Baker Hughes Retiree Medical

2026 Summary Plan Description

Baker Hughes

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This Summary Plan Description describes the medical and prescription drug benefits provided by Baker Hughes and its participating affiliates under the Baker Hughes Retiree Health & Welfare Benefits Plans (collectively, the plan or the Baker Hughes plan) as of January 1, 2026. The plan is a benefit program offered under the Baker Hughes Retiree Welfare Benefits Plan (the Welfare Benefits Plan).

Please note that retirees of Baker Hughes and its affiliates that have adopted the Welfare Benefits Plan who are eligible for retiree medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606) or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and Prior To January 1, 1990 (Division 607) are not eligible for the benefits described in this SPD (contact Baker Hughes North America Total Rewards for the summary plan descriptions covering the benefits under those programs).

Please note that the information presented in this SPD is only a summary. It replaces all previously published Summary Plan Descriptions for the plan. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern the plan are contained in the plan documents. If, in our efforts to make the plan easy to understand, any of the plan's provisions have been omitted or misstated, the official plan documents for the plan must remain the final authority. The legal documents also govern the administration of the plan and payment of benefits. In the case of any dispute, the information in the plan documents will prevail. To request a copy of the plan documents, write to:

Baker Hughes
Attn: North America Total Rewards
575 N. Dairy Ashford Rd.
Suite 100
Houston, Texas 77079-1117

The information contained in this document is intended to meet the Federal disclosure requirements for Summary Plan Descriptions of employee benefit plans. Baker Hughes intends to continue the plan and the Welfare Benefits Plan indefinitely. However, Baker Hughes reserves the right to amend, cancel, change the carrier for, or discontinue all or any part of the plan and/or the Welfare Benefits Plan at any time.

Este documento contiene un resumen en inglés de los planes de beneficios de salud y bienestar de Baker Hughes. Si tuviera alguna dificultad para entender alguna parte de este documento, por favor comuníquese con el **Baker Hughes Benefits Center** en **1-866-244-3539** en los Estados Unidos o **1-847-883-0945** (resto del mundo) entre 7 a.m. y 7 p.m. tiempo central, de lunes a viernes.

This document contains a summary in English of the Baker Hughes Retiree Health & Welfare Benefits Plans. If you have difficulty understanding any part of this document, contact the Baker Hughes Benefits Center at **1-866-244-3539** or **1-847-883-0945** (worldwide) between 7 a.m. and 7 p.m. (Central Time), Monday through Friday.

About Your Baker Hughes Summary Plan Description

This document, called a Summary Plan Description (SPD), provides information about certain retiree medical benefits offered by the Company effective January 1, 2026. It describes important features of each benefit program, services that are covered, and how your benefits are paid. To help you find information quickly, this SPD is divided into five main sections:

- General Information — details about eligibility, enrollment procedures, and when coverage starts and ends for the plan
- Retiree Medical — information about your Medical and Prescription Drug coverage options, as well as continuation of coverage under the Baker Hughes active employee Dental and Vision plans, and the Baker Hughes Health Care Flexible Spending Account Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Benefits Rights — information about your rights under the law
- Important Plan Information — reference details, such as plan number and administrator
- Glossary of Terms — definition of terms found throughout these sections

It's important for you to understand your benefit choices and how these benefits can work for you. We've taken care to explain the plan as clearly as possible and have included definitions, examples, reminders, tips, and tools to highlight key information. Please keep this SPD for your future reference.

Benefits Resources At-A-Glance

	Vendor	Plan	Phone	Website
Retiree Medical	**Baker Hughes Benefits Center**	• Eligibility • Enrollment • COBRA Administrator	**1-866-244-3539** (toll-free) **1-847-883-0945** (worldwide)	**bakerhughes.ehr.com**
	UnitedHealthcare (UHC)	• Basic Choice Plus • Catastrophic Choice Plus	**1-866-743-6549** (toll-free) **1-866-802-8572** (worldwide)	**myuhc.com**
	Via Benefits	• Supplemental Medicare coverage	**1-855-663-4227**	**my.viabenefits.com/bakerhughes**
	CVS/caremark	• Prescription Drug • Specialty Pharmacy	**1-877-252-3485**	**caremark.com**

General Information

The following section describes general information about coverage including:

- Eligibility
- How to Enroll
- Identification Cards
- Making Changes After Enrollment
- Cost of Benefits

Baker Hughes

Am I Eligible?

Retiree Eligibility

You must be at least age 60 with at least 10 years of consecutive service on the date of your retirement plus be enrolled in a Baker Hughes active medical plan to participate in the Baker Hughes Retiree Medical plan.

Employees who are inpatriates to the US or Non-US Assignees/Rotators are not eligible for benefits under the plan. Retirees of the Company who are eligible for retiree medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606), or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and prior to January 1, 1990 (Division 607), are not eligible for benefits under the plan.

If you are enrolled in a Baker Hughes active employee group health plan providing Dental or Vision coverage, or if you participate in the Baker Hughes Health Care Flexible Spending Account Plan at the time of your retirement from the Company, you may be eligible to continue that coverage under COBRA. Refer to the *COBRA* section in the Baker Hughes Health & Welfare 2026 Summary Plan Description for active employees for additional information.

Retiree Dependent Eligibility

If you're an eligible retiree as described above, you may cover your eligible dependents under the plan.

The eligible dependents you may cover are:

- Your spouse of the opposite or same gender, including common law in states recognizing common law marriage, or a legally separated spouse in states recognizing legal separation;
- Your dependent children up to age 26, regardless of whether they are married, full-time students, or eligible for other group health plan coverage; or
- Your unmarried dependent children up to any age who are supported by you because of mental or physical disability; the disability must have occurred during the period in which they were an eligible dependent enrolled under the plan or under a Baker Hughes active employee medical plan.

The retiree must reimburse the plan for any benefits that the plan pays for a spouse or dependent at a time when the spouse or child did not satisfy these conditions.

Eligible Dependents Do Not Include

- Those who are in full-time military service
- Parents, siblings, grandparents, nephews, nieces, etc.
- Domestic partners

Definition – *Children* include:

- Your biological children
- Your adopted children and children placed for adoption
- Your stepchildren
- Any children for whom you have legal custody
- Foster children in your care
- A child for whom you are required to provide coverage under a qualified medical child support order (QMCSO)

Call the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) with questions about eligibility for coverage.

Special Note on Dependent Children

Please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) if there are any changes to your dependents' status.

Please note that you have 31 days after the birth of a newborn to enroll him or her in an option under the plan. The newborn will be automatically covered for four days after birth under the mother's health insurance coverage under the plan (if she has coverage). If you wish coverage to be continuous, you must enroll the newborn within four days of birth. If you enroll the newborn after four days but before 31 days, coverage will be retroactive to the date of birth, but this also means you may have to pay out-of-pocket for any medical expenses incurred during the time the coverage for the newborn is not effective.

If You Retire but Your Spouse Continues to Work at Baker Hughes

In general, every eligible retiree and eligible employee may enroll eligible dependents in Company-provided medical plan and prescription drug program coverage. However, if you retire but your spouse continues to work at Baker Hughes, you may either:

- Choose to enroll yourself in plan coverage as a retiree, while your spouse enrolls in You Only active employee coverage; or
- Choose to enroll yourself as a dependent of your spouse under the active employee coverage. However, if you decline retiree coverage when you first become eligible, you will not be able to elect retiree coverage at a later date (for example, if your spouse leaves Baker Hughes). If you choose to decline coverage, you must actively make this election.

Eligible children may be enrolled as dependents of either you or your spouse, but not both.

How Do I Enroll?

New Retirees

If you're a new retiree, you may enroll in the plan and choose Baker Hughes retiree medical and prescription drug coverage offered under the plan (Retiree Medical coverage) within 31 days of your date of retirement. The information you'll need to enroll can be found in your **Retiree Benefits Guide** for new retirees and employees considering retirement.

To request a copy, contact the **Baker Hughes Benefits Center** at **1-866-244-3539** or **1-847-883-0945** (worldwide). You may also access the Retiree Benefits Guide online at **BakerHughesBenefits.com**.

If you do not enroll in the plan within 31 days from the date of your retirement, you will not have coverage. If you do not elect Retiree Medical coverage when you first become eligible, you will not be able to elect Retiree Medical coverage (for you or your qualifying dependents) at a later date.

If you elect coverage, you will only be able to make changes to these elections during the Annual Enrollment period typically held in October or November of each year or if you have a qualified change in status, such as marriage or divorce. For more information, refer to the *Can I Make Changes After I Enroll* section. If you have a change in status, you will need to make any election changes within 31 days of the date the status change occurred.

Note: If you elect No Coverage, you will not be able to enroll in any Retiree Medical coverage offered under the plan in the future and you will forfeit any funding subsidy balance, if applicable.

Annual Enrollment

Annual Enrollment occurs each year, typically during October or November. This is the time when you may review your current coverage and think about what you'll need in the coming year.

If you do not make any changes during Annual Enrollment and you remain eligible for Retiree Medical coverage under the plan for the following year, you will receive the Retiree Medical coverage you had the previous year.

Two Ways to Enroll in Your Retiree Benefits

Online	By phone — Baker Hughes Benefits Center representative
bakerhughes.ehr.com Access is available 24 hours a day, Monday through Saturday, and after 12 p.m. Central Time on Sundays	**1-866-244-3539** (within the US) **1-847-883-0945** (worldwide) Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time.

If you cannot remember your User ID or Password and cannot answer the security questions online, call the **Baker Hughes Benefits Center**. If you need assistance enrolling online, a Representative can walk you through the process while you're logged in.

Dental, Vision, and Health Care Flexible Spending Account Enrollment

If you were enrolled in a Baker Hughes active employee Dental or Vision plan, or the Baker Hughes Health Care Flexible Spending Account at the time you retired, you and your covered dependents may be eligible to continue your coverage through COBRA. To enroll in COBRA coverage, contact the **Baker Hughes Benefits Center** by the enrollment deadline listed on your COBRA enrollment worksheet. Once enrolled, you have 45 days to make your first premium payment. Refer to the *COBRA* section in the Baker Hughes Health & Welfare 2026 Summary Plan Description for active employees for additional information.

Identification Cards

Once you enroll in the plan, your medical and/or prescription drug administrator will send your identification card(s) to your address on file at the **Baker Hughes Benefits Center**. Your ID card shows the plan name, your coverage, and other information to help your physician, pharmacist, or health care provider verify your eligibility or submit your claim. If you don't receive a card, find errors on the card, or would like additional cards, contact the provider (refer to the *Benefits Resources At-A-Glance* section in this SPD for contact information).

Can I Make Changes After I Enroll?

The choices you make during the Annual Enrollment period or at retirement stay in effect for the entire plan year (January 1 through December 31) or that portion of the plan year after you first enroll in the plan. However, during the year you may change your elections if you have a qualified change in status. Such changes are comparable to those defined by the Internal Revenue Service (IRS) for purposes of section 125 of the Internal Revenue Code and include changes such as marriage, divorce, or adoption of a child. Under the plan, any election changes must be consistent with the status change.

The limited benefit changes that are permitted must be made within **31 days** of the qualifying change in status or the coverage you had before the change will remain in effect for the remainder of the calendar year.

Remember...

You must keep the Baker Hughes Benefits Center informed of your current mailing address, email address, and phone number, otherwise you may not get important information about your benefits.

Qualified Changes in Status Include:

- If you marry
- If you divorce
- If you have a birth, adoption, or placement for adoption or court-ordered guardianship
- If you or your dependent gains or loses Medicare coverage
- If you or your dependent loses eligibility or becomes eligible for assistance under Medicaid or a State child health plan*

*The approved changes must be made within 60 days of the date eligibility is lost or within 60 days from the date the retiree or dependent is determined to be eligible for assistance under Medicaid or a state child health plan.

How Do I Make Approved Changes After I Enroll?

The approved changes must be made within the timeframe specified above. To make the approved changes, go to **bakerhughes.ehr.com** or contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide), Monday through Friday, 7 a.m. to 7 p.m. (Central Time).

Who Pays the Cost of My Coverage?

You are responsible for paying the full cost of your Retiree Medical coverage option and prescription drug program. If you have a funding subsidy, once your funding subsidy is depleted, you will be required to pay 100% of the premiums to continue your Retiree Medical coverage option and prescription drug program. **The funding subsidy is associated with a particular retiree. If you drop coverage through the Baker Hughes Benefits Center or Via Benefits, or die, the funding subsidy is forfeited.**

When Does My Coverage Begin?

New Retiree Effective Date

You have 31 days from your retirement date to complete the Retiree Medical benefits enrollment process.

Once enrolled, your Retiree Medical coverage is effective as of your first date of retirement for you and any enrolled dependents. If you do not actively enroll within 31 days of becoming eligible, you will not have coverage.

Remember...
If you elect new coverage during Annual Enrollment, your new coverage will take effect January 1 of the following year.

Current Retiree Effective Date

If you're an existing retiree, any change in your coverage that you elect during Annual Enrollment will generally take effect the following January 1. If you have a qualified change in status and make a timely benefit coverage change during a calendar year, your change in your coverage will generally become effective as of the date of your status change. In other words, if the change is due to marriage, divorce, etc., the change will take effect retroactively to the date of the marriage or divorce as long as the change is made within the required timeframe, as detailed in *Can I Make Changes After I Enroll*.

Dependent Effective Date

If you enroll family members in the plan, their coverage will start on the later of the following dates:

- Date your coverage becomes effective; or
- Date you enroll your dependent(s) for coverage; if enrollment is due to a qualified status change, coverage will start as of the effective date of the status change (e.g., the date of birth).

When Does My Coverage End?

If coverage ends for any reason other than death (for example, you obtain insurance from another source), coverage for you and/or your dependent(s) will end on the day:

- You stop paying premiums to the plan or are late in paying your premiums
- You're no longer eligible (refer to the *Am I Eligible* section)
- Your dependent(s) is no longer eligible (refer to the *Am I Eligible* section)
- Baker Hughes changes or terminates the plan

Tip!

To receive benefit-related information it is important you maintain a current address on file at the **Baker Hughes Benefits Center**. Refer to the Benefits Information section for more details.

Benefit coverage for your eligible dependent ends either on the day that he or she no longer qualifies as dependents or on the day that your coverage ends for one of the reasons above, whichever comes first. If you drop coverage at any time or do not pay the required premiums, you will not be allowed to re-enter the plan in the future.

In certain situations, your qualifying dependent(s) may be able to continue group health plan coverage under the plan through COBRA. Refer to the *COBRA* section for additional information.

If You Die

If you die while receiving Retiree Medical coverage under the Baker Hughes plan, and have coverage other than *You Only*, your eligible dependent(s) may be eligible to elect to continue their coverage through COBRA for up to 36 months. If they enroll in COBRA, the first three months of COBRA coverage will cost nothing ($0) only if the beneficiary had coverage in place at time of your death. For the remaining months, the cost will be equal to 100% of the applicable COBRA premium, plus an administrative fee.

The funding subsidy (if applicable) will be forfeited and cannot be used toward your dependents' COBRA coverage. Cost sharing under the Rule of 65 provision will no longer apply and dependent(s) will be required to pay 100% of the applicable COBRA premiums plus an administrative fee (after the first three months).

COBRA coverage will end if your covered dependent(s):

- Becomes covered under another group health plan or Medicare
- Is no longer eligible
- Stops paying premiums to the plan or is late in paying these premiums
- COBRA coverage expires

Retiree Medical

The Baker Hughes Retiree Medical coverage offered under the plan is designed to help you manage your medical and prescription drug needs, whether you have a specific health concern or primarily use preventive health care services. The choices for Retiree Medical coverage under the plan depend on your age and the age of your eligible dependent(s).

Medical Benefits	If you're under age 65	If you're age 65 or older	If your dependent(s) are under 65	If your dependent(s) are age 65 or older
UnitedHealthcare (UHC) Basic Choice Plus	✓	Via Benefits	✓	Via Benefits
UnitedHealthcare (UHC) Catastrophic Choice Plus	✓	Via Benefits	✓	Via Benefits

Pre-65 Retiree Medical Coverage Options

If you and your dependent(s) are under 65 years of age, your choices for Retiree Medical coverage under the plan are one of the following options (each a Retiree Medical coverage option):

Retiree Medical Coverage Options	UHC Provider Network
• **UHC Basic Choice Plus** • **UHC Catastrophic Choice Plus**	UHC Choice Plus Network
• **UHC Basic Out-of-Area PPO*** • **UHC Catastrophic Out-of-Area PPO***	UHC Options PPO Network

**If your home zip code is out of the UHC Choice Plus Network service area, you and/or your dependent(s) will be offered the out-of-area Retiree Medical coverage options.*

If you are under 65 years of age, enroll in the plan and choose one of the Retiree Medical coverage, you automatically receive prescription drug and medical coverage options. See the *Prescription Drug Program* section for details.

The choices for Retiree Medical coverage depend on your age and the age of your dependents. If your age is different from your dependent, you and your dependent may be offered different medical coverage options.

If you participate in the Basic or Catastrophic option, you may use health care providers in the UHC Choice Plus network, plus any out-of-network provider. These are the key features:

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for specialist visit
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services are covered at 80% in-network or 60% out-of-network after the deductible is met. Out-of-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see the *Glossary of Terms*.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible network expenses

The Basic or Catastrophic Out-of-Area option use the UHC Options PPO Network. If you are eligible for an Out-of-Area plan, that means there are too few UHC providers, facilities, and/or hospitals in your area. As a result, you can use any provider for your health care. The UHC Options PPO pays 80% for eligible health care expenses after the deductible. Services are subject to the Claims Administrator's eligible expenses determination. For non-network services, you are required to submit a claim form for reimbursement. Please note that when you search for providers, you will need to access UHC's Options PPO network.

To find out if you reside within the UHC Choice Plus network service area, go to **bakerhughes.ehr.com** or call a **Baker Hughes Benefits Center** Representative.

Understanding UHC Networks

If you use a network provider, the amount you pay will be lower because UHC has negotiated lower fees with their network providers.

With the plan's medical coverage options, you make an appointment when you need care without the need for a referral. The plan provides both network and non-network coverage; however, you will obtain a greater cost savings by utilizing a network provider. It is your responsibility to verify the network status of the provider with UHC each time you seek care. Many providers will accept UHC administered coverage and file claims on your behalf, but not all providers are contracted with UHC. Out-of-network services are subject to eligible expense cost limits and you are required to submit a claim for for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, see the *Glossary of Terms*.

If you don't use a health care provider in the network, your reimbursement for non-network services is based on eligible expenses costs. If your expenses exceed these charges, you will pay any amount over the eligible expense costs.

What Happens if My Local Physicians Are Not in the UHC Network?

If you do not have a physician or health care provider near where you live, you may:

- Drive to a physician or health care provider in the Choice Plus network to receive network coverage; or
- Talk to your physician about joining the UHC Choice Plus network.

What if I Need a Specialist Who isn't in the UHC Choice Plus Network?

If you are enrolled in a UHC Choice Network option (UHC Basic Choice Plus or UHC Catastrophic Choice Plus) and need highly specialized care but that specialty is not represented in your network area (within 30 miles from your home), you may request authorization to receive benefits at the network level. To request authorization before your appointment, contact UHC Care Coordination at **1-866-743-6549**.

How Do I Know if My Physician is a Regular Physician or Specialist?

Regular physicians include general practitioners, family practitioners, internists, and pediatricians. They are primarily responsible for your health care and preventive exams. When necessary, they will also work with you to select a specialist, however, a referral to see a specialist is not required. A specialist is a physician that has further education in a particular field of medicine. Examples of specialists include neurologists, cardiologists, orthopedists, oncologists, obstetricians, and gynecologists.

Tip! Use network providers when possible. You generally have lower out-of-pocket cost for most services when you go to a network provider. If you do not use a health care provider in the network, your reimbursement for non-network services is based on Eligible Expense costs. If your expenses exceed these charges, you pay any amount over the Eligible Expense costs.

How the Plan Works

Network benefits apply to covered health services that are provided by a network physician or other network provider. You are not required to select a primary physician in order to obtain network benefits. In general health care terminology, a primary physician may also be referred to as a *Primary Care physician* or *PCP*.

Non-network benefits apply to covered health services that are provided by a non-network physician or other non-network provider, or covered health services that are provided at a non-network facility. In general health care terminology, non-network benefits may also be referred to as non-network benefits.

Emergency health services provided by a non-network provider will be reimbursed as set forth under *Eligible Expenses*.

Covered health services provided at certain network facilities by a non-network physician, when not emergency health services, will be reimbursed as set forth under *eligible expenses* as described at the end of this section. For these covered health services, "certain network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the secretary.

Air ambulance transport provided by a non-network provider will be reimbursed as set forth under *Eligible Expenses.*

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a network. At your request, UnitedHealthcare will send you a directory of network providers free of charge. Keep in mind, a provider's network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **myuhc.com**.

Network providers are independent practitioners and are not employees of the employer or UnitedHealthcare.

UnitedHealthcare credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Before obtaining services, you should always verify the network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **myuhc.com** or by calling the telephone number on your ID card to request a copy. If you receive a covered health service from a non-network provider and were informed incorrectly prior to receipt of the covered health service that the provider was a network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based, or internet-based means), you may be eligible for network benefits.

It is possible that you might not be able to obtain services from a particular network provider. The network of providers is subject to change. Or you might find that a particular network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another network provider to get network benefits. However, if you are currently receiving treatment for covered health services from a provider whose network status changes from network to non-network during such treatment due to expiration or nonrenewal of the provider’s contract, you may be eligible to request continued care from your current provider at the network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing a non-network physician or health care facility, you may be eligible to receive transition of care benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care benefits, please contact UnitedHealthcare at the telephone number on your ID card.

Do not assume that a network provider's agreement includes all covered health services. Some network providers contract with UnitedHealthcare to provide only certain covered health services, but not all covered health services. Some network providers choose to be a network provider for only some of UnitedHealthcare's products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Eligible Expenses

Baker Hughes has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits.

- For designated network benefits and network benefits for covered health services provided by a network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.
- For non-network benefits, except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for eligible expenses.
- For non-emergency covered health services received at certain network facilities from non-network physicians when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the secretary (including non-ancillary services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the eligible expense is based on one of the following in the order listed below as applicable:
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the secretary.

IMPORTANT NOTICE: For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible which is based on the recognized amount as defined in the SPD.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

For non-network benefits, except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for eligible expenses. For covered health services that are ancillary services received at certain network facilities on a non-emergency basis from non-network physicians, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your copayment, coinsurance, or deductible which is based on the recognized amount as defined in this SPD.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible expenses are based on the following:

- When covered health services are received from a designated network and network provider, eligible expenses are our contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as arranged by UnitedHealthcare, eligible expenses are negotiated by UnitedHealthcare or an amount permitted by law.
- When covered health services are received from a non-network provider as arranged by the Claims Administrator, eligible expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When covered health services are received from a non-network provider as described below, eligible expenses are determined as follows:

- For non-emergency covered health services received at certain network facilities from non-network physicians when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR).*

  For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

  IMPORTANT NOTICE: For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible which is based on the recognized amount as defined in the SPD.
- For emergency health services provided by a non-network provider, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  IMPORTANT NOTICE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible which is based on the recognized amount as defined in the SPD.

- **For air ambulance transportation provided by a non-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-network provider may not bill you, for amounts in excess of your copayment, coinsurance, or deductible which is based on the rates that would apply if the service was provided by a network provider which is based on the recognized amount as defined in the SPD.
- When covered health services are received from a non-network provider, except as described above, eligible expenses are determined, based on one of the following:
  - Negotiated rates agreed to by the non-network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates, or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - For covered health services provided by a facility or certain ancillary providers, eligible expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-network provider's reimbursement by utilizing, when available:
      - *CMS* data for hospitals and other facilities and providers to identify the cost structure for those providers and services in a similar category to determine the national median rate which is adjusted to take into account factors that include, but are not limited to, margin markup, geographical area, and the place of service. UnitedHealthcare may modify the reimbursement methodology to maintain the reasonableness of the Eligible.
    - For covered health services provided by a professional or certain ancillary providers, eligible expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-network provider's reimbursement by utilizing:
      - The vendor's database of recently-available national private professional and ancillary provider claims data. The national median rate is determined for procedure codes on the non-network provider's claim, which is adjusted to take into account factors that include, but are not limited to, general provider expenses, the geographic area, the place of service, and the relative amount of time, level of skill and intensity of the covered health services performed. UnitedHealthcare may modify the reimbursement methodology to maintain the reasonableness of the eligible expense.

  IMPORTANT NOTICE: Non-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here. This includes non-ancillary services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Service Act*.

Advocacy Services

This Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expense and how UnitedHealthcare determined these amounts. Please call UnitedHealthcare at the number on your ID card to access these advocacy services if you are billed for amounts in excess of your applicable coinsurance or copayment. In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and UnitedHealthcare, or its designee, believes that it would serve the best interests of the Plan and its participants (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare, or its designee, may use its sole discretion to increase the eligible expense for that particular claim.

- The amount that is applied to the annual deductible is calculated on the basis of the eligible expenses or the recognized amount when applicable.
- The out-of-pocket maximum does not include charges that exceed eligible expenses, when applicable.
- Coinsurance includes the charge stated as the percentage of the recognized amount when applicable.
- When a copayment applies, the covered person is responsible for paying the lesser of the copayment, or the eligible expense or the recognized amount when applicable.
- When a per occurrence deductible applies, the covered person is responsible for paying the lesser of the per occurrence deductible, or the eligible expense or the recognized amount when applicable.

Additional Resources

UHC Customer Service: 1-866-743-6549

Via Internet: myuhc.com

When you enroll in either the Basic or Catastrophic medical plans or their respective Out-of-Area plans, you'll be able to register at myuhc.com. This is a self-service health and well-being web-site. It is secure and easy to use.

Through myuhc.com, you will be able to:

- Make real-time inquiries into the status and history of your health claims
- Order new or replacement ID cards for the entire family or print a temporary ID card
- Search for doctors available in your plan through the online directory
- View, modify, or print your Personal Health Record
- Access health and well-being information
- View your eligibility information

The Pre-65 Retiree Medical Options differ by:

- The amount of annual deductible
- The amount of annual out-of-pocket maximum
- The premium you pay to cover the cost of the option

Plan Features

When you obtain medical care, you and the plan share in the cost of covered services. This means that you'll pay a deductible and coinsurance, depending on the type of service you receive and if you use a provider in the Retiree Medical plan network.

Coinsurance

Coinsurance is the percentage of the cost of a covered health care service you pay after you've met your deductible.

Deductible

A deductible is the amount you pay each year before the plan begins to share in the cost of covered services.

The **individual** deductible applies separately to you and each of your covered family members. When one person meets his or her individual deductible in a plan year, the plan begins to share in the cost of covered services for that person for the remainder of the plan year.

The **family** deductible can be satisfied by two or more covered family members, even if each covered family member does not satisfy the individual deductible amount. Once you reach your family deductible, the plan shares in the cost of covered services for all enrolled family members for the remainder of the plan year.

The deductible does not apply toward the out-of-pocket maximum.

Out-of-pocket maximum

The out-of-pocket maximum limits the total amount of network coinsurance you pay. Non-network expenses, deductibles, non-covered expenses, and amounts above eligible expenses do not apply to the out-of-pocket maximum. If you are enrolled in the UHC Basic Out-of-Area PPO or UHC Catastrophic Out-of-Area PPO options, your eligible in-network and non-network coinsurance applies.

The **individual** out-of-pocket maximum applies separately to you and each of your covered family members. When one person meets his or her individual annual out-of-pocket maximum in a plan year, the plan pays 100% of eligible in-network expenses for that individual for the remainder of the plan year.

The **family** out-of-pocket maximum can be satisfied by two or more covered family members, even if each does not satisfy the individual out-of-pocket maximum. Once you reach your family out-of-pocket maximum, the plan pays 100% of eligible in-network expenses for all enrolled family members for the remainder of the plan year. However, no one individual can contribute more than the single out-of-pocket maximum amount to the family out-of-pocket maximum.

The **Pre-65 Retiree Medical Schedule of Benefits** in this SPD lists your coinsurance, deductible, and out-of-pocket maximum amounts under each plan.

*The deductible, out-of-network expenses, non-covered expenses, and amounts you pay for eligible expenses do not apply to the out-of-pocket maximum. Your eligible in-network and out-of-network coinsurance do apply.

Annual Maximums

An annual maximum is the most the plan pays in benefits per person per year, depending on the type of treatment or service. Annual maximum benefits are:

Service	Limitation
Acupuncture	20 visits per calendar year
Chiropractic, Speech, Physical, or Occupational Therapy	40 visits per calendar year
Home Health Care	90 visits per calendar year
Nutrition	10 visits annually (non-preventive)
Skilled Nursing or Extended Care Facilities	60-day limit per calendar year

***Note:** All maximums are combined whether Network, Non-network, or Out-of-Area.

Important Notice: Non-network providers may bill you for any difference between the provider's billed charges and the eligible expense described in this SPD.

Pre-65 Retiree Medical Option Schedule of Benefits

The following tables provide a summary of your benefits. Depending on where you live, you will be eligible for either the Basic Choice Plus or Catastrophic Choice Plus coverage **OR** Out-of-Area coverage. Check your enrollment worksheet to confirm the option(s) for which you are eligible.

Important

For information on covered expenses, refer to the *Covered Expenses* and *Exclusions and Limitations* sections. Also, to confirm that the services you plan to receive are covered, request a predetermination from UHC Care Coordination.

When you see your primary care physician or a specialist, and when you go to urgent care, you pay coinsurance (a percentage of the total cost of the visit) rather than paying a copay (a one-time flat fee each time you have a visit). You could pay more out-of-pocket depending on how often you have visits. Rather than paying for your visit at the time you see your doctor or go to urgent care, you may receive a bill in the mail with the cost of your visit. You can view your bill on **myuhc.com**.

Here is what you pay:

- Primary Care Office Visit: 80% after deductible is met
- Specialist Visit: 80% after deductible is met
- Urgent Care Visit: 80% after deductible is met

After you meet your deductible, the plan will pay 80% of the cost of the visit and you will pay the remaining 20% of the cost. There is no copay: you pay the full cost of these visits until you meet your deductible ($750 Individual/$1,500 family or $3,000 individual/$6,000 family, depending on the plan you elect).

UHC Basic Choice Plus

Plan feature	Network	Non-network[1]
Deductible	$750 Individual/$1,500 Family	
Out-of-pocket maximum *(All maximums are combined, whether network, non-network, or out-of-area)*	$2,500 Individual/$5,000 Family	
Acupuncture *(up to 20 visits per year)*	80% after deductible	80% of eligible expenses after deductible
Allergy care *Diagnostic testing*	80% after deductible	60% of eligible expenses after deductible
Allergy injection only	100%; no deductible	60% of eligible expenses after deductible
Ambulance *Non-emergency*	80% after deductible	80% of eligible expenses after deductible
True emergency	100%; no deductible	100%; no deductible
Anesthesia	80% after deductible	80% after deductible
Birthing center *(pre-certification required; minimum stay for vaginal delivery = 48 hours, C-section = 96 hours)*	80% after deductible	60% of eligible expenses after deductible
Chiropractic, speech, physical or occupational therapy *(up to 40 visits per calendar year)* *Certain exclusions apply; contact Care Coordination for a pre-determination* *Office setting*	80% after deductible	60% of eligible expenses after deductible
Outpatient	80% after deductible	60% of eligible expenses after deductible
Colonoscopy (diagnostic) *Outpatient surgery* *(diagnostic office visits subject to deductible and coinsurance)*	100% after deductible	60% of eligible expenses after deductible

Plan feature	Network	Non-network[1]
Congenital heart disease	80% after deductible	60% of eligible expenses after deductible
Durable Medical Equipment (DME)	80% after deductible	60% of eligible expenses after deductible
Emergency room *Non-emergency*	100% after $100 copay	100% after $100 copay
True emergency	100% after $100 copay	100% after $100 copay
Home health care *(pre-certification required; 90 visits per calendar year)*	80% after deductible	60% of eligible expenses after deductible
Hospice care *(pre-certification required for inpatient)*	100%; no deductible	60% of eligible expenses after deductible
Hospital care *Outpatient and inpatient services (pre-certification required for inpatient)*	80% after deductible	60% of eligible expenses after deductible
Immunizations *(routine child and adult immunizations)*	100%; no deductible	60% of eligible expenses after deductible
Injections *(professionally assisted)*	100%; no deductible	60% of eligible expenses after deductible
Laboratory services *Office setting or outpatient facility*	100%; no deductible	60% of eligible expenses after deductible
Maternity care *(you or a covered dependent)*	80% after deductible	60% of eligible expenses after deductible
Mental health *Inpatient (pre-certification required)*	80% after deductible	60% of eligible expenses after deductible
Outpatient professional fees and office setting	80% after deductible	
Nutrition counseling *(up to 10 visits annually; non-preventive)*	100%; no deductible	60% of eligible expenses after deductible
Outpatient surgery *Office setting*	80% after deductible	60% of eligible expenses after deductible
Outpatient hospital	80% after deductible	60% of eligible expenses after deductible
Physician office visit	80% after deductible	60% of eligible expenses after deductible
Physician services *Outpatient and inpatient services*	80% after deductible	60% of eligible expenses after deductible
Preventive care *Includes annual physical; Well Woman, Well Man and Well Child visits; Colonoscopy*	100%; no deductible	60% of eligible expenses after deductible
Second/third surgical opinions (voluntary) *Office setting*	80% after deductible	60% of eligible expenses after deductible
Skilled nursing/inpatient rehabilitation *(pre-certification required; up to 60 days per calendar year)*	80% after deductible	60% of eligible expenses after deductible
Substance abuse *Outpatient, office setting* *– Professional fees*	80% after deductible	60% of eligible expenses after deductible
– Facility fees	80% after deductible	60% of eligible expenses after deductible

Plan feature	Network	Non-network[1]
Inpatient (pre-certification required for inpatient)	80% after deductible	60% of eligible expenses after deductible
TMJ *($500 lifetime maximum for non-surgical)* *Office setting*	80% after deductible	60% of eligible expenses after deductible
Transgender benefits	80% after deductible	60% of eligible expenses after deductible
Outpatient facility	80% after deductible	60% of eligible expenses after deductible
Transplant services[2] with Designated Provider *Travel/Lodging ($10,000 lifetime maximum)* *Lodging Allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child - $200 maximum applies)* *Organ Search and Procurement (except bone marrow, limited to $25,000)*	100% (designated provider only)	60% of eligible expenses after deductible
Urgent care	80% after deductible	60% of eligible expenses after deductible
Virtual Care services	80% after deductible	Not covered
X-ray major services *Office setting or outpatient facility* *(MRIs, scans, PET scans, nuclear scans, etc.)*	80% after deductible	60% of eligible expenses after deductible
Inpatient Hospital	80% after deductible	60% of eligible expenses after deductible
X-ray services *Office setting or outpatient facility* *(outpatient facility; excludes major x-ray services)*	100%; no deductible	60% of eligible expenses after deductible
Inpatient Hospital	80% after deductible	60% of eligible expenses after deductible
All other eligible coverage	80% after deductible	60% of eligible expenses after deductible
Maximum benefit *(aggregate lifetime maximum for all benefits covered under the plan)*	Unlimited	

[1]Services received from a non-network provider are subject to Eligible Expense costs.

[2]If the facility and provider are not part of the Designated Provider, your coverage will be subject to the deductible and coinsurance — Network - 80% after deductible; non-network — 60% of eligible expenses after deductible.

Note: The deductible, non-network services, copays, ineligible expenses, and amounts above eligible expenses do not apply to the out-of-pocket maximum.

UHC Catastrophic Choice Plus

Plan feature	Network	Non-network[1]
Deductible	$3,000 Individual/$6,000 Family	
Out-of-pocket maximum *(All maximums are combined, whether network, non-network, or out-of-area)*	$4,000 Individual/$8,000 Family	
Acupuncture *(up to 20 visits per year)*	80% after deductible	80% of eligible expenses after deductible
Allergy care *Diagnostic testing*	80% after deductible	60% of eligible expenses after deductible
Allergy injection only	100%	60% of eligible expenses after deductible
Ambulance *Non-emergency*	80% after deductible	80% of eligible expenses after deductible
True emergency	100%	100%
Anesthesia	80% after deductible	80% after deductible
Birthing center *(pre-certification required; minimum stay for vaginal delivery = 48 hours, C-section = 96 hours)*	80% after deductible	60% of eligible expenses after deductible
Chiropractic, speech, physical or occupational therapy *(up to 40 visits per calendar year)* *Certain exclusions apply; contact Care Coordination for a pre-determination* *Office setting*	80% after deductible	60% of eligible expenses after deductible
Outpatient	80% after deductible	60% of eligible expenses after deductible
Colonoscopy (diagnostic) *Outpatient surgery* *(diagnostic office visits subject to deductible and coinsurance)*	100% after deductible	60% of eligible expenses after deductible
Congenital heart disease	80% after deductible	60% of eligible expenses after deductible
Durable Medical Equipment (DME)	80% after deductible	60% of eligible expenses after deductible
Emergency room *Non-emergency*	100% after $100 copay	100% after $100 copay
True emergency	100% after $100 copay	100% after $100 copay
Home health care *(pre-certification required; 90 visits per calendar year)*	80% after deductible	60% of eligible expenses after deductible
Hospice care *(pre-certification notification required)*	100%; no deductible	60% of eligible expenses after deductible
Hospital care *Outpatient and inpatient services* *(pre-certification required for inpatient)*	80% after deductible	60% of eligible expenses after deductible
Immunizations *(routine child and adult immunizations)*	100%; no deductible	60% of eligible expenses after deductible
Injections *(professionally assisted)*	100%; no deductible	60% of eligible expenses after deductible
Laboratory services *(office setting or outpatient facility)*	100%; no deductible	60% of eligible expenses after deductible
Maternity care *(you or a covered dependent)*	80% after deductible	60% of eligible expenses after deductible
Mental health *Inpatient (pre-certification required)*	80% after deductible	60% of eligible expenses after deductible
Outpatient professional fees and office setting	80% after deductible	

Plan feature	Network	Non-network[1]
Nutrition counseling *(up to 10 visits annually; non-preventive)*	100%; no deductible	60% of eligible expenses after deductible
Outpatient surgery *Office setting*	80% after deductible	60% of eligible expenses after deductible
Outpatient hospital	80% after deductible	
Physician office visit	80% after deductible	60% of eligible expenses after deductible
Physician services *(outpatient and inpatient services)*	80% after deductible	60% of eligible expenses after deductible
Preventive care *Includes annual physical; Well Woman, Well Man and Well Child visits; Colonoscopy*	100%; no deductible	60% of eligible expenses after deductible
Second/third surgical opinions (voluntary) *Office setting*	80% after deductible	60% of eligible expenses after deductible
Skilled nursing/inpatient rehabilitation *(pre-notification required; up to 60 days per calendar year)*	80% after deductible	60% of eligible expenses after deductible
Substance abuse *Outpatient, office setting*	80% after deductible	60% of eligible expenses after deductible
– Professional fees *– Facility fees of eligible expenses*	80% after deductible	60% of eligible expenses after deductible
Inpatient (pre-certification required for inpatient)	80% after deductible	60% of eligible expenses after deductible
TMJ *Office setting*	80% after deductible	60% of eligible expenses after deductible
Outpatient facility	80% after deductible	60% of eligible expenses after deductible
Transgender benefits	80% after deductible	60% of eligible expenses after deductible
Transplant services[2] with Designated Provider *Travel/Lodging ($10,000 lifetime maximum)* *Lodging Allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child - $200 maximum applies)* *Organ Search and Procurement (except bone marrow, limited to $25,000)*	100% with Designated Provider	60% of eligible expenses after deductible
Urgent care	80% after deductible	60% of eligible expenses after deductible
Virtual Care services	80% after deductible	Not Covered
All other eligible coverage	80% after deductible	60% of eligible expenses after deductible
Maximum benefit *(aggregate lifetime maximum for all benefits covered under the plan)*	Unlimited	

[1]Applies to eligible expenses reimbursed by the plan.

[2]If the facility is not part of the transplant network, your coverage will be subject to the deductible and coinsurance — Network -80% after deductible; Non-network — 60% of eligible expenses after deductible).

Note: The deductible, non-network services, ineligible expenses, and amounts above eligible expenses do not apply to the out-of-pocket maximum.

What if I Have a Medical Emergency?

For each emergency room visit, you must pay a $100 emergency room copay whether you use a network or non-network facility. If you have a true medical emergency and are admitted to the hospital within 24 hours, the copay is waived.

For an emergency room visit that is not considered to be a true emergency (non-emergency), any covered expenses incurred are paid based upon whether the facility is network or non-network. The applicable network or non-network option level coinsurance applies, once the deductible is met. Refer to the *Pre-65 Retiree Medical Schedule of Benefits* for plan benefit levels.

Definition: A *true emergency* means a serious medical condition or symptom resulting from injury, sickness, or mental illness which arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

What if I am Admitted to a Hospital?

If you're admitted to the hospital through the emergency room within 24 hours, the $100 emergency room copay will be waived. If you're admitted to a non-network hospital, contact UHC to notify Care Coordination. You will need to be transferred to a network facility (unless you're in an Out-of-Area option) once your condition is stabilized in order to continue to receive benefits at the network level. Otherwise, your covered charges would be paid on a non-network basis.

Medical Coverage Outside the US

The Medical plan options administered through UHC provide coverage at the network level for services received outside the US. If you need to seek medical attention while traveling outside the US, you will pay for the services out-of-pocket and file an International Claim Form with UHC for reimbursement. You can obtain the International Claim Form via **BakerHughesBenefits.com** or by calling UHC.

Wellness and Preventive Care

The plan is designed to encourage you, your spouse, and your eligible dependents to have routine checkups by providing an annual wellness benefit. Covered expenses are payable at 100% when services are received from a network provider;* no calendar year deductible or coinsurance applies. The benefit for non-network providers is 60% after you meet the calendar-year deductible.

Examples of preventive care include:

- Well-woman, well-man, or well-child
- Prostate exam
- Cholesterol check
- Immunizations, including flu shots
- Blood pressure screening
- Colonoscopy (refer to the Pre-65 Retiree Medical Schedule for additional coverage details)

*Out-of-Area plan participants may use network or non-network providers.

Note: This is a screening and prevention benefit — it does not apply to diagnostic services or ongoing care related to a diagnosed condition.

What is a Preventive Service? Preventive services are services that contribute to the prevention of a condition or disease. Examples include annual well-woman, well-man, and well-child exams, and mammograms and colonoscopies.

What is a Diagnostic Service? Diagnostic services are services to diagnose a condition or treat a particular disease or condition that has been identified and may require ongoing or more extensive care.

Nutrition Counseling

The plan also provides a nutrition counseling benefit. Participants may receive up to 10 nutrition counseling sessions annually covered at 100% when received from a network provider. Refer to the *Pre-65 Retiree Medical Schedule of Benefits* for additional coverage details.

Emergency Services

Emergency services are services required to stabilize or initiate treatment in an emergency. Emergency services must be received on an outpatient basis at a Hospital or Alternate Facility. For purposes of this provision, emergency illness or emergency injury means a serious medical condition or symptom resulting from injury, illness, or mental illness that both:

- Arises suddenly; and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

If it is determined by UHC that the emergency care was necessary, the regular plan benefits will be paid. If a dispute should arise, UHC reserves the right to make the final decision.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for any other illness. Payment for pregnancy-related expenses will not be withheld because the pregnancy occurred before coverage took effect. Federal law prohibits the Medical plan from:

- Limiting the length of a hospital stay for you and your newborn child to less than 48 hours following a vaginal delivery or 96 hours following a Caesarean delivery (if you're discharged earlier, the Medical plan will pay for two post-delivery home visits by a health care provider);
- Requiring a provider to obtain authorization from the Medical plan for prescribing any length of stay described above;
- Denying mother or newborn eligibility or continued eligibility to enroll or reenroll for coverage just to avoid legal requirements;
- Making financial payments or rebates to mothers to encourage them to accept a shorter stay than described above;
- Providing financial incentives to the provider to encourage him or her to provide care inconsistent with current law; and
- Restricting benefits for any portion of such hospital stay to be less than benefits for any stay prior to the birth.

However, if the mother chooses, she and the newborn may be released earlier.

Newborn Coverage

Please note that you have 31 days after the birth of a newborn to enroll him or her in the Medical plan. The newborn will be automatically covered for four days after birth under the mother's health insurance coverage under the Medical plan (if she has coverage). If you wish coverage to be continuous, you must enroll the newborn within four days of birth. If you enroll the newborn after four days but before 31 days, coverage will be retroactive to the date of birth, but this also means you may have to pay out-of-pocket for any medical expenses incurred during the time the newborn is not covered. Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** to enroll your newborn. You will be required to provide dependent verification documents.

Immunizations

Preventive adult and child immunizations received in-network are covered by the Medical plan at 100% (no deductible applies). For the UHC Basic and Catastrophic Choice Plus options, travel immunizations are covered at 80%, after the deductible. Your provider may bill you for the office visit or the cost to administer the immunizations if services other than the immunizations are provided. If immunizations are billed as preventive health care, they will be covered by the Medical plan at 100%.

Immunizations received from a non-network provider are paid according to the *Medical Schedule of Benefits.*

What if I Have a Pre-Existing Condition?

The Baker Hughes Medical plan options administered through UHC do not have any pre-existing condition limitations. For information on covered expenses, refer to the *Medical Schedule of Benefits* and the *Covered Expenses* and *Exclusions and Limitations* sections.

UHC Care Coordination℠ Program

The *Care Coordination℠* program is designed to make sure that reimbursements of the cost of the health care services you receive are covered by the plan. This may include admission counseling, inpatient care advocacy, and disease and risk management. *Care Coordination℠* does not replace your physician's recommendations, and the final decision about care is up to you and your physician.

You must obtain a prior authorization with UHC *Care Coordination℠* prior to incurring certain covered expenses including:

- Ambulance – non-emergency;
- Clinical trials;
- Genetic testing;
- Bariatric surgery;
- Lab, X-ray, and diagnostics;
- Outpatient – sleep studies;
- Obesity surgery;
- Congenital heart disease surgeries;
- Infertility services;
- Outpatient surgery;
- Diagnostic and therapeutic services;
- Cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, and electrophysiology implants;
- Sleep apnea surgeries;
- Orthognathic surgeries;
- Inpatient facility admissions;*
- Home health care services;
- Durable medical equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes and prosthetic devices;
- Reconstructive procedures;
- Maternity services (if the stay is longer than 48 hours for a vaginal delivery or 96 hours for a Caesarean section);
- Accident-related dental services;
- Transplant services**;
- Hospice care;
- Skilled nursing/inpatient rehabilitation facilities**;
- Mental health/substance use disorder services for inpatient care (including day treatment and services at a Residential Treatment Facility)*; and
- Therapeutic treatments.

For UHC *Care Coordination℠* or the Mental Health/Substance Use Disorder Administrator, call **1-866-743-6549**.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay benefits under the plan), the notification requirements described in this SPD do not apply to you.

Important: If you fail to obtain prior authorization from Care Coordination, a $300 penalty will apply.

*For planned or scheduled admissions, call **five days** before admission. For urgent, unscheduled admissions, call within **one day** of admission. For emergency admissions, call within **two business days** or as soon as reasonably possible. Outpatient surgery that results in hospitalization for more than 23 1/2 hours is considered an inpatient admission.

** In addition, for non-network benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).

Covered Expenses

Pre-65 UHC Retiree Medical Options

Covered expenses are charges for services covered by the plan and are reimbursed up to the Reasonable and Customary charge or the rate that has been negotiated with network providers for the applicable plan option. In most cases, services or supplies must be ordered by or be provided under the direction of a physician. To encourage good health, certain wellness and preventive services are also covered.

Covered expenses include the covered services shown below and those shown on the *Schedule of Benefits.*

Ambulance

- **Emergency.** The Medical plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers emergency health services. Ambulance service by air is covered in an emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, the Medical plan may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services. The Medical plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities when the transport is:
  - From a non-network hospital to a network hospital;
  - To a hospital that provides a higher level of care that was not available at the original hospital;
  - To a more cost-effective acute care facility; or
  - From an acute facility to a sub-acute setting.
- **Non-Emergency.** Non-emergency service is defined as transportation by professional ambulance, other than an air ambulance, to and from a medical facility. The Medical plan only covers these services when you require transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat you.
- **Non-Emergency Air (airplane or helicopter).** The Medical plan does not cover non-emergency air service via airplane or helicopter. The only exception is when you require transport to a hospital or from one hospital to another because:
  - The first hospital does not have the required services and/or facilities to treat you, and ground ambulance transportation is not medically appropriate because of the distance involved; or
  - You have an unstable condition requiring medical supervision and rapid transport.

Cellular and Gene Therapy

Cellular therapy and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office. Benefits for CAR-T therapy for malignancies are provided as described under transplantation services.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or another life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- Cardiovascular disease (cardiac/stroke) that is not life-threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- Surgical musculoskeletal disorders of the spine, hip, and knees that are not life-threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and
- Other diseases or disorders that are not life-threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial. Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

- The experimental or investigational service or item. The only exceptions to this are:
  - Certain Category B devices;
  - Certain promising interventions for patients with terminal illnesses;
  - Other items and services that meet specified criteria in accordance with our medical and drug policies;
  - Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
  - Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

- With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and that meets any of the following criteria in the bulleted list below.
- With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders that are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and that meets any of the following criteria in the bulleted list below.
- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH) (includes National Cancer Institute [NCI]);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - The study or investigation is conducted under an investigational new drug application reviewed by the US Food and Drug Administration;
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
  - The clinical trial must have a written protocol that describes a scientifically sound study and has been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or
  - The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the plan.

Please remember that you must obtain prior authorization from UnitedHealthcare by calling Personal Health Support as soon as the possibility of participation in a clinical trial arises. If Personal Health Support is not notified, you will be responsible for paying all charges and no benefits will be paid.

Congenital Heart Disease

Services for Congenital Heart Disease (CHD) when ordered by a physician for the following:

- Congenital heart disease surgical interventions
- Interventional cardiac catheterizations
- Fetal echocardiograms
- Approved fetal interventions
  - CHD services other than those listed above are excluded from coverage, unless determined by *Care Coordination*SM to be a proven procedure for the involved diagnoses. Unproven, investigational, or experimental services are not covered.
  - Covered CHD services may be received from a network provider or through the Congenital Heart Disease Resource Services program (United Resource Network).
  - Contact *Care Coordination*SM at the telephone number on your ID card for information about CHD services. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Diabetes Services

Benefits include reimbursements for outpatient self-management training for the treatment of diabetes, education, and medical nutrition therapy services. These services must be ordered by a physician and must be provided by appropriately licensed or registered health care professionals. Benefits under this section also include reimbursements for:

- Medical eye examinations (dilated retinal examinations);
- Preventive foot care for covered persons with diabetes; and
- Insulin pumps and supplies for the management and treatment of diabetes (based on the medical needs of the covered person).

An insulin pump is subject to all the conditions of coverage stated under the *Durable Medical Equipment* section.

- Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets, and lancets and lancet devices are covered under the Medical and Prescription Drug plans.
- Benefits for diabetes equipment that meet the definition of durable medical equipment (DME) are not subject to the limit stated in the Durable Medical Equipment section.

Remember that for non-network benefits, you should obtain prior authorization from *Care Coordination*SM before obtaining any DME for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed $1,000. You must purchase or rent the DME from the vendor that *Care Coordination*SM identifies. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Durable Medical Equipment and Prosthesis

- Purchase of artificial limb(s) or eye(s), if the loss of the limb or eye is the result of an accidental injury or a surgical operation (replacements, if necessary, are covered only after five years; repairs, as needed, will also be covered)
- Purchase of prostheses following a mastectomy. Other expenses related to mastectomy include: reconstructive surgery for the breast on which surgery was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and physical complications of mastectomy (including lymphedema)
- Braces or orthotics that stabilize, support, or straighten a non-functional body part due to congenital or acquired deformity or injury, including braces to treat curvature of the spine and diabetic shoes; shoe/foot orthotics — physician-prescribed, custom orthotics to treat an injury or illness
- Purchase (with physician's prescription) or rental (not to exceed the purchase price) of DME, including but not limited to: hospital bed or manually operated wheelchair, iron lung, kidney dialysis equipment, or other durable medical equipment made and used only for treatment of injury or illness. DME also includes speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury.
- Replacement of DME more than three years old, and prosthetics more than five years old; however, may be replaced sooner if not fulfilling its function
- Insulin pumps and all related necessary supplies as described under the *Diabetes* section
- Requirements:
  - Prior authorization required on any expense over $1,000
  - Must meet all of the following criteria:
    - Ordered or provided by a physician for outpatient use
    - Used for medical purposes
    - Not consumable or disposable
    - Not of use to a person in the absence of sickness, injury, or disability
    - Durable enough to withstand repeated use
    - Appropriate for use in the home

If more than one piece of equipment can meet the patient's functional needs, DME benefits are available only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME. Examples include: equipment to assist mobility such as wheelchairs, hospital-type beds, oxygen concentrator units, and the purchase or rental of equipment to administer oxygen (including tubing and connectors), or braces (including adjustments to shoes to accommodate braces that stabilize any injured body part).

If you rent or purchase a piece of DME that exceeds this guideline, you may be responsible for any cost differences between the price you rent or purchase and the price UHC has determined is the most cost-effective. To receive network benefits, you must purchase or rent the DME from the vendor that UHC identifies or purchase it directly from the prescribing network physician.

For non-network benefits you must obtain prior authorization before obtaining any DME that exceeds $1,000 in cost. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a physician. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease
- Severe food allergies
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract

Benefits for prescription or over-the-counter formula are available when a physician issues a prescription or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a physician or registered dietitian.

For the purpose of this benefit, "enteral formulas" include:

- Amino acid-based elemental formulas;
- Extensively hydrolyzed protein formulas;
- Modified nutrient content formulas.

For the purpose of this benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Facility/Hospital

- Hospital care for room, board, and general nursing care (including charges for the nursery care of a newborn child)
  - Semi-private room charge — if a private room is used, the difference between the hospital's private and semi-private room rate is excluded from covered expenses. If the hospital does not have semi-private rooms, the difference between the hospital's daily charge and the prevailing rate in area hospitals for semi-private rooms is excluded from covered expenses.
  - Intensive care room charge while confined as an inpatient
- Charges for other hospital services and supplies required for treatment, except those by outside agencies and supplies not used while confined in the hospital as an inpatient
- Services and supplies required for outpatient, non-surgical treatment provided by a hospital or facility and used while at the hospital or facility
- Services and supplies required for treatment provided by a hospital or facility and used while at the facility as an outpatient for a surgical operation or for treatment of bodily injuries
- Care in a convalescent, skilled nursing, or extended care facility if admitted immediately after a hospital stay of at least five consecutive days for:
  - Room, board, and general nursing care — except that the difference between the facility's semi-private room rates and private room rates will be excluded from covered expenses. If the facility does not have semi-private rooms, that part of the facility's daily charge above the area facilities' prevailing rate for semi-private rooms is excluded from covered expenses; and
  - Charges for medical services and supplies required for treatment provided by the facility and used while in the facility as an inpatient.
- In addition, for non-network benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in this SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in this SPD.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in *Prescription Drugs*.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Breast augmentation
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Vulvectomy (removal of vulva)

Gender Dysphoria Prior Authorization Requirement

For non-network benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises. If you fail to obtain prior authorization as required, benefits will be subject to a $300 reduction.

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be subject to a $300 penalty.

In addition, for Non-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

For outpatient rehabilitation services for speech therapy, the Plan will pay benefits for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from injury, stroke, cancer, or congenital anomaly. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain injury or stroke.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

The Claims Administrator will determine if certain benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, or physician.
- The initial or continued treatment must be proven and not experimental or investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, educational/vocational training, and residential treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals.

The Plan may require the following be provided:

- Medical records.
- Other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment and Prosthetic Devices*.

Hearing Aids

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the plan will pay only the amount that the plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone-anchored hearing aids. Bone anchored hearing aids are a covered health service for which benefits are available under the applicable medical/surgical covered health services categories in this section except for covered persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to the purchase of a single pair (including repair/replacement) per hearing impaired ear every three calendar years.

Home Health Care

- Charges for services and supplies for home health care made by a home health care agency if the plan of care is prescribed, approved, and supervised by a physician, and confinement in a hospital or convalescent facility would otherwise be required (limited to 90 visits per calendar year). A copy of this plan of care must be provided to UHC.
- Home health care includes: part-time (four hours or less per visit) nursing care by or under the supervision of a registered nurse and part-time home health aide services; physical, occupational, or speech therapy provided by the home health care agency. This benefit is limited to expenses made by an organization or agency that meets the requirements for participation as a home health care agency under state licensing regulations.

Hospice

Charges for services and supplies for hospice care incurred by you or your dependent if such charges are made or ordered by the attending physician and are made by a hospice care team for a covered person diagnosed by a physician as having six months or less to live. The hospice care plan must be approved by UHC. Covered services include charges for emotional support services provided in counseling sessions with covered dependents for up to six months following the death of the covered person.

Hospice Prior Authorization Requirement

For non-network benefits, you must obtain prior authorization from the Claims Administrator five business days before admission for an inpatient stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain authorization as required, a $300 penalty will apply. In addition, for non-network benefits, you must contact the Claims Administrator within 24 hours of admission for an inpatient stay in a hospice facility.

Lab, X-Ray, and Diagnostic — Outpatient

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include:

- Lab and radiology/X-ray
- Mammography

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists, and pathologists. (Benefits for other physician services are described under physician fees for surgical and medical services.)
- Presumptive drug tests and definitive drug tests.
  - Limited to 18 presumptive drug tests per year.
  - Limited to 18 definitive drug tests per year.

Benefits for other physician services are described in this section under physician fees for surgical and medical services. Lab, X-ray, and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services are described under *Lab, X-Ray, and Major Diagnostics - CT, PET Scans, MRI, MRA, and Nuclear Medicine - Outpatient* in this section.

Genetic Testing and Sleep Studies Prior Authorization Requirement

For non-network benefits for genetic testing and sleep studies, you must obtain prior authorization from the claims administrator five business days before scheduled services are received. If you fail to obtain authorization as required, benefits will be subject to a $300 reduction.

Licensed Medical Providers

- Charges by licensed medical personnel operating within the scope of their license, for:
  - Speech therapy to restore or correct impaired function due to: accidental injury, surgical operation, cerebrovascular accident (stroke), or congenital defects and birth abnormalities; covered if the rehabilitation services are expected to result in significant improvement in the patient's condition within two months of the start of treatment. Limited to 40 visits per calendar year; see the *Exclusions and Limitations* section for important provisions.
  - Occupational therapy to improve the patient's ability to perform tasks required for independent functioning when function has been temporarily lost and can be restored (e.g. stroke or cerebrovascular accidents); covered if the rehabilitation services are expected to result in significant improvement in the patient's condition within two months of the start of treatment. Limited to 40 visits per calendar year.
  - Physical therapy if the rehabilitation services are expected to result in significant improvement in the patient's condition within two months after the start of treatment. Limited to 40 visits per calendar year.
  - Acupuncture for pain control, nausea related to chemotherapy, post-operative nausea, and nausea related to early pregnancy. Other diagnoses must be reviewed. Limited to 20 visits per calendar year.
  - Use of X-ray, radium, and other radioactive substances for treatment.
  - Oxygen, other gases, and rental of equipment to administer them, up to purchase price of the equipment.
  - Blood, blood plasma, and the testing and storage of blood for future use.
  - Drugs and medicines, including allergy sera and drugs purchased outside the United States, which are not payable under the Prescription Drug Program (these drugs and medicines must be legally obtained only by the written prescription of a licensed physician and approved by the US Food and Drug Administration for general use by humans).

Mental Health and Substance Use Disorder Services – Compliance with Mental Health Parity and Addiction Equity Act

Please note that the Medical plan provides Mental Health Services and Substance-Related and Addictive Disorders Services in accordance with all applicable requirements of the Mental Health Parity Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), and other applicable law. The MHPAEA provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) for mental health and substance use disorder benefits may not be more restrictive than the most common financial requirements and treatment limitations that apply to all or substantially all medical and surgical benefits in a classification under the Medical plan. In addition, the Medical plan may not have separate cost-sharing requirements that are applicable only to covered Mental Health Services and Substance-Related and Addictive Disorders Services.

The Medical plan will not impose a more restrictive financial requirement or treatment limitation than the predominant level that applies to all or substantially all medical/surgical benefits on any Mental Health Services and Substance- Related and Addictive Disorders Services within each of the above classifications.

Mental Health Care, Neurobiological Disorders - Autism Spectrum Disorder Service, and Substance-Related and Addictive Disorder Services

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family, and group therapy.
- Crisis intervention.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a hospital and an alternate facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Mental Health Services Prior Authorization Requirement

For non-network benefits for a scheduled admission for mental health services (including an admission for services at a residential treatment facility), you must obtain prior authorization from the Claims Administrator five business days before admission. For non-scheduled admission (including emergency admissions), you must provide notification as soon as reasonably possible.

In addition, for non-network benefits, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization include: partial hospitalization/day treatment; intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from the Claims Administrator as required, a $300 penalty will apply.

Health Management Virtual Behavioral Therapy and Coaching Programs

The Virtual Behavioral Therapy and Coaching program identifies covered persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer, or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for covered persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up to date. The site also includes links to other helpful tools and resources for behavioral health.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Neurobiological Disorders – Autism Spectrum Disorder Services

The plan pays benefits for behavioral services for Autism Spectrum Disorder, including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by a board certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, and property and impairment in daily functioning.

Neurobiological Disorders – Autism Spectrum Disorder Prior Authorization Requirement

For non-network benefits, please remember:

- **For a scheduled admission for neurobiological disorders – autism spectrum disorder (including an admission for services at a residential treatment facility)**, you must obtain authorization from the Claims Administrator five business days before admission.
- **For a non-scheduled admission (including emergency admissions)** you must provide notification as soon as is reasonably possible.

In addition, for non-network benefits, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization include: partial hospitalization/day treatment; intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; intensive behavioral therapy, including applied behavior analysis (ABA)

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, benefits will be subject to a $300 penalty.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a hospital, an alternate facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Services include those received on an inpatient or outpatient basis in a hospital, an alternate facility, or in a provider's office

All services must be provided by or under the direction of a properly qualified behavioral health provider.The Mental Health

Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Substance-Related and Addictive Disorders Services Prior Authorization Requirement

For Non-Network Benefits for:

- **A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility)**, you must obtain authorization from the Claims Administrator five business days before admission.
- **A non-scheduled admission (including Emergency admissions)**, you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a $300 reduction.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a physician when all of the following are true:

- You have enrolled in the Bariatric Resource Services (BRS) program.
- You have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last two years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under the Plan, unless there were complications with your first procedure.
- You have a three-month physician supervised diet documented within the last 2 years.

Bariatric Resource Service (BRS)

BRS is a surgical weight loss solution for those individuals who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. BRS is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information, and education important in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence (COE). In order to receive a benefit, you must access services through a provider or facility designated as a COE. If you reside more than 50 miles from a COE, you will need to contact a BRS nurse to locate a network facility near you prior to starting treatment.

Covered participants seeking coverage for bariatric surgery should notify Optum as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) by calling Optum at **1-888-936-7246** to enroll in the program.

Obesity Surgery Prior Authorization Requirement

You must enroll with the Bariatric Resource Services (BRS) program as soon as possible. If you fail to enroll with a BRS nurse as required, you will be responsible for paying all charges and no benefits will be paid. Contact a BRS nurse at **1-888-936-7246**. In addition, you must contact the Claims Administrator 24 hours before admission for an inpatient stay.

Neonatal Resource Services

The Neonatal Resource Services (NRS) program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

- To take part in the NRS program, call a neonatal nurse toll-free at **1-866-534-7209**. The Medical plan will only pay benefits under the NRS program if the NRS provides the proper notification to the designated facility provider performing the services (even if you self-refer to a provider in that network).

You or a covered dependent may also:

- Call UHC or *Care Coordination*^{SM}; or
- Call NRS toll-free at **1-866-534-7209** and select the NRS prompt.

To receive NICU benefits, you are not required to visit a designated facility.

If you receive services from a facility that is not a designated facility, the Medical plan pays benefits as described under Covered Expenses.

Specialist Management Solutions Program

Specialist Management Solutions (SMS) is a holistic specialty solution that opens the door to affordable, quality care. SMS has a broad network of physicians in local communities, making finding a doctor more convenient for members. The SMS advocates can help members schedule consults with a provider, connect members with other benefit programs, and serve as the single point of contact throughout their health care journey. Specialists in the SMS alliance use ambulatory surgery centers (ASC) and centers of excellence (COE), which means employees may receive surgical care and other procedures in an outpatient setting which may result in cost savings. The SMS program is available at no cost to the member.

You are eligible for SMS if you enrolled in a Baker Hughes Medical plan. Specialties include:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery

Specialist Management Solutions is part of your health plan and exists to simplify your path to affordable, quality surgery. Think of SMS as a surgical concierge service. In one phone call to SMS, you get instant access to a care advocate who will help you find a local surgeon who specializes in your condition, schedule an appointment for you and talk to you about your options for where you can receive care for a surgery or other outpatient procedure. SMS will be available for you or your family member throughout the experience of getting surgery and is available to answer questions and provide assistance at any time.

To speak to an SMS surgical care advocate, you may be warm transferred to **1-833-332-1011** or call SMS directly at **1-833-433-1339**. For more information, go to **specialistmanagementsolutions.com**.

Pharmaceutical Products - Outpatient

The Plan pays for pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office, or in a covered person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for pharmaceutical products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the pharmaceutical product is administered, benefits will be provided for administration of the pharmaceutical product under the corresponding benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under the Outpatient Prescription Drug program. Benefits under this section do not include medications for the treatment of infertility.

If you require certain pharmaceutical products, including specialty pharmaceutical products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those pharmaceutical products. Such dispensing entities may include an outpatient pharmacy, specialty pharmacy, home health agency provider, hospital-affiliated pharmacy, or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your pharmaceutical product from a designated dispensing entity, Network Benefits are not available for that pharmaceutical product.

Certain pharmaceutical products are subject to step therapy requirements. This means that in order to receive benefits for such pharmaceutical products, you must use a different pharmaceutical product and/or prescription drug product first. You may find out whether a particular pharmaceutical product is subject to step therapy requirements by contacting UnitedHealthcare at **myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **myuhc.com** or by calling the number on your ID card.

Physician Fees

- Physicians' fees for:
  - Surgical operations and assisting at surgery, when required for medical reasons
  - Non-surgical medical care
  - Inpatient treatment of mental and nervous disorders
  - Pregnancy/childbirth for you or a covered dependent
  - Administration of general anesthetic other than by the operating surgeon
  - Expenses that are related to pregnancy, childbirth, and related medical conditions
  - Routine annual wellness exams, including mammograms, gynecological exams, and Pap smears, and the administration of Norplant® and Depo-Provera®
  - Hyper-alimentation or total parenteral nutrition for persons recovering from or preparing for surgery, or as sole source of nutrition

Sterilization

Charges for services and supplies for sterilization (not reversal) and contraceptives administered by a provider (example: the administration of Norplant® and Depo-Provera®).

Temporomandibular Joint (TMJ) Services

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs, and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, and open or closed reduction of dislocations.

Transgender Benefits

Coverage for breast enlargement, including augmentation, mammaplasty, and breast implants (for male to female patients only), rhinoplasty, and thyroid cartilage reduction, including reduction of thyroid chondroplasty and trachea shave, the removal or reduction of the Adam's apple (for male to female patients only).

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service and is not an experimental or investigational or an unproven service.

Examples of transplants for which benefits are available include bone marrow, including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel, and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under the Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches, and transplantation procedures may be received by a designated provider, network facility that is not a designated provider, or a non-network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator of a cornea transplant nor is the cornea transplant required to be performed by a designated provider.

Travel and Lodging Provision

The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with transplant services described by a designated provider.

Travel and Lodging

Travel and lodging services are covered only in connection with the cancer, congenital heart disease (CHD), and transplant programs.

The Travel and Lodging Assistance Program will assist the patient and family with travel and lodging arrangements. Reimbursement for expenses for travel and lodging for the recipient of cancer, CHD, and transplant services and a companion are available under the Medical plan as follows:

- Transportation of the patient and one companion who is traveling on the same days to and/ or from the site of the services for the purposes of an evaluation, the procedure, or necessary post-discharge follow-up. If travel is by airplane, only economy/coach fare is eligible. Automobile rental and gas are not covered. Contact the UHC Travel and Lodging Assistance Program at **1-800-842-0843** for additional details. A companion must be a spouse, family member, or guardian of the patient.
- Eligible expenses for lodging for the patient (while not confined to a medical facility) and one companion. Benefits are paid at a per diem rate of up to $150 for one person or up to $200 for two people. The benefit is not intended to cover all expenses for lodging. In addition, certain exclusions apply, including but not limited to: meals, non-food items, medical supplies, non-itemized receipts, alcoholic beverages, phone calls, newspapers, and movie rentals. Travel and lodging expenses are only available if the recipient resides more than 50 miles from the eligible services program facility.
- If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered (subject to the same $10,000 lifetime maximum), and lodging expenses will be reimbursed up to the $200 per diem rate.

There is a combined overall lifetime maximum benefit of $10,000 per covered person for all transportation and lodging expenses incurred by the recipient and companions under the Medical plan in connection with all cancer, CHD, and transplant procedures.

Urinary Catheters

Benefits are provided for external indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Urgent on-demand health care delivered through live technology for treatment of acute but non-emergency medical needs. Virtual care provides communication of medical information in real-time between the patient and a distant physician or health specialist, outside of a medical facility (for example, from home or from work).

Network benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.

Benefits are available urgent on-demand health care delivered through live technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The designated virtual network provider will identify any condition for which treatment by in-person physician contact is needed.

Benefits do not include email, fax, and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Wigs

The Plans pays benefits for wigs (purchased upon the advice of a physician for the mental health of a patient with loss of hair due to medical reasons).

Any combination of network benefits and non-network benefits is limited to $1,000 per calendar year.

Exclusions and Limitations

Pre-65 Retiree Medical Options

The plan does not pay or approve Benefits for any of the services, medical care, or treatments, items, or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a physician; or
- It is the only available treatment for your condition.

The services, treatments, items, or supplies listed in this section are not Covered Expenses, except as may be specifically provided for in the *Retiree Medical* section of this SPD or through an amendment to the SPD.

Alternate Treatments

- Aromatherapy
- Hypnotism
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- Holistic or homeopathic care
- Wilderness, adventure, camping, outdoor, or other similar programs

Ambulance

- Transportation for convenience

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service
- Supplies, equipment, and similar incidental services and supplies for personal comfort.

  Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Dehumidifiers
  - Humidifiers
- Devices and computers to assist in communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools)

Dental

Dental work or treatment which includes professional charges in connection with:

- Orthodontic care or treatment of malocclusion except for:
  - A jaw deformity resulting from facial trauma or cancer; or
  - A skeletal anomaly of either the maxilla or mandible, that demonstrates a functional medical impairment such as one of the following:
- Inability to incise solid foods;
- Choking on incompletely masticated solid foods;
- Damage to soft tissue during mastication;
- Speech impediment determined to be due to the jaw deformity; or
- Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include all of the following:
  - Extraction, restoration, and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- Dental implants
- Dental braces
- Dental X-rays, supplies, and appliances, and all associated expenses, including hospitalizations and anesthesia.
  - The only exceptions to this are for any of the following:
    - Transplant preparation;
    - Initiation of immunosuppresives;
    - The direct treatment of acute traumatic injury, cancer, or cleft palate; and
    - Anesthesia charges and inpatient or outpatient facility charges are covered when dental treatment must be performed in a hospital setting due to an underlying medical condition or disability. Anesthesia charges and inpatient or outpatient facility charges are not covered if treatment is required due to poor dental hygiene. Pre-service review required to confirm benefit coverage.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly
- Operation or treatment in connection with the fitting and wearing of dentures
- Dental care for any operation on or treatment of or to the teeth or the supporting tissues of the teeth except for removal of a tumor or treatment of an accidental injury to sound natural teeth other than eating or chewing (including their replacement) immediately after an accident.

Drugs

Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.

Note: Some of these expenses may be covered under your prescription drug program. Refer to the *Prescription Drug* section for more information.

Durable Medical Equipment and Prosthetics

- Duplicate prosthetics, cost for the replacement of stolen prosthetic devices, and prosthetics that are less than five years old are not covered, except as stated in *Covered Expenses*
- Duplicate durable medical equipment, cost for the replacement of stolen durable medical equipment, and durable medical equipment that is less than three years old are not covered, except as stated in *Covered Expenses*

Experimental or Investigational Services

Experimental or investigational services are medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time UHC makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the US Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use (devices that are FDA-approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions

Clinical trials for which benefits are available as described under Clinical Trials.

If you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, UHC may, at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, UHC must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Foot Care

- Except when needed for severe systemic disease, this exclusion does not apply to preventive foot care due to conditions associated with metabolic neurologic or peripheral vascular disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming or cutting
  - Debriding (removal of dead skin or underlying tissue)
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - Other services that are performed when there is not a localized illness, injury, or symptom involving the foot**
- Treatment of flat feet
- Any fallen arches, chronic foot strain, or instability or imbalance of the feet
- Shoe inserts
- Shoes (standard or custom lifts and wedges)
- Shoe orthotics
- Toenails (other than the removal of nail matrix or root, or services furnished in connection with treatment of a metabolic or peripheral vascular disease or a neurological condition); or
- Treatment of subluxation of the foot

**This exclusion does not apply to preventive foot care due to conditions associated with metabolic neurological or peripheral vascular disease.

Exclusions and Limitations: What the Medical Plan will not cover

Gender Dysphoria

Cosmetic Procedures, including the following:

1. Abdominoplasty.
2. Blepharoplasty.
3. Body contouring, such as lipoplasty.
4. Brow lift.
5. Calf implants.
6. Cheek, chin, and nose implants.
7. Injection of fillers or neurotoxins.
8. Face lift, forehead lift, or neck tightening.
9. Facial bone remodeling for facial feminizations.
10. Hair removal except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.
11. Hair transplantation.
12. Lip augmentation.
13. Lip reduction.
14. Liposuction.
15. Mastopexy.
16. Pectoral implants for chest masculinization.
17. Skin resurfacing.

Home Health Care

Charges for services or supplies for custodial care or to assist with activities of daily living, including but not limited to, dressing, feeding, bathing, or transferring from bed to chair.

Medical Supplies and Appliances

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Prescribed or non-prescribed medical supplies. Examples include:
  - Compression stockings
  - Ace bandages
  - Gauze and dressings
- Powered and non-powered exoskeleton devices
- Tubings, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment

This exclusion does not apply to:

- Diabetic supplies for which benefits are provided as described under *Diabetes Services*.
- Ostomy supplies for which benefits are provided as described under *Ostomy Supplies*.
- Urinary catheters for which benefits are provided as described under *Urinary Catheters*.

Mental Health, Neurobiological Disorders – Autism Spectrum Disorder Services, and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this *Exclusions and Limitations* section, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services, and/or Substance-Related and Addictive Disorders Services* in *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional living services.

Nutrition

- Megavitamin and nutrition based therapy
- Nutrition counseling for either individuals or groups, including weight loss programs, health clubs, and spa programs other than as provided under the plan's nutrition provisions
- Intracellular micronutrient testing
- Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which benefits are provided as described under *Enteral Nutrition*.
- Hyper-alimentation or total parenteral nutrition except as provided under *Covered Expenses*

Orthotics

- Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME). This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over the counter. This exclusion does not include diabetic footwear which may be covered for a covered person with diabetic foot disease.
- Braces, orthotics, or equipment used specifically as safety items or to affect performance primarily in sport-related activities

Physical Appearance

- Cosmetic or reconstructive procedures and any related services or supplies, which alter appearance but do not restore or improve impaired physical function, except when performed to:
  - Repair defects from an accident
  - Replace diseased tissue which has been surgically removed
  - Reconstruct a breast following mastectomy, including reconstruction of the other breast to produce symmetry
  - Correct birth defects
- Excluded Cosmetic Procedures. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures)
  - Sclerotherapy treatment of veins
  - Skin abrasion procedures performed as a treatment for acne
    - Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure
    - All expenses related to conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
    - Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded except as provided under the Medical plan's nutrition provisions
    - Services received from a personal trainer
    - Liposuction

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a freestanding or hospital-based diagnostic facility, when that physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service or
  - Is not actively involved in your medical care after the service is received.
- This exclusion does not apply to mammography testing

Reproduction

- The following infertility treatment-related services:
  - Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue;
  - Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees);
  - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes;
  - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma;
  - All costs associated with surrogate motherhood;
  - Non-medical costs associated with a gestational carrier; and
  - Ovulation predictor kits.
- Surrogate parenting, and host uterus
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes
- Infertility treatment following a voluntary sterilization procedure in place
- Contraceptive supplies and services

Services Provided Under Another Plan

- Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation.
- If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental illness that would have been covered under Workers' Compensation or similar legislation had that coverage been elected.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.
- Charges for which benefits are paid under other benefit options of the plan.

Remember...

It's always a good idea to file your claims on a timely basis and to keep a copy of your claim forms, receipts, and all supporting evidence for your records.

Transplants

- Health services for organ and tissue transplants, except those described in the *Covered Expenses* section
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient'sbenefits under the Medical plan.)
- Health services for transplants involving animal organs
- Artificial or non-human transplants
- Any multiple organ transplant not listed as a covered expense under the heading Organ and/or Tissue Transplant unless determined by *Care Coordination*℠ to be a proven procedure for the involved diagnoses
- Transportation and lodging expenses if a United Resource Network is not used
- Expenses for meals and other living expenses while traveling to and from a transplant site
- The cost for, and associated with organ, bone marrow, or stem cell donations, except as provided under the *Covered Expenses* section
- The costs for, and associated with autologous bone marrow or stem cell harvesting and storage, if not followed by subsequent transplant within six months
- Bone marrow or stem cell transplants when the human leukocyte antigen is not an identical five out of six allogenic match between the donor and the recipient

Travel

Travel or transportation expenses, even if ordered by a physician, except as identified under the *Travel and Lodging* for the *Covered Health Services* section. Additional travel expenses related to Covered Health Services received from a designated provider or other network provider may be reimbursed at the Medical plan's discretion. This exclusion does not apply to ambulance transportation for which benefits are provided as described under *Ambulance Services*.

Unproven Services

Unproven Services are health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UHC has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UHC issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **myuhc.com**.

Please note: If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), UHC may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that sickness or condition. Prior to such a consideration, UHC must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UHC'S discretion. Other apparently similar promising but unproven services may not qualify.

Vision and Hearing

- Purchase cost or fitting charge for eye glasses or contact lenses
- Routine eye or hearing exams, eye refractions, hearing aids, or any type of external appliances used to improve visual or hearing acuity and their fittings, except as specifically provided under Covered Expenses
- Eye exercise therapy
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery
- Any procedure performed for the purpose of correcting myopia (nearsightedness), hyperopia (farsightedness), or astigmatism and expenses related to such procedures

Bundled Payments

Certain network providers receive a bundled payment for a group of covered health services for a particular procedure or medical condition. Your copayment and/or coinsurance will be calculated based on the provider type that received the bundled payment. The network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional copayment and/or coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some covered health services that are not considered part of the inclusive bundled payment and those covered health services would be subject to the applicable copayment and/or coinsurance as described in your schedule of benefits.

The Claims Administrator uses various payment methods to pay specific network providers. From time to time, the payment method may change. If you have questions about whether your network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your network provider is paid by any financial incentive, including those listed above.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Expense (see the definition in *Glossary of Terms*)
- Charges that exceed Reasonable and Customary limits
- Education or training, except as provided under Covered Expenses
- Food supplements, except as provided under Covered Expenses
- Equipment or supplies made or used for physical fitness, athletic training, or general health upkeep
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the plan when:
  - Required solely for purposes of education, sports or camp, insurance, marriage, or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the Medical plan ends
- Health services for which you have no legal responsibility to pay or for which a charge would not ordinarily be made in the absence of coverage under the Medical plan
- In the event a non-network provider waives, does not pursue, or fails to collect, copayments, coinsurance, and/or any deductible or other amount owed for a particular health care service, no benefits are provided for the health care service when the copayments, coinsurance, and/or deductible are waived, not pursued, or not collected.
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- Weight reduction or control (however, where there is a diagnosis of morbid obesity or severe obesity with co-morbidities, the expense for surgery will be covered)
- Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a physical congenital anomaly; speech therapy to treat stuttering, stammering, or other articulation disorders is not covered; speech therapy to treat learning disabilities or developmental delay is not covered
- Outpatient rehabilitation services, spinal treatment, or supplies including, but not limited to, spinal manipulations by a chiropractor or other physician, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Overall treatment that is intended to maintain a current state and is not effective at treating an existing medical condition
- Custodial care
- Domiciliary care
- Private duty nursing received on an inpatient basis
- Respite care
- Rest cures
- Psychosurgery

- Treatment of benign gynecomastia (abnormal breast enlargement in males), except as needed to treat a medical condition
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing
- Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
- Any charge for services, supplies, or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a Federal program for reason of fraud, abuse, or medical competency
- Any charges related to Christian Science
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Any outpatient facility charge in excess of payable amounts under Medicare
- Chelation therapy, except to treat heavy metal poisoning
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services
- Overall treatment that is intended to maintain a current state and is not effective at treating an existing medical condition
- Additional charges submitted after payment has been made and the self-funded corporate account balance is zero
- The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

Claims Procedures

If you use a network physician, specialist, or health care provider, the provider will submit claims on your behalf. You're only responsible for copays, deductibles, coinsurance, and non-covered items (as applicable).

If you use a non-network physician, specialist, or health care provider, you need to submit a claim form to UHC for any services you receive to receive reimbursement from the Medical plan.

Claim forms are available from your Baker Hughes benefits account at **myuhc.com** or by calling UHC at **1-866-743-6549.**

Read your claim form carefully and make sure you answer all questions and include all required information and documentation. Once you complete the form, attach all evidence to support your claim, including receipts, and file your claim directly with UHC as soon as possible after your treatment.

You have 12 months from the date of service to file a claim for expenses incurred. If a non-network provider submits a claim on your behalf, you'll be responsible for the timeliness of the submission. If you do not provide this information to UHC within 12 months of the date of service, benefits for that service will be denied. This time limit does not apply if you're legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide UHC with a written authorization to allow direct payment to a provider (on the claim form), all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of you. UHC will not reimburse third parties who have purchased or been assigned benefits by physicians and other providers. Unless you authorize payment to be sent to a health care provider or your provider notifies UHC that your signature is on file assigning benefits directly to that provider, payment will be forwarded to you once your claim is processed.

You may not assign your benefits under the plan to a provider without UHC's consent. When you assign your Benefits under the Welfare Benefits Plan to a non-network provider with UHC's consent, and the non-network provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Welfare Benefits Plan, the assignment must reflect the Covered Person's agreement that the non-network provider will be entitled to all the Covered Person's rights under the Welfare Benefit Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non Network provider is made, the Company reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes to the plan.

UnitedHealthcare will pay Benefits to you unless:

- UnitedHealthcare has consented to the assignment
- The provider submits to UnitedHealthcare a claim form provided by UnitedHealthcare that you have signed authorizing payment of Benefits directly to that provider. (You make a written request for the non-Network provider to be paid directly at the time you submit your claim.)

UnitedHealthcare will only pay Benefits to you or, with proper written authorization by you and approval by UnitedHealthcare, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

When UHC has not consented to an assignment, UHC will send the reimbursement directly to you for you to reimburse the provider upon receipt of their bill. However, UHC reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, UHC may consider whether you have requested that payment of your benefits be made directly to the provider. Under no circumstances will UHC pay benefits to anyone other than you or, in its discretion, your provider.

Direct payment to a provider shall not be deemed to constitute consent by UHC to an assignment or to waive the consent requirement. When UHC in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your benefits will be directed to you, although UHC may in its discretion send information concerning the benefits to the provider as well. If payment to a provider is made, the Medical plan reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes the Medical plan.

Required information for claims includes:

- Your name and address
- The patient's name, age, and relationship to you
- The member number stated on your identification card
- An itemized bill from your provider that includes the following:
  - Patient diagnosis
  - Date(s) of service
  - Procedure code(s) and descriptions of service(s) rendered
  - Place of service (e.g., office, outpatient hospital, inpatient hospital, independent lab, birthing center, home, or other)
  - Charge for each service rendered
  - Service provider's name, address, and tax identification number
- The date the injury or illness began
- Statements indicating either that you are or are not enrolled in coverage under any other health insurance plan or program. If you're enrolled for other coverage, you must include the name of the other carrier(s).

Send your completed claim forms and supporting documentation to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555

Payment of Benefits

Except as required by the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your benefits under the Plan or any cause of action related to your benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for benefits.

The Plan will not recognize claims for benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a covered person or beneficiary, or derivatively, as an assignee of a covered person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a covered person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your benefits; and
- is NOT a waiver of the prohibition on assignment of benefits under the Plan; and
- shall NOT stop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such benefits is extinguished by such payment. If any payment of your benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for benefits, and the Plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* the section *Coordination of Benefits.*

Information and Records

Baker Hughes and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Baker Hughes and the Claims Administrator may request additional information from you to decide your claim for Benefits. Baker Hughes the Claims Administrator will keep this information confidential. Baker Hughes and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Baker Hughes and the Claims Administrator with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. Baker Hughes and the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the employee's enrollment form. Baker Hughes and the Claims Administrator agree that such information and records will be considered confidential.

What is a Health Statement or an EOB?

A Health Statement is sent to your home by UHC for all claim activity on a monthly basis. You will only receive a Health Statement for the months in which claims have been processed. Health Statements outline all processed claims for that period, as well as remaining balances for deductibles and out-of-pocket expenses. If you would like to stop mail delivery of your Health Statement, visit **myuhc.com** and select Account Settings.

An Explanation of Benefits (EOB) is specific to individual claims and is designed to outline your coverage, the benefits paid to your provider, and any amounts you owe for treatments or services. Your EOB statements may be accessed on the UHC website at **myuhc.com**.

Remember...
Participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with Medical Plan access or claims issues that you have not been able to resolve. Call the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) for more information. Advocates are available Monday through Friday, 7 a.m. to 6 p.m., Central Time.

Notification of Claims Decision

Urgent care claims

Your claim may require immediate action if the claims administrator or your physician judge that the application of the time periods for making a non-urgent care determination could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment covered by the benefit claim. Such a benefit claim is referred to as an "urgent care claim."

If your claim is an urgent care claim:

- You will receive notice of the claims administrator's decision (whether adverse or not) in writing or electronically as soon as possible, taking into account the seriousness of your condition, but not later than 72 hours after the claims administrator receives all necessary information to determine the claim; and
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If your claim for benefits is incomplete, the claims administrator must notify you as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. In these situations:

- You will be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information to the claims administrator; and
- The claims administrator will notify you of the plan's determination regarding your claim as soon as possible, but in no case later than 48 hours after the earlier of the claims administrator's receipt of the specified information or the end of the period within which you were to provide the specified additional information, if the information is not received within that time.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the course of treatment is an urgent care claim as defined above, your request will be decided as soon as possible. The claims administrator will take into account the seriousness of your condition, and will notify you of the claims decision (whether adverse or not) within 24 hours after receipt of your claim, provided your claim is made at least 24 hours prior to the end of the approved course of treatment.

If your request for extended treatment is an urgent care claim but is not made at least 24 hours prior to the end of the approved course of treatment, the request will be treated as an urgent care claim and decided according to the time frames specified above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Non-Urgent Care Claims

Concurrent Care. A "concurrent care claim" is a claim involving an ongoing course of treatment that was previously approved under the plan for a specific period of time or number of treatments. If the plan has approved an ongoing course of treatment, any reduction or termination of the benefit (other than by plan amendment or termination) before the end of such period of treatment constitutes an adverse claims decision. The claims administrator will notify you of its determination at a time sufficiently in advance of the reduction or termination to allow you to file an appeal and obtain a determination on that appeal before the benefit is reduced or terminated.

The plan will provide continued coverage pending the outcome of the appeal of a concurrent care claim.

If your request to extend the course of treatment beyond the period of time or the number of treatments previously approved by the plan is an urgent care claim, your request will be decided under the Urgent Care Claim procedures described above.

If your request to extend the course of treatment beyond the period of time or the number of treatments previously approved is not an urgent care claim, your request will be considered a new claim and determined in accordance with the Pre-Service Claims and Post-Service Claims procedures described below.

Pre-Service Claims. A "pre-service claim" is any request for approval of a benefit, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (i.e., preauthorization).

The claims administrator will notify you of the plan's decision within a reasonable time period taking into account the medical circumstances, but not later than 15 days after the claim is received. The claims administrator may extend this period for up to 15 days, as long as the extension is necessary due to matters beyond the control of the claims administrator and the claims administrator notifies you in writing or electronically before the initial 15 day period expires. The notice to you will state the reason for the extension and the date by which the plan expects to provide a decision.

If the extension is necessary because you failed to submit the information necessary to make a decision regarding the claim, the notice of extension provided by the claims administrator will specifically describe the information you failed to submit and the date by which you must submit such information to the claims administrator. You will be allowed at least 45 days from the date you receive the notice to provide the specified information.

Post-Service Claims. A "post-service claim" is any medical coverage option claim under the plan that is filed after medical care has been received. A post-service claim must be filed under the plan not later than 365 days after the date on which the medical care relating to such claim has been received. Any benefit claim filed under the plan after such date will be denied by the claims administrator, unless the claims administrator determines there was reasonable cause for filing such benefit claim after such date.

The claims administrator will notify you of the plan's benefit determination within a reasonable time period, but not later than 30 days after receipt of the claim by the plan. The claims administrator may extend this period for up to 15 days, as long as the extension is necessary due to matters beyond the control of the Medical plan and the claims administrator notifies you in writing or electronically before the initial 30 day period expires. The notice to you will state the reason for the extension and the date by which the Medical plan expects to provide a decision. If the extension is necessary because you failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. You then have 45 days from the date you receive the notice to provide the specified information. If you do not provide the required information on or before the date specified in such notice, the benefit claim will be denied on the day following the date specified in the notice and the claims administrator will provide notice of that benefit determination.

Manner and Content of Notification of Claims Decision

The claims administrator will provide you with written or electronic notice of the plan's claims decision. In the case of an adverse claims decision, the notice will include:

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the decision is based;
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the plan's claims denial appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of such rule, guideline, protocol, or other criteria, or (2) a statement that such rule, guideline, protocol, or other criteria was relied upon and that a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request;
- If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you upon request;
- For an adverse claims decision involving an urgent care claim, a description of the expedited claims denial appeal process applicable to such claims;
- Information sufficient to identify the benefit claim involved, including (1) the date of service, (2) the health care provider, and (3) the benefit claim amount (if applicable);
- An explanation of the reason or reasons for the adverse claims decision, including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the benefit claim;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and if you request such information, the request will not be treated as a request for an appeal of the adverse claims decision; and
- A description of the plan's available claims denial appeal processes and procedures applicable to the plan, including information regarding how to initiate an appeal and the time limits applicable to such processes and procedures.

In the case of an adverse claims decision involving an urgent care claim, the information may be provided to you orally within the time frame prescribed, if you are given written or electronic notice within three days after the oral notification.

What If My Medical Claim Is Denied?

If Your Claim is Denied. If a claim for benefits is denied in part or in whole, you may discuss, on an informal basis, your questions regarding the determination by calling a UHC customer service representative at the number on the back of your ID card. This procedure is voluntary. You are not required to call UHC customer service before filing an appeal. If UHC cannot resolve your questions to your satisfaction over the phone, you have the right to file an appeal as described below.

How to Appeal a Denied Claim

Level One: If you wish to appeal a denied claim, including a denied pre-service request for benefits, post-service claim, or a rescission of coverage, you must submit your appeal in writing within 180 days after receiving the denial. Your written appeal must include:

- The patient's name and ID number on the ID card;
- The provider's name;
- The date of medical service;
- The reason you think your claim should be paid; and
- Any documentation or other written information to support your request.

You, your eligible dependent, or authorized representative must send the written request for an appeal to:

Claims Administrator
UnitedHealthcare — Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For urgent care claims that have been denied, you or your service provider can call UHC at the toll-free number on the back of your ID card to request an appeal.

You or your authorized representative may submit written comments, documents, records, and other information relating to the benefit claim at issue in the appeal, and all comments, documents, records, and other information submitted by you or your authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial review of that benefit claim.

You or your authorized representative will be provided, upon request to the plan and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your benefit claim at issue in the appeal. The appeal process will not afford deference to the initial decision regarding your claim and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse claims decision regarding your claim nor the subordinate of such individual.

If the appeal involves an adverse claims decision that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary of the plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the initial decision regarding your claim nor the subordinate of any such individual. A "health care professional" means a physician or other professional who is licensed, accredited, or certified to perform specified health services consistent with state law.

The claims administrator will identify the medical and vocational experts whose advice was obtained on behalf of the plan in connection with your appeal, without regard to whether the advice was relied on in making a decision regarding your appeal.

You and your authorized representative will be allowed, upon request to the claims administrator and free of charge, to review the benefit claim file for your benefit claim at issue in the appeal at the location where such benefit claim file is maintained.

The claims administrator will provide you and your authorized representative, free of charge, with any new or additional evidence considered, relied on, or generated by the plan or at the direction of the plan in connection with your benefit claim. The claims administrator will also provide you a copy of such evidence as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under the plan to give you a reasonable opportunity to respond prior to that date. A "final internal adverse benefit determination" is (1) an adverse decision with respect to an appeal under the plan that has been upheld by the claims administrator at the completion of the plan's internal appeals process, or (2) an adverse benefit determination of a benefit claim under the plan with respect to which the plan's internal appeals process has been exhausted under the deemed exhaustion rules of Treasury Regulation §54.9815-2719T(b) (2)(ii)(f).

You or your authorized representative will be allowed to present evidence and testimony to the appropriate named fiduciary of the plan who will conduct the appeal. Before the claims administrator can issue a final internal adverse benefit determination based on a new or additional rationale, you or your authorized representative will be provided, free of charge, with the rationale and the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under the plan to give you a reasonable opportunity to respond prior to that date.

The plan will ensure that all benefit determination appeals are adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision. To the extent required under regulations of the Department of Labor, the Department of Treasury and the Department of Health and Human Services, the plan will provide continued coverage for a claimant who files a benefit determination appeal pending the outcome of the benefit determination appeal. For this purpose, the plan must comply with the requirements of Department of Labor Regulation §2560.503 1(f) (2)(ii), which generally requires that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

The timing of the claims administrator's decision regarding your appeal is based on the type of claim you are appealing. UHC's response time is as follows:

- Urgent care*
  - The claimant must be notified of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account medical emergencies, but not later than 72 hours after the receipt of the claim.
  - Urgent appeals must meet one or both of the following criteria:
- Application of the time periods for making a non-urgent care determination could seriously jeopardize the patient's life or health or ability to regain maximum functionality; and/or
- In the opinion of a physician with knowledge of the medical condition, could cause severe pain.

- Pre-service claim, within 15 days
- Post-service claim, within 30 days

The timing above assumes that all required appeal documentation has been submitted.

The timing of the claims appeal process is based on the type of claim you are appealing. UHC's response time is as follows for urgent care request for benefits.*

Type of Request for Benefits on Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide a completed request for benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for benefits, you must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

Once the review is complete, you will receive a written explanation of the reasons and facts relating to the denial as described below in the section titled *Manner and Content of Notification of Appeals Decision*.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeal and submit opinions and comments. UHC will review all claims in accordance with the rules established by the US Department of Labor.

*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for benefits.

Level Two: If you are not satisfied with the appeal decision from Level One, you have the right to request a second level of appeal from UHC within 60 days of receipt of the Level One decision. Because your appeal will be reviewed by an appropriate individual(s) who did not make the initial benefit determination and was not consulted with respect to that determination, you must follow the same procedures as set out in Level One. However, your appeal must be filed within 60 days from receipt of the Level One decision. The response time from UHC will be the same as set out in Level One.

Once the review is complete, you will receive a written explanation of the reasons and facts relating to the denial as described below in the section titled *Manner and Content of Notification of Appeals Decision*.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeal and submit opinions and comments. UHC will review all claims in accordance with the rules established by the US Department of Labor.

Manner and Content of Notification of Appeals Decision

Every notice issued by the claims administrator regarding the claims administrator's decision on an appeal under the plan will be provided in writing (or, alternatively, notification by telephone or other timely method in the case of determination regarding the benefit determination appeal with respect to an urgent care claim) and, if the appeal upholds all or any part of the initial denial of the claim for benefits, the notice will include the following:

- The specific reasons for the claims administrator's decision regarding the appeal;
- Reference to the specific plan provisions on which the claims administrator's decision regarding the appeal is based;
- If an internal rule, guideline, protocol, or other similar criterion was relied on in making the decision regarding the appeal, either (1) a copy of such specific rule, guideline, protocol, or other similar criterion, or (2) a statement that such rule, guideline, protocol or other similar criterion was relied on in making the determination regarding the appeal and that a copy thereof will be provided free of charge to you upon request to the plan;
- If the decision regarding the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you upon request to the plan;
- A statement that you are entitled to receive, upon request to the plan and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your benefit claim at issue in the appeal;
- A statement of your right to bring a civil action in court under Section 502(a) of ERISA;
- Information sufficient to identify the benefit claim involved in the appeal, including (1) the date of service, (2) the health care provider, and (3) the benefit claim amount (if applicable);
- An explanation of the reason or reasons for the claims administrator's decision, including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the appeal and a discussion of the decision;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and if you request such information, the request will not be treated as a request for an appeal of the adverse claims decision;
- A description of the Medical plan's available claims denial appeal and external review processes and procedures, including information regarding how to initiate an appeal and the time limits applicable to such processes and procedures; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHSA Section 2793 to assist individuals with the internal claims and appeals and external review processes.

Communications in Foreign Languages

In connection with the claims and appeals described above, to the extent required under Department of Labor and Department of Treasury regulations, the Claims Administrator will communicate with claimants in a culturally and linguistically appropriate manner. If a person filing a benefit claim or appeal resides in a United States county in which 10 percent or more of the population is literate in a Non-English language, as determined in guidance published by the Secretary of Labor or Department of Treasury (an "applicable non-English language"), then in connection with such individuals' claims and appeals described above (1) the Claims Administrator will provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language and providing assistance with filing claims and appeals in the applicable non-English language and (2) the Claims Administrator will provide, upon request, any notices in the applicable non-English language and (3) the Claims Administrator will include in the English versions of all notices, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the Medical plan.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based on any of the following:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The covered person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard External Review

A standard external review comprises all of the following:

- A preliminary review by UnitedHealthcare of the request;
- A referral of the request by UnitedHealthcare to the IRO; and
- A decision by the IRO.

Within the applicable time frame after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- All relevant medical records;
- All other documents relied on by UnitedHealthcare; and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "final external review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of final external review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination, a general description of the reason for the request for external review, including information sufficient to identify the benefit claim (including, the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial), the date the IRO received the assignment to conduct the external review and the date of the IRO's decision, references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision.

Upon receipt of a final external review decision reversing UnitedHealthcare's determination, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the plan, and any applicable law regarding plan remedies. If the final external review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter and, in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or oral request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a oral request for an expedited external review.

Coordination of Benefits (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how benefits under the this Plan will be coordinated with those of any other plan that provides benefits to you.

When Coordination of Benefits Applies

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

The order of benefit determination rules below governs the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense. allowable expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1. The Plan of the parent whose birthday falls earlier in the [calendar][Plan] year is the Primary Plan; or
      2. If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
      4. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         a. The Plan covering the Custodial Parent.

         b. The Plan covering the Custodial Parent's spouse.

         c. The Plan covering the non-Custodial Parent.

         d. The Plan covering the non-Custodial Parent's spouse.

         For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

   c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. **If the preceding rules do not determine the order of benefits,** the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Benefits are Paid When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a covered health services by following the steps below.

- The Plan determines the amount it would have paid based on the allowable expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable copayment, coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference less any applicable copayment, coinsurance or Deductible requirements of the Plan.

Determining the Allowable Expense If this Plan is Secondary

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a network provider for both the Primary Plan and this Plan, the allowable expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-network provider for this Plan, the allowable expense is the Primary Plan's network rate. When the provider is a non-network provider for the Primary Plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-network provider for both the Primary Plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the allowable expense When this Plan is Secondary to Medicare.*

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in, Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Determining Which Plan is Primary When You Qualify for Medicare

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers.

When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

As permitted by law, the Medical plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Medical plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic
- Partners are excluded as provided by Medicare)
- Individuals with end-stage renal disease, for a limited period of time
- Disabled individuals under age 65 with current employment status and their Dependents under age 65

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

If this Plan is secondary to Medicare, it determines the amount it will pay for a covered health services by following the steps below.

- The Plan determines the amount it would have paid based on the Primary Plan's allowable expense.
- If this Plan would have paid less than the Primary Plan paid, the Plan pays no benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

- The Plan determines the amount it would have paid based on its contract.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference less any applicable Deductible and Coinsurance and Copayment requirements of the Plan.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the Explanation of Medicare Benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Claims Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Right of Recovery

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments,* below.

Refund of Overpayments

If the Plan pays for benefits for expenses incurred on account of a covered person, that covered person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits that are payable in connection with services provided to other covered persons under the Plan; or (ii) future benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Post-65 Retiree Medical Coverage

Your Via Benefits benefit advisor will help you understand all of your options for selecting an individual Medicare supplement plan from the Medicare marketplace. While you will have a choice of different plan designs, all of the supplement plans that are available fall into the categories shown below. **You must enroll through Via Benefits to receive your funding subsidy, if applicable. If you do not enroll in individual supplemental health care coverage through Via Benefits, you will forfeit your remaining subsidy balance (if any).**

Medicare Supplement Insurance plan

(often called a Medigap plan), which helps pay some or all of the medical costs not covered by Medicare Parts A and B, such as coinsurance, deductibles, and copayments.

With this type of plan, you can use the doctors and hospitals of your choice.

+

Medicare Part D plan,
which covers a portion of your prescription drug costs.

OR

Medicare Advantage plan

(also known as Medicare Part C), which generally replaces and covers the same services as Medicare Parts A and B and often includes coverage for prescription drugs.

Note: Medicare Advantage plan options vary depending on where you live.

With this type of plan, you may need to choose doctors and hospitals in the plan's network.

You must enroll in Medicare Part B before you can elect any supplemental insurance coverage, and you should do it well in advance of your retirement date, unless you are enrolled in a high-deductible health plan and are making contributions to a Health Savings Account. Medicare allows you to enroll up to 90 days prior to retirement.

Important

Details about these plans will be included in an Enrollment Guide that Via Benefits will send to you. Your Via Benefits benefit advisor will also walk through your options with you over the phone. You may also review your options at **my.viabenefits.com/bakerhughes.**

Coordinating with Medicare

The following table shows how the plan's Medical options coordinate with Medicare:

Age/Disability	Baker Hughes Plan	Medicare	Via Benefits
Retired < 65	Primary	Not Eligible	Not Eligible
Retired < 65 with disability	Secondary	Primary	Eligible
Retired 65+	Not Eligible	Primary	Eligible

Prescription Drug Program

The following is a summary of the prescription drug program (the Prescription Drug program) offered under the plan. The Prescription Drug program is available only to retirees and qualifying dependents who are under 65 years of age and enrolled in one of the Retiree Medical coverage options offered under the plan—the Pre-65 Basic Choice Plus and Catastrophic Choice Plus including Out-of-Area option alternatives.

Your Prescription Drug Program Choices

If you enroll in any of the Retiree Medical coverage options offered under the plan, you'll automatically receive prescription drug coverage through CVS/caremark. This program allows you to receive prescription drugs by paying a fixed copay or coinsurance amount. For all of the Retiree Medical coverage options, costs are based on whether you purchase your prescription drugs through the CVS/caremark network of retail pharmacies, CVS/caremark Home Delivery, or a non-network pharmacy.

UHC Basic and UHC Catastrophic Choice Plus Options (including Out-of-Area Alternatives) for Pre-65 Retirees

If you enroll in the UHC Basic Choice Plus or Catastrophic Choice Plus option, you will pay copays for generic medications. Formulary and non-formulary medications are subject to coinsurance with minimums and maximums. Coinsurance is a percentage of eligible covered expenses shared between you and the plan. The amount of network coinsurance you pay applies to the out-of-pocket maximum. After you reach the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. The cost for each drug category is listed below.

Pre-65 Coverage – CVS/caremark

Drug Category	Retail Pharmacy up to a 30-day Supply	Home Delivery up to a 90-day Supply
Generic	$15	$30
Formulary Brand	25% coinsurance ($40 minimum/$60 maximum)	25% coinsurance ($100 minimum/$150 maximum)
Non-Formulary Brand*	30% coinsurance ($60 minimum/$80 maximum)	30% coinsurance ($150 minimum/$200 maximum)
Specialty	30% coinsurance ($250 maximum/30-day supply only)	
Out-of-Pocket Maximum**	$2,000 individual/$4,000 family	

*Non-formulary drugs do not apply toward the out-of-pocket maximum.

**Coinsurance and copays apply.

Tip! In order to keep your costs low, check with your physician to make sure that generic or formulary brand name drugs are prescribed whenever possible.

If you use a non-network pharmacy, you will need to pay the full cost of the prescription up front and submit a claim form to CVS/caremark for reimbursement. You will be reimbursed up to the discounted retail pharmacy price minus the applicable copay/coinsurance amount.

If you have questions about your Baker Hughes Retiree Medical coverage or Prescription Drug program coverage, contact the **Baker Hughes Benefits Center** at **1-866-244-3539** or **1-847-883-0945** (worldwide).

Generic drugs are identified by a chemical name rather than the advertised brand name. These drugs are made with the same active ingredients and are available in the same strength and dosages as the equivalent brand name drugs. Additionally, generic drugs meet the same FDA standards for safety, strength, and effectiveness as brand name drugs.

A formulary drug is a brand name drug that is on the CVS/caremark preferred drug list, while a non-formulary drug is one that is not. Generally, each non-formulary drug has at least one formulary alternative available at a lower cost on the list. Non-formulary drugs are covered by the plan, but at higher costs.

CVS/caremark National Network of Retail Pharmacies

The CVS/caremark national network of retail pharmacies includes more than 67,000 pharmacies nationwide, including chain pharmacies (e.g., Walgreens), 27,000 independent pharmacies, and 7,500 CVS/pharmacy stores. Use a retail pharmacy that is part of the national network when filling short-term prescriptions for medications such as antibiotics.

To locate a retail pharmacy that is part of the CVS/caremark national network:

- Ask your local pharmacist if he or she participates in the CVS/caremark national network;
- Log on to the CVS/caremark website at **caremark.com** and use the pharmacy locator; or
- Call CVS/caremark Customer Care at **1-877-252-3485**.

Show your CVS/caremark ID card at a retail pharmacy that is part of the CVS/caremark national network, and pay the appropriate cost based on the drug category of your prescription.

Note: If you choose to have your prescriptions filled at a pharmacy that is not part of the CVS/caremark national network, you'll need to pay the full amount of the prescription price. You will then need to submit a claim form to CVS/caremark for reimbursement. Reimbursement of covered expenses will be at the discounted cost of the medication minus the coinsurance or copay amount and is subject to the same plan rules, such as clinical guidelines and mandatory Maintenance Choice®, etc.

If your physician has prescribed certain specialty or biotech medications for you or a covered family member, you'll need to have the prescription filled through CVS/caremark Specialty Pharmacy. You may access the CVS/caremark Specialty Pharmacy through **caremark.com** or by calling **1-800-237-2767***.

Tip!

In order to help keep your prescription costs low, check with your physician to make sure that generic or preferred brand name drugs are prescribed whenever possible.

Additional Resources

bakerhughes.ehr.com

CVS/caremark Customer Care: **1-877-252-3485** | Internet: **caremark.com**

You can register online at **caremark.com** after you have enrolled in the plan.

Allow approximately two weeks for your enrollment to be updated with CVS/caremark.

- Process new orders for prescription drugs
- Order prescription refills
- Verify order status of refills
- View the CVS/caremark Advance Control Drug Formulary Drug List to determine if a particular drug is preferred or non-preferred.
- Research drug information
- View prescription drug history
- Locate retail pharmacies that are part of the CVS/caremark national network and run cost comparisons between pharmacies
- Access health and drug information

*Residents of FL, MN, OK, TN, and WV should log on to CVS/caremark website at **caremark.com** to locate a Specialty Pharmacy.

Maintenance Choice®

Prescription drugs that your doctor requires you to take on a regular basis are considered "maintenance" medications. Examples include medications prescribed for the treatment of long-term or chronic conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc.

CVS/caremark's Maintenance Choice program is a good option for you if you take maintenance medications because it will save you time and money over the long term. You start by obtaining up to three 30-day prescription fills through a retail pharmacy (original fill and two refills). After the third 30-day fill at retail, the plan requires you to use Maintenance Choice, which allows you to fill your 90-day supply one of three ways:

- a CVS/pharmacy store
- a 90-day supply network pharmacy
- an approved mail-service pharmacy

Either way, you will pay mail service prices. You can locate approved participating pharmacies and mail service providers at **caremark.com**.

Please note that if you do not use Maintenance Choice® after your third fill at retail, your medication will not be covered and you will have to pay 100% of the cost. In addition, if you try to fill your maintenance medication at a pharmacy other than a select participating pharmacy, your prescription will be rejected.

To participate in Maintenance Choice®, please ask your physician for two separate prescriptions. The first prescription will be for the 30-day supply with two refills that you can fill at a retail pharmacy. Your second prescription should be for a 90-day supply (with appropriate refills) that you will fill through Maintenance Choice®. You may pay for your prescription by check, electronic check, money order, or via a debit or credit card (Visa, MasterCard, American Express, Discover). If you use mail service, the mail service provider will deliver your order directly to the destination of your choice via First Class US mail within 7 to 10 days of receipt of the order.

CVS/caremark's FastStart® service offers easy ways to get started with mail service for your maintenance medications. With FastStart®, you can register for mail service online, by phone or by mail. When you're ready to call, have your prescription benefit card number, the names of your medicines, your doctor's information, and your payment information available.

- Call FastStart® toll-free at **1-800-875-0867** from 7 a.m. to 7 p.m., Central Time, Monday through Friday.
- Log on to **caremark.com** and select "Order Prescription" and request a prescription.

Additional Resources

For questions regarding Maintenance Choice® or to enroll in mail service call **1-877-252-3485** | Internet: **caremark.com**.

CVS Transform Diabetes Care Management Program

The Baker Hughes Company pharmacy plan includes the Next Generation Transform Diabetes Care (TDC) program. The TDC program is a complete approach to help members and/or their dependents manage their diabetes. Members and/or dependents diagnosed with diabetes who enroll in TDC will receive a glucometer and testing strips at no cost.

Request a Free Caremark Diabetes Meter

To request a free Caremark diabetes meter, call **1-877-418-4746** or go to **caremark.com/ManagingDiabetes**.

Customized Care Plan

You will receive a customized care plan that includes:

- Blood glucose monitoring
- Medication review to help make sure you're taking the right medications
- Help staying on track with your medications
- Help with lifestyle changes and managing co-morbidities

Valuable Resources

These resources can help you take care of your health:

- Pharmacist counseling in person or by phone
- Consultations at CVS HealthHUB or MinuteClinic locations
- Important information by phone, email or text message

MinuteClinic Vouchers

Vouchers are available to members and/or dependents for **two diabetes visits at any MinuteClinic**, the walk in medical clinic located inside many CVS Pharmacy locations. These visits may help prevent complications or related conditions with help that can include:

- Blood pressure check
- Body Mass Index (BMI) assessment
- Lipid panel (Cholesterol)
- Foot and eye physical exam
- Urinalysis
- Blood sugar check (Glucose)
- Education materials and follow-up recommendations

For Additional Information

If you have questions about your participation in the CVS Caremark next generation Transform Diabetes Care Program, please call Customer Care using the phone number on the back of your CVS Caremark member ID card. If you do not have a member ID card, visit **caremark.com**.

Refills

Refills can be ordered by mail, phone, or online. Refills typically take around five days to process. If your prescription is out of refills, you or your doctor can send in a new prescription. Faxes are only allowable directly from the doctor; faxes are not allowed from members. You may also sign up for ReadyFill® via phone or email. ReadyFill® offers automatic refill reminders wherein CVS/caremark will contact you to notify you that your refill will automatically ship within a week.

Understanding the CVS/caremark Advance Control Formulary Drug List

A CVS/caremark Advanced Control Formulary™ (ACF) Drug List is a more highly controlled formulary that was developed to drive greater savings. ACF helps to deliver value across the various classes of the formulary, including specialty. It offers the ability to control spend while promoting cost effective care.Drugs are included on the CVS/caremark ACF Drug List only after a team of pharmacists and physicians evaluate their efficacy and cost relative to available alternatives. Final decisions for CVS/caremark are made by an independent group of clinical pharmacists and physicians known as the Pharmacy and Therapeutics (P&T) committee. Baker Hughes is not involved in this process. The P&T Committee evaluates the safety and effectiveness of available prescription drugs. They apply their expertise to evaluate the options in various therapeutic classes of drugs. (Examples of therapeutic classes are cholesterol-reducing agents, antibiotics, etc.)

As a Prescription Drug program member, it is important that you understand your CVS/caremark ACF Drug List. It is a convenient reference guide that helps doctors select medications that will achieve the best results for patients while controlling health care costs for the patient and the plan.

The CVS/caremark list is reviewed quarterly and prescription drugs can move on or off of the list after each review.

Remember...
When a brand name drug has an FDA-approved generic alternative, the generic drug is always considered the preferential drug.

The CVS/caremark ACF Drug List is made up of two categories of medications: generics and preferred brand name drugs. Non-preferred brand name drugs may be processed at a tier 3 co-insurance. Certain drugs are excluded from the list and require a "medical exceptions process" in order to dispense them for medical necessity purposes. Within the list, generic drugs are identified by a chemical name rather than the advertised brand name. These drugs are made with the same active ingredients and are available in the same strength and dosages as the equivalent brand name drugs. Additionally, generic drugs meet the same FDA standards for safety, strength, and effectiveness as brand name drugs. A preferred drug is a brand name drug that is on the CVS/caremark ACF Drug List, while a non-preferred drug is one that is not. Generally, each non-preferred drug has at least one preferred brand or generic alternative available at a lower cost.

The Prescription Drug program as administered by CVS/caremark contains a generic substitution provision. This means that at retail pharmacies or through mail service, **your prescription will automatically be filled with the generic equivalent when available and permissible by law, unless you or your physician specifically request the use of a brand name drug**. State law permits pharmacists to substitute a generically equivalent drug for a brand name drug unless you or your physician specifically direct otherwise.

If your physician requests that your prescription not be substituted for a generic, his or her signature must appear on the original prescription in the Dispense as Written (DAW) designated area.

If you request not to substitute for generic, or if you fill a brand name drug when a generic alternative is available, you are required to pay additional costs. These include the applicable cost, the difference in cost between the brand name drug and the generic alternative (cost differential), and the brand copay. (Please note that this cost differential does not apply toward the out-of-pocket maximum.) **If you or your physician request a brand name drug when a generic alternative is available, you will be required to pay the brand or non-preferred brand cost, including the cost differential as described above.**

Note: A pharmacist can't substitute a preferred drug for a non-preferred drug. The pharmacist would need to contact your physician to obtain a new prescription for the preferred drug.

The CVS/caremark ACF Drug List can be found at **caremark.com** or by calling Customer Care at **1-877-252-3485**. You should take the CVS/caremark ACF Drug List with you when you visit your physician so that he/she can prescribe a preferred drug whenever possible.

Explanation of Terms

Generic: A drug that is no longer under patent protection and may be a lower-cost equivalent of a brand medication. The US Food and Drug Administration (FDA) requires that all generic drugs have the same active ingredients, strength and dosage form as the brand name equivalents.

Preferred: A brand drug that is on the CVS/caremark Advance Control Formulary Drug List and/or processes at a tier 2 copay/coinsurance. These drugs have been determined to be either more effective than or just as effective as another product in the same therapeutic class.

Non-Preferred: A brand drug that is not on the CVS/caremark Advance Control Formulary Drug List and processes at a tier 3 copay/coinsurance. Generally speaking, these are higher-cost medications that have recently come to the market. In most cases, an alternative preferred medication (brand or generic) is available.

Excluded: These are drugs that are not covered under the formulary due to more cost-effective and clinically appropriate products out in the market. If you choose to utilize these products, you would be responsible for 100% of the cost of the medication.

Clinical Guidelines

In an ongoing effort to effectively manage your Prescription Drug benefits, clinical guidelines are included as part of the Prescription Drug program design. These clinical guidelines are known as Prior Authorization, Quantity Level Limits, and Step Therapy.

Clinical guidelines are important because there are certain medications that require closer review to support the benefits of the prescription drug to the patient. CVS/caremark provides recommendations concerning coverage of these medications by verifying their appropriateness before payment of a prescription can be authorized.

The medications selected for Prior Authorization and Quantity Level Limits typically have off-label uses (not approved by the Food and Drug Administration FDA, have the potential to be used inappropriately, or tend to be higher in cost).

In most cases, members taking one or more of the medications requiring a review will not experience a delay in obtaining their medicine. However, you may experience a delay if the appropriate documentation cannot be obtained/provided in a timely manner.

If you would like to determine whether your drug is subject to Clinical Guidelines, please visit **caremark.com**, or call Customer Care at **1-877-252-3485**.

Prior Authorization

CVS/caremark will conduct reviews of certain medications before allowing coverage under the Prescription Drug program. Some reviews are as simple as verifying age and/or gender, while others may require proof of medical necessity from the prescribing physician. Typically, this review consists of two steps:

- **Step 1:** A medical diagnosis is obtained from the prescribing physician (some medications may require additional information, such as proof of medical necessity). Your physician (or sometimes a pharmacist) can call or fax the appropriate medical documentation directly to CVS/caremark.
- **Step 2:** Clinical personnel at CVS/caremark then determine if the diagnosis falls within the appropriate medical guidelines, which are based on both clinical judgment and current medical literature. The decision of the Prior Authorization Department will determine if a benefit with respect to the medication will be covered by the Prescription Drug program. If the medication does not meet the Prior Authorization requirements, the Prescription Drug program will not pay a benefit with respect to the medication. Members may speak with their prescribing physicians about an alternative, or pay the full amount for the non-authorized drug.

Quantity Level Limits

For some medications, the Prescription Drug program will only cover a certain number of pills or units (i.e. injections or nasal spray bottles) within a specified time period, usually 30 days. This limitation is typically in place for medications that have a potential for abuse or for medications that the FDA has determined to be safe in only limited amounts. Quantity Level Limits are in place for a limited number of medications; however, this clinical guideline may be added to newly approved medication.

Step Therapy Program

Step Therapy is a program for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma or high blood pressure. The program ensures you are getting the prescription drugs you need, with safety, cost, and — most importantly — your health in mind. The program also makes prescription drugs more affordable for most members.

In Step Therapy, the covered drugs you take are organized in a series of "steps," with your doctor ultimately writing and approving your prescriptions.

- **Step 1:** The program usually starts with generic drugs as the "first step." Rigorously tested and approved by the US Food and Drug Administration (FDA), the generics covered by the plan have proven to be effective in treating many medical conditions. This first step allows you to begin or continue treatment with safe, effective prescription drugs that are also affordable: your copay is usually the lowest with a first-step drug.
- **Step 2:** More expensive brand name drugs are usually covered in the "second step" (even though the generics covered by the plan have proven to be effective in treating many medical conditions).

Your doctor is consulted, writing and approving your prescriptions based on the Step Therapy drugs covered by the plan. For instance, your doctor must write a new prescription for you when you change from a second-step drug to a first-step one.

CVS/caremark identifies which drugs are covered in Step Therapy under the guidance and direction of independent, licensed doctors, pharmacists, and other medical experts. Together with CVS/caremark, this group reviews the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Next, the Step Therapy team recommends appropriate prescription drugs for the Step Therapy Program, and the Prescription Drug program chooses the drugs that will be covered.

CVS/caremark Specialty Pharmacy

Specialty medications are classified as "specialty" for any of the following reasons:

- They treat chronic, serious, or rare diseases
- They are delivered by non-oral means, such as injection or infusion
- They are typically very expensive or in limited distribution
- They may require complex care, special storage and handling, strict adherence requirements, or extra patient support

Examples of diseases or conditions for which medications may be obtained through CVS/caremark Specialty Pharmacy include — but are not limited to — multiple sclerosis (e.g., Avonex, Betaseron), rheumatoid arthritis (e.g. Enbrel, Humira), and growth hormone deficiency (e.g., Genotropin, Humatrope). Certain injectable medications such as insulin, Imitrex®, epinephrine, and glucagon are not considered specialty medications.

As part of the CVS/caremark Specialty Pharmacy program, CVS/caremark offers personalized care from an experienced Care Team of pharmacists and nurses trained in complex health conditions and the latest medication therapies. You obtain your specialty medications by filling up to two prescriptions through any retail pharmacy that is part of the CVS/caremark national network. Afterward, you must obtain your prescription through a CVS/pharmacy store or the CVS/caremark Specialty Pharmacy*.

You can bring your specialty prescription to any CVS retail pharmacy location where they will transfer it to CVS Specialty for processing. A member of the CVS Specialty Care Team will contact you, once received, to assist in processing your medication and ask the location to deliver your medication including a CVS retail pharmacy. However, this does not apply if the medication in question is considered Limited Distribution or if it is subject to a Prior Authorization. If the prescription is Limited Distribution or if a Prior Authorization is required, the pharmacist will provide you with the appropriate action that you should take to obtain the medication.

If you have a prescription for a specialty drug, or a refill for a specialty drug, there are two options for getting started with the CVS/caremark Specialty Pharmacy:

- A CVS/caremark representative will call you and your doctor to fill the prescription, or you can call the CVS/caremark Specialty Pharmacy at **1-800-237-2767**. Hours are 6:30 a.m to 8 p.m. Central Time Monday through Friday.
- CVS/caremark Specialty Pharmacy will work with you to fill the prescription and have it delivered to your home, to a local CVS/pharmacy store, the physician's office, or another location you choose.

Specialty drugs can only be filled with a monthly supply. Please note that the cost of a specialty drug can be significantly higher.

Please also be advised that some medications may require administration under a controlled medical environment, such as a physician's office. CVS/caremark Specialty Pharmacy has the ability to administer several types of inventory programs for a designated eligible health care provider (e.g., a physician).

Access CVS/caremark Specialty Pharmacy at **caremark.com** or by calling **1-800-237-2767**.

*Residents of FL, MN, OK, TN, and WV should log on to the CVS/caremark website at **caremark.com** to locate a Specialty Pharmacy.

Covered Drugs

The following are covered:

- Drugs and medications for which a physician's prescription is required (also called federal legend drugs);
- Legend drugs, which are medications that require a prescription from a licensed health care professional;
- An extemporaneously prepared combination of two or more drug products containing at least one federallegend drug in a therapeutic amount;
- Insulin, needles, and syringes;
- Ostomy supplies;
- Any other drug which, under applicable state law, may only be dispensed by a physician's (or other authorized person's) written prescription; and
- Tobacco cessation medications for up to a 90-day supply (retail pharmacy only; no mail service). Beyond 90 days, participant must be enrolled in the Tobacco Cessation Program.

Remember...

It's always a good idea to file your claims on a timely basis and keep a copy of your claim form, receipts, and all supporting evidence for your records.

Definition: *Legend* describes medications that require a prescription from a licensed health care professional.

AccordantCare Complex Conditions Nurse Care Management Program

What is the AccordantCare™ for complex conditions?

AccordantCare™ for complex conditions specialized program that gives members the support they need to manage their complex condition, find helpful information and stay as healthy as possible. AccordantCare is offered to members with the following complex conditions:

- Amyotrophic Lateral Sclerosis (ALS)
- Juvenile Idiopathic Arthritis (JIA)
- CIDP (Chronic Inflammatory Demyelinating Polyradiculoneuropathy)
- Multiple Sclerosis
- Crohn's Disease
- Myasthenia Gravis
- Cystic Fibrosis
- Parkinson's Disease
- Dermatomyositis
- Polymyositis
- Epilepsy (Seizures)
- Pulmonary Arterial
- Hypertension (PAH)
- Gaucher Disease
- Rheumatoid Arthritis
- Hemophilia

- Scleroderma
- Hereditary Angioedema (HAE)
- Sickle Cell Disease
- Human Immunodeficiency Virus (HIV)
- Systemic Lupus Erythematosus (SLE or Lupus)
- Inclusion Body Myositis (IBM)
- Ulcerative Colitis

Who is eligible?

All Baker Hughes Pharmacy Drug Program members with any of the complex conditions listed above are eligible to enroll and participate as much or as little as they like at no additional cost.

Why is this program offered for Baker Hughes members?

It helps achieve results that matter most to Baker Hughes. AccordantCare provides a better experience for members, which leads to better outcomes. The complex conditions supported by this program may make up a small percentage of your population, but they cost many times more than common chronic conditions. Members with these complex conditions have a higher hospital and emergency room rate and their conditions progress and become more expensive over time. AccordantCare services have been shown to be associated with better health, lower costs and fewer hospital readmissions.

How are members identified to participate in this program?

Members are identified via claims data analysis and individual case management referrals. Once identified, eligible members will receive introductory mailings and phone calls to enroll in the program.

Is participation mandatory?

No, it's completely voluntary and members can opt out at any time. AccordantCare offers options to meet the needs of all members. Members can continue in the program as long as they are eligible.

What are the levels of participation?

AccordantCare offers two levels of participation – interactive and self-directed. Interactive members are assigned a dedicated RN who contacts them at least quarterly to complete a risk assessment and more frequently as needed. Self-directed members receive the same benefits as interactive members except they have opted not to have a nurse contact them on a regular basis. These levels allow members to participate as much or as little as they like.

What can a member expect to receive if enrolled in this program?

- 24/7 access to a dedicated registered nurse (RN) who specializes in the member'scomplex condition and provides ongoing support and education, including co-morbidity management
- Routine health risk assessments conducted by an RN to identify risk factors, gaps in care and opportunities for optimal self-management
- Personalized education and monitoring based on individual needs, including specialized support for health goals
- Monthly newsletters focusing on condition-specific self-management strategies
- Targeted educational mailings triggered by claims-based gaps in care and adverse events
- A wide range of online resources, including educational materials and interactive forums available at **Accordant.com**
- Physician notification of program enrollment and ongoing collaboration on the member'splan of care
- Help finding resources that provide psychosocial support, end-of-life counseling and caregiver assistance
- Case management and coordination of care
- Periodic wellness outreach, including flu and pneumonia vaccine reminder

Questions about the program?

- Call 1-800-342-5441
- Website: **Accordant.com**

Exclusions and Limitations

The Baker Hughes Company Pharmacy Plan shall exclude from coverage certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs). The Baker Hughes Company designee, CVS/caremark, shall determine which drugs meet the criteria for exclusion. The following are excluded from coverage:

- Drugs and medications that can be obtained without a physician's prescription
- Non-legend drugs other than insulin
- Hair growth agents
- Immunization agents (excluding preventive vaccinations), biological serums, blood products, or blood plasma
- Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs.
- Experimental or investigational drugs; or drugs prescribed for experimental indications
- Drugs or medicines dispensed or administered to you or your covered dependents while in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, physician's office, or any other institution that dispenses drugs or medicines (these drugs may be covered under the plan)
- Any refill of a prescription that exceeds the number of refills ordered by a physician
- Any refill dispensed more than one year after the date of the prescription
- Prescription drugs that may be obtained without charge under local, state, or federal programs (such as Workers' Compensation)
- Drugs purchased outside the United States that are not legal inside the United States
- Therapy devices or appliances, including support garments and other non-medical substances, regardless of their intended use
- Certain legend products with over-the-counter (OTC) equivalents
- Legend homeopathic products
- Legend medical foods
- Drugs or medicines for:
  - Any cosmetic procedure or treatment (i.e., photo-aged skin products and skin de-pigmentation products)
  - Experimental treatment
- Extemporaneously prepared combinations of raw bulk chemical ingredients or combinations of federal legend drugs in a non-FDA approved dosage form
- Drugs prescribed for consumption or use during a period when no coverage is in force
- Contraceptive implants, diaphragms, and IUDs
- Allergens
- Diagnostic, testing, and imaging supplies
- Non-sedating antihistamines and brand name oral tetracyclines

Filing Prescription Drug Claims

Remember...
It's always a good idea to file your claims on a timely basis and keep a copy of your claim form, receipts, and all supporting evidence for your records.

Please note that you do not need to file a claim form when you use a pharmacy that is part of the CVS/caremark national network, provided you present your card to the pharmacy and are deemed eligible. If you use a non-network pharmacy, you're responsible for the full cost of the prescription drug at the time of purchase. You will need to submit a claim form to CVS/caremark for reimbursement for such prescription drug purchases. CVS/caremark will reimburse covered expenses minus the coinsurance or copay amount. Remember that drug expenditures for which you file claims are also subject to the same plan rules that apply when filling prescriptions at your network retail pharmacy, such as Clinical Guidelines, mandatory Maintenance Choice®, etc.

Your claim form includes instructions on how to file a claim. Read the claim form carefully and make sure you answer all questions and include all required information and documentation.

Once you complete the claim form, attach all evidence to support your claim, including receipts, and file your claim directly with CVS/caremark as soon as possible after your purchase. You have 12 months from the date the prescription was filled to file a claim for expenses incurred.

Unless the Prescription Drug claim form provides otherwise, you should send your claim forms to:

CVS/caremark Claims
P.O. Box 52136
Phoenix, AZ 85072-2136

Deadline to File a Claim. To receive a reimbursement for covered expenses, CVS/caremark must receive your claim form and supporting documentation no later than 12 months from the date the prescription was filled.

Claim Decision. CVS/caremark has 30 calendar days in which to decide your claim and to notify you if your claim is denied in whole or in part. If your claim is denied, you will receive a notice of the adverse benefit determination, which includes the reason for the denial, reference to the relevant plan provisions, and other information as required by federal law or regulations. You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond CVS/caremark's control.

About Compound Drug Claims. Health Insurance Portability and Accountability Act (HIPAA) regulations require claims for compound drugs to include information on all of the ingredients in order for the plan to process the claims for payment. If the pharmacy that fills your compound drug prescription submits the claim directly to CVS/caremark, you are not required to provide any additional information. However, if you fill your compound prescription at an out-of-network pharmacy or you submit a claim form for reimbursement of a compound drug, you must include the following information on the claim form (missing information may result in non-reimbursement):

- A valid 11-digit National Drug Code (NDC) number for each ingredient used in the compound;
- The ingredient name for each NDC;
- The metric quantity (i.e., number of tablets, grams or milliliters) for each NDC ingredient;
- The cost for each ingredient;
- The total compounded quantity; and
- The total dollar amount paid for the compound drug.

If your claim is denied, you can call or write to CVS/caremark as listed on your claim form.

If you are not satisfied with the results of the coverage decision, you may begin the appeals process. Except for appeals involving urgent claims, you must submit all appeals in writing.

Tip!

Prescription Drug claim forms are available at **caremark.com**, or by calling Customer Care at **1-877-252-3485**.

Appealing a Denied Claim

Remember...

For each level of appeal, you may submit a letter of medical necessity from your physician to support your claim.

1st Level Appeal and Decision

You must file an appeal within 180 days after the date you receive the adverse benefit determination with the notice that your claim is denied. You or your prescribing physician may file an appeal. Send anything that shows why the drug should be covered under your health benefit plan. You may also have a relative, friend, advocate, or anyone else (including an attorney) act on your behalf as your authorized representative.

How to File an Appeal. You may send a letter from prescriber describing why medicine is necessary, clinical notes, test results, or any other supporting documentation. Mail or fax your appeal to:

CVS/caremark, Inc.
Prescription Claim Appeals
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Fax: **1-866-443-1172**

Upon request, you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claims process.

1st Level Appeal Decision. Once CVS/caremark receives all of your information, CVS/caremark has 15 days (or, in the case of an urgent care claim, as soon as possible but no later than 72 hours) to make a decision and notify you of that decision. If your appeal is denied, you will receive a notice of the adverse benefit determination, which includes the reason for the denial, reference to the relevant plan provisions, and other information as required by federal law or regulations.

If your situation meets the definition of urgent under the law, your request will be reviewed on an expedited basis. Generally, an urgent situation is defined by law as one in which your health is in serious jeopardy; or in the opinion of your prescriber, you will experience pain that cannot be adequately controlled while you wait for a decision on the appeal. You or your prescriber may ask for an expedited appeal by calling Customer Care toll-free at the number on the benefit ID card or by faxing the appeal to 1-866-443-1172. Urgent requests must be clearly identified as "urgent" when submitted.

2nd Level Appeal and Decision

CVS/caremark contracts with an Independent Review Organization (IRO) to conduct independent specialist physician reviews of denials of authorization of benefits when the plan participant or beneficiary is entitled to obtain such a review.

Your written appeal must be submitted to CVS/caremark. Appeals may be forwarded directly to the CVS/caremark Appeals Department by following the directions in the denial letter. You should include the reasons you disagree with the denial of your claims and any information, documents or arguments you want considered in the 2nd level appeal. You may submit written comments, documents, records, and other information relating to your claim. Upon request, you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claims process.

2nd Level Appeal Decision. Once CVS/caremark receives all of your information, the IRO has 15 days (or in the case of an urgent care claim, as soon as possible but no later than 72 hours) to make a decision and notify you of that decision. If your appeal is denied, you will receive a final adverse benefit determination notice, which includes the reason for the denial, reference to the relevant plan provisions and other information as required by federal law or regulations. At the same time you ask for an expedited appeal, you may also ask for an expedited external review. External review requests must be clearly identified as an "external review" when submitted. If you or your provider have any questions, please call the phone number on your benefit ID card.

Benefits Rights

Baker Hughes

Important Benefits Rights

Please read this section carefully. It contains information concerning the Baker Hughes Retiree Health & Welfare Benefits Plans benefit programs described in this SPD and it includes important facts and information about your rights as a plan participant.

This SPD is designed to inform you about certain retiree benefits that Baker Hughes provides and how you may receive them. You cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit payable under the plan.

Importance of a Current Address on File After You Retire

Because most benefit-related information is mailed to you, you must contact the **Baker Hughes Benefits Center** and inform a **Baker Hughes Benefits Center** representative of any change to your current mailing address, email address, and phone number. Otherwise, you may not receive important information about your benefits.

Sending a USPS change of address card does not change your address on file – many of our benefits program administrators require the security of a User ID and/or Password to make changes to your account – that includes making changes to your mailing and/or email address.

If you provided a personal email address on **bakerhughes.ehr.com**, you will also need to update your email address should it change.

Keeping Your Health Information Private

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.

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the plan is required to protect the confidentiality of your private health information, and to provide individuals with notice of its legal duties and privacy practices with respect to that information. This notice covers the privacy practices of the plan.

The plan and Baker Hughes (as the Plan Sponsor) will not use or disclose health information protected by HIPAA, except when such use or disclosure is necessary for treatment, payment, health plan operations (collectively known as "TPO"), or as permitted or required by other state and federal law. All of the plan's business associates (organizations who have a contract with the Company to provide certain services, such as legal, actuarial, accounting, consulting, and data aggregation of financial circumstances) must also observe HIPAA's privacy rules. Furthermore, the plan will not use or disclose protected health information for employment-related actions and decisions (or in connection with any other company employee benefit plan), unless it has obtained your written authorization for such use and disclosure.

Protected Health Information (PHI) is "individually identifiable" health information, including genetic information, related to your physical or mental health or condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider and that is transmitted by electronic media or maintained in an electronic format, or transmitted or maintained in any other form or medium.

How the Plan may use your Protected Health Information

In order to manage your health effectively, the plan is permitted by law to use and disclose your Protected Health Information in certain ways, without your consent or authorization, as follows:

For treatment. So that you receive the right treatment and care, your Protected Health Information may be used as providers coordinate or manage your health care services. For example, your information may be used when your physician consults with a specialist regarding your condition.

For payment. To make sure that claims are paid correctly and you receive the benefits you are entitled to, your Protected Health Information may be used and disclosed to determine plan eligibility and responsibility for coverage and benefits. For example, your information may be used when the plan confers with another health plan to resolve a coordination of benefits issue.

For health care operations. To ensure quality and efficient plan operations, your Protected Health Information may be used in a number of ways, including plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, when the plan contacts you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the plan.

Your Protected Health Information may also be disclosed to certain designated employees of Baker Hughes (as Plan Sponsor) in connection with these activities. Baker Hughes has designated a limited number of employees of its affiliates who are the only ones permitted to access and use your Protected Health Information for plan operations and administration. When appropriate, there are two types of Protected Health Information that may be shared with other Baker Hughes employees and its affiliates' employees:

- Enrollment/disenrollment data – information on whether you participate in the plan or whether you have enrolled or disenrolled from a plan coverage option; and
- Summary health information – summaries of claims from which names and other identifying information have been removed for purposes of obtaining premium bids from providers or modifying, amending, or terminating the plan or a Retiree Medical coverage option.

Baker Hughes agrees not to use or disclose your Protected Health Information for any purposes not authorized by the HIPAA privacy regulations.

Permitted Uses and Disclosures

Federal regulations allow use and disclosure of your Protected Health Information by the plan, without your authorization, for several additional purposes.

- Public health activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect, or domestic violence
- Oversight activities of a health oversight agency authorized by law
- Judicial and administrative proceedings
- Law enforcement activities
- To a coroner or medical examiner
- Research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Workers' Compensation or similar programs that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law

In Special Situations

The plan may disclose your Protected Health Information to a family member, relative, close family friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care. The plan may also use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, the plan will use sound judgment to determine what is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

The plan is generally prohibited from using or disclosing your Protected Health Information when it is considered genetic information for underwriting purposes.

Uses of Protected Health Information Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the plan has already undertaken an action in reliance upon your authorization.

- **Psychotherapy notes.** Save for certain limited exceptions, the plan must obtain authorization for any use or disclosure of your psychotherapy notes.
- **Marketing.** The plan must obtain authorization for all treatment and health care operations communications where it receives financial remuneration for making the communications from a third party whose product or service is being marketed.
- **Sale of Protected Health Information.** The plan must obtain an authorization for any disclosure that is a sale of Protected Health Information. Such an authorization must state that the disclosure will result in remuneration to the plan.

Your Rights Regarding Protected Health Information

You have certain rights regarding your Protected Health Information. To exercise the rights described below, you must send a written request to the Baker Hughes Global Benefits Department located at 12645 W. Airport Rd., Sugarland, TX, 77478.

Access: You have the right to inspect and receive a copy of your Protected Health Information, with limited exception. You have the right to request a readily-producible form in which your Protected Health Information may be delivered. If the plan uses or maintains an electronic health record of your Protected Health Information, you may obtain a copy in an electronic format, and, if you choose, direct the plan to transmit a copy to a party you designate. The plan may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, the plan may deny your request to see your Protected Health Information. You may be entitled to have a licensed health care professional review that denial.

Disclosure Accounting: You have the right to request an accounting of certain disclosures made by the plan during the six years prior to your request (however, you are not entitled to an accounting of disclosures made for payment, treatment or health care operations, disclosures you authorized in writing, or other disclosures for which federal law does not require Baker Hughes or the plan to provide an accounting).

Restriction: You have the right to ask the plan to restrict how your Protected Health Information is used and disclosed for treatment, payment, and health care operations. You may also ask the plan to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. The plan is not, however, required to agree to such requests.

Confidential Communications: You have the right to request that you receive your Protected Health Information by alternative means or at an alternative location the request is determined to be reasonable and will not materially interfere with the operation of the plan. For example, you may only want to have information sent by mail or to a work address.

Amendment: You have the right to amend or correct inaccurate Protected Health Information. A request for amendment may be denied in certain circumstances (e.g., if the Protected Health Information is accurate and correct as it is). If the request is denied, you have the right to add a statement of your disagreement to your Protected Health Information.

Right to Notice of Breach of Unsecured Protected Health Information: You have the right to receive notice in the event that a reportable breach for purposes of HIPAA has occurred in which unsecured Protected Health Information identifying you has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner.

Right to a Paper Copy of the Notice: If you agree to receive notice of your rights under HIPAA electronically, you have the right to request and obtain a paper copy of those rights from the plan.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the plan or with the Secretary of the US Department of Health and Human Services. If you wish to file a HIPAA complaint with the plan, please contact:

Baker Hughes Company
Privacy Officer – Corporate Benefits Department
575 N. Dairy Ashford Rd.
Suite 100
Houston, Texas 77079-1117
Tel: **1-800-229-7447** or **1-713-439-8600** (worldwide)

The plan will not retaliate against any individual for filing a complaint as described above.

The plan maintains a privacy notice (i.e., notice of privacy practices), which provides a complete description of your rights under HIPAA's privacy rules. The most recent version of the privacy notice is located on **bakerhughes.ehr.com**. The plan is required to abide by the terms of the notice currently in place. The effective date of the most current notice is September 1, 2018. The plan reserves the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information that it maintains. The plan will provide individuals with a revised notice on the Baker Hughes Intranet.

Contact the HIPAA privacy officer to obtain a printed copy of the privacy notice. If you have questions about the privacy of your health information, please contact the Company's privacy officer.

The plan and Baker Hughes are treated as separate and independent entities under HIPAA that must exchange information to coordinate your plan coverage. For the purpose of obtaining summary health information from vendors and to report summary health information to Baker Hughes, the plan will share data such as aggregate claim reports with a listing of diagnosis and treatment (no individual participant information is included in this kind of report) with Baker Hughes. PHI required for plan administrative functions will only be shared with Baker Hughes if Baker Hughes has certified that it will:

- Not further use or disclose PHI other than as permitted, as required by the plan documents, or as required by law
- Ensure that anyone or any organization to which Baker Hughes provides PHI agrees to the same restrictions and conditions that apply to Baker Hughes
- Not further use or disclose PHI for employment actions or decisions
- Not further use or disclose PHI in connection with any company benefits
- Report to the plan any PHI use or disclosure that has not met HIPAA requirements
- Make PHI available to an individual according to HIPAA's access requirements
- Make PHI available for amendment and incorporate amendments according to HIPAA's privacy rules
- Make available any information required for an accounting of disclosures
- Make available to the US Department of Health and Human Services the Company's internal practices, books, and records relating to the use and disclosure of PHI from the group health plan to determine the plan's compliance with HIPAA
- Return or destroy PHI received from the plan for the purposes for which the disclosure was made when no longer needed
- Ensure an adequate separation between the plan and Baker Hughes

The plan will disclose PHI to Baker Hughes only upon certification by Baker Hughes that the plan documents have been amended to include the provisions required in the HIPAA Privacy regulations and that Baker Hughes will comply with the provisions set forth in this section.

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 plan and the Retiree Medical coverage options offered under the plan are in compliance with this law.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Act. Under the Act, the plan and the claim administrators that offer mastectomy coverage under the Retiree Medical coverage options, 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. These benefits will be provided subject to the same annual deductibles and co-insurance provision consistent with those established for other benefits under the plan's Retiree Medical coverage options.

Coverage for Maternity Hospital Stay

Benefits are payable for pregnancy-related expenses of female retirees and dependents on the same basis as for any illness. Payment for pregnancy-related expenses will not be withheld because the pregnancy occurred before coverage took effect.

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).

Federal law prohibits the plan from:

- Limiting the length of a hospital stay for you and your newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean delivery
- Requiring a provider to obtain authorization from the plan for prescribing any length of stay required above
- Denying mother or newborn eligibility or continued eligibility to enroll or re-enroll for coverage just to avoid legal requirements
- Making financial payments or rebates to mothers to encourage them to accept a shorter stay than described above
- Providing financial incentives to the provider to encourage him or her to provide care inconsistent with current law
- Restricting benefits for any portion of such hospital stay to be less than benefits for any stay prior to the birth

If the mother chooses, she and the newborn may be released earlier. Authorization is required for lengths of stay that exceed those listed above for participants enrolled in a Retiree Medical coverage option.

Overpayment and Underpayment of Benefits

If you are covered under the plan and a similar plan of another employer, there is a possibility that the other employer's plan will pay a benefit that the claims administrator should have paid under the Baker Hughes plan. If this occurs, the Baker Hughes plan may pay the other employer's plan some or all of the amount owed to you.

If the Baker Hughes plan pays you more than it owes, you should pay the excess back to the plan promptly. Otherwise, Baker Hughes may recover the amount from benefits payable under any Baker Hughes funded benefit plans. Baker Hughes also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the plan overpays a health care provider, the claims administrator reserves the right to recover the excess amount from the provider.

Refund of Overpayments

If the plan pays benefits with respect to expenses incurred on account of a covered person, that covered person, and any other person or organization that was paid, must make a refund to the plan if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the covered person, but all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person;
- All or some of the payment the plan made exceeded the benefits under he plan; or
- All or some of the payment was made in error. The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the covered person agrees to assist the plan obtain the refund, when requested.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a plan participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to the following rights.

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed for the plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each retiree with a copy of this summary annual report.

Continue Group Health Care Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money or if you're discriminated against for asserting your rights, you may seek assistance from the US Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), US Department of Labor, listed in your telephone directory or at **dol.gov/ebsa** or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

COBRA

What Is COBRA Coverage?

Under certain provisions of ERISA and the Internal Revenue Code enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Baker Hughes must offer your qualifying family members, and may be required to offer you, the opportunity to temporarily extend coverage under the plan at group rates in certain instances where that coverage, would otherwise end (called COBRA coverage). Your rights and obligations under COBRA are briefly summarized below.

COBRA coverage can become available to members of your family who are covered under the plan when they would otherwise lose their group health coverage. COBRA coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event described below, referred to as a COBRA qualifying event.

To qualify to elect COBRA coverage, an individual must be covered under the plan on the day prior to a COBRA qualifying event listed below. Otherwise, the individual has no rights to elect COBRA coverage. However, once your spouse or other dependent gains coverage under COBRA, your covered spouse or dependent may elect to add eligible dependents according to the same provisions that apply to retirees covered under the plan.

COBRA Qualifying Events

If you're a covered spouse of a covered retiree, you may elect COBRA coverage for yourself if your coverage under the plan is lost for any of these reasons:

- Your spouse dies;
- You are divorced or legally separated from your spouse; or
- Your spouse becomes entitled to coverage under Medicare.

Tip!

You and your dependents should take the time to read this section carefully to understand your COBRA rights. If you have any questions after reading this section, please go to **bakerhughes.ehr.com** or the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

If you're a covered dependent child of a covered retiree, you may elect COBRA coverage for yourself if your coverage under the plan is lost for any of these reasons:

- The covered retiree dies;
- Your parents divorce or legally separate;
- You cease to qualify as a dependent child of the covered retiree under the plan; or
- The covered retiree becomes entitled to coverage under Medicare

Should an employer declare bankruptcy, retirees may elect COBRA coverage, but only if the retiree's coverage ends or is substantially reduced on or after the retirement date but within one year prior to the start of the bankruptcy proceedings.

Type of Coverage Available Under COBRA

Continuation of coverage under the plan that is available under COBRA is the same coverage provided to covered retirees on the day before the COBRA qualifying event. If coverage under the plan is modified for covered retirees, the COBRA coverage will also be modified in the same manner. During the Annual Enrollment periods, as long as you are entitled to COBRA coverage, you have the same Annual Enrollment period rights that covered retirees have to add or eliminate coverage of family members or to switch to another applicable Retiree Medical coverage option under the plan for which you are eligible for coverage.

COBRA Eligibility

To receive continuation coverage under COBRA, you or a family member **must** notify the **Baker Hughes Benefits Center** when a covered retiree and spouse divorce or legally separate, when a dependent child of the covered retiree ceases to qualify as a dependent child under the plan, or when a covered retiree or covered dependent becomes disabled. You, or your spouse or dependent, must contact the **Baker Hughes Benefits Center** at **1-866-244-3539** within 60 days after the event and provide the necessary information regarding the event. If you do not provide timely information to the **Baker Hughes Benefits Center**, the **Baker Hughes Benefits Center** cannot provide notice of COBRA continuation coverage rights resulting from that event and your spouse or dependents will not be entitled to receive COBRA continuation coverage. After the **Baker Hughes Benefits Center** is notified that a COBRA qualifying event has occurred, your qualifying dependents will be notified of their rights (via mail) to elect COBRA coverage and provided with application materials.

They then have 60 days from the post-mark date of those materials to call the **Baker Hughes Benefits Center** to make COBRA elections. Covered retirees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

You do not have to provide Evidence of Insurability to elect COBRA coverage.

Once you or your dependents are receiving COBRA coverage, if you change your marital status or if you, your spouse, or your dependents change addresses, you should notify the **Baker Hughes Benefits Center** immediately.

If you do not elect COBRA coverage, your coverage under the plan will end at the time of the applicable COBRA qualifying event. If you elect COBRA coverage, Baker Hughes is required to offer coverage which, at the time the coverage is being provided, is the same as coverage provided to similarly situated retirees or family members.

Electing COBRA Coverage for New Dependents

While you are enrolled in COBRA coverage, you may add new dependents to your coverage as long as you notify the **Baker Hughes Benefits Center** within 31 days of the date you acquire the new family member. Any child(ren) born to you or placed for adoption by you during the COBRA period may be enrolled immediately for the duration of the COBRA period, including any extended coverage in the event of multiple qualifying events.

COBRA Period

COBRA allows continuation of coverage under the plan for up to the periods described below:

If You Experience One of these Qualifying Events	COBRA Coverage May be Elected for	Up to a Maximum of
Your death	Your spouse and/or dependent child(ren)	36 months
Your divorce or legal separation	Your spouse and/or dependent child(ren)	
Your child(ren) is no longer eligible for benefits under the plan	Your child	
Your eligibility for Medicare benefits	Your spouse and/or dependent child(ren)	

If a person becomes eligible for COBRA coverage as a result of more than one COBRA qualifying event, the maximum COBRA coverage period for the individual will never be more than 36 months total for all events (other than in certain bankruptcy situations). Notwithstanding any of the provisions of this SPD or any other document provided to you, COBRA coverage is provided under the plan only to the extent required by COBRA except as permitted by the plan administrator.

Ending COBRA Coverage

Your COBRA coverage will end immediately for any of the following reasons:

- Baker Hughes no longer provides group health coverage to any of its employees;
- You do not timely pay the premium for your coverage;
- You become entitled to Medicare after making your COBRA coverage election;
- You become covered under another group health plan; or
- The maximum required COBRA coverage period expires.

Cost of COBRA Coverage

You must pay the full required premium for your COBRA coverage. You will pay your COBRA coverage premiums on an after-tax basis.

You or your eligible dependents may be charged 100% of the total cost for COBRA coverage plus a 2% administration fee. You'll receive information about the cost of COBRA coverage from the **Baker Hughes Benefits Center**. Coverage will end automatically at the end of the continuation period or if you or your dependents stop making COBRA premium payments.

If you elect COBRA coverage and pay the appropriate monthly cost, your existing coverage will continue from the date coverage is originally scheduled to end. The first payment, which must cover all back payments due, is due **45 days from the date your election is received**. As long as an individual remains eligible for COBRA, payments are due at the time set forth in the information provided by the **Baker Hughes Benefits Center**. If a payment is received after the due date and any applicable grace period, COBRA coverage ends and **cannot be reinstated**.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) generally prohibits group health plans from using the genetic information of plan participants to discriminate in providing coverage or benefits. The plan is administered by Baker Hughes to comply with the applicable requirements of GINA.

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMSCO) is issued with respect to your child, that child will be eligible for coverage as required by the order if you are enrolled in the plan.

A QMCSO is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law) or to an administrative process, which provides for child support or provides for health benefit coverage for a child and relates to benefits under the plan and satisfies all of the following:

1. The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible under the plan;
2. The order specifies your name and last known mailing address and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. The order provides a reasonable description of the coverage to be provided or the manner in which the type of coverage is to be determined;
4. The order states the period to which it applies; and
5. The order does not require the plan to provide coverage for any type or form of benefit or option not otherwise provided under the plan, with limited exceptions.

If the order is a properly completed National Medical Support Notice, such notice meets the requirements above.

Any payment of benefits under the plan shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

When the plan administrator receives a medical child support order, the following steps will be taken. The plan administrator will:

- Notify both the eligible retiree and the representative of each child covered by the order of receipt of the order;
- Furnish an explanation of the plan's procedures for determining whether the court order is a QMCSO;
- Determine if the order is qualified; and
- Notify the eligible retiree and the representative of each child covered by the order of the determination and, if the order is determined to be qualified, provide the representative of the child covered by the order with a full explanation of the benefits hereunder.

Participants and beneficiaries under the plan can obtain, without charge, a copy of the plan's QMCSO procedures from the **Baker Hughes Benefits Center** by calling **1-866-244-3539** (toll free in the US) or **1-847-883-0945** (worldwide) between 7 a.m. and 7 p.m. (Central), Monday through Friday.

The plan administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

Important Plan Information

Baker Hughes

Plan Administration and Funding

The plan is funded by participant and/or Company contributions.

Plan Administrator

Baker Hughes Company, the plan administrator has discretionary authority to interpret plan provisions, construe unclear terms, determine eligibility for benefits, and otherwise make all decisions and determinations regarding plan administration. By participating in the plan, you (and your dependents or beneficiaries, if any) agree to accept the plan administrator's authority. You can contact the plan administrator as follows:

Baker Hughes Company

Attn: Total Rewards H&W Department

575 N. Dairy Ashford Rd.
Suite 100
Houston, Texas 77079-1117

1-713-439-8600 or **1-800-229-7447** (worldwide)

Claim Administrator

For the programs under the plan, Baker Hughes has delegated authority to third party administrators to administer benefit claims under the plan. The claim administrator for each benefit plan is listed in the *Claim Administrators* section beginning on the next page. Subject to Baker Hughes' overall authority as plan administrator, the claim administrator has discretionary authority to interpret plan provisions and is the named fiduciary to determine benefit claims.

Cost of Administering the Plan

Baker Hughes intends to pay certain expenses of administering the plan except for COBRA and other plan costs described herein, which are paid by retirees and/or qualifying dependents.

The programs offered under the plan are individually identified by name and number, if applicable, as shown in the following table. The records of the plan are kept on a calendar-year basis.

Claim Administrators

Plan Name	Baker Hughes Retiree Welfare Benefits Plan
Plan Administrator and Plan Sponsor	Baker Hughes Attn: Total Rewards H&W Department 575 N. Dairy Ashford Rd. Suite 100 Houston, Texas 77079-1117 For information call **1-713-439-8600** or **1-800-229-7447** worldwide
Plan Sponsor's Employer Identification Number (EIN)	76-0207995
Plan Number for the Welfare Benefits Plan	513
Plan Year	The plan year begins January 1 and ends December 31
Agent For Service of Legal Process	Baker Hughes Chief Legal Officer 575 N. Dairy Ashford Rd. Suite 100 Houston, Texas 77079-1117
Constituent Benefit Program Name	**Baker Hughes Retiree Health & Welfare Benefits Plans Medical Program (UHC Basic Choice Plus and Catastrophic Choice Plus Options)**
Program Type	Welfare Plan providing comprehensive medical benefits
Type of Administration	Self insured
Program Number	701368
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555
Constituent Benefit Program Name	**Baker Hughes Retiree Health & Welfare Benefits Plans Prescription Drug Program**
Program Type	Welfare plan providing prescription medication benefits
Type of Administration	Self insured
Program Number	BHUA
Benefit Administrator	CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Rights of the Plan Administrator

The plan administrator (or its designee as it relates to functions delegated by the plan administrator) has complete and final discretionary authority to interpret the plan and maintain control over the operation and administration of the plan.

General Powers of the Plan Administrator

The plan administrator will have all rights and powers reasonably necessary to supervise and control the administration of the Welfare Benefits Plan, the plan and the benefit programs described in this SPD. The plan administrator will have the power and the duty to take all action and to make all decisions that will be necessary or proper in order to interpret and carry out the provisions of the Welfare Benefits Plan, the plan and the benefit programs described in this SPD.

The plan administrator (or its designee as it relates to functions delegated by the plan administrator) has full and absolute discretion in the exercise of each and every aspect of its authority under the Welfare Benefits Plan, the plan and the benefit programs described in this SPD, including without limitation, the authority to determine any person's right to Continuation Coverage under the plan. Except to the extent that a benefit program is insured, a health maintenance organization (HMO) or a dental maintenance organization (DMO), the plan administrator will have the exclusive right and discretionary authority to interpret the terms and provisions of the Welfare Benefits Plan, the plan and the benefit programs described in this SPD and to determine any and all questions arising under the Welfare Benefits Plan, the plan and the benefit programs described in this SPD or in connection with the administration thereof, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies, or omissions, by general rule or particular decision. All findings of fact, determinations, interpretations, and decisions of the plan administrator (or its designee as it relates to functions delegated by the plan administrator) will be conclusive and binding upon all persons having or claiming to have an interest or right under the Welfare Benefits Plan, the plan and the benefit programs described in this SPD and will be given the maximum possible deference allowed by law. Notwithstanding any provision of law or any explicit or implicit provision of this document, any action taken, or ruling or decision made, by the plan administrator (or its designee as it relates to functions delegated by the plan administrator) in the exercise of any of its powers and authorities under the Welfare Benefits Plan, the plan and the benefit programs described in this SPD shall be final and conclusive as to all parties, including without limitation all participants and dependents, regardless of whether the plan administrator (or its designee as it relates to functions delegated by the plan administrator) may have an actual or potential conflict of interest with respect to the subject matter of the action, ruling, or decision.

Determinations of the Plan Administrator Final and Binding

Without limiting the arbitration procedures described herein, no final action, ruling, or decision of the plan administrator (or its designee as it relates to functions delegated by the plan administrator) shall be subject to de novo review in any arbitration or judicial proceeding. A final action, ruling, or decision of the plan administrator (or its designee as it relates to functions delegated by the plan administrator) may only be reversed if an arbitrator (or, in limited circumstances as applicable, a court) finds that the plan administrator's (or its designee's) decision was arbitrary and capricious.

Benefit Claims Disputes

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or a DMO. By accepting benefits under the plan, you agree to the following provisions.

Exhaustion of Administrative Remedies/Arbitration

As described below any controversy relating to any of the Welfare Benefits Plan, the plan and the benefit programs described in this SPD (Benefit Programs) other than a benefit program that is insured, an HMO or a DMO, must be resolved by arbitration on an individual basis in accordance with the Employee Benefit Plan Claim Arbitration Rules of the American Arbitration Association as described below. You must exhaust the claims review and appeals procedures under the plan and Benefit Program before you may initiate an arbitration proceeding.

By accepting benefits described in this SPD or seeking benefits described in this SPD you agree to the plan's and Benefit Program's arbitration procedures described below.

Except for any claim that is pending in a court as of December 31, 2018, any controversy arising out of or relating to the plan or any of the Benefit Programs, including without limitation, any and all disputes, claims (whether in contract, statutory or otherwise) or disagreements concerning the interpretation or application of the provisions of the plan, any Benefit Programs or this SPD, (each, a "Covered Claim") shall be resolved by arbitration in accordance with the Employee Benefit Plan Claims Arbitration Rules ("Rules") of the American Arbitration Association (the "AAA") in effect at the initiation of the arbitration.

All Covered Claims shall be arbitrated on an individual basis and you shall not have any right or authority to assert or pursue any Covered Claims as a class action or derivative action of any sort. In addition, notwithstanding anything to the contrary in the Rules (including Rule 12 entitled "Grouping of Claims for Hearing" or this rule's successor), a Covered Claim by one participant shall not be grouped or consolidated with a Covered Claim by another participant in a single proceeding.

No arbitration proceeding relating to the plan or any of the Benefit Programs may be initiated by either Baker Hughes or you, unless the plan's and the Benefit Program's claims review and appeals procedures have been exhausted.

The arbitration shall be administered by the AAA. Three arbitrators shall hear and determine the controversy. Within twenty (20) business days of the initiation of an arbitration hereunder, Baker Hughes and you will each separately designate an arbitrator, and within twenty (20) business days of such selection, the appointed arbitrators will appoint a neutral arbitrator from the panel of AAA National Panel of Employee Benefit Plan Claims Arbitrators. All arbitrators shall be impartial and independent. The award (including a statement of finding of facts) shall be made promptly and no later than forty-five (45) days from the date of closing the hearings or, if the hearing has been on documents only, from the date of transmittal of the final statements and proofs to the arbitrator.

The arbitrators shall have the power to rule on their own jurisdiction, including any objections with respect to the existence, scope, or validity of the arbitration agreement or to the arbitrability of any claim or counterclaim, including a Covered Claim. The decision of the arbitrators selected hereunder will be final and binding upon both parties, and judgment on the award may be entered in any court having jurisdiction. This arbitration provision is expressly made pursuant to, and shall be governed by, the Federal Arbitration Act, 9 U.S.C. Sections 1-16 (or replacement or successor statute). Nothing in the plan's arbitration procedures will be construed to, in any way, limit the rights, powers, and authorities of the plan administrator. In any arbitration proceeding full effect shall be given to the rights, powers, and authorities of the plan administrator under the plan.

Venue

Without limiting the arbitration procedures described herein, (1) venue for arbitration concerning any dispute relating to a claim for benefits under the Welfare Benefits Plan, the plan and the benefit programs described in this SPD or any claim of breach of fiduciary duty under ERISA will be in Harris County, Texas and (2) venue for litigation concerning any dispute relating to a claim for benefits under the Plan or any benefit program described in this SPD or any claim of breach of fiduciary duty under ERISA will be in the United States District Court for the Southern District of Texas (Houston Division).

Controlling Law

Subject to the provisions of ERISA that may be applicable and provide to the contrary the Welfare Benefits Plan, the plan and the benefit programs described in this SPD will 261 be construed, regulated and administered under the laws of the state of Texas and, to the extent applicable, by the laws of the United States.

Limitations on Legal Actions

You may not bring any action (whether litigation or arbitration) pertaining to a claim for benefits under the plan that are not funded by insurance following the earlier of (1) 365 days after the final denial of your claim for benefits, or (2) the applicable limitations period under ERISA (which is the limitations period under Texas contract law). The period during which you may bring any action (whether litigation or arbitration) pertaining to a claim for benefits under the plan that is funded by insurance is set forth in the applicable insurance policy.

Assignments of Benefits

No benefits under the Welfare Benefits Plan, the plan or the benefit programs described in this SPD may be assigned by you (except for assignments expressly authorized by the plan administrator) or may be subject to attachment by, interference with, or control of any of your creditors or assignees, or may be taken or reached by any legal or equitable process in satisfaction of any of your debts or liabilities prior to your actual receipt of benefits under the plan or program. Any attempted conveyance, transfer, assignment, mortgage, pledge, or encumbrance of such benefits prior to payment to you will be void, whether that conveyance, transfer, assignment, mortgage, pledge, or encumbrance is intended to take place or become effective before or after any payment. The sponsor of the plan, the Administrative Committee, insurer, HMO or DMO will never under any circumstances be required to recognize any conveyance, transfer, assignment, mortgage, pledge or encumbrance by you of plan benefits, or to pay any money or thing of value to any of your creditors or assignees. (These prohibitions against the alienation of your plan benefits will not apply to assignments under Qualified Medical Support Orders.)

Payments to Minors and Incapacitated Persons

If any person entitled to receive any benefits under the plan is a minor or is determined by the Administrative Committee, in its sole discretion, to be incapacitated, the Administrative Committee in its discretion may pay such benefits to the duly appointed guardian or conservator of such person or to any third party who is authorized (as determined in the discretion of the Administrative Committee) to receive any benefit under the plan for the account of such participant or dependent. Such payment will operate as a full discharge of all liabilities and obligations of the plan, the Administrative Committee and all other persons under the plan with respect to such benefits.

No Vested Right to Benefits

No person will have any right to, or interest in, any benefits provided under the plan or any benefit program offered under the plan, except as specifically provided under the plan.

Name and Address Changes

You are responsible for notifying the Administrative Committee of any change in your name or address. If any check in payment of a benefit hereunder (which was mailed to your last address of the payee as shown on the Administrative Committee's records) is returned unclaimed, further payments under the plan will be discontinued until the Administrative Committee directs otherwise.

Change in Marital Status

You must inform the plan as to any change in your marital status and until so informed the plan will be entitled to rely on your assertion of marital status as originally established.

Modifications of the Plan

The following provisions apply to any benefits under the Plan that are not insured by a third party or provided by an HMO or a DMO. By accepting benefits under the Plan, you agree to the following provisions.

No Oral Modifications

No person has the authority to orally modify the plan, any Benefit Program offered under the plan or described in this SPD. So, neither you nor any person claiming through you may rely upon any oral representations of any person concerning the coverage or benefits provided under the plan, and no separate contract will be created with any person as a result of any such oral statement.

Written Modifications

The plan is comprised of only the official plan document and this SPD (to the extent not inconsistent with the official plan document, as amended in writing by the sponsor from time to time). You are not entitled to rely on any written document other than the official plan document and this Summary Plan Description (to the extent not inconsistent with the official plan document) with regard to the coverage or benefits provided under the plan. No separate contract will be created with the Sponsor as a result of any other written document relating to welfare benefits (within the meaning of ERISA) unless the other written document is approved and signed by the Chief Human Resources Officer of the Sponsor.

Reimbursement and Subrogation

If you or a dependent (or your or the dependent's guardian or estate) (each, a benefit recipient) receives a benefit payment from a Baker Hughes funded plan as a result of an injury or illness for which the benefit recipient has, may have, or asserts any claim or right to recovery against a third party (such as an insurance company or the employer of the person who caused the injury or some other person affiliated with them) then any payment under the plan for such benefit will only be made on the condition and with the understanding that the Baker Hughes funded plan will be reimbursed. For these purposes, a Baker Hughes funded plan means a Baker Hughes health & welfare benefit program that was not provided or funded through an insurance policy, an HMO or DMO.

The reimbursement will be made to the Baker Hughes funded plan or claims administrator of the plan by the benefit recipient, their legal counsel, or other person who holds a recovery payment received with respect to the claim or right of recovery to the extent of, but not exceeding, the total amount payable from any insurance policy or contract or any third party, plan, or fund as a result of judgment or settlement.

In addition to the right of reimbursement, the Baker Hughes funded plan has the right to enforce any claim or right to recovery that the benefit recipient has, may have, or asserts against a third party or parties in connection with an injury or illness when the plan pays benefits with respect to that injury or illness. This process of enforcing the rights of benefit recipients after payment of plan benefits is called subrogation.

Under the Baker Hughes funded plan, a benefit recipient and their legal counsel and other affiliates have a duty to cooperate fully with the plan, the claims administrator of the plan and Baker Hughes in asserting and protecting the plan's right of reimbursement and subrogation. All such persons also have a duty to sign and deliver original papers and documents, provide information, and take all other actions necessary for the plan or claims administrator to fully protect the plan's rights. Each benefit recipient agrees to provide all such necessary assistance as a condition of participation in a Baker Hughes funded plan, including cooperation and information submitted to Workers' Compensation, liability insurance carriers, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable. Each Baker Hughes funded plan and the claims administrator for the plan may seek reimbursement for the reasonable value of services and benefits provided to a benefit recipient from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages, and
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as third parties).

By electing coverage and accepting benefits under the Baker Hughes funded plan, you and each other benefit recipient agree (for himself or herself and all affiliates):

- That the Baker Hughes funded plan will be reimbursed in full before any amounts (including attorney's fees incurred by the benefit recipient or affiliate) are deducted from the recovery proceeds for any reason, without regard to the sufficiency of the recovery;
- That the amount of the Baker Hughes funded plan's reimbursement will not be reduced by virtue of any characterization of the recovery proceeds in any settlement agreement or other agreement. For example, the Baker Hughes funded plan's right of recovery will not be negatively affected by virtue of the fact that a settlement agreement allocates a portion of the recovery proceeds to attorneys' fees, future medical costs, pain and suffering, a special needs trust, or otherwise;

- That the Baker Hughes funded plan and claims administrator will have a first priority lien on any and all recovery proceeds recovered until the plan has been reimbursed in full for any benefits paid under the plan with respect to the injury or illness, whether or not the benefit recipient is fully compensated for his or her loss;
- That regardless of whether or not you have been fully compensated, the Baker Hughes funded plan and claims administrator may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Baker Hughes funded plan;
- That no doctrine, including the "make whole" doctrine or the "common fund" doctrine, will apply to qualify the Baker Hughes funded plan's right of reimbursement;
- That the benefit recipient will be responsible for all attorneys' fees incurred by him or her in seeking a recovery against a third party or parties and the Baker Hughes funded plan will have no liability with respect to such attorneys' fees;
- To assign to the Baker Hughes funded plan or claims administrator of the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits provided, plus reasonable costs of collection;
- That no action will be taken that will frustrate or impede the Baker Hughes funded plan's right of reimbursement or subrogation;
- To notify the Baker Hughes funded plan and claims administrator of the plan as soon as administratively practicable, in writing, of the existence of any potential third party liability with respect to any injury or illness for which the plan may pay benefits;
- To promptly notify the Baker Hughes funded plan and claims administrator of the plan of any developments of which he or she is aware that may impact the plan's reimbursement or subrogation rights;
- To not enter into any settlement or compromise agreement concerning recovery proceeds without the prior express approval of Baker Hughes;
- To not dispose of any recovery proceeds before the Baker Hughes funded plan has been reimbursed in full;
- That any recovery proceeds held by the person will be deemed to be held in constructive trust for the benefit of the Baker Hughes funded plan until the plan's reimbursement rights with respect thereto have been satisfied in full. Any person who holds such recovery proceeds in a constructive trust for the benefit of the Baker Hughes Funded Plan will be subject to liability under ERISA if he or she disposes of such recovery proceeds prior to the satisfaction of the Baker Hughes funded plan's reimbursement rights;
- That any person who holds recovery proceeds in constructive trust for the Baker Hughes funded plan is a fiduciary with respect to the plan within the meaning of ERISA and will comply with the fiduciary standards of ERISA with respect to such recovery proceeds until the plan's reimbursement rights relating to such recovery proceeds have been satisfied in full;
- To cooperate in protecting the legal rights of the Baker Hughes funded plan or claims administrator of the plan to subrogation and reimbursement;
- That you will do nothing to prejudice the Baker Hughes funded plan or claims administrator rights under the plan, either before or after the need for services or benefits under the plan;
- That the Baker Hughes funded plan or claims administrator may take necessary and appropriate action to preserve their rights under the plan's subrogation provisions, including filing suit in your name;
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Baker Hughes funded plan or claims administrator may reasonably request from you; and
- If a benefit recipient or their affiliate described above fails to comply with a benefit recipient's duties and obligations with respect to the Baker Hughes funded plan's reimbursement and subrogation rights, the benefit recipient's benefits under the plan may, in the discretion of the plan administrator and as permitted by applicable law, be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to the benefit recipient (including his or her dependents or any persons claiming through them) until the plan has recovered an amount equal to the amount of recovery proceeds it would have been reimbursed had the plan's reimbursement rights been complied with in full or until the plan's subrogation provisions are complied with.

The coverage of any person under a Baker Hughes funded plan is conditioned upon the understanding that such person, on behalf of himself or herself and any person claiming through him or her, agrees to and will comply with all of the plan's reimbursement and subrogation rights.

Benefits Administrators and Claims Payers

Baker Hughes has contracts with benefit administrators and claims payers. These providers are independent contractors and Baker Hughes is not responsible for any acts or omissions of any of these organizations, their providers, or independent contractors, including the quality of goods and services provided through any health care provider or program.

Plan Amendment or Termination

Although Baker Hughes intends to continue the Welfare Benefits Plan, the plan and the benefit programs described in this SPD, Baker Hughes reserves the right to terminate or amend any and all of such plans and programs in whole or in part at any time and for any reason. The Company's right to amend or terminate the Welfare Benefits Plan, the plan and the benefit programs described in this SPD includes, but is not limited to, changes in the eligibility requirements, premiums, or other payments charged, benefits provided, and termination of all or a portion of the coverage provided under the plan(s) and programs. If the benefit under a plan or program is amended or terminated, you'll be subject to all the changes effective as a result of such amendment or termination, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any benefit under the Welfare Benefits Plan, the plan or the benefit programs described in this SPD other than payment of any covered expenses you incurred prior to the amendment or termination.

Information and Records

Baker Hughes and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Baker Hughes and the Claims Administrator may request additional information from you to decide your claim for benefits. Baker Hughes and the Claims Administrator will keep this information confidential. Baker Hughes and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Baker Hughes and the Claims Administrator with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. Baker Hughes and the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled dependents whether or not they have signed the Participant's enrollment form. Baker Hughes and the Claims Administrator agree that such information and records will be considered confidential.

Glossary of Terms

Baker Hughes

Glossary of Terms

Term	Definition
Accident	An unforeseen and unavoidable event resulting in an injury that is not due to any fault of the covered person, excluding any work-related injuries.
Administrative Committee	The committee appointed by the Board of Directors of Baker Hughes to perform any administrative functions with respect to the plan that an insurer, HMO, or DMO is not required to perform.
Air Ambulance	Medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in *42 CFR 414.605*.
Alternate Facility	A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law: • Surgical services; • Emergency Health Services; or • Rehabilitative, laboratory, diagnostic, or therapeutic services. An Alternate Facility may also provide Mental Health or Substance Abuse Services on an outpatient basis or inpatient basis (for example, a residential treatment facility).
Ancillary Services	Items and services provided by non-network physicians at a network facility that are any of the following: • Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; • Provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the secretary; • Provided by such other specialty practitioners as determined by the secretary; and • Provided by a non-network physician when no other network physician is available.
Annual Enrollment Period	The period each year during the fall when eligible covered retirees are eligible to change benefit coverage elections.
Autism Spectrum Disorder	A group of neurobiological disorders that includes autistic disorder, Rhett's syndrome, Asperger's disorder, childhood disintegrated disorder, and pervasive development disorders not otherwise specified.
Benefits	Your right to payment for services that are available under the plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the plan, including those described in this SPD.
Birthing or Birthing Center	A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests: • It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located • It meets all of the following requirements: — It is operated and equipped in accordance with any applicable state law. — It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity. — It has the ability to handle foreseeable emergencies, trained personnel, and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature, and ventilation and blood expanders. — It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or registered graduate nurse (R.N.). — It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications. — It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary. — It is expected to discharge or transfer patients within 24 hours following delivery. A birthing center which is part of a Hospital, as defined herein, will be considered a birthing center for the purposes of this plan.

Term	Definition
Brand Name Drug	Drugs manufactured under a registered trade name or trademark.
Center of Excellence	A facility or provider that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan to provide covered health services for the treatment of specified diseases or conditions. A Center of Excellence facility or provider may or may not be located within your geographic area. To be considered a Center of Excellence, a facility or provider must meet certain standards of excellence and have a proven track record of treating specified conditions.
Chemical Dependency	A physiological or psychological dependency or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.
Claims Administrator	The person designated by Baker Hughes to administer claims under the Welfare Benefits Plan, the plan or any program thereunder.
COBRA	The provisions of ERISA and the Internal Revenue Code enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This act allows qualifying dependents, and could allow qualifying retirees, to continue their health coverage for a specified length of time on the occurrence of certain events.
Coinsurance	The charge, stated as a percentage of eligible expenses or the recognized amount when applicable, that you are required to pay for certain covered health services.
Company	Baker Hughes and its affiliated companies that have adopted the Welfare Benefits Plan.
Confinement	A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center resulting from an illness or injury diagnosed by a physician. Later stays will be considered part of the original confinement unless there was either complete recovery during the interim from the illness or injury causing the initial stay or the latter stay results from a cause or causes unrelated to the illness or injury causing the initial stay.
Contribution	The amount that the retiree pays toward the cost of coverage to participate in a plan.
Coordination of Benefits	You and your dependents may have medical coverage under another group plan. In such cases, any incurred services may be subject to COB applicable industry rules to determine which plan will pay as primary and to what extent.
Copayment (or Copay)	The charge, stated as a set dollar amount, that you are required to pay for certain covered health services. For covered health services, you are responsible for paying the lesser of the following: • The applicable copayment. • The eligible expense or the recognized amount when applicable.
Covered Expenses	The items of expense for which benefits may be paid are called covered expenses.
Covered Health Services	Those health services, including services, supplies or pharmaceutical products, which the claims administrator determines to be: • Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms • Medically Necessary • Described as a Covered Health Service in this SPD under Plan Highlights and Additional Coverage Details and Outpatient Prescription Drugs • Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Introduction • Not otherwise excluded in this SPD under Exclusions and Limitations or Outpatient Prescription Drugs
Covered Person	A person who is eligible for and enrolled in coverage under the plan described in this SPD upon satisfying the eligibility and participation requirements.

Term	Definition
Custodial Care	Services that: • Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or • Are health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient who requires the services is not changing; or • Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.
Deductible	The amount you must pay for covered expenses in a plan year before the plan begins to share in the cost of covered expenses services.
Designated Diagnostic Provider	A provider and/or facility identified through the designation programs as a Designated Diagnostic Provider.
Designated Provider	A provider and/or facility that: • Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions, or • The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures. A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers. You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **myuhc.com** or the telephone number on your ID card.
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with UHC, or with an organization contracting on UHC's behalf, to deliver Covered Health Services via interactive audio and video modalities.
Durable Medical Equipment	Medical equipment that is all of the following: • Can withstand repeated use • Is not disposable • Is used to serve a medical purpose • Is generally not useful to a person in the absence of sickness, injury, or their symptoms • Is appropriate for use in the home
Eligible Expenses	For covered health services, incurred while the Plan is in effect, eligible expenses are determined by the UnitedHealthcare as stated in the section, *How the Plan Works*. Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies: • As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS).* • As reported by generally recognized professionals or publications. • As used for Medicare. • As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Term	Definition
Eligible Retiree	You are eligible for Retiree Medical benefits under the plan if you are at least 60 years of age and have at least 10 years of consecutive service with Baker Hughes or a subsidiary of Baker Hughes on the date of your retirement from Baker Hughes or a subsidiary of Baker Hughes. In addition, you must be covered under a Baker Hughes active employee medical plan at the time of your retirement to be eligible for Retiree Medical benefits under the plan. Employees who are inpatriates to the US or Non-US Assignees/Rotators are not eligible for benefits under the plan. Retirees of Baker Hughes and its subsidiaries who are eligible for Retiree Medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606) or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and Prior To January 1, 1990 (Division 607) are not eligible for benefits under the plan. If you are enrolled in a Baker Hughes active employee Dental or Vision plan, or the Baker Hughes Health Care Flexible Spending Account Plan at the time of your retirement from the Company, you may be eligible to continue that coverage under COBRA. Refer to the *COBRA* section in the Baker Hughes Incorporated Health & Welfare Plan Summary 2026 Description for active employees for additional information.
Emergency Health Services	With respect to an emergency, both of the following: • An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency. • Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)). • Emergency health services include items and services otherwise covered under the Plan when provided by a non-network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original emergency unless the following conditions are met: a. The attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available network provider or facility located within a reasonable distance taking into consideration the patient's medical condition. b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law. d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law. e. Any other conditions as specified by the Secretary. The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.
Emergency or True Emergency	A serious medical condition or symptom resulting from injury, sickness, or mental illness which is both: • Arises suddenly, and • In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health.
ERISA	Employee Retirement Income Security Act of 1974, as amended

Term	Definition
Excluded Drug	These are drugs that are not covered under the formulary due to more cost-effective and clinically appropriate products out in the market. If you choose to utilize these products, you would be responsible for 100% of the cost of the medication.
Experimental and/or Investigational Services	Medical, surgical, diagnostic, psychiatric, mental health, substance related, and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the UHC makes a determination regarding coverage in a particular case, are determined to be any of the following: • Not approved by the US Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or • The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. **Exceptions:** • Clinical Trials for which Benefits are available as described under Clinical Trials. • If you are not a participant in a qualifying Clinical Trial as described under Clinical Trials, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
Explanation of Benefits (EOB)	A statement provided by UnitedHealthcare to you, your physician, or another health care professional that explains: • The benefits provided (if any); • The allowable reimbursement amounts; • Deductibles; • Coinsurance; • Any other reductions taken; • The net amount paid by the plan; and • The reason(s) why the service or supply was not covered by the plan.
External Review	A review of an adverse benefit determination by an IRO described in the federal external review program section.
Full-time Student	A person who is enrolled in and attending, full time, a recognized course of study or training at one of the following: • An accredited high school; • An accredited college or university; or • A licensed vocational school, technical school, beautician school, automotive school, or similar training school. Full-time student status is determined in accordance with the standards set forth by the educational institution.

Term	Definition
Gender Dysphoria	*Diagnostic Criteria for Adults and Adolescents* A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following: • A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics). • A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics). • A strong desire for the primary and/or secondary sex characteristics of the other gender. • A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). • A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender). • A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender). The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning. *Diagnostic Criteria for Children* A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below): • A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender). • In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing. • A strong preference for cross-gender roles in make-believe play or fantasy play. • A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender. • A strong preference for playmates of the other gender. • In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities. • A strong dislike of ones' sexual anatomy. • A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.
Generic Drug	A drug that is no longer under patent protection and may be a lower-cost equivalent of a brand medication. The US Food and Drug Administration (FDA) requires that all generic drugs have the same active ingredients, strength and dosage form as the brand name equivalents.

Term	Definition
Gene Therapy	Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.
Genetic Counseling	Counseling by a qualified clinician that includes: • Identifying your potential risks for suspected genetic disorders; • An individualized discussion about the benefits, risks and limitations of genetic testing to help you make informed decisions about genetic testing; and • Interpretation of the genetic testing results in order to guide health decisions. Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.
Genetic Testing	Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.
Health Care Provider	A provider authorized by law to provide health care services in the home.
Home Health Care Agency	A program or organization authorized by law to provide health care services in the home.
Hospice	Hospice care is an integrated program recommended by a physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical and psychological care for the terminally ill person, and short-term grief counseling for immediate family members covered under the plan while the member is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
Hospice Facility	A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six months or less. The facility must have an interdisciplinary medical team consisting of at least one Physician, one registered Nurse, one social worker, one volunteer, and a volunteer plan. A Hospice Facility is not a facility or part thereof that is primarily a place for rest, custodial care of the aged, drug addicts or alcoholics, a hotel, or similar institution.
Hospital or Health Care Facility	An institution, operated as required by law, that both: • Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of physicians. • Has 24 hour nursing services A hospital is not primarily a place for rest, custodial care, or care of the aged, and is not a nursing home, convalescent home, or similar institution.
Illness	Physical sickness, disease, or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.
Independent Freestanding Emergency Department	A health care facility that: • Is geographically separate and distinct and licensed separately from a hospital under applicable law; and • Provides emergency health services.
Injury	Bodily damage other than sickness, including all related conditions and recurrent symptoms.
Infertility	A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.
Inpatient	An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility, or inpatient rehabilitation facility.

Term	Definition
Inpatient Rehabilitation Facility	A hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides physical therapy, occupational therapy, and/or speech therapy on an inpatient basis, as authorized by law.
Intensive Care	A service that is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance prescribed by the attending physician.
Intensive Outpatient Treatment	• For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week. • For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.
Intermediate Care	Mental Health/Substance Abuse treatment that encompasses the following: • Care at a residential treatment center which provides a program of effective Mental Health Services and Substance Abuse Services and:— Is established and operated in accordance with any applicable state law; • Provides a program of treatment approved by a physician and the Mental Health/Substance Abuse Administrator; • Has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient; — Provides at least the following basic services: — Room and board; — Evaluation and diagnosis; — Counseling; — Referral and orientation to specialized community resources; • Care at a partial Hospital/day treatment program, which is a freestanding or hospital-based program that provides services for at least 20 hours per week; and • Care through an intensive outpatient program, which is a freestanding or hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.
Lifetime	The covered participant's lifetime, which is the period of time during which the covered participant may receive certain benefits of the plan (or any prior or successor plan of the plan sponsor).
Maximum Benefits	The maximum amount that the plan will pay for benefits during the entire period of time that you are enrolled under the plan, or any other plan of the plan sponsor.
Medicaid	A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the programs' costs.
Medicare	Parts A, B, C, and D of the insurance program established by Title XVIII of the United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Term	Definition
Medical Necessity	Health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion. The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **UHCprovider.com**.
Medical Plan	Baker Hughes Company Comprehensive Major Medical Plan
Mental Health Services	Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a covered health service.
Mental Illness	Those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.
Military Service	Service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service pertaining to the military.
Network	This means a provider has a participation agreement in effect with the claims administrator or an affiliate (directly or through one or more other organizations) to provide covered expenses to covered persons. A provider may enter into an agreement to provide only certain covered expenses, but not all covered expenses, or to be a Network provider for only some of the plan's products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement and a Non-Network provider for other Health Services and products. The participation status of providers is subject to change throughout the plan year.
Network Provider	A physician, hospital, pharmacy, or other health care provider who has agreed to provide services to plan participants pursuant to a negotiated arrangement. A list of the network providers is available through all Baker Hughes-sponsored plans.

New Pharmaceutical Product	A Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *US Food and Drug Administration* (FDA) and ends on the earlier of the following dates: • The date it is reviewed; or • December 31 of the following calendar year.
Non-Medical 24-Hour Withdrawal Management	An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer, and social support rather than medical and nursing care.
Non-Network Provider	A physician, hospital, pharmacy, or other health care provider that does not have a network Provider agreement in effect with the plan administrator at the time services are rendered.
Non-Preferred Drug	A brand drug that is not on the CVS/caremark Advance Control Formulary Drug List and processes at a tier 3 copay/coinsurance. Generally speaking, these are higher-cost medications that have recently come to the market. In most cases, an alternative preferred medication (brand or generic) is available.
Nurse	A person holding the License of Registered Nurse (R.N.), Licensed Vocational Nurse, or Licensed Practical Nurse who is practicing within the scope of the license.
Nursery Care	Care for the initial confinement of a newborn if the child is enrolled in a hospital-sponsored medical option.
Oral Surgery	Necessary procedures for surgery in the oral cavity, including pre-operative and post-operative care.
Organ and/or Tissue Procurement	All professional, facility, ancillary, transportation, and other services necessary to acquire a transplantable human organ or to procure bone marrow or stem cells including but not limited to: expenses associated with listing on a UNOS-approved waiting list; the surgical removal of a donor organ from a living person or a human cadaver; the storage and preservation of a donor organ; transportation expenses associated with procuring a human organ; and the harvesting or apheresis, cryopreservation, and storage of bone marrow or stem cells from a covered person or a related or unrelated donor, including any fees associated with locating an unrelated donor through the National Marrow Donor Program.
Other Plans	Any of the following plan types that provide health benefits or services for medical care or treatment: • Group policies or plans, whether insured or self-insured (this does not include school accident-type coverage); • Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group; • Group insurance and group subscriber contracts; • Uninsured arrangements of group coverage; • The medical benefits coverage in a group or individual automobile no fault and traditional automobile fault type contract; or • Medicare and other government benefits, except a state plan under Medicaid and except as mandated by Federal law.
Out-of-Area	Refers to a geographic area where the plan does not offer sufficient network access to contracted providers. Eligibility for Out-of-Area plans is determined by the Retiree's home zip/postal code on file with the Baker Hughes Benefits Center.
Out-of-Pocket Maximum	The maximum amount of network coinsurance you pay each plan year for covered expenses. Once you reach the out-of-pocket maximum, benefits are payable at 100% of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any of the following: • Non-network expenses (except for UHC Out-of-Area options; non-network coinsurance applies) • Deductibles • Any charges for non-covered expenses • Charges that exceed eligible expenses • Amounts above reasonable and customary limits • Copays

Term	Definition
Outpatient	A covered person will be considered to be an outpatient if he or she is treated at: • A hospital as other than an inpatient • A physician's office, laboratory, or X-ray facility • An ambulatory surgical facility and the stay is less than 24 consecutive hours
Partial Hospitalization/ Day Treatment	A structured ambulatory program that may be a freestanding or hospital-based program and that provides services for at least 20 hours per week.
Per Occurrence Deductible	For benefit plans that have a Per Occurrence Deductible, this is the amount of eligible expenses or the recognized amount when applicable (stated as a set dollar amount) that you must pay for certain covered health services prior to and in addition to any annual deductible before the Plan will begin paying benefits for those covered health services. When a benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The eligible expense, or the recognized amount when applicable. Refer to *How the Plan Works*, and *Plan Highlights* to determine whether or not your benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific covered health services to which the Per Occurrence Deductible applies.
Personal Health Support	A program provided by the claims administrator designed to encourage an efficient system of care for covered persons by identifying and addressing possible unmet covered health care needs.
Physician	Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed and qualified by law. Please note: any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that we describe a provider as a physician does not mean that benefits for services from that provider are available to you under the plan. A physician cannot be yourself or an immediate member of your family.
Placed for Adoption	The date the participant assumes legal obligation for the total or partial financial support of a child during the adoption process.
Plan Administrator	Baker Hughes or its designee.
Plan Sponsor	Baker Hughes
Plan Year	January 1 through December 31, the 12-month period of time on which the plan's records are maintained.
Preferred Drug	A brand drug that is on the CVS/caremark Advance Control Formulary Drug List and/or processes at a tier 2 copay/coinsurance. These drugs have been determined to be either more effective than or just as effective as another product in the same therapeutic class.
Preferred Provider Organization (PPO)	UHC selects and contracts with certain hospitals, physicians and other health care providers to provide services, supplies and treatment at a discounted rate.
Pregnancy	Includes all of the following: • Prenatal care • Postnatal care • Childbirth • Any complications associated with pregnancy
Prescription Drug	Drugs and medicines which require a prescription by a physician to dispense and are approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury.
Preventive Care	Defined as services that contribute to the prevention of a condition or disease, such as: annual well-woman, well-man, and well-child exams.

Term	Definition
Prior Authorization	The process of determining benefit coverage based on medical necessity criteria, for services, tests or procedures that are appropriate and cost-effective for the individual member. It is a member-centric review to evaluate the clinical appropriateness of requested services in terms of the type, frequency, extent and duration.
Private Duty Nursing	Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true: • Services exceed the scope of Intermittent Care in the home. • The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing. • Skilled nursing resources are available in the facility. • The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
Recognized Amount	The amount which copayment, coinsurance and applicable deductible, is based on for the below covered health services when provided by non-network providers. • Non-network emergency health services. • Non-emergency covered health services received at certain network facilities by non-network physicians, when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act,* and any other facility specified by the Secretary. The recognized amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider. Note: Covered health services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these covered health services were determined based upon an eligible expense.
Remote Physiologic Monitoring	The automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.
Residential Treatment Facility	Treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements: • It is established and operated in accordance with applicable state law for Residential Treatment programs. • It provides a program of treatment under the active participation and direction of a Physician. • It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services; – Room and board. – Evaluation and diagnosis. – Counseling. – Referral and orientation to specialized community resources.
Retail Network Pharmacy	A pharmacy which contracts with the pharmacy benefit manager to fill or refill your prescription when you present a valid Prescription Drug program ID card.

Term	Definition
Retiree	An eligible person who is properly enrolled under the plan.
Secretary	As that term is applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).*
Semi-Private Room	A room with two or more beds. When an inpatient stay in a semi-private room is a covered health service, the difference in cost between a semi-private room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice or when a semi-private room is not available.
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law.
SPD	This Summary Plan Description which describes the Baker Hughes, Retiree Health & Welfare Benefits Plans.
Substance Abuse	Covered services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.
Substance-Related and Addictive Disorders Services	Covered expenses for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a covered health service.
Surgery	Any operative procedure performed in the treatment of an injury, disease, or illness by an instrument or cutting procedure through any natural body opening or incision.
Telehealth/ Telemedicine	Live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.
Unproven Services	Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. If you have a life threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the plan may consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, the plan must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
Urgent Care	Must meet one or both of the following criteria: • A delay in treatment that could seriously jeopardize life or ability to regain functionality; and/or, • Could cause severe pain.

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