits per calendar year combined in/out-of- <u>network</u> . Pre-authorization required out-of- <u>network</u> for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40 visits each per calendar year combined in/out-of- <u>network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year combined in/out-of- <u>network</u> . Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 out-of- <u>network</u> or \$300 penalty.
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**If your child needs dental or eye care**

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Child vision glasses</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul>

- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

**Does this [plan](#) meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüjigo holne' 1-866-743-6549.

\_\_\_\_\_ *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Specialist office visits (pre-natal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,920</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

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You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

**XIN LUU Ý:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of ( ) التغطية (Arabic), فإن كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزاي والتغطية (Arabic) هنا. (Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。

本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。





## Standard Plan Out-of-Area



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network*: \$750 Individual / \$1,500 Family Non-Network*: \$750 Individual / \$1,500 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive Care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>What is the out-of-pocket limit for this plan?</b>	For network provider*: \$4,000 Individual / \$8,000 Family For out-of-network providers*: \$4,000 Individual / \$8,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	Pre-authorization required in/out-of- <u>network</u> or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></p>	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	Out-of-Network may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 25% <u>coinsurance deductible</u> does not apply Mail Order: 25% <u>coinsurance deductible</u> does not apply	Retail: 25% <u>coinsurance deductible</u> does not apply	Retail: \$30min/\$60max. Mail: \$75min/\$150max. Out-of-Network may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Retail: 30% <u>coinsurance deductible</u> does not apply	Retail: \$60min/\$100max. Mail: \$150min/\$250max. Out-of-Network may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance deductible</u> does not apply Mail Order: 30% <u>coinsurance deductible</u> does not apply	Retail: 30% <u>coinsurance deductible</u> does not apply	30% (30 day supply only.)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of-network for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If admitted pre-authorization required within 2 days in/out-of-network or \$300 penalty.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of-network or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> for certain outpatient services or \$300 penalty. Pre-authorization is also required in/out-of- <u>network</u> for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation and ongoing therapeutic treatments. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> or \$300 penalty.
	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Routine prenatal care is covered at no charge. Pre-authorization required for stay over 48/96 hours c-section or \$300 penalty.
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	90 visits per calendar year combined in/out-of- <u>network</u> . Pre-authorization required in/out-of- <u>network</u> for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40 visits each per calendar year combined in/ <u>out-of-network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/ <u>out-of-network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year combined in/ <u>out-of-network</u> . Pre-authorization required in/ <u>out-of-network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 in/ <u>out-of-network</u> or \$300 penalty.
	<u>Hospice services</u>	No charge	No charge	Pre-authorization required in/ <u>out-of-network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Child vision glasses</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Private-duty nursing</li> </ul>

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol minisingo, kwijigo holne' 1-866-743-6549.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Specialist office visits (pre-natal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (ultrasounds and blood work)  
Specialist visit (anesthesia)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,920</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (including disease education)  
Diagnostic tests (blood work)  
Prescription drugs  
Durable medical equipment (glucose meter)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$750
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

**This EXAMPLE event includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$960</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

**請注意：**如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免費電話號碼。

**XIN LUU Ý:** Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of ( ) التغطية والتغطية ( )  
Summary of ( ) الخدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المدرج بداخل مخلص المزاي والتغطية ( )  
هذا. (Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sevis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Reziime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。  
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー  
ダイヤルにてお電話ください。

Summary of ) پوشش و مزایا و فوائد در این خلاصه مزیایا و پوشش ( Summary of ) اگر زیان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش ( Summary of ) تماس بگیرید. SBC

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm T'sab Ntawv Nthuav Qhia Cov T'xiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកម្រៃថ្លៃ ដែលមានកំរិតខ្ពស់ សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i. T'áá shqóódi Naaltsoos Bee 'Aa'ahayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'í biká'ígíí bee hodiilinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



## Premium HSA Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<p><u>Network</u>*: \$1,500 Individual / \$3,000 Family  <u>Non-Network</u>*: \$1,500 Individual / \$3,000 Family per calendar year. *<u>Deductibles</u> cross-apply</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<b>Are there services covered before you meet your deductible?</b>	<p>Yes. <u>Preventive Care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<b>Are there other deductibles for specific services?</b>	<p>No, there are no other <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>
<b>What is the out-of-pocket limit for this plan?</b>	<p>For <u>network provider</u>: \$5,000 Individual / \$10,000 Family                      For <u>out-of-network providers</u>: \$0 Individual / \$0 Family per calendar year</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<b>What is not included in the out-of-pocket limit?</b>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></p>	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$100 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> . If admitted pre-authorization required within 2 days out-of- <u>network</u> or \$300 penalty.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for certain outpatient services or \$300 penalty. Pre-authorization is also required out-of-network for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in-network <u>plan deductible</u> is satisfied. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Routine prenatal care is covered at no charge. Pre-Authorization required out-of-network for stay over 48/96 hours section or \$300 penalty.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits per calendar year combined in/out-of-network. Pre-authorization required out-of-network for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40 visits each per calendar year combined in/out-of- <u>network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year combined in/out-of- <u>network</u> . Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 out-of- <u>network</u> or \$300 penalty.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**If your child needs dental or eye care**

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul>

- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

**Does this [plan](#) meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüjigo holne' 1-866-743-6549.

\_\_\_\_\_ *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,770</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,810</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đãi thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of ( ) التغطية والتغطية ( )  
Summary of ( ) الخدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج بداخل ملخص المزاي والتغطية ( )  
هذا. (Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Reziime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。  
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー  
ダイヤルにてお電話ください。

Summary of ) پوشش و مزایا و فوائد در این خلاصه مزایا و پوشش (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Farsi) تماس بگیرید. SBC

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm T'sab Ntawv Nthuav Qhia Cov T'xiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: ស៊ីស៊ីអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកម្រៃថ្លៃ ដែលមានកំរិតខ្ពស់ សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាប់ដង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i. T'áá shqódi Naaltsoos Bee 'Aa'ahayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'í biká'ígíí bee hodiilinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



## Premium HSA Out-of-Area Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><u>Network</u>*: \$1,500 Individual / \$3,000 Family  <u>Non-Network</u>*: \$1,500 Individual / \$3,000 Family per calendar year. *<u>Deductibles</u> cross-apply</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<p><b>Are there services covered before you meet your <u>deductible</u>?</b></p>	<p>Yes. <u>Preventive Care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No, there are no other <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>

Important Questions	Answers	Why This Matters:
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p>For <u>network provider</u>*: \$5,000 Individual / \$10,000 Family            For out-of-<u>network providers</u>*: \$5,000 Individual / \$10,000 Family per calendar year            *Out-of-pockets cross-apply</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u>.</p>
<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	Virtual visit - In network 0% co-ins after deductible by a Designated Virtual Network Provider. No virtual visit coverage for out of network. If you receive services in addition to office visit, additional deductibles, or co-ins may apply.
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	Pre-authorization required in/out-of-network or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a>	Generic Drugs (Tier 1)	Retail: \$10 copay Mail Order: \$25 copay	Retail: \$10 copay	Copay applies after deductible. Out-of-Network may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% coinsurance Mail Order: 30% coinsurance	Retail: 30% coinsurance	Coinsurance applies after deductible. Out-of-Network may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% coinsurance Mail Order: 30% coinsurance	Retail: 30% coinsurance	Coinsurance applies after deductible. Out-of-Network may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% coinsurance Mail Order: 30% coinsurance	Retail: 30% coinsurance	Coinsurance applies after deductible. 30 day supply only.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of-network for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If admitted pre-authorization required within 2 days in/out-of-network or \$300 penalty.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of-network or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> for certain outpatient services or \$300 penalty. Pre-authorization is also required in/out-of- <u>network</u> for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in <u>Network plan deductible</u> is satisfied. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Routine prenatal care is covered at no charge. Pre-Authorization required for stay over 48/96 hours c-section or \$300 penalty.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	90 visits per calendar year combined in/out-of- <u>network</u> . Pre-authorization required in/out-of- <u>network</u> for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40 visits each per calendar year combined in/ <u>out-of-network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/ <u>out-of-network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year combined in/ <u>out-of-network</u> . Pre-authorization required in/ <u>out-of-network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 in/ <u>out-of-network</u> or \$300 penalty.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/ <u>out-of-network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does <b>NOT</b> Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Child vision glasses</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Private-duty nursing</li> </ul>

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol minisingo, kwijigo holne' 1-866-743-6549.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,770</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services**

**like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,810</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免費電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of ( ) التغطية و التغطية )  
Summary of ( ) التغطية و التغطية )  
فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المدرج بداخل ملخص المزاي و التغطية ) هذا. (Benefits and Coverage, SBC

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Reziime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。  
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー  
ダイヤルにてお電話ください。

Summary of) پوشش و مزایا و خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش ( Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm T'sab Ntawv Nthuav Qhia Cov T'xiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកម្រៃថ្លៃ ដែលមានកម្រៃនៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាបង់រង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i'. T'áá shqóódi Naaltsoos Bee 'Aa'ahayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béésh bee hane'í biká'ígíí bee hodiilinih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



## Basic HSA Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$3,250 Individual / \$6,500 Family <u>Non-Network</u> *: \$3,250 Individual / \$6,500 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$6,500 Individual / \$13,000 Family For <u>out-of-network providers</u> : \$0 Individual / \$0 Family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></p>	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$100 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> . If admitted pre-authorization required within 2 days out-of- <u>network</u> or \$300 penalty.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain outpatient services or \$300 penalty. Pre-authorization is also required out-of- <u>network</u> for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in- <u>Network plan deductible</u> is satisfied. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.  Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	20% <u>coinsurance</u> 20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u> 40% <u>coinsurance</u>	
If you are pregnant				Routine prenatal care is covered at no charge. Pre-authorization required out-of- <u>network</u> for stay over 48/96 hours section or \$300 penalty.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	90 visits per calendar year combined in/out-of- <u>network</u> . Pre-authorization required out-of- <u>network</u> for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40 visits each per calendar year combined in/out-of- <u>network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year combined in/out-of- <u>network</u> . Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 out-of- <u>network</u> or \$300 penalty.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**If your child needs dental or eye care**

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Child vision glasses</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul>

- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

**Does this [plan](#) meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüjigo holne' 1-866-743-6549.

\_\_\_\_\_ *To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,220</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,970</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,570</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

Summary of ( ) التغطية (Arabic), فإن كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزاي والتغطية (Arabic) هنا. (Benefits and Coverage, SBC)

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。

本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリーダイヤルにてお電話ください。

Summary of ) پوشش و مزایا و خلاصه مزایا و این شده در این زبان نکر شده در این خلاصه مزایا و پوشش ( Summary of )  
توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش ( Summary of ) تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយកាសខ្មែរ (Khmer) សេវាជំនួយកាសដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការិយប័ណ្ណ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqoqí Naaltsoos Bee 'Aa'ahayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíik'ehgo béesh bee hane'í biká'ígíí bee hodílinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).



## Basic HSA Out-of-Area Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<p><u>Network</u>*: \$3,250 Individual / \$6,500 Family  <u>Non-Network</u>*: \$3,250 Individual / \$6,500 Family per calendar year. *<u>Deductibles</u> cross-apply</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p>
<b>Are there services covered before you meet your deductible?</b>	<p>Yes. <u>Preventive Care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></p>
<b>Are there other deductibles for specific services?</b>	<p>No, there are no other <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.</p>
<b>What is the out-of-pocket limit for this plan?</b>	<p>For <u>network provider</u>*: \$6,500 Individual / \$13,000 Family                      For out-of-<u>network providers</u>*: \$6,500 Individual / \$13,000 Family per calendar year                      *Out-of-pockets cross-apply</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<b>What is not included in the out-of-pocket limit?</b>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider in the plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></p>	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If admitted pre-authorization required within 2 days in/out-of- <u>network</u> or \$300 penalty.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Urgent care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/out-of- <u>network</u> for certain outpatient services or \$300 penalty. Pre-authorization is also required in/out-of- <u>network</u> for benefits provided for Applied Behavioral Analysis (ABA) or \$300 penalty. The Employee Assistance Program offers up to 5 visits at no cost. Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for initial consultation; ongoing therapeutic treatments are payable at 100% after in <u>Network plan deductible</u> is satisfied. AbleTo is a contracted <u>provider</u> for Optum Behavioral services specifically for Cognitive Behavioral Therapy.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Routine prenatal care is covered at no charge. Pre-Authorization required for stay over 48/96 hours c-section or \$300 penalty.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	90 visits per calendar year combined in/out-of- <u>network</u> . Pre-authorization required in/out-of- <u>network</u> for <u>Home Health care</u> for certain services (skilled nursing by RN or LPN) and Private Duty Nursing or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40 visits each per calendar year combined in/ <u>out-of-network</u> Physical, Occupational and Speech Therapy. Visit Limit does not apply to autism spectrum disorders.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/ <u>out-of-network</u> for certain services or \$300 penalty.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year combined in/ <u>out-of-network</u> . Pre-authorization required in/ <u>out-of-network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1000 in/ <u>out-of-network</u> or \$300 penalty.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required in/ <u>out-of-network</u> for inpatient hospice or \$300 penalty.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)	
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Child dental check-up</li> <li>Child routine vision exam (i.e. refraction)</li> </ul>	<ul style="list-style-type: none"> <li>Child vision glasses</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Private-duty nursing</li> </ul>

<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-866-743-6549 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-743-6549.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-743-6549.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-743-6549.

Navajo (Dine): Dinek'ehgo shika at'ohwol minisingo, kwijigo holne' 1-866-743-6549.

\_\_\_\_\_To see examples of how this plan might cover costs for a sample medical situation, see the next section.

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,220</b>

**Managing Joe's type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,970</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,570</b>

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** [UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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**ATENCIÓN:** Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打本福利和承保摘要 (Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어 (**Korean**) 를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서 (Summary of Benefits and Coverage, SBC) 에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

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Summary of ( ) التغطية و التغطية )  
فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال برقم الهاتف المدرج بداخل ملخص المزاي و التغطية ) هذا. (Benefits and Coverage, SBC

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Reziime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項： **日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。  
本「保障および給付の概要」 (Summary of Benefits and Coverage, SBC) に記載されているフリー  
ダイヤルにてお電話ください。

Summary of ) پوشش و مزایا و فوائد در این خلاصه مزایا و پوشش (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Farsi) تماس بگیرید. SBC

ध्यान दें: यदि आप हिंदी (Hindi) बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm T'sab Ntawv Nthuav Qhia Cov T'xiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខកម្រៃថ្លៃ ដែលមានកំរិតខ្ពស់ សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការ៉ាប់ដង (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍI BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jík'eh, bee ná'ahóót'i. T'áá shqódi Naaltsoos Bee 'Aa'ahayání dóo Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jík'ehgo béesh bee hane'í biká'ígíí bee hodiilinih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

## **Questions About Your 2022 Benefits?**

Baker Hughes benefits representatives are available at 1-866-244-3539. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST. 401(k) representatives are available Monday - Friday 7:00 a.m. to 9:00 p.m. and Saturdays 8:00 a.m. to 4:30 p.m. CST.