Health & Welfare

2026 Summary Plan Description

Baker Hughes

This document describes the health and welfare plans offered by Baker Hughes Holdings, LLC under the Baker Hughes Company Welfare Benefits Plan as of January 1, 2026. Please note that the information presented is only a summary. It replaces all previously published Health & Welfare Summary Plan Descriptions. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern these plans are contained in the plan documents or group insurance contracts. If, in our efforts to make the plans easy to understand, any of the plan provisions have been omitted or misstated, the official plan documents or insurance contracts must remain the final authority. The legal documents also govern the administration of the plans and payment of benefits. In the case of any dispute, the information in the plan documents or contracts will prevail. To request a copy of the plan documents for a Baker Hughes Health & Welfare benefit program described herein, write to:

Baker Hughes Company
Attn: Total Rewards H&W Department
575 N. Dairy Ashford Rd., Suite 100
Houston, Texas 77079-1117

(Please provide your name and mailing address.)

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 plans indefinitely. However, Baker Hughes reserves the right to amend, cancel, change the carrier, or discontinue all or any part of the plans at any time.

This Summary Plan Description does not guarantee employment for any specified term and is not to be construed as a contract limiting Baker Hughes right to terminate the employment relationship at any time.

This document contains a summary in English of your Baker Hughes 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.

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** al **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.

Baker Hughes is committed to its employees and their well-being. As part of that commitment, we provide a competitive Total Rewards package, including a comprehensive Health & Welfare (H&W) benefits program to meet the varying benefit needs of our employees. Making sure the Total Rewards package works for you and your family is a shared responsibility.

About Your Baker Hughes Summary Plan Description

This Health & Welfare (H&W) benefits document, called a Summary Plan Description (SPD), gives you information about benefits offered at Baker Hughes effective January 1, 2026. It describes important features of each benefit plan, services that are covered, and how your benefits are paid.

To help you find information quickly, this SPD is divided into six main sections:

- **General Information** — details about eligibility, enrollment procedures, and when coverage starts and ends for all the plans;
- **Health** — information about your Medical, Wellness, Prescription Drug, Dental, and Vision plans, as well as Flexible Spending Accounts, Health Savings Account, and Emotional Wellbeing Solutions;
- **Protection** — information on the various insurance plans available to protect you and your family from financial hardship due to illness, accident, or death;
- **Benefits Rights** — information about your rights under the law and continuation of coverage if you leave Baker Hughes;
- **Important Plan Information** — reference details, such as plan number, sponsor, and the administrator; and
- **Glossary of Terms** — definition of terms found throughout this SPD.

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

Baker Hughes gives you the power to choose the coverage options that best suit the needs of you and your family by offering the following:

- Medical plan
- Wellness
- Prescription Drug plan
- Fertility Program
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account*
- Emotional Wellbeing Solutions
- Short-Term Disability
- Long-Term Disability
- Basic Life insurance
- Supplemental Life insurance
- Basic Accidental Death & Dismemberment insurance
- Voluntary Accidental Death & Dismemberment insurance
- Business Travel Accident insurance
- Legal Plan
- Critical Illness plan
- Accident Protection plan
- Hospital Indemnity Protection Plan
- Pet Insurance

*Only available if Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area plan elected.

Who Do I Call?

If you don't have Internet access, the contacts table on the following page provides you with telephone contact information. Before you pick up the telephone, reference the table below to be sure you call the right resource.

Contact the Baker Hughes Benefits Center Regarding:

- Eligibility for coverage
- The cost of your H&W benefits
- Changes in status that may affect your benefits (such as enrolling a new dependent due to birth, marriage, or adoption)
- Updating beneficiary information
- Changes in work status (such as from full-time to part-time) that may affect your benefits
- Your benefit options
- The Annual Enrollment process
- Your confirmation statements
- Obtaining help with a health care issue or claim

Contact Your Human Resources Department Through MySupport P&C Regarding:

- Taking a leave of absence
- Filing a Workers' Compensation claim
- Transferring within Baker Hughes
- Leaving Baker Hughes
- Changing your address or phone numbers via Workday

Contact the Administrator or Insurance Company Regarding:

- ID cards
- Network providers, facilities, hospitals, and pharmacies
- Questions or disputes about your Explanation of Benefits (EOB) or Health Statement
- The status of a claim or an appeal
- Your covered benefits
- How to file a claim

In addition to the resources mentioned here, there are several other tools available online. We've highlighted several of these tools throughout the SPD using an "Additional Resources" box like the one shown below.

Additional Resources

Via Internet: myuhc.com

- Search for providers in the UnitedHealthcare network or at **BakerHughesBenefits.com**
- Order new ID cards or print a temporary ID card
- Make real-time inquiries into the status and history of your health claims
- Access health and well-being information

Customer Service: 1-866-743-6549

Accessing Your Account

To access your benefits account online, from **BakerHughesBenefits.com**, click on *Enroll, Change, or Review Benefits*. The first time you access the enrollment system, you will need to create a new user ID and password.

- If you are inside the Baker Hughes network, select *Health & Protection Benefits - single sign-on from Baker Hughes Intranet*
- If you are outside the Baker Hughes network, select *Health & Protection Benefits - access with login and password*

Access is available 24 hours a day Monday through Saturday and after 12 p.m. Central Time on Sundays.

Baker Hughes Benefits Center

1-866-244-3539 (within the US)

1-847-883-0945 (worldwide)

With your user ID and password, you can access your personal account information. Please say "representative" at any time to speak with a Baker Hughes Benefits Center representative. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time.

Contacts

Below you'll find the customer/member services telephone numbers and websites for the administrators and insurance companies that administer the Baker Hughes H&W benefits.

Baker Hughes Benefit Plan	Provider	Phone Number	Website
Enrollment, Eligibility, Summary Plan Descriptions, Advocacy, and Survivor Support	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Medical	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Prescription Drug	CVS/caremark	1-877-252-3485	www.caremark.com
Dental	Cigna	1-800-542-4293	www.mycigna.com
Vision	VSP	1-800-877-7195 or 1-916-635-7373 (worldwide)	www.vsp.com
Flexible Spending Accounts	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Health Savings Account	Optum Bank	1-866-743-6549 or 1-866-802-8572 (worldwide) 1-800-791-9361	www.optumbank.com
Emotional Wellbeing Solutions - the Employee Assistance Program (EAP)	Optum	1-855-409-7074	www.liveandworkwell.com
Short-Term Disability	Sedgwick	1-877-423-8677	www.mysedgwick.com/bakerhughes
Long-Term Disability	Prudential	1-800-842-1718	mybenefits.prudential.com
Life Insurance/Accidental Death & Dismemberment (AD&D)	Prudential	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Business Travel Accident (BTA)	Chubb	1-877-297-4225, Option 4	CAHadmin@chubb.com
Legal Plan	Legal Access Plans LLC	1-888-416-4313	www.legaleaseplan.com/bakerhughes
Critical Illness Plan	UnitedHealthcare (UHC)	1-800-444-5854	www.myuhcfp.com Group Number: 305735
Accident Plan	UnitedHealthcare (UHC)	1-800-444-5854	www.myuhcfp.com Group Number: 305735
Hospital Indemnity Protection Plan	UnitedHealthcare (UHC)	1-800-444-5854	www.myuhcfp.com Group Number: 305735
Pet Insurance	MetLife	1-855-270-7387	https://metlife.pathfactory.com/bakerhughes
401(k) Plan and Pension Plan	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com

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Am I Eligible?

Employee Eligibility

If your payroll is US-based and you're either a regular full-time employee or a benefits-eligible, part-time employee (regularly scheduled to work at least 20 hours per week), you're eligible for coverage under the H&W benefits described in this SPD. Employees are allowed to appeal a determination of an individual's eligibility for coverage (see next page).

Note: You'll be notified by Baker Hughes if you're benefits-eligible when you're hired or transferred to a position with US benefits.

Eligible Employees Do Not Include:

- Temporary, contract, intern, or seasonal employees
- Employees hired outside of the United States and who work outside of the United States
- Employees who are members of a bargaining unit whose agreement does not provide for these benefits

Remember...

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.

Are My Dependents Eligible?

If you're an eligible employee as defined above, you may cover your eligible dependents under your Baker Hughes H&W plans. Note that domestic partners and their children are not tax dependents under IRS rules. You must pay the premium for their health benefits on an after-tax basis. The employer portion of the premium is subject to imputed tax.

Eligible dependents include:

Family Member	Eligibility Requirements
Your Spouse	• Your legal spouse of opposite or same gender, including common-law in states recognizing common-law marriage, or a legally separated spouse in states recognizing legal separation
Your Children	• Your dependent children up to age 26, regardless of whether they are married, full-time students, or eligible for other group health plan coverage • Your unmarried dependent children up to any age who are supported mainly by you because of mental or physical disability; the disability must have occurred during the period in which they were eligible dependents under the Baker Hughes Health & Welfare plans (up to age 26) • You may add your domestic partner's children to your benefits, but your domestic partner must also be covered under that same benefit
Your Domestic Partner	Your domestic partner. To be eligible, you and your domestic partner must meet the following requirements: • You have entered into a state-recognized same- or opposite-gender civil union or registered domestic partnership, or • You have not entered into a state-recognized same-or opposite-gender civil union or registered domestic partnership, and you and your partner satisfy all of the following: – Are at least 18 years of age and mentally competent to consent to a contract; – Are financially interdependent; – Are each other's sole domestic partners; – Are living together and share the common necessities of life; – Are not so closely related that marriage would otherwise be prohibited; and – Are not legally married to, or the domestic partner of, another person either under statutory or common law.

Eligible Children Include:

- Your biological children
- Your or your domestic partner's adopted children and children placed with you for adoption
- Your stepchildren
- Your domestic partner's children
- Your or your domestic partner's foster children in your care
- Any children for whom you or your domestic partner are the legal guardian
- Any children for whom there is a Qualified Medical Child Support Order (QMCSO) requiring you or your domestic partner to provide coverage*

Eligible Dependents Do Not Include:

- A spouse who is in full-time military service
- Parents, siblings, grandparents, nieces, nephews, etc., under the Medical, Dental, or Vision plans. Note: They may qualify under the Flexible Spending Accounts, but only if they meet the requirements described in the *Flexible Spending Accounts* section.

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) and report any changes to your dependents' status. Your dependent or domestic partner's dependent will lose eligibility on his or her 26th birthday, and coverage will be terminated on the last day of the month in which he or she turns 26.

Newborn Coverage

Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** to enroll your newborn. 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 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.

Note: Upon request, you will be required to comply with Baker Hughes Dependent Eligibility Verification process. As a result, you will be required to provide proof of dependent eligibility for any dependents, including domestic partners, covered under a Baker Hughes-provided benefit plan. Intentionally covering ineligible persons under the Baker Hughes Health and Welfare benefit plans may be subject to discipline, up to and including termination. You must immediately notify the Baker Hughes Benefits Center if your dependent becomes ineligible.

Coverage for a Disabled Dependent Child

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond the limiting age if both of the following are true regarding the enrolled Dependent child:

- Is not able to be self-supporting because of mental, developmental, or physical disability
- Depends mainly on you for support

Medical Coverage Certification

Medical coverage will continue as long as UnitedHealthcare (UHC), the Plan's current medical provider, medically certifies the enrolled Dependent as disabled and dependent. Unless coverage is otherwise terminated in accordance with the terms of the Plan. The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date; coverage would otherwise have ended because the child reached a certain age.

*Requires domestic partner to be enrolled into same benefit plans as required by the order.

Process

Before the Plan agrees to extend the child's coverage, you are required to complete the UHC Disabled Dependent form. Submit the form to UHC using either the address or fax number at the top of the form. You can download the Disabled Dependent form by accessing your Baker Hughes Benefits Account through **BakerHughesBenefits.com** or by going to **myUHC.com**. Upon review, UHC may require a Physician chosen by UHC to examine the child. The Plan will pay the examination cost.

Certification

If UHC certifies the child as disabled and dependent, UHC may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year. **The UHC medical certification may also extend the dependent's Dental and Vision coverage.**

Note: The UHC disabled dependent denial letter will outline the appeal process for denied certifications.

Child Life Insurance Certification (No Medical Coverage)

Child Life insurance coverage will continue as long as Prudential, the Plan's current life insurance provider, certifies the enrolled Dependent child as disabled and dependent. Unless coverage is otherwise terminated in accordance with the terms of the Plan. The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age.

Process

Before the Plan agrees to extend the child's coverage, you are required to complete the Prudential Statement of Dependent Eligibility form. Submit the form to Prudential either using the address or fax number at the top of the form. You can download the Statement of Dependent Eligibility form by accessing your Baker Hughes Benefits Account through **BakerHughesBenefits.com** or going to **www.prudential.com**. Upon review, Prudential may require a Physician chosen by Prudential to examine the child. The Plan will pay the examination cost.

Certification

If Prudential certifies your child as disabled and dependent, Prudential will not require you to provide periodic proof nor will the Plan require you to do so. **The Prudential Statement of Dependent Eligibility certification may also extend your dependent child's Dental and Vision coverage.**

The Prudential Statement of Dependent Eligibility certification denial letter will outline the appeal process for denied certifications.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan's request as described by one of the options above, coverage for the child will end. Disabled dependents are not eligible to add to your coverage due to a qualified status change or Annual Enrollment event.

If Eligibility for Benefits Coverage is Denied — How to Appeal

If eligibility for benefits coverage is denied, you have the right to file an appeal under Section 503 of the Employee Retirement Income Security Act (ERISA), as described below:

- Request a Claim Initiation Form from the **Baker Hughes Benefits Center** within 60 days after receipt of eligibility denial. You may contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or 1-847-883-0945 (worldwide)
- Complete the Claim Initiation Form, provide a description of the nature of the claim (e.g., calculation of service, eligibility for coverage) and a statement of the reason why you think you are entitled to such coverage or benefit
- Return all pages of the form, including any documentation you feel supports your claim. Please do not submit any original documentation. Documents submitted for claim processing cannot be returned to you. Keep a copy of this form for your records; and
- Mail all pages of the original form along with any documentation to:

  Baker Hughes Company
  Attn: Total Rewards H&W Appeals Department
  575 N. Dairy Ashford Rd., Suite 100
  Houston, Texas 77079-1117

A decision on the review will be made by Baker Hughes under Section 503 of the Employee Retirement Income Security Act (ERISA), as described below.

- Baker Hughes will process your claim within 60 days after receiving the Claim Initiation Form, unless special circumstances require an extension of time
- If Baker Hughes needs additional time to process your claim, you will receive a written notice of the need for a longer processing period, the reasons for the longer period, and a date on which you can expect your claim to be processed
- The decision on the review will be made in writing, include specific reasons for the decision and will reference the plan provision on which the decision is based

If Both You and Your Spouse or Domestic Partner Work at Baker Hughes

In general, every eligible employee may enroll eligible dependents. However, if both you and your spouse or Domestic Partner are Baker Hughes employees, you may:

- Choose to enroll yourself as the employee and your spouse or Domestic Partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees
- Eligible children may be enrolled as dependents of either you or your spouse or domestic partner, but not both

Retroactive Cancellation of Coverage

Your coverage (or your dependent's coverage) may be canceled retroactively if you or your dependent performs an act, practice, or omission that constitutes fraud, or you or your dependent makes an intentional misrepresentation of material fact, in connection with enrollment in the plan.

How Do I Enroll?

New Hires

If you're a new hire or an existing employee transferring to a position with US benefits, you may enroll and choose H&W benefit coverage within 31 days of your date of hire or date of transfer. You can enroll online via **BakerHughesBenefits.com** or via phone through the **Baker Hughes Benefits Center** by calling **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) after you have received your first paycheck. As this will be your first time enrolling, you'll need to create a user ID and password. The information you'll need to register as a new user can be found in your new hire employee Benefits Guide. For assistance with the enrollment process, contact the Baker Hughes Benefits Center.

If you do not enroll within 31 days, you'll be provided the default coverage shown on the following page. (Default coverage may be different for employees transferring to US benefits.) If you do not want default coverage, you must enroll and choose the coverage you do want or select the "No Coverage" option. You will only be able to change these elections during the Annual Enrollment period typically held in October or November of each year, or if you have a qualifying change in status such as the birth or adoption of a child. If you have a qualifying change in status, you will need to make your election within 31 days of the date the change occurred. Please see the *Can I Make Changes After I Enroll?* information located in this section for more details.

Your Default Coverage

Health	
Benefit Plan	**Default Coverage Level**
Medical and Prescription Drug*	You Only coverage under the Standard plan or Standard Out-of-Area plan and Prescription Drug coverage through CVS/caremark
Dental	No coverage
Vision	No coverage
Flexible Spending Accounts	No participation
Health Savings Account**	No participation
Emotional Wellbeing Solutions (Employee Assistance Program)	Automatic coverage

Protection	
Benefit Plan	**Default Coverage Level**
Short-Term Disability	Automatic coverage
Long-Term Disability (Core)	Automatic Core coverage
Basic Life Insurance	Automatic coverage
Supplemental Life Insurance	No coverage
Basic AD&D Insurance	Automatic coverage
Voluntary AD&D Insurance	No coverage
Business Travel Accident Insurance	Automatic coverage
Legal Plan	No coverage
Critical Illness Plan	No coverage
Accident Protection Plan	No coverage
Hospital Indemnity Protection Plan	No coverage
Pet Insurance	No coverage

*You will be required to pay for the default Medical and Prescription Drug coverage. All other default coverage is provided at no cost to you.

**Only available if Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area plan elected.

Important: If you do not want to participate in a Baker Hughes Medical plan, you *must* elect "No Coverage" during your enrollment. If you fail to elect "No Coverage," you'll be automatically enrolled in the default benefit coverage (see *Your Default Coverage* chart above). Coverage for STD, Core LTD, Basic Life, Basic AD&D, Emotional Wellbeing Solutions (the EAP), and Business Travel Accident insurance are Company-provided and cannot be waived.

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.

There are two ways to enroll in Health & Protection benefits. Both are described below:

Online — BakerHughesBenefits.com

To access your benefits account online, from **BakerHughesBenefits.com**, click on *Enroll, Change, or Review Benefits*. The first time you access the enrollment system, you will need to create a new user ID and password.

- If you are inside the Baker Hughes network, select *Health & Protection Benefits - single sign-on from Baker Hughes Intranet.*
- If you are outside the Baker Hughes network, select *Health & Protection Benefits - access with login and password.*

By phone — Baker Hughes Benefits Center

Call the Baker Hughes Benefits Center

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. CST.

If you're a new hire or an existing employee transferring to a position with US benefits, you can enroll via the telephone after you receive your first paycheck.

Tip!

Baker Hughes automatically provides the benefits enrollment website with your Baker Hughes email address. If you forget your password, a password reset can be sent to your Baker Hughes email address within 15 minutes of your request unless you prefer to set up a personal email address as your preferred email.

If You Do Not Enroll

If you do not enroll during Annual Enrollment and you remain eligible to participate in the plans, you will receive the benefit options and coverage levels you had the previous year. **However, during Annual Enrollment, you'll need to actively change your contribution to your Flexible Spending Account(s) and/or Health Savings Account or your contribution amount will default to $0.**

Remember...

You must have a user ID and password to enroll. If you don't already have one, you may create one by accessing your account at **BakerHughesBenefits.com** or by calling the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

Tip!

If you are planning to retire and meet the eligibility requirements, you will need to be enrolled in Baker Hughes active Medical plan at the time of your retirement to be offered retiree medical benefits, if any are available to you.

Deduction Authorization

As a Baker Hughes employee, you may be eligible for Health and Welfare benefit coverage. Certain benefits are provided and paid for by Baker Hughes. Other plans and coverage levels require an employee contribution. Upon election of any level of coverage which requires an employee contribution via payroll deduction, you authorize Baker Hughes to deduct the applicable contribution from your paycheck as required. Premium amounts may be adjusted by the benefit providers/ administrators or Baker Hughes, and you will be notified in writing of such changes.

Baker Hughes accepts no liability or responsibility for paying any employee portion of premiums. Depending upon timing of plan election, payroll deduction of retroactive premiums may be necessary. If during the course of employment with Baker Hughes, you are approved for a Leave of Absence (LOA), understand that you will be responsible for employee contributions for coverage in place prior to leave. Payment of these premiums for continuation of coverages will be deducted from your paycheck. **If you are not receiving pay during the leave, the benefit deductions will go into arrears and will be deducted from your regular pay upon your return to work or you will be direct billed by the Baker Hughes Benefits Center**. Upon termination of employment, it may be necessary for Baker Hughes to deduct the remainder of any employee contributions for the current month's coverages, in addition to any outstanding amounts.

Identification Cards

After you enroll, your Medical and Prescription Drug Plan Administrators will send identification cards to your address on file at Baker Hughes. You will get a separate card for the Medical Plan and the Prescription Drug Plan. The ID cards will show the type of plan, 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 the cards or you would like additional cards, contact:

Remember...
If you are enrolled in a Baker Hughes Medical Plan, you will receive a separate ID card for the Medical Plan and the Prescription Drug Plan.

Plan	Administrator	Website	Telephone
Medical Plan	UnitedHealthcare	myuhc.com	1-866-743-6549
Prescription Drug Plan	CVS/caremark	www.caremark.com	1-877-252-3485

Note: You'll only receive identification cards from the Plan Administrators listed in the table above. Generally, a new ID card will not be issued if there was not a change in the plan option or covered dependents during Annual Enrollment. If the plan is not listed above, then you will not receive an ID card. When you show your ID card to network providers, the network provider submits claims on your behalf and you are only responsible to pay the applicable deductible, copay, or coinsurance. For those plans that do not issue an ID card, you may need to provide a claim form prior to service to facilitate the claim process or complete a claim form for reimbursement after services are provided. Claim forms may be found on **BakerHughesBenefits.com** or may be obtained from each provider.

Can I Make Changes After I Enroll?

Normally, the choices you make during the Annual Enrollment period stay in effect for the entire plan year (January 1 through December 31). However, during the year you may change certain elections if you have a qualifying change in family or employment status (change in status). These permitted changes are defined by the Internal Revenue Service (IRS) and include changes such as marriage, the birth or adoption of a child, or career-related changes such as moving from a part-time status that is not benefits-eligible to full-time status.

The benefit changes that are permitted must generally 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 full plan year (certain exceptions apply).

Approved IRS Changes in Status Include:

- If you marry
- If you register a domestic partner
- If you return from an unpaid leave of absence
- If you divorce, your marriage is annulled, your domestic partnership dissolves, or you become legally separated (in states that recognize legal separation)
- If you gain or lose benefits eligibility due to a work situation change
- If you have a birth, adoption, placement for adoption, or court-ordered guardianship
- If COBRA coverage from another employer expires
- If you die
- If the employee or dependent gains or loses Medicare coverage
- If your spouse, domestic partner, or child dies
- If a family member gains or loses benefits eligibility due to a work situation change
- If the employee or dependent loses eligibility for, or becomes eligible for, assistance under Medicaid or a state child health plan*
- If you relocate outside your current network area
- If you take an unpaid military leave of absence
- If a child loses or gains eligibility under the H&W plan
- If there is a qualifying change in coverage or cost of coverage

*The approved changes must be made within 60 days of the date eligibility is lost, or within 60 days from the date the employee 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 time frame specified above. To make the approved changes, access your account online 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.

Tip!

In most cases, changes to your benefits must be consistent with the change in your status. For example, if you get married, you may add your spouse. If you want to know what changes you're allowed to make, access your account at **BakerHughesBenefits.com** or call the Baker Hughes Benefits Center at 1-866-244-3539 (toll-free in the US) or 1-847-883-0945 (worldwide).

When Does My Coverage Begin?

Newly Hired or Transferred Employee

If you're a newly hired or an existing employee transferring to a position with US benefits, you are eligible for benefits on your date of hire or date of transfer and you may enroll after you receive your first paycheck from Baker Hughes. For **Protection** benefits, you will need to be actively at work for coverage to take effect. You must complete the benefits enrollment process within 31 days from your date of hire or date of transfer (see the *How Do I Enroll?* information in this section). Any dependents that you enroll during that time are also covered immediately. If you do not actively enroll within 31 days of becoming eligible, you'll automatically be enrolled in the default benefits listed in the *Your Default Coverage* section.

Definition: Actively at Work means that you are working at your normal work location or on assignment for Baker Hughes, and you are performing the material and substantial duties of your Baker Hughes occupation.

Rehired Employees

Benefits coverage for employees rehired within the same plan year in which their employment terminated will be reinstated at the same level of coverage the employee had prior to leaving, with the exception of the Dependent Care and Health Care Flexible Spending Account and the Health Savings Account which default to $0. The employee does not need to enroll in benefits. However, if the employee is rehired more than 30 days after leaving the Company, the employee may change his or her Health Care or Dependent Care Flexible Spending Account elections. The new contribution election may not be less than what was previously contributed or less than what was previously reimbursed by the plan, whichever amount is greater. Health Savings Account, Dependent Care FSA, and Health Care FSA deductions are not automatically reinstated at rehire. The employee must contact the **Baker Hughes Benefits Center** to re-enroll or make any desired benefits changes within 31 days of the date of rehire.

Employees returning to Baker Hughes in a new plan year will be required to complete the benefits enrollment process.

Current Employee

If you're an existing employee, any new coverage you elect during Annual Enrollment will generally take effect the following January 1. However, some coverage may require evidence of insurability; if this applies, the new coverage will begin either January 1 or once such evidence is received and approved by the administrator, whichever is later.

If you have a qualifying change in status, and make a timely benefit coverage change, your new coverage will take effect on the date of your status change. In other words, if the change is due to birth, adoption, placement for adoption, or marriage, etc., the change will generally take effect retroactively to the date of the birth, adoption, placement, or marriage etc., as long as the change is made within 31 days of the event.

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

- Date your coverage becomes effective
- Date you enroll your dependents for coverage; if enrollment is due to a status change, coverage will start as of the effective date of the status change (e.g., the date of birth), or
- If coverage requires evidence of insurability (EOI), coverage will be effective the date the EOI is approved or according to the plan rules (e.g., the first of the plan year if elected during Annual Enrollment)

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

When Does My Coverage End?

Coverage for you and/or your eligible dependents will end on the day:

- You stop working for Baker Hughes
- You stop making contributions to the plan
- You're no longer eligible
- Your dependent is no longer eligible

Benefit coverage for your eligible dependents ends either on the day that they no longer qualify as dependents, or on the day that your coverage ends for one of the reasons above, whichever comes first. (Please note that a dependent child loses coverage on the last day of the month in which he or she turns 26.)

Note: If your group health plan coverage terminates, you may be eligible to continue your health coverage by electing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA coverage continues the same health coverage you have as an employee, but you pay the full premiums plus a 2% administration fee. Refer to the *COBRA* section for more information on COBRA coverage. If you are interested in continuing other coverage (i.e., Life insurance, or Accidental Death & Dismemberment insurance), refer to the applicable benefit section for details on how to continue your coverage.

Rescission of Coverage

Once an individual is enrolled and covered, your coverage under one of the Baker Hughes Medical plans may not be rescinded retroactively unless such individual was enrolled in the Medical plan either:

- As a result of an act, practice, or omission by the individual that constitutes fraud or another person, such as the employee or employee's spouse or domestic partner, seeking coverage on behalf of the individual under the Medical plan that constitutes fraud, or
- As a result of an intentional misrepresentation of a material fact made by such individual

If any of the above circumstances occurs, then both the eligible employee and any affected eligible dependents will be given at least 30 days advance written notice of the rescission.

If You Retire

Baker Hughes offers Medical benefits to certain retired employees. To be eligible, you must be considered a retiree of Baker Hughes on your date of retirement. Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) to learn more about the medical coverage for retirees.

While Baker Hughes intends to provide medical coverage for certain retirees now and in the future, Baker Hughes reserves the right to amend, cancel, change the carrier for, or discontinue all or any part of the medical coverage provided to retirees at any time.

If You Become Disabled

If you become disabled, you and your dependents may continue to receive Baker Hughes H&W benefits as follows:

	Coverage Under Short-Term Disability, When Eligible*	Coverage Under Long-Term Disability, When Eligible*
"Health" benefits, including Medical, Prescription Drug, Dental, Vision, Flexible Spending Accounts, Health Savings Accounts, and Emotional Wellbeing Solutions (the EAP)	All continue during STD period	Only certain Baker Hughes Medical plan coverage may continue — see the *Long-Term Disability* section for limitations and further information. You may elect to continue Dental, Vision, and in some cases your Health Care Flexible Spending Account through COBRA coverage at your own expense. Your Health Savings Account deductions will cease. (Contact UHC/Optum for more information regarding your Health Savings Account.) For information on COBRA coverage, refer to the *COBRA* section of this Summary Plan Description.
"Protection" benefits, including Basic and Supplemental Life insurance, Basic and Voluntary Accidental Death & Dismemberment insurance, Critical Illness Insurance, Accident Protection Plan, Hospital Indemnity Protection Plan, the Legal Plan, and Pet Insurance	All continue during STD period	Only Basic Life and Voluntary AD&D will continue (if enrolled prior to disability). You may elect to convert your Basic AD&D, Supplemental Life, or Legal Plan coverage to an individual policy. Refer to the applicable benefit section for more information.

*Benefit premium deductions will continue while on a paid/approved STD leave.

Leave of Absence

Coverage Continuation

Under the Family and Medical Leave Act of 1993 (FMLA) employees are entitled to continuation of coverage during an eligible leave of absence, and reinstatement of any coverage that terminated as a result of the FMLA leave upon return to active status.

If you are not receiving pay during a Company-approved leave, you will be direct billed through the Baker Hughes Benefits Center. If you do not pay the required premiums within the specified timeframe, your coverage will be terminated. You will be direct billed OR accumulate arrears which you **have agreed to pay upon your return to work**.

If you are enrolled in a Health Savings Account (HSA), deductions will cease. However, if you continue to be covered under the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area Plan, you can continue to make contributions to your HSA by sending contributions directly to Optum Bank. Contact Optum Bank directly at **1-866-743-6549** for more information. **To re-enroll/reinstate benefits upon your return from a leave, contact the Baker Hughes Benefits Center immediately upon your return to work.**

At the exhaustion of the FMLA leave period (if the leave continues)* or when your employment otherwise terminates (whichever comes first), you and your covered dependents may be eligible for COBRA continuation coverage for Medical, Dental, and Vision coverage, and the Health Care Flexible Spending Account. Your cost is 100% of the gross premium plus a 2% administration fee. You may go to **BakerHughesBeneifts.com** to access your online benefits account.

Paid Leave

During a paid leave of absence your portion of the cost of your H&W coverage during the leave of absence will be deducted from your paycheck. If your paid leave has a combination of pay from the Company or its affilitate that employs you, state benefits, and/or worker's compensation, your paycheck may not cover all of your premium payments for your benefits coverage. If this occurs, **you will be responsible for repayment of any arrears upon your return to work**. If your benefits terminate due to non-payment, you will be responsible for contacting the Baker Hughes Benefits Center to reinstate your benefits upon your return to work.

For information on the billing process or your coverage, please contact a **Baker Hughes Benefits Center** representative at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

*Unless otherwise required by state-specific guidelines.

Reinstatement of Canceled Coverage Following Unpaid Leave

When you return to work after your unpaid leave, you may be eligible to enroll into a Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, and/or the Health Savings Account. In addition, you may be eligible to change some of your benefit coverages, including any benefits that were terminated during your Unpaid Leave. If you are returning from a military leave you may reinstate the coverage you elected to stop as well as the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, and/or the Health Savings Account. You must contact the **Baker Hughes Benefits Center** within 31 days of your return from unpaid FMLA leave to reinstate your coverage. If you are on an unpaid leave in January when the employer seed amount is applied, your account will not receive the employer seed. Upon your return to an actively at work status the employer seed will be applied and prorated based on your date of return.

Upon request, Baker Hughes will give you detailed information about FMLA and its effect on your benefits.

Military Leave Continuation and Your Rights Under USERRA

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you have the right to temporarily continue health coverage for yourself and your dependents at group rates if you're called for military service. If you're covered by a group health plan and are placed on a military leave:

- Up to and including 180 days, you automatically continue coverage at the same rates as active employees, or
- For longer than 180 days, you may elect military leave continuation coverage up to 24 months or the date your reinstatement rights expire, whichever occurs first. Your cost is 100% of the gross premium plus a 2% administration fee. You must apply for or return to employment within the period required under USERRA

If your coverage under the plan terminates on account of the performance of duties in the uniformed services and you're later reinstated as an employee, you'll not be subject to any waiting period requirements or limitations which would otherwise apply to a new employee, provided that those requirements would not have been imposed on you (or your covered dependents) had coverage not ended due to military leave. This rule does not apply to illness or injuries incurred or aggravated while in uniformed service.

Only Medical, Dental, and Vision coverage continues while you are on an approved military leave. **You will be direct billed through the Baker Hughes Benefits Center.** If you do not pay the required premiums while on leave and coverage continues, the repayment of unpaid arrears will be required upon return from work. If an employee chooses to stop coverage while out on an unpaid military leave, he/she should contact the Baker Hughes Benefits Center at the onset of his/her leave. When you return to work after your unpaid military leave, you may be eligible to enroll into the Dependent Care Flexible Spending Account, Health Care Flexible Spending Account, and/or the Health Savings Account. In addition, you may be eligible to change some of your benefit coverages, including any benefits that you elected to stop or were terminated during your military leave.

Health

Benefits described under Health are designed to help create a healthier life for you and your family. These benefits include:

- Medical plan
- Wellness
- Prescription Drug plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account
- Emotional Wellbeing Solution (Employee Assistance Program)

The following pages provide information about each of the Health benefits.

Medical Plan

Medical Benefits At-a-Glance

Type of Plan	Voluntary medical coverage
Who Pays the Cost	You share the cost of medical coverage with Baker Hughes.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days of becoming eligible for coverage. If you do not enroll and elect coverage (including "no coverage"), you'll be given default coverage. • Employees can change their Medical plan election during Annual Enrollment or during the year if they have a qualified change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year as long as you remain eligible.
Medical Choices	• Standard Plan • Premium HSA Plan • Basic HSA Plan • Standard Out-of-Area Plan • Premium HSA Out-of-Area Plan • Basic HSA Out-of-Area Plan **Note:** Your home ZIP/postal code on file with Baker Hughes determines the plan options available to you.
Coverage Level	• You • You + Children* • You + Spouse or Domestic Partner • You + Family
Contact	• UnitedHealthcare: www.myuhc.com or 1-866-743-6549 • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

*Includes children of your covered domestic partner

Medical Plan Features At-a-Glance

Plan Feature	Standard [1], [4], [5] (Choice Plus Network)	Premium HSA [2], [4], [5] (Choice Plus Network)	Basic HSA [2], [4], [5] (Choice Plus Network)
Deductible	$800 Individual $1,600 Family	$1,700 Individual $3,400 Family [2]	$3,300 Individual [2] $6,600 Family [2]
Coinsurance	80% in-network; 60% of Eligible Expenses out-of-network		
Physician Office Visit	80% in-network; 60% of Eligible Expenses out-of-network		
Virtual Visits	80% in-network; No out-of-network coverage		
Emergency Room (ER)	$150 copay then 80% in-network; 80% of Eligible Expenses out-of-network		
HSA Employer Contribution	N/A	You Only: $500 [3] You + Spouse or Domestic Partner: $750 [3] You + Children: $750 [3] You + Family: $1,000 [3]	N/A
Preventive Care	100% in-network; 60% of Eligible Expenses out-of-network		
Out-of-Pocket Maximum (only in-network coinsurance applies)	$4,000 Individual $8,000 Family (includes deductible)	$5,000 Individual [2] $10,000 Family (includes deductible) [2]	$6,500 Individual [2] $13,000 Family (includes deductible) [2]
Plan Feature	**Standard Out-of-Area PPO (Options PPO Network)**	**Premium HSA [2] Out-of-Area (Options PPO Network) [2]**	**Basic HSA Out-of-Area (Options PPO Network)**
Deductible	$800 Individual/$1,600 Family	$1,700 Individual/$3,400 Family	$3,300 Individual/$6,600 Family
Coinsurance	80% in-network; 80% of Eligible Expenses out-of-network		
Physician Office Visit	Subject to deductible and coinsurance		
Virtual Visits	80% in-network; No out-of-network coverage		
Emergency Room (ER)	Subject to deductible and coinsurance (ER copay does not apply to out-of-area plan.)		
HSA Employer Contribution	N/A	You Only: $500 [3] You + Spouse or Domestic Partner: $750 [3] You + Children: $750 [3] You + Family: $1,000 [3]	N/A
Preventive Care	100% in-network; 100% of Eligible Expenses out-of-network		
Out-of-Pocket Maximum (only in-network coinsurance applies)	$4,000 Individual $8,000 Family (includes deductible)	$5,000 Individual $10,000 Family (includes deductible)	$6,500 Individual $13,000 Family (includes deductible)

[1] The out-of-pocket maximum is included in the Prescription Drug Plan.

[2] The deductible is indexed with inflation per the Internal Revenue Code guidelines; therefore, it may increase each year. The deductible and out-of-pocket maximum under these plans are combined with the Prescription Drug plan. You must meet the combined Medical and Prescription Drug Family deductible if your coverage level is other than *You Only*.

[3] When you elect the Premium HSA or Basic HSA option, you may also elect to open a Health Savings Account (HSA). If you enroll in the Premium HSA option, Baker Hughes will automatically deposit money in your HSA if you are eligible. This contribution is subject to review and change in future years.

[4] The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

[5] The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.

Medical Choices

Baker Hughes offers managed care Medical plan options under the Baker Hughes Company Comprehensive Major Medical Plan (the Medical plan), and all plans options under the Medical plan provide comprehensive major medical coverage. All Medical plan options are administered by UnitedHealthcare (UHC). Managed care is a way to receive medical care through networks of physicians, specialists, hospitals, clinics, and other health care providers. The network provides services at pre-negotiated fees, which are usually lower than the fees charged by non-network providers.

If your home ZIP/postal code on file with Baker Hughes is within the UHC Choice Plus network service area, your options for Medical plan coverage are:

- Standard Plan
- Premium HSA Plan
- Basic HSA Plan

OR

If your home ZIP/postal code on file with Baker Hughes is out of the Choice Plus network service area, your options for Medical plan coverage are:

- Standard Out-of-Area Plan
- Premium HSA Out-of-Area Plan
- Basic HSA Out-of-Area Plan

These plans utilize 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. Your medical expense reimbursements are subject to the plan deductible, coinsurance, and Eligible Expense cost limitations. Eligible Expenses are determined by UHC's reimbursement policy guidelines. You will be responsible for any costs in excess of what are considered Eligible Expenses. See the section *Eligible Expenses* for a complete definition.

To find out if you reside within the UHC Choice Plus network service area, go online to the Baker Hughes Benefits website at **BakerHughesBenefits.com** to access your myUHC account or call a Baker Hughes Benefits Center representative. If you do not live within the UHC Choice Plus network service area, you will be offered out-of-area coverage options.

To ensure that your coverage fits your needs, you can choose from four different levels of coverage:

- You Only
- You + Spouse or Domestic Partner
- You + Children
- You + Family

As a newly hired employee or an employee transferred to a US benefits-eligible position, you must enroll within the first 31 days of your date of hire or transfer. **If you do not make an enrollment election (including electing "no coverage"), you'll be covered by the Standard Plan (or Standard Out-of-Area Plan, as appropriate) with *You Only* coverage**. You will be responsible for the applicable premiums. Employees transferring to US benefits, please contact the Baker Hughes Benefits Center for further information and assistance.

All Medical plans cover expenses for certain hospital services, medical services, and supplies. These expenses must be for the treatment of a non-occupational injury or illness.

Definition: Non-occupational Injury or Illness means any injury or illness that does not:

- Occur due to work performed for pay or profit, or
- Result from an injury acquired during a job-related incident.

If Your Home ZIP/Postal Code is Within the UHC Choice Plus Network Service Area

1 Medical Plan Options

If you participate in the **Standard Plan**, you may use health care providers in the UHC Choice Plus network plus any out-of-network provider. The plan's key features are outlined below.

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for specialist visit
- You are required to meet the deductible before the Medical plan will begin to share in the cost of covered services with you
- 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. See the section *Eligible Expenses* for a complete definition
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible network expenses
- Prescription drug costs apply to the out-of-pocket maximum

2

The **Premium HSA Plan** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect to open a Health Savings Account (HSA). If you do, Baker Hughes will automatically deposit money in your HSA. This employer contribution is subject to review and change in future years. The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. See the *Health Savings Account* section for more information. The plan's key features are outlined below.

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for a specialist visit
- You are required to meet the combined Medical and Prescription Drug deductible before the Medical plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services covered at 80% in-network or 60% out-of-network after the deductible is met. Non-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. See the section *Eligible Expenses* for a complete definition
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible in-network expenses

3

The **Basic HSA Plan** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect to open a Health Savings Account (HSA). The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. See the *Health Savings Account* section for more information. The plan's key features are outlined below.

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for a specialist visit
- You are required to meet the combined Medical and Prescription Drug deductible before the Medical plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)

- Most services covered at 80% in-network or 60% out-of-network after the deductible is met. Non-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. See the section *Eligible Expenses* for a complete definition
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible in-network expenses

If Your Home ZIP/Postal Code is Out of the UHC Choice Plus Network Service Area

That means there are too few UHC network providers in your area. As a result, you can use any provider for your health care and receive coverage for Eligible Expenses at the in-network coinsurance level. The out-of-area plans cover the same types of health care expenses as the UHC Choice Plus network plans, however, if you use an out-of-network provider, you are required to pay the amount that exceeds Eligible Expenses. The amount in excess of Eligible Expenses could be significant, and this amount does not apply to the out-of-pocket maximum. For non-network services, you are required to submit a claim form for reimbursement.

Three Medical Plans

1 The **Standard Out-of-Area option** 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.

2 The **Premium HSA Out-of-Area option** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums, but has higher out-of-pocket expenses than the other Medical plan choices. The Health Savings Account (HSA) allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. See the *Health Savings Account* section for more information. If you enroll in this plan, you have the option to elect to open an HSA. If you do, Baker Hughes will automatically deposit money in your HSA. This Employer contribution is subject to review and change in future years. The plan pays 80% for eligible health care expenses after you meet the combined Medical and Prescription Drug 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.

3 The **Basic HSA Out-of-Area option** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums, but has higher out-of-pocket expenses than the other Medical plan choices. The Health Savings Account (HSA) allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. See the *Health Savings Account* section for more information. If you enroll in this plan, you have the option to elect to open an HSA. The plan pays 80% for eligible health care expenses after you meet the combined Medical and Prescription Drug 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.

Out-of-Area PPO Coverage Example

If you have out-of-area coverage and need to see a physician, take a look at your options and how the out-of-area process works. When you have out-of-area coverage, you may choose any physician. In this example, you would be enrolled in You Only coverage in the Standard Out-of-Area option and you would have already met your $800 deductible. You decide to see Dr. Brown, a non-network provider.

You make an appointment to see Dr. Brown. (You have already met your $800 deductible.)

You may be required to pay the total fee for service for your visit with Dr. Brown – $75.

You then complete a claim form and submit the form and receipts directly to UnitedHealthcare for processing. Forms are available via **www.myuhc.com** or by calling **1-866-743-6549**.

UnitedHealthcare determines the Eligible Expenses.

Most doctors in the area, with the same qualifications and experience as Dr. Brown, charge less for the same service. UHC processes your claim and pays 80% of $67.50 (Eligible Expenses allowed amount). UHC reimburses you for $54.

The doctor visit costs you the balance, or $21.

The Eligible Expenses allowable amount is $67.50 x 80% (plan benefit) = $54.
You will pay $7.50 (difference between Eligible Expenses and billed charges) + $13.50 (20% coinsurance after UHC payment) = $21.

Tip!

If you need to travel to seek the care of a specialist, check to see if the specialist is in the UnitedHealthcare network to automatically receive the network-level benefits of a Medical plan option under the Medical plan.

What is the Cost of these Plans?

You and Baker Hughes share the cost of medical coverage provided under the Medical plan. Your cost of coverage is determined by both the Medical plan option and the level of coverage you choose.

You pay your portion of the cost with pre-tax dollars, which means that your monthly premiums are deducted from your paycheck before federal and state income taxes and Social Security taxes are calculated and withheld. The premiums are not included on your W-2 form as taxable wages, so your taxable income is lower. Note: The Internal Revenue Service generally does not consider domestic partners and their children eligible dependents. Therefore, the value of Baker Hughes' cost in covering a domestic partner may be imputed to the employee as income. In addition, the share of the employee's contribution that covers a domestic partner and their children may be paid using after-tax payroll deductions.

Note: New Jersey does not recognize pre-tax deductions. In New Jersey, only your federal taxable income would be affected.

Your share of the cost of Medical coverage is included in the employee Benefits Guide or can be found through the resources below. You will need to receive your first paycheck before calling the **Baker Hughes Benefits Center**.

Online	By Phone – Baker Hughes Benefits Center Representative
To access your benefits account online, from **BakerHughesBenefits.com**, click on *Enroll, Change, or Review Benefits*. The first time you access the enrollment system, you will need to create a new user ID and password. • If you are inside the Baker Hughes network, select *Health & Protection Benefits - single sign-on from Baker Hughes Intranet* • If you are outside the Baker Hughes network, select *Health & Protection Benefits - access with login and password*	Call the **Baker Hughes Benefits Center** **1-866-244-3539** (within the US) **1-847-883-0945** (worldwide)

Understanding UHC Networks

All Medical plan options are offered through UnitedHealthcare (UHC), and depending on the plan for which you are eligible, you will have the following UHC network available:

Medical Plan Options	Network
Standard Plan	UnitedHealthcare Choice Plus
Premium HSA Plan	
Basic HSA Plan	
Standard Out-of-Area Plan	UnitedHealthcare Options PPO
Premium HSA Out-of-Area Plan	
Basic HSA Out-of-Area Plan	

Remember...

Health care providers can move in and out of network at any time. Do not choose a Medical plan option based on a particular network physician.

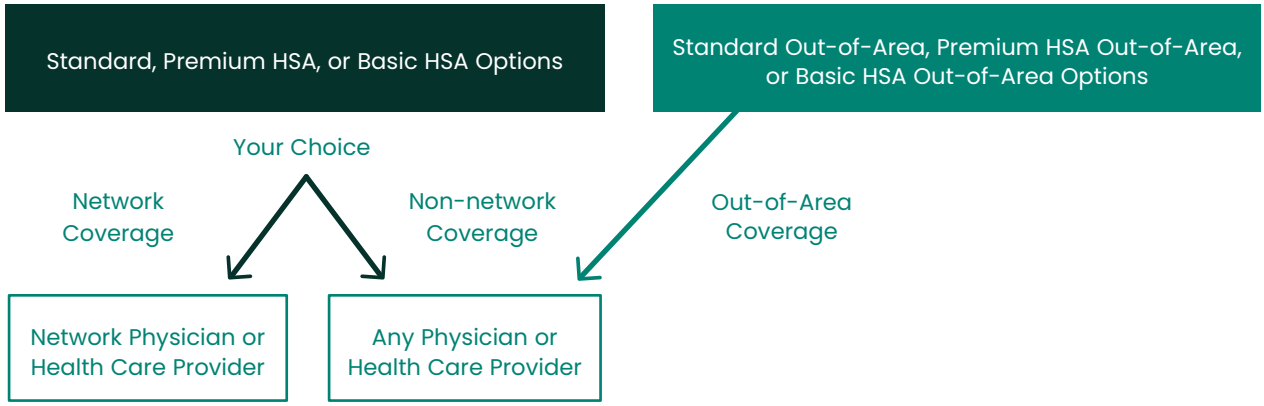
If you are a new hire or are considering enrolling in a Medical plan option for the first time, you may determine the network health care providers available in your area online at **www.myuhc.com** or by calling UHC at **1-866-743-6549**.

Tip!

To find out if your physician is currently in the UHC network:

- Go to **www.myuhc.com**. After you log in, select "Find Care and Costs" and follow the instructions on the screen
- Call UHC Member Services at **1-866-743-6549**; or
- Go to **BakerHughesBenefits.com** and select *Vendor Tools*, then UnitedHealthcare, and then "I want to Find a Provider or Network Hospital" and follow the instructions on the screen.

Here is how the managed care network affects your choice of health care provider:



Tip!

If you're enrolled in out-of-area coverage and you travel to see a UHC network physician or specialist, you'll automatically receive the network level benefits of the plan.

What if I Need a Specialist who isn't in the UHC Network?

If you are enrolled in a UHC network plan (Standard, Premium HSA, or Basic HSA) and need to access specialized care, but that specialty is not represented in your network area (within 30 miles from your home ZIP/postal code on file), you may qualify to receive the network level of benefits with a network gap exception. To request authorization for a network gap exception, contact UHC Care Coordination℠ at **1-866-743-6549**. UHC will generally respond within two to three weeks with a determination.

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 costs for most services when you go to a network provider.

If you don't 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.

What if my Covered Dependents do not live in an Area Covered by the Plan?

While UHC provides a nationwide network of providers, you may have dependents who are covered by your Medical plan option who do not live with you and who do not live in an area covered by the option (for example, a child attending college in another state). The Medical plan options offer both network and non-network coverage. You will pay lower out-of-pocket costs for most services when you use a network provider.

UnitedHealth Premium℠ Program

The UnitedHealth Premium Program was designed to help you make informed decisions on where to receive care. The program identifies network physicians and facilities that meet the UnitedHealth Premium Program criteria for quality and efficiency.

UnitedHealth Premium – Physician and Facility Designation Program

The Premium Designation Program recognizes certain specialty and primary care physicians and cardiac facilities that meet nationally recognized evidence-based medical guidelines for quality and efficiency of care. Only providers who meet the quality criteria are evaluated for efficiency.

UnitedHealth Premium – Hospital Comparison Program

The Hospital Comparison Program allows you to see how a particular health care facility scores for quality and cost for certain inpatient procedures.

Important: For information on covered services, 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*℠.

Additional Resources

Via **BakerHughesBenefits.com**
Via Internet: **www.myuhc.com**

When you enroll in one of the Medical plan options, you'll be able to register at **www.myuhc.com**. This is a self-service health and well-being website. It is secure and easy to use. Through **www.myuhc.com**, you will be able to:

- Make real-time inquiries into the status and history of your health claims
- Obtain Medical and FSA claim forms
- View your eligibility information
- Register using your own password and view personal data online
- Search for providers in your area, including UnitedHealth Premium providers
- Order new or replacement ID cards for the entire family or print a temporary ID card
- Access health and well-being information and participate in live events
- Price various procedures through "Find Care and Costs"
- Enroll in Wellness Coaching
- Access your Optum Bank account

Customer Service: 1-866-743-6549

The UnitedHealth Premium Program is not available in all ZIP codes. For details on the UnitedHealth Premium Program, including how to locate a UnitedHealth Premium physician or facility, log on to **www.myuhc.com** or call the toll-free number on your ID card.

How do the Medical Options work?

With the Medical plan, you make an appointment when you need care without the need for a referral. The Medical 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.

When you receive covered medical services, your health care provider may ask you to pay in one of several ways. This decision is made by your health care provider.

Remember...

If you choose the Standard option, you can enroll in a Health Care Flexible Spending Account and you may be reimbursed for your eligible out-of-pocket medical expenses (see the *Flexible Spending Accounts* section for more information).

Preferred Method

1 **Your health care provider will submit a claim directly to UHC before they request payment for any amount you owe.** In this case, UHC will pay your provider directly based on the claim your health care provider filed.

After the claim has been processed, your provider will receive both payment and a benefits statement from UHC, detailing the contracted rates for services and the amount you are responsible for paying.

You will receive information from UHC detailing how your claim was processed. Your provider will bill you directly for the remaining amount you owe. You, in turn, make your payment directly to your provider.

2 **Your health care provider may request partial or full payment at the time of your visit and file a claim with UHC on your behalf.** In this case, you will be required to pay for services on the day of your visit. Your provider determines the payment options for his/her office, specifically as it relates to whether or not you have met your plan year deductible. However, network providers should only charge the UHC-contracted rate for the care you receive.

Your network provider will submit a claim to UHC on your behalf. After the claim has been processed, your provider will receive both payment and a benefits statement from UHC, detailing the contracted rates for services and the amount you are responsible for paying.

You will receive information from UHC detailing how your claim was processed. If you have underpaid, your provider will bill you for the balance you owe. If you have overpaid, contact your provider to request a refund or service credit.

3 **Your health care provider requests full payment at the time of your visit and does not file a claim with UHC (non-network providers only).** Non-network providers may require that you pay for services on the day of your visit. It is then up to you to file your expenses with a claim form to UHC for reimbursement.

In this case, UHC will review your claim and reimburse you up to the Eligible Expense limits. Your reimbursement will be sent to you along with an explanation of how your claim was processed. See the section *Eligible Expenses* for a complete definition.

Claim forms can be obtained online at **www.myuhc.com**, or by calling UHC at **1-866-743-6549**, or from **BakerHughesBenefits.com**.

It is important in all cases to review your health statement from UHC so you are informed on the processing and payment of your claims. If you have any questions regarding your claims, contact UHC at **1-866-743-6549**.

Out-of-Pocket Expenses and Your Bottom Line

The Medical plan options may differ by:

- The amount of annual deductible
- The amount of annual out-of-pocket maximum
- How the deductible and out-of-pocket maximum work
- Your payroll deduction to cover the employee premium
- Whether non-network coverage is allowed
- Whether you may contribute to a Health Savings Account (HSA)

When you receive medical care, you and the Medical plan share the cost. This means that you'll pay deductibles and coinsurance according to the type of service you receive and the Medical plan option you elect.

Deductibles

A deductible is an amount you must pay each Medical plan year before the Medical plan begins to share in the cost of covered services with you. When choosing a Medical plan option, consider the premium cost, deductible amount, and how the deductible works for the different plans. The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your annual out-of-pocket maximum.

Deductible	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plan	Basic HSA and Basic HSA Out-of-Area Plans
Individual	$800*	$1,700**	$3,300**
Family	$1,600*	$3,400**	$6,600**

*Prescription drug costs are included in the out-of-pocket maximum.

**The deductible and out-of-pocket maximum under these Medical plan options are combined with the Prescription Drug plan. You must meet the combined Family deductible if your coverage is other than *You Only*.

Important Note about the Standard Plan and Standard Out-of-Area PPO Network Deductibles

Individual Deductible: The individual deductible applies 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.

Family Deductible: 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. However, no one individual can contribute more than the single deductible amount to the family deductible. 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.

Important Note about the Premium HSA, Premium HSA Out-of-Area Plan, Basic HSA, and Basic HSA Out-of-Area Plan:

Individual Deductible: The combined medical and prescription drug individual deductible only applies if you elect *You Only* coverage. When you meet the individual deductible in a plan year, the plan begins to share in the cost of covered medical and prescription drug services with you. If you elect anything other than *You Only* coverage, you must meet the family deductible before any benefits are paid by the plan.

Family Deductible: The combined medical and prescription drug family deductible applies if you elect to cover dependents. The family deductible can be satisfied by one or more covered family members. Once the family deductible is met, the plan shares in the cost of covered medical and prescription drug services for all enrolled family members for the remainder of the plan year. The Medical plan will not begin to share in the cost of covered medical and prescription drug services for any enrolled members until the family deductible has been met.

Also, in order for the Premium HSA and Basic HSA Plans to coordinate with a Health Savings Account (HSA), this plan must qualify as a high deductible health plan (HDHP). An HDHP must meet certain legal requirements for annual deductibles and the deductible must be indexed each year for inflation. This means that the individual and family deductibles could increase each year, based on the government's cost of living adjustments (COLA). Any increase would be effective at the beginning of the plan year (January 1) and would remain constant throughout the year. An HSA is offered through Optum Bank, however, you are encouraged to consult your financial or tax advisor prior to electing to participate in an HSA.

Coinsurance

Coinsurance is a form of cost-sharing between you and the Medical plan. After you've satisfied your annual deductible, you and the Medical plan share in the cost of eligible covered expenses based on the Medical plan option you elect. When you stay in the network, the Medical plan covers a higher percentage of the costs.

Network coinsurance applies to the out-of-pocket maximum.

Remember...

In a true medical emergency, call 911 or seek immediate treatment from the nearest emergency medical facility.

Note: If you are enrolled in an Out-of-Area Plan, your in-network and non-network coinsurance applies to the out-of-pocket maximum.

Network Out-of-Pocket Maximum

The Medical plan includes an important feature that limits the total amount of **network expenses** you pay out-of-pocket each year for medical care. Once you've paid the annual maximum amount, the Medical plan pays 100% of eligible expenses for the remainder of the plan year. While coinsurance counts toward your out-of-pocket maximum, the following expenses **do not** apply toward the out-of-pocket limit each year:

- Non-network expenses (except for out-of-area plans or amounts described in this SPD)
- Charges that are not considered covered plan expenses
- Amounts above the Eligible Expenses cost limit
- Preventive drug expenses paid through the Prescription Drug plan

Refer to the *Medical Schedule of Benefits* for more information.

Important Note about the Standard Plan and Standard Out-of-Area Plan, Premium HSA, Premium HSA Out-of-Area Plan, Basic HSA, and Basic HSA Out-of-Area Plan

Individual Out-of-Pocket Maximum: The combined medical and prescription drug individual out-of-pocket maximum for these plans 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.

Family Out-of-Pocket Maximum: The combined medical and prescription drug family out-of-pocket maximum can be satisfied by two or more covered family members, even if each covered family member does not satisfy the individual out-of-pocket maximum. However, no one individual can contribute more than the single out-of-pocket maximum amount to the family 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.

Annual and Lifetime Maximums

Certain services have an annual or lifetime maximum benefit allowed under the Medical plan. An annual or lifetime maximum is the most the Medical plan pays in benefits per person either per year or per lifetime, depending on the type of treatment or service. The table below summarizes some of the Medical plan limits. However, only eligible services are covered by the Medical plan.

Important

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

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 Counseling	Up to 10 visits annually; non-preventive *(mental health services, substance-related and addictive disorders services are not subject to the limit visits)*
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.

How The Plan Works

Network benefits apply to Covered Health Services that are provided by a network physican or other network provider. You are not required to select a primary care physician in order to obtain network benefits.

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.

Emergency Health Services provided by a non-network provider will be reimbursed as set forth under Eligible Expenses as described below.

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 below. For these Covered Health Services, the term "certain network facility" means (1) a hospital (as defined in section 1861(e) of the Social Security Act), (2) a hospital outpatient department, (3) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act), (4) an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and (5) any other facility specified by the Secretary of Health and Human Services. Air ambulance transport provided by a non-network provider will be reimbursed as set forth under Eligible Expenses as described in the *Eligible Expenses* section below.

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 **www.myuhc.com**.

Network providers are independent practitioners and are not employees of 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 **www.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 at the network benefits level. 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 further information and assistance.

Eligible Expenses

Baker Hughes Company 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 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.

For Covered Health Services that are non-ancillary services received at certain network facilities on a non-Emergency basis from non-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, 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 the SPD.

For Covered Health Services that are emergency health services provided by a non-network provider, you are not responsible, and the 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 this SPD.

For Covered Health Services that are air ambulance services provided by a non-network provider, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable 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.

Eligible Expenses are determined in accordance with UnitedHealthcare 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 the Claims Administrator, including when there is no network provider who is reasonably accessible or available to provide Covered Health Services, 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 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 reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - 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.

Out-of-Area PPO Plan Eligble Expenses

Baker Hughes Company 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 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.

For Covered Health Services that are non-Ancillary Services received at certain network facilities on a non-emergency basis from non-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, 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 the SPD.

For Covered Health Services that are emergency Health Services provided by a non-network provider, you are not responsible, and the 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 this SPD.

For Covered Health Services that are Air Ambulance services provided by a non-network provider, you are not responsible, and the non-network provider may not bill you, for amounts in excess of your applicable 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.

Eligible Expenses are determined in accordance with UnitedHealthcare 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 the Claims Administrator, including when there is no network provider who is reasonably accessible or available to provide Covered Health Services, 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 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 reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - 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.

Advocacy Services

The Plan has contracted with the Claims Administrator to provide advocacy services on your behalf with respect to non-network providers that have questions about the Eligible Expenses and how the Claims Administrator determined those amounts. Please call the Claims Administrator 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.

When Covered Health Services are received from a non-network provider in the following cases: Non-ancillary services received at certain network facilities on a non-emergency basis from non-network Physicians who have satisfied the notice and consent criteria as described below; and Emergency ground ambulance transportation provided by a non-Network provider; then, in such circumstances, if the Claims Administrator, 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 the Claims Administrator, or its designee, determines 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), the Claims Administrator, or its designee, may use its sole discretion to increase the Eligible Expense for that particular claim.

When Covered Health Services are received from a non-network provider that are not:

- Ancillary services received at certain network facilities on a non-emergency basis;
- Non-ancillary services received at certain network facilities on a non-Emergency basis;
- Emergency health services;
- Air ambulance services; or
- Emergency ground ambulance transportation;

then, in such circumstances, the Claims Administrator, or its designee, will either work with the provider on your behalf, or provide you with tools and support for you to work with the provider, to attempt to reduce the amount you owe beyond your coinsurance, copayment, and deductible.

Medical Schedule of Benefits

	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area	Non-network	Network or Out-of-Area	Non-network	Network or Out-of-Area	Non-network
Deductible (applies to out-of-pocket maximum)	$800 Individual $1,600 Family		$1,700 Individual $3,400 Family**		$3,300 Individual $6,600 Family**	
Out-of-Pocket Maximum (only network and out-of-area coinsurance applies; non-network coinsurance does not apply)	$4,000 Individual $8,000 Family* (includes deductible)	None	$5,000 Individual $10,000 Family** (includes deductible)	None	$6,500 Individual $13,000 Family** (includes deductible)	None

*Prescription drugs apply to the out-of-pocket maximum

**The deductible and out-of-pocket maximum under these Medical plan options are combined with the Prescription Drug plan. You must meet the combined Family deductible if your coverage level is other than *You Only*.

Important

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

Note: Certain covered expenses are subject to day, visit, or dollar limits.

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*
Acupuncture (up to 20 visits per calendar year)	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Allergy Care **— Diagnostic testing**	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Allergy injections only	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Ambulance **— True emergency**	100%; no deductible	100%; no deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
— Non-emergency	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Birthing Center	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Chiropractic, Physical, or Occupational Therapy (Only Spinal Manipulation applies to limit)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Colonoscopy Procedure (diagnostic) **— Outpatient Surgery** (diagnostic office visits subject to deductible and coinsurance)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Congenital Heart Disease (see *Covered Expenses* section for additional details)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Durable Medical Equipment (items over $1,000 require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Emergency Room (Subject to $150 copay. Copay is waived if admitted.) **— True emergency**	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
— Non-emergency	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area options	
	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*
Gender Dysphoria	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Home Health Care (up to 90 visits per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospice	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospital Care — Inpatient and outpatient	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Immunizations: Child and adult (routine and travel immunizations covered)	100%; no deductible	60% of Eligible Expenses after deductible	Network Routine: 100% Network Travel: 80% after deductible	60% of Eligible Expenses after deductible	Network Routine: 100% Network Travel: 80% after deductible	60% of Eligible Expenses after deductible
Injections	100%; no deductible	60% of Eligible Expenses after deductible	80%; no deductible	60% of Eligible Expenses after deductible	80%; no deductible	60% of Eligible Expenses after deductible
Laboratory Services — Office setting, outpatient hospital, or independent lab	100%; no deductible	60% of Eligible Expenses; after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Maternity Care (you or a covered dependent)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Mental Health — Inpatient Services	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Mental Health — Outpatient Services (Office visit and all other outpatient services, including partial hospitalization/day treatment/high intensity outpatient/intensive outpatient programs)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Neurobiological Disorders – Autism Spectrum Disorder Services - Inpatient	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*
Neurobiological Disorders – Autism Spectrum Disorder Services - Outpatient (Office visit, all other outpatient services, including partial hospitalization/day treatment/high intensity outpatient/intensive outpatient programs and intensive behavioral therapy)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Nutrition Counseling (up to 10 visits annually non-preventive; mental health services, substance-related and addictive disorders services are not subject to the limit visits)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Physician's Services — Office settings	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Preventive Care (i.e., annual well woman, well man, and well child services; annual mammogram, annual physical, and colonoscopy)	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible
Anesthesiologist Services	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Second/Third Surgical Opinions (voluntary)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Skilled Nursing Facility/ Inpatient Rehabilitation Facility (up to 60 days per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Speech Therapy (up to 40 visits per calendar year) Certain exclusions apply; contact UHC Care Coordination℠ for a pre-determination	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Substance-Related and Addictive Disorder Services — Inpatient	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*
Substance-Related and Addictive Disorder Services — **Outpatient** (Office Visit and All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
TMJ Non-surgical; excluding prescription drugs	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Transplant Services Designated Provider	100% designated provider only	60% of Eligible Expenses after deductible	80% after deductible designated provider only	60% of Eligible Expenses after deductible	80% after deductible designated provider only	60% of Eligible Expenses after deductible
— **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)	Covered	All services covered, except for travel and lodging	Covered	All services covered, except for travel and lodging	Covered	All services covered, except for travel and lodging
Other Network (not designated provider)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— **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)	Not Covered		Not Covered		Not Covered	

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*	Network or Out-of-Area*	Non-network*
Urgent Care	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Virtual Visits	$0 after deductible	Not covered	$0 after deductible	Not covered	$0 after deductible	Not covered
Wigs (limited to $1,000 per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
X-ray Services (excluding major services such as MRIs, CT scans, PET scans, nuclear scans, etc.) **— Office setting or outpatient hospital**	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
X-ray – Major Services (i.e., MRIs, CT scans, PET scans, nuclear scans, etc.) **— Office setting or outpatient hospital**	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
All Other Eligible Coverage	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Maximum Benefit Aggregate lifetime maximum for all benefits while covered under the Medical plan option	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

*Services received from a non-network provider are subject to Eligible Expense costs. See the section *Eligible Expenses* for a complete definition.

Note: All maximums are combined whether network, non-network, or out-of-area.

Adding It All Up

Let's take a look at some real life examples. Below is an example of a hospital bill for $4,000 and how each Medical plan option pays according to the option's deductibles and coinsurance provisions. Let's assume that our sample employee, Joe Baker, is planning to elect *You Only* coverage.

Services	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plans	Basic HSA and Basic HSA Out-of-Area Plans
Deductible	$800/$1,600	$1,700/$3,400*	$3,300/$6,600*
Hospital Charge (in-network)	$4,000	$4,000	$4,000
Joe pays	$800 (Individual deductible applies)	$1,700 (Individual deductible applies)	$3,300 (Individual deductible applies)
Amount to apply to coinsurance	$3,200	$2,300	$700
Plan option pays	$2,560 (80% coinsurance)	$1,840 (80% coinsurance)	$560 (80% coinsurance)
Joe's coinsurance	$640 (20% coinsurance)	$460 (20% coinsurance)	$140 (20% coinsurance)
Joe's cost for claim	$1,440	$2,160	$3,440

*Deductible will be indexed with inflation; it must also meet the combined Medical and Prescription Drug family deductible if coverage is other than *You Only*.

Now let's see another example where this time our sample employee, Joe Baker, is planning to elect *You + Spouse or Domestic Partner* coverage.

Services	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plans	Basic HSA and Basic HSA Out-of-Area Plans
Deductible	$800/$1,600	$1,700/$3,400*	$3,300/$6,600*
Hospital Charge (in-network)	$7,000	$7,000	$7,000
Joe pays	$800 (Individual deductible applies)	$3,400 (Family deductible applies)	$6,600 (Family deductible applies)
Amount to apply to coinsurance	$6,200	$3,600	$400
Plan option pays	$4,960 (80% coinsurance)	$2,880 (80% coinsurance)	$320 (80% coinsurance)
Joe's coinsurance	$1,240 (20% coinsurance)	$720 (20% coinsurance)	$80 (20% coinsurance)
Joe's cost for claim	$2,040	$4,120	$6,680

*Deductible will be indexed with inflation; must also meet the combined Medical and Prescription Drug family deductible if coverage is other than *You Only*.

Note: Before making your choice, be sure to read how the Prescription Drug plan works with each Medical plan option (see the *Prescription Drug Plan* section).

Emergency at or Away From Home

In an emergency, you should get the treatment you need. If considered to be a true emergency by UHC, the Claims Administrator, the Medical plan pays according to the network schedule of benefits, regardless of the facility you go to.

The applicable network or non-network option level coinsurance after deductible applies.

Definition: A True Emergency means a serious medical condition or symptom resulting from injury, sickness, or mental illness that 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.

Tip!

To better manage your care and expenses, visit Emergency Rooms only in true emergencies. They're not intended to be a replacement for a physician visit. If you are unsure whether your situation is a medical emergency, you can call the UHC Advocate at **1-866-635-9530** (direct) or **1-866-743-6549** (when prompted, say "speak with an Advocate"). An Advocate is available to answer your questions 24 hours a day, seven days a week.

What if I am Admitted to a Hospital?

If you're admitted to the hospital through the Emergency Room, your visit will be subject to any applicable deductible and coinsurance, however, the $150 copay will be waived. If you're admitted to a non-network hospital, you must be transferred to a network facility (unless you're in an out-of-area plan) 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.

Note: If you go to the Emergency Room and are admitted to the hospital, you must contact UHC within two business days of your Emergency Room visit, or as soon as reasonably possible, otherwise a non-notification penalty will apply.

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.

Preventive Health Services

The Baker Hughes Medical plan network benefits are designed to encourage you, your spouse, or domestic partner, and your eligible dependents to have routine, preventive checkups. Preventive health services provided under the Medical plan are summarized below.

- Preventive health services received from a network provider are covered by the Choice Plus (Standard, Premium HSA, and Basic HSA options) and the UnitedHealthcare Options PPO (Standard, Premium HSA, and Basic HSA Out-of-Area options)
- No calendar year deductible applies and no other cost-sharing requirement (such as a copay or coinsurance) applies to preventive health services received from a network provider under those plans
- The benefit includes the costs of services and tests performed during a wellness office visit with a network or out-of-area provider

Medical plan options may impose some cost-sharing requirements in connection with preventive health services.

- If the preventive health service is billed or tracked separately from an office visit, the Medical plan may impose cost-sharing requirements with respect to the office visit
- If the preventive health service is delivered during an office visit and the primary purpose of the office visit is not for the delivery of the preventive health service, the Medical plan may impose cost-sharing requirements with respect to the office visit
- If you receive preventive health services from a non-network provider under the Choice Plus (Standard, Premium HSA, or Basic HSA options), the benefit will be limited to 60% of the Eligible Expense costs for the preventive health service after you meet the plan's annual deductible

Preventive health services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, or have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved to the extent such recommendations are considered current under regulations and guidance issued by the Department of Labor and other governmental agencies. A listing of these covered services can be found online at **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations**
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention)

A list of the immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be found online at **https://www.cdc.gov/vaccines/** and **https://www.uhc.com/health-and-wellness/preventive-care**.

The following preventive health services are provided to women under the Medical plan:

- **Gestational diabetes screening**: This screening is for women who are 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes
- **HPV DNA testing**: Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results
- **HIV screening and counseling**: Sexually active women will have access to annual counseling on HIV
- **STI counseling**: Sexually active women will have access to annual counseling on sexually transmitted infections (STIs)
- **Contraception and contraceptive counseling**: Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs
- **Breastfeeding support, supplies, and counseling**: Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider or physician.

If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. The Claims Administrator will determine the following:

  - Which pump is the most cost-effective, or
  - The timing of an acquisition

- **Interpersonal and domestic violence screening and counseling**: Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women

When a new recommendation or guideline is issued by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration and becomes effective, the Medical plan will provide coverage for the new recommendation or guideline beginning with the plan year that starts on or after the date that is one year after the date the recommendation or guideline is issued and becomes effective.

When a recommendation or guideline is deleted from the current recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration, the Medical plan will stop providing coverage for that recommendation or guideline to the extent allowed by applicable law.

Examples of preventive health services are listed below:

- Well woman, well man, or well child exam
- Prostate exam
- Diabetes screening
- Cholesterol check
- Tetanus-Diphtheria booster
- Flu shot (Influenza immunization)
- Blood pressure screening
- Colonoscopy (refer to Medical Schedule of Benefits for additional coverage details)

Preventive health services do not include diagnostic services or ongoing care related to a diagnosed condition. For a service to be covered under the Medical plan as a preventive health service, the service must be for preventive care, not a diagnostic service.

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.

Note: Preventive health services will be provided under the Medical plan in accordance with the requirements of, and subject to the limitations allowed under, the Patient Protection and Affordable Care Act (PPACA) and the Department of Labor and other governmental agency guidance issued thereunder. Applicable regulations allow the Medical plan to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service that constitutes a preventive health service. If the guidelines do not specify the applicable frequency, method, treatment, or setting for an item or service that constitutes a preventive health service then the applicable frequency, method, treatment, or setting for such item or service shall be determined for purposes of the Medical plan in accordance with generally accepted standards of medical practice.

Preventive health care is a screening and prevention benefit — it does not apply to diagnostic services or ongoing care related to a diagnosed condition. For a service to be covered under the preventive health service benefit provisions, the claim must be filed as routine preventive care, not diagnostic treatment.

What is a Preventive Service? Preventive services are services that contribute to the prevention of a condition or disease.

Nutrition Counseling

The Medical plan also provides a nutrition counseling benefit. Participants may receive up to 10 nutrition counseling sessions per calendar year (this limit applies to non-preventive nutritional counseling services only ; mental health services, substance-related and addictive disorders services are not subject to the limit visits). Coverage details for each Medical plan option are provided in the *Medical Schedule of Benefits*.

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 (or your covered dependent) 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 do not wish to change your benefit election due to the birth of a newborn, the automatic coverage for the newborn will terminate immediately following day 4 after birth. You will need to wait until the next Annual Enrollment to change your election if coverage has not been selected within 31 days. 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 enrolled.

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). Preventive immunizations required for travel are also covered at 100% when received in-network for the Standard option. For the Premium and Basic HSA 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.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, Personal Health Support Nurses will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education, and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

Important Notice

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network primary physicians and other network providers are responsible for obtaining prior authorization before they provide these services to you.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans UnitedHealthcare requires prior authorization for certain Covered Health Services. You are responsible for obtaining authorization before you receive the services.

Important: if you fail to obtain prior authorization, a $300 penalty will apply. Except for ambulance (non-emergent), clinical trials, DME over $1,000, and prosthetics over $1,000 you will be responsible for paying all charges and no benefits will be paid.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services have been prior authorized as required. Before receiving these services from a network provider, you may want to contact the Claims Administrator to verify that the hospital, physician and other providers are network providers and that they have obtained the required prior authorization. Network facilities and network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-network provider intends to admit you to a network facility or refers you to other network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

Note: Contacting the UnitedHealthcare or Personal Health Support is easy. Simply call the number on your ID card.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain Covered Health Services from non-network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your non-network benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in the Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

The Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans requires prior authorization for certain Covered Health Services.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-network provider intends to admit you to a Network facility or refers you to other network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no benefits will be paid.

Services for which you are required to obtain prior authorization are identified within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in *Coordination of Benefits (COB).* You are not required to obtain authorization before receiving Covered Health Services.

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 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 you are confined in a non-network hospital after you receive outpatient emergency health services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a network hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-network hospital after the date the Claims Administrator decides a transfer is medically appropriate, network benefits will not be provided. Non-network benefits may be available if the continued stay is determined to be a Covered Health Service.

If it is determined by UHC that the emergency care was necessary, the regular Medical plan benefits will be paid. Refer to the *Medical Schedule of Benefits* for Medical plan coverage details.

If a dispute should arise, UHC, as the Claims Administrator of all the Medical plan options under the Medical plan, reserves the right to make the final decision.

Covered Expenses

Covered expenses are charges for services covered by the Medical plan and are reimbursed up to Eligible Expense costs or the rate that has been negotiated with network providers for the applicable Medical 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 those shown on the *Medical Schedule of Benefits*.

2nd.MD

2nd.MD is a service available to help you when you're faced with an important medical decision. Based on the traditional practice of getting a second opinion, but with additional features, this service works with leading medical specialists to review your case and then provide feedback on your diagnosis and treatment plan. 2nd.MD is another resource for you to collect information about your diagnosis and treatment plan so you can make informed decisions about your care.

For example, this second medical opinion service could be used when you or an eligible dependent:

- Are facing a new medical diagnosis
- Have questions about your treatment plan or medications
- Are considering possible surgery
- Are managing ongoing medical conditions

With your permission, the 2nd.MD team will collect and analyze all your relevant medical records and then connect you with a specialist, via phone or video, to discuss your case and conduct a full review of your diagnosis and treatment plan.

2nd.MD can help you possibly avoid unnecessary procedures, spot misdiagnoses, and improve existing treatment plans. Sometimes the second opinion might confirm your current course of action; other times it might provide a different viewpoint.

You are under no obligation to follow the recommendations provided by 2nd.MD. In fact, you're strongly encouraged to share the information with your doctor and discuss next steps or options together.

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

Note: Prior authorization is required only for non-emergency air ambulance. If you are enrolled in the Standard plan, you must get prior authorization for both in- and out-of-network non-emergency air ambulance. For the Premium and Basic HSA Plans, you must get prior authorization for out-of-network non-emergency air ambulance only.

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 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 the number on your ID card as soon as the possibility of participation in a clinical trial arises. If you do not call the Claims Administrator, you will be responsible for paying all of the charges and no benefits will be paid. If you are enrolled in the Standard plan, you must get prior authorization for both in- and out-of-network services. For the Premium and Basic HSA Plans, you must get prior authorization for out-of-network services only.

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 the Claims Administrator 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 the Claims Administrator 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 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 the Claims Administrator before obtaining any Durable Medical Equipment 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 the Claims Administrator identifies.

If you fail to obtain prior authorization as required, a $300 penalty will apply. Except for DME over $1,000, you will be responsible for paying all charges and no benefits will be paid.

Durable Medical Equipment (DME) and Prosthesis

- Purchase of artificial limbs or eyes, 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 impairment 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 obtain the Durable Medical Equipment or orthotic from UnitedHealthcare or from the prescribing network physician.

For non-network benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost. If you fail to obtain prior authorization as required, a $300 penalty will apply. Except for DME over $1,000, and prosthetics over $1,000, you will be responsible for paying all charges and no benefits will be paid.

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 and products 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 (limited to 60-day maximum per calendar year), 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 provided by or under the direction of a Physician. For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*. 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.
- 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*.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under the *Prescription Drug* plan.
- 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)

Prior Authorization Requirement: Gender Dysphoria

For non-network benefits you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. Failure to obtain prior authorization from the Claims Administrator as required will result in a $300 Penalty.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

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.

Hearing Aids

The Plan pays benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and receiver.

Benefits are available for a hearing aid that is purchased 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.

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 only 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.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Prior Authorization Requirement: Home Health Care

For non-network benefits you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. Failure to obtain prior authorization from the Claims Administrator as required will result in a $300 Penalty.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

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). If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, and Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

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, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Prior Authorization Requirement: Hospice

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. Failure to obtain prior authorization from the Claims Administrator as required will result in a $300 Penalty.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

Infertility Services

See the section *Kindbody Fertility and Family Building* for information on infertility services.

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.

Prior Authorization Requirement: Genetic Testing and Sleep Studies

For non-network benefits you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. Failure to obtain prior authorization from the Claims Administrator as required will result in a $300 Penalty.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

Licensed Medical Providers

- Charges by licensed medical personnel operating within the scope of their license (when required by state law) for:
  - Speech therapy to restore or correct impaired function due to: accidental injury, surgical operation, cerebrovascular accident (stroke), or physical 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 of 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.

When the Medical plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits will be provided to every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

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 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 who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a referral to providers and coordination of care.

Prior Authorization Requirement: Mental Health Services

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 five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for non-network benefits you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and transcranial magnetic stimulation.

If you do not obtain prior authorization as required, benefits will be subject to a $300 reduction.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

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.

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care. You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

Prior Authorization Requirement: Neurobiological Disorders – Autism Spectrum Disorder Services

For non-network benefits for a scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services, including an admission for services at a Residential Treatment facility, you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for non-network benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Programs; psychological testing and Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization as required, benefits will be subject to a $300 reduction.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

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.

Benefits include the following levels of care:

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

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

Prior Authorization Requirement: Substance-Related and Addictive Disorders Services

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 prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for non-network benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient programs; psychological testing.

If you do not obtain prior authorization as required, benefits will be subject to a $300 reduction.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans this prior authorization and penalty applies to both network and non-network benefits.

Virtual Behavioral Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo provides behavioral Covered Health Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no deductibles, copayments, or coinsurance you must meet or pay for when receiving these services.

If you would like information regarding these services, you may contact the Claims Administrator at the telephone number on your ID Card.

Non-Preventive Nutritional Counseling

The Plan covers non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease and that are non-disease specific by appropriately licensed or registered health care professionals.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described.

The Plan covers non-preventive nutritional counseling services for mental health and substance-related and addictive disorders.

Prior Authorization Requirement: Morbid Obesity Surgery

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 Personal Health Support, 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.*

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 2 years
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure

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, and provide 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 a pre-surgical evaluation is performed) by calling Optum at **1-888-936-7246** to enroll in the program.

Pharmaceutical Products - Outpatient

The Plan pays for pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physican’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, written, order or refill are provided as described under your Outpatient Prescription Drug program.

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, in-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 **www.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 **www.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
  - Hyper-alimentation or total parenteral nutrition for persons recovering from or preparing for surgery, or as the sole source of nutrition

Physician's Office Services – Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a hospital. Benefits under this section include allergy injections and hearing exams in case of injury or sickness.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals.

Covered Health Services include Genetic Counseling.

Benefits include allergy injections.

Benefits for preventive services are described under Preventive Care Services in this section. Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.

When a test is performed or a sample is drawn in the Physician's office benefits for the analysis or testing of a lab, radiology/X-ray, or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-Ray and Diagnostics - Outpatient*.

Rehabilitation Services – Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services):

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person with a medical or behavioral disabling condition to 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 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 medical or behavioral 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 medical or behavioral 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 is not a habilitative service.

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.*

Specialist Management Solutions

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
- MSK/Spine
- Ophthalmology
- Orthopedic
- Pain Management
- Podiatry
- Urology
- Women's Health

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, members may be warm transferred to 1-833-332-1011 or the member may call SMS direct at 1-833-433-1339.

For more information: **www.specialistmanagementsolutions.com**

* Medical appointments and treatments remain the Medical plan member's responsibility and are subject to the Medical plan benefit requirements.

Sterilization

Charges for services and supplies for sterilization (not reversal) and the administration of Norplant® and Depo-Provera®.

Temporomandibular Joint (TMJ) Services

The Medical 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, open or closed reduction of dislocations.

Therapeutic Treatments – Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy, or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists, and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

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 or 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.

Note: The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with transplant services received by a Designated Provider.

Travel and Lodging

The Medical plan may provide you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the number on your ID card or Contact the UHC Travel and Lodging Assistance Program at **1-800-842-0843** for additional details.

Travel and Lodging Expenses

The Medical plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare as follows:

- Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
- If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

Travel and lodging expenses are only available if the Covered Person resides at least 50 miles from the Designated Provider.

Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Medical plan participant if the reimbursement exceeds the non-taxable per diem rate.

The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Medical plan in connection with all qualified procedures.

Lodging Reimbursement Assistance

A per diem rate, up to $150.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.

A per diem, up to $200.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

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

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious conditions. 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 **www.myuhc.com** or the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency needs.

Please Note: Not all 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, or fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

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

Wigs

The Medical plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss. Any combination of network benefits and non-network benefits is limited to $1,000 per calendar year.

Exclusions and Limitations

The Medical 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 *Medical* section or through an amendment to this SPD.

Alternative Treatments

- Aromatherapy
- Hypnotism
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described.

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 that 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; and
  - 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 immunosuppressives
  - 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 supernumerary 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

Devices, Appliances, and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME), Orthotics and Supplies*. This exclusion does not apply to cranial molding helmets and cranial banding.
3. Examples of excluded orthotic appliances and devices include but are not limited to, 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. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

4. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
5. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment*.
7. Oral appliances for snoring.
8. Powered and non-powered exoskeleton devices.
9. Over-the-counter continuous glucose monitors.

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.

A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described. Such determinations may be made up to six times during a calendar year.

A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described. Such determinations may be made up to six times during a calendar year.

A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescription drug product as described. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product or prescription drug product as described, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.

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 or preventive foot care for a covered person with diabetes*:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming or cutting; or
  - 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; or
  - 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

*Benefits are provided as described under the *Covered Expenses, Diabetes* section.

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

Gender Dysphoria

Cosmetic procedures, including the following:

- Abdominoplasty
- Blepharoplasty
- Body contouring, such as lipoplasty
- Brow lift
- Calf implants
- Cheek, chin, and nose implants
- Injection of fillers or neurotoxins
- Face lift, forehead lift, or neck tightening
- Facial bone remodeling for facial feminizations
- Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria
- Hair transplantation
- Lip augmentation
- Lip reduction
- Liposuction
- Mastopexy
- Pectoral implants for chest masculinization
- 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 and disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages; or
  - Gauze and dressings
- Powered and non-powered exoskeleton devices
- Diabetic supplies (for which benefits are provided as described under the *Covered Expenses, Diabetes* section); and
- Tubings, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment

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 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 (including recovery residences)
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care
9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment

Nutrition

- Megavitamin and nutrition-based therapy
- Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control, or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion does not apply to medical or behavioral/mental health related education services as described in *Physician Office Service's – Sickness and Injury*.
- 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 the *Covered Expenses* section

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.

Physical Appearance

- Cosmetic or reconstructive procedures, and any related services or supplies, that alter appearance but do not restore or improve impaired physical function, except when performed to:
  - Repair defects from an accident
  - Replace diseased tissue that has been surgically removed
  - Reconstruct a breast following mastectomy, including reconstruction of the other breast to produce symmetry; or
  - Correct birth defects
- Excluded cosmetic procedures. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments
  - Sclerotherapy treatment of veins
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures); and
  - 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 or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under Reconstructive Procedures

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse or domestic partner, 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 free-standing 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

See the section *Kindbody Fertility and Family Building* for information on infertility services exclusions.

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's benefits 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 in the *Organ and/or Tissue Transplant* section unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses
- Transportation and lodging expenses if the designed provider is not used
- Expenses for meals and other living expenses while traveling to and from a transplant site
- The costs 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 *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 **www.myuhc.com**.

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 eyeglasses or contact lenses
- Routine eye or hearing exams, eye refractions, or any type of external appliances used to improve visual or hearing acuity and their fittings, except as specifically provided under the *Covered Expenses* section
- 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

All Other Exclusions

- Health services and supplies that are not listed as a covered expense
- Charges that exceed Eligible Expense limits
- Education or training, except as provided under the *Covered Expenses* section
- Any charges for services prohibited by applicable state law to the extent state law is not preempted by ERISA or other applicable federal law
- Food supplements, except as provided under the *Covered Expenses* section
- 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 Medical 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; or
  - 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 Medical 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 that 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 service, no benefits are provided for the health service for which 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
- 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
- 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)
- 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 prohibited by federal anti-kickback or self-referral statutes

- Any additional charges submitted after payment has been made and your account balance is zero
- Any outpatient facility charge in excess of payable amounts under Medicare
- Any charges related to Christian Science
- 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
- Additional charges submitted after payment has been made and the 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

How do I File a Medical Claim?

If you use a **network** physician, specialist, or health care provider, the network provider will submit claims on your behalf. You're only responsible for 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 be reimbursed from the Medical plan.

Claim forms are available from:

- **BakerHughesBenefits.com**
- **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 after 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 after 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.

After UHC has processed your claim, you will receive payment for benefits that the Medical plan allows. It is your responsibility to pay the non-network provider the charges you have incurred, including any difference between what you were billed and what the Medical plan paid.

You may not assign your benefits under the Medical plan to a provider without UHC's consent. When you assign your benefits under the 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 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 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, Baker Hughes reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes to the Medical 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
  - Charge for each service rendered
  - Dates of service
  - Service provider's name, address, and tax identification number
  - Procedure codes and descriptions of services rendered
- Place of service (office, inpatient hospital, outpatient hospital, independent lab, birthing center, home, or other)
- 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 in other coverage, you must include the name of the other plans and/or carriers

Send your claim forms 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 2021 (P.L. 116-260), you may not assign, transfer, or in any way convey your Benefits under the Medical plan or any cause of action related to your Benefits under the plan to a provider or to any other third party. Nothing in the Medical 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 Medical 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 receivable 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 Medical 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 Medical plan; and
- shall NOT stop the Medical 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 Medical 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 Medical plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Medical Plan pursuant to Refund of Overpayments in 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 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 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 **www.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 UHC's website at **www.myuhc.com**.

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

Remember...

A 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 from 7:00 a.m. to 6:00 p.m. Central 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 Medical plan for a specific period of time or number of treatments. If the Medical 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 Medical 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 Medical plan is an urgent care claim, your request will be decided under the Urgent Care Claim procedures described above.

If your requests 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 in advance of obtaining the related medical care (i.e., preauthorization).

The Claims Administrator will notify you of the Medical 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 Medical 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 plan claim that is filed after medical care has been received. A post-service claim must be filed under the Medical 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 Medical 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 Medical plan's benefit determination within a reasonable time period, but not later than 30 days after receipt of the claim by the Medical 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 Medical 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 Medical 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 Medical 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 criteria was relied on 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 Medical 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 Medical 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 or a request for an External Review of that decision)
- A description of the Medical plan's available claims denial appeal and External Review processes and procedures applicable to the Medical plan, including information regarding how to initiate an appeal and the time limits applicable to such processes and procedures
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act (PHSA) to assist individuals with the internal claims and appeals and External Review processes; and
- A disclosure about the restrictions on balance billing in certain circumstances and information on contacting appropriate agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing

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, as applicable:
  - 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, UT 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 Medical 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 Medical 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 Medical 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 Medical 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 Medical plan or at the direction of the Medical 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 Medical 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 Medical plan that has been upheld by the Claims Administrator at the completion of the Medical plan's internal appeals process, or (2) an adverse benefit determination of a benefit claim under the Medical 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 Medical 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 Medical plan to give you a reasonable opportunity to respond prior to that date.

The Medical 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 Medical 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 Medical 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.

* 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.

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 an 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.

- **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 from receipt of the Level One decision. Because your appeal will be reviewed by appropriate individuals 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*.

Important

A participant may not request an external review of a determination by Baker Hughes that the participant is not eligible to participate in and receive benefits under the Medical plan.

* 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.

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 Medical 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 Medical 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 Medical 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 Medical plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you upon request to the Medical plan
- A statement that you are entitled to receive, upon request to the Medical 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 Medical 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 or a request for an External Review of that 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
- A determination regarding surprise billing and cost-sharing protections or an air ambulance bill

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 an 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 Medical plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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 the Medical plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

Example:

If you and your spouse or domestic partner work at different companies and you both enroll in each other's Medical plans:

	Your Coverage	Your Spouse's or Domestic Partner's Coverage
Baker Hughes Medical Plan	Primary	Secondary
Your Spouse's or Domestic Partner's Company Plan	Secondary	Primary

Raul's wife, Jane, works for a different employer. She has medical coverage through her company and is also enrolled as a dependent under Raul's Baker Hughes's Standard option under the Medical plan. Jane's company medical coverage is her primary plan coverage and the Baker Hughes Medical plan is secondary.

If Jane's total outstanding medical fees are $100 and her company's Medical plan pays 80%, she will be reimbursed $80 from her company's plan. The Baker Hughes Medical plan, which is secondary, will pay $0 because the maximum benefit has already been met.

If her company's plan pays 75% ($75), the Baker Hughes Medical plan will pay 5% ($5) to reach the maximum benefit if the deductible has been met.

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

Order of Benefit Determination Rules

- The order of benefit determination rules determine whether the Medical plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one plan. When the Medical plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When the Medical 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 govern 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. The Medical 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 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 Medical 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 or domestic partner does, that parent's spouse's or domestic partner'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 or domestic partner.

(c). The plan covering the non-Custodial Parent.

(d). The plan covering the non-Custodial Parent's spouse or domestic partner. 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 or domestic partner's plan, the rule in paragraph (5) applies. (ii) In the event the dependent child's coverage under the spouse's or domestic partner'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 or domestic partner.

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, the Medical plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When The Medical Plan is Secondary?

If the Medical plan is secondary to any plan or coverage other than Medicare, the Medical plan determines the amount it will pay for a Covered Health Services by following the steps below.

- The Medical plan determines the amount it would have paid based on the Allowable Expense
- If the Medical plan would have paid the same amount or less than the Primary Plan paid, the Medical plan pays no Benefits
- If the Medical 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 Medical plan determines the amount it would have paid based on its contract
- If the Medical plan would have paid more than the Primary Plan paid, the the Medical plan will pay the difference less any applicable copayment, coinsurance, or deductible requirements of the plan.

Determining the Allowable Expense If the Medical 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 the Medical 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 the Medical 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 the Medical 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 the Medical plan, the Allowable Expense is the greater of the two plans' reasonable and customary charges. If the Medical plan is secondary to Medicare, please also refer to the discussion in the section *Determining the Allowable Expense When this Plan is Secondary to Medicare*.

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 the Medical 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 Medical plan benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and the Medical 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 the Medical plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Medical plan's benefits in these situations, and when Medicare does not issue an EOMB, the Claims Administrator will use the Medicare approved amount or Medicare limiting charge as the limiting charge.

If the Medical plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Services by following the steps below.

- The Medical plan determines the amount it would have paid based on the Primary Plan's Allowable Expense
- If the Medical plan would have paid less than the Primary Plan paid, the Medical plan pays no benefits
- If the Medical plan would have paid more than the Primary Plan paid, the the Medical 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 Medical plan determines the amount it would have paid based on its contract
- If the Medical plan would have paid more than the Primary Plan paid, the Medical plan will pay the difference less any applicable deductible, coinsurance, and copyament requirements of the Medical plan.

Medicare Crossover Program

The Medical 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 Medical 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 the Medical 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 the Medical 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 the Medical 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 the Medical 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 the Medical 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.

Does The Medical Plan Have the 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 Medical plan should have paid. If this occurs, the Medical plan may pay the other plan the amount owed.

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

If the Medical 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 Medical 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 Medical plan if:

- The Medical 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 Medical 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 Medical plan paid in excess of the amount that should have been paid under the Medical plan. If the refund is due from another person or organization, you agree to help the Medical plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Medical 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 Medical plan. If the refund is due from a person or organization other than you, the Medical plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits that are payable in connection with services provided to other Covered Persons under the Medical plan 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 Medical plan

The Medical 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.

Care Management Programs

Your health is important to Baker Hughes. That is why Baker Hughes has partnered with UnitedHealthcare to offer employees a set of care management programs to improve your overall health. All services provided through the care management programs are free and confidential. By participating in programs such as these, we can be better health care consumers, take better care of our families and ourselves, and reduce the cost of health care. Please refer to the following table for program eligibility guidelines.

Programs and Services	Is Program Voluntary or by Invitation?	Offered to Spouses or Domestic Partners	Offered to Dependents	Must be in Medical plan to Participate
Chronic Health Management Programs **UHC: 1-866-743-6549**	Voluntary, and participants invited based on: • Medical and Prescription Drug claims data	✓	✓	✓
Personal Health Support **(UHC Nurse Case Management)** **UHC: 1-866-743-6549**	Voluntary, and participants invited based on: • Medical and Prescription Drug claims data • Hospital stay	✓	✓	✓
Hinge Health	Voluntary	✓	*	✓
Maven Maternity Support	Voluntary	✓	✓	✓
Kidney Resources Program **UHC: 1-866-561-7518**	Voluntary	✓	✓	✓
Bariatric Resource Services **UHC: 1-866-743-6549**	Voluntary	✓	✓	✓

*Dependents must be over 18 to participate.

Care Management Programs are Voluntary and Confidential

We encourage you to choose well, be well, and live better by participating in the care management programs. All programs are designed to help you manage current health problems and/or help avoid future problems. As indicated in the table on the previous page, you may be invited to join a program based on medical and/or prescription drug claims data or Health Survey feedback. For other programs, you can volunteer to participate. Whether you are invited or volunteer, the decision to participate is yours.

Important: All information will be treated as confidential. This means that none of your personal health information will be shared with Baker Hughes. However, a few of our care management program vendors may share your health information amongst themselves to be able to invite you to participate in other care management programs. All vendors adhere to HIPAA privacy regulations to ensure your information remains private and confidential.

Chronic Health Management Programs

A confidential and voluntary program available through UHC for Medical plan members who have:

- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Diabetes
- Asthma/Chronic Obstructive Pulmonary Disorder (COPD)

These programs provide participants with information on the applicable chronic disease, including how to recognize associated symptoms and how to avoid complications. UHC supports, encourages, and inspires people to become active managers of their health condition. Program highlights include:

- Telephonic coaching by licensed professionals
- Addressing of life barriers
- Compliance with screening recommendations
- Medication education, side effect management, and adherence
- Promotion of healthy eating habits and regular physical activity
- Specialty consults for co-morbid conditions by specialists

Participants receive telephonic counseling from clinicians, such as registered nurses, registered dietitians, and exercise physiologists. Participants also receive educational booklets and support materials on disease and related topics (for example diet, exercise, stress management, etc.).

Participants are invited to join the program based on medical and prescription drug claims data. An information packet describing the program will be mailed to the participant's home.

To learn more about the program, call UHC at **1-866-743-6549**.

Important: Claims data is transferred to the care management vendors in a manner that complies with HIPAA privacy guidelines.

Personal Health Support and Prior Authorization

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission Counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient Care Management** - If you are hospitalized, Personal Health Support Nurses will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education, and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CDK stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

Important Notice

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

If you are enrolled in the Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans UnitedHealthcare requires prior authorization for certain Covered Health Services. You are responsible for obtaining authorization before you receive the services.

Important: if you fail to obtain prior authorization, a $300 penalty will apply. Except for Ambulance (non-emergent), Clinical Trials, DME over $1,000, and Prosthetics over $1,000, you will be responsible for paying all charges and no Benefits will be paid.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician, and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review, or similar programs.

Contacting UnitedHealthcare or Personal Health Support is Easy

Simply call the number on your ID card.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in the Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

The Standard Out-of-Area, Premium HSA Out-of-Area, or Basic HSA Out-of-Area Plans requires prior authorization for certain Covered Health Services.

When you choose to receive certain Covered Health Services, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Services for which you are required to obtain prior authorization are identified within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Coordination of Benefits (COB). You are not required to obtain authorization before receiving Covered Health Services.

Bariatric Resource Services

If you're considering bariatric surgery to lose a significant amount of weight, you have access to a team of clinical experts who specialize in weight loss and bariatric surgery. Nurses can help you:

- Find Centers of Excellence network facilities that specialize in bariatric surgery
- Learn steps you can take to avoid complications
- Adjust to and maintain emotional and lifestyle changes
- Learn more about nutrition and fitness

Healthcare Reminders

Based on medical and prescription drug data, opportunities to improve health will be identified based on evidence-based medicine guidelines. Healthcare reminders are generated and mailed monthly to your home by UHC.

Opportunities available in the mailings will include:

- Disease/drug interactions
- Medical management
- Disease monitoring
- Drug on drug interactions
- Therapy duplications
- Money-saving tips
- Potential medication adherence issues

Health screening reminders will include the following:

- Childhood immunizations
- Mammograms
- Adolescent immunizations
- Screening services for diabetes
- Cervical cancer screenings
- Pneumonia immunizations

Hinge Health

Hinge Health is a digital exercise therapy program that provides personalized care plans to help support back and joint health. Hinge Health offers virtual physical therapy with a physical therapist via a video visit.

Hinge Health gives you the tools you need to conquer back and joint pain, recover from injuries, prepare for surgery, and stay healthy and pain free. Their programs are available to you and your eligible dependents at no cost. Plus, you can complete your customized care plan anywhere, any time.

If you have any questions, contact Hinge Health at 855-902-2777 or **hello@hingehealth.com**.

Register at **hinge.health/bakerhughes**.

Maternity Support

Maven's Maternity & Newborn Care program provides education and support throughout pregnancy (9 months) and postpartum (3 months), for a total of 12 months of support. With Maven, employees have 24/7 access to unlimited coaching and education from providers across 35+ specialties including OB-GYNs, lactation consultants, midwives, and infant sleep coaches. Employees also have a dedicated Care Advocate to help them navigate their health benefits and connect to in-person support when needed. Employees can sign up at **mavenclinic.com/join/uhc-support**.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. You will receive 30 Energize reward points to the employee's Energize account compliments of Baker Hughes and the Care Management Program.

As a program participant, you can always call your Personal Health nurse with any questions or concerns you might have. To get started with a Maven Care Advocate or to enroll, call the number on the back of your ID card for more information, go to **mavenclinic.com/join/uhc-join**, or download the Maven Clinic app in the **App Store** or **Google Play**.

Fertility Program

Fertility At-a-Glance

Type of Plan	Voluntary medical fertility coverage
Who Pays the Cost	You share the cost with Baker Hughes.
Employee Eligibility	All Baker Hughes employees and spouses and domestic partners enrolled in a UnitedHealthcare Standard PPO, Premium HSA, or Basic HSA plan are eligible to opt-in to the Kindbody fertility and family-building benefit.*
When Coverage Begins Enrollment Period	Coverage begins on your date of hire or date of transfer New hires and employees transferring to a position with US benefits, within 31 days of becoming eligible for coverage. If you do not enroll and elect coverage in a Baker Hughes Medical Plan*, you will not be eligible for the Kindbody Fertility Program.
Plan Information	**Fertility and family-building benefit:** Up to $20,000 per member per lifetime for fertility diagnostic and treatment services including in vitro fertilization (IVF), intrauterine insemination (IUI), and egg/embryo/sperm preservation. Up to $10,000 per member per lifetime for fertility medication through KindRx. Medical plan cost share applies to fertility medical and medication services. Up to one (1) year of storage covered with applicable cycle and up to five (5) holistic health sessions.
Contact	Kindbody: **employeebenefits@kindbody.com** **1-855-950-2047**, option 3

Important Information: Services are only covered if provided by health care providers within Kindbody's High Value network of providers – there is no coverage under this Plan if you seek care outside of the Kindbody network.

Benefits described above are only covered if you activate your Kindbody account and follow the instructions provided in the Kindbody platform or your Patient Care Navigator.

For example, you must schedule appointments via the Kindbody platform or using your Patient Care Navigator.

Covered benefits are still subject to the Plan's general terms and conditions, including enrollee cost-sharing provisions.

Overview

Kindbody provides fertility and family planning services to Baker Hughes employees and their spouses or domestic partners enrolled in a Baker Hughes medical plan. The services offered by Kindbody include egg freezing, IVF, LGBTQ+ support, holistic health, and more. You and your spouse or domestic partner must use providers within Kindbody's High Value Network to receive these services. Your UnitedHealthcare medical plan will process fertility services claims, where deductibles, coinsurance, and lifetime maximums may apply. Please refer to the additional plan information in this section for further details.

- Up to $20,000 per member per lifetime for fertility diagnostic and treatment services including in vitro fertilization (IVF), intrauterine insemination (IUI), and egg/embryo/sperm preservation. Medical plan cost share applies to fertility treatment services.
- Up to $10,000 per member per lifetime for fertility medication coverage through Medical plan cost share applies to fertility medication.
- Up to one (1) year of storage covered with applicable cycle.
- Up to five (5) holistic health sessions which includes mental health sessions, nutrition counseling, doula/midwives/birth coaches, lactation support, return to work coaching, etc., through Kindbody360.
- There is no additional fee for ancillary or other services associated with Fertility Services. In the event that you have exhausted or utilized the dollar value limit or cycle limit under the benefit plan, you have the option of obtaining services as a self-pay patient at Kindbody Signature clinics. As a self-pay patient, you will be charged the agreed upon Baker Hughes rate.
- Access to Kindbody's High Value Network of providers.
- Dedicated Kindbody Patient Care Navigators are available to provide program support to you throughout your fertility journey.

Participants also have access to exclusive Kindbody rates at Kindbody Signature Clinics for any non-covered Kindbody services, inclusive of any services utilized after reaching your per lifetime benefit maximum.

* Program not available to employees enrolled in the Hawaii Options PPO Plan or Retiree Medical Plan

How Kindbody Coordinates With Your Medical Plan

UnitedHealthcare (Integrated) Plans

The Kindbody fertility benefit is integrated with your medical plan. All fertility treatment services, including diagnostic testing and fertility medications are subject to your medical plans' medical deductible, coinsurance, and out-of-pocket maximums.

Once you've reached your out-of-pocket maximum, covered treatments and medications will be covered in full with no additional cost to you. These examples assume you have not paid any deductible or out-of- pocket costs for medical or fertility treatment services.

Example 1: Sarah

Sarah is enrolled in the UnitedHealthcare Standard Plan, with a deductible of $800, 20% coinsurance, and out-of-pocket max of $4,000.

UnitedHealthcare Pays	Example Cycle Example Cycle Cost	$10,000	You Pay
	Deductible You Pay	$800	$800
	Remaining Balance	$9,200	+
	Coinsurance Insurance Pays	Coinsurance You Pay	$1,840
$7,360	80%	20%	= $2,640

Example 2: Michelle

Michelle enrolled in the UnitedHealthcare Basic HSA plan, with a deductible of $3,300, 20% coinsurance, and out-of-pocket max of $6,500.

UnitedHealthcare Pays	Example Cycle Example Cycle Cost	$10,000	You Pay
$5,400	Deductible You Pay	$3,300	$3,300
	Remaining Balance	$6,700	+
	Coinsurance Insurance Pays	Coinsurance You Pay	$1,340
$5,360	80%	20%	= $4,640

Using Kindbody

Kindbody Portal

To verify your eligibility and opt-in to the Kindbody benefit, activate your benefit at **https://kindbody.com/activate/**. You will need to input your Kindbody Access Code: KINDBAKERHUGHES and your Unique ID. Your Unique ID is your employee ID. Your spouse/domestic partner's Unique ID is your employee ID + an 'S' at the end.

For example, if you are the employee, your Unique ID will be ABC999, and your spouse/domestic partner's Unique ID will be ABC999S.

Once your Kindbody benefit is activated, you'll have access to a variety of tools, both online or via your Care Navigation Team. Both help you learn more about your benefit information, treatment options and process, book appointments and more. Through the Kindbody Portal, you can:

- Review your employer benefit coverage
- Schedule an appointment virtually or at a nearby clinic
- Secure message with your Care Navigation Team
- Review results and next steps for your care plan
- Access educational content and video tutorials
- Access videos for medication injections

Your Care Navigation Team will help you:

- Understand your coverage options
- Navigate your fertility journey
- Support and direct you on how to access care when you need it
- Assist in booking appointments for your virtual holistic services
- Help troubleshoot any billing or technical issues

Finding a Care Location

You have access to fertility services at Kindbody clinics and a network of high quality partner clinics. In addition to wholly-owned clinics, Kindbody has a network of Partner Clinics that provide fertility care accessible to you in over 400+ locations nationwide.

Access information to obtain fertility & family-building services via the Kindbody portal after you've activated your benefit at **https://kindbody.com/activate/**. Once your benefit is activated, you can search for a clinic location closest to you.

Covered Services

The following treatments are covered:

- Comprehensive Fertility Services
- Intrauterine Insemination
- ART (Assisted Reproductive Technology) Cycles
- In Vitro Fertilization (Fresh and Frozen)
- Frozen Embryo Transfers
- Frozen Oocyte Thaw + Fertilization
- Embryo Banking
- Preimplantation Genetic Testing (PGT-A; PGT-M, etc.)
- Cryopreservation of Oocyte (based on approved criteria)
- Cryopreservation of Sperm
- Storage one (1) year

Exclusions

Services and items outside of the scope of the *Benefit Description/Coverage* and *Covered Services* sections above.

Prescription Drug Plan

Prescription Drug Plan Benefits At-a-Glance

Type of Plan	Prescription Drug plan for members enrolled in a Medical plan option (including out-of-area options)		
Who Pays the Cost	The Prescription Drug plan is included with your medical coverage, the cost of which you share with Baker Hughes.		
Employee Eligibility	Employees and eligible dependents enrolled in one of the following Medical plan options: • Standard option • Standard Out-of-Area option • Premium HSA option • Premium HSA Out-of-Area option • Basic HSA option • Basic HSA Out-of-Area option		
When Coverage Begins	Coverage begins on your date of hire or date of transfer.		
Enrollment Period	Eligible employees are automatically enrolled in the Prescription Drug plan upon enrolling in the Medical plan.		
Cost	**Standard and Standard Out-of-Area Options**		
	Deductible	N/A	
30-day	Retail – Generic	$10	
30-day	Retail – Preferred Brand	25% ($30 minimum/$60 maximum)	
30-day	Retail – Non-Preferred Brand	30% ($60 minimum/$100 maximum)	
30-day	Retail or Mail – Specialty	30%***	
90-day	Mail – Generic	$25	
90-day	Mail – Preferred Brand	25% ($75 minimum/$150 maximum)	
90-day	Mail – Non-Preferred Brand	30% ($150 minimum/$250 maximum)	
	Out-of-Pocket Maximum	$4,000 Individual/$8,000 Family*	
	Premium HSA, Basic HSA, Premium HSA Out-of-Area, and Basic HSA Out-of-Area Options		
	Deductible	Premium HSA and Premium HSA Out-of-Area Options: Combined with Medical** ($1,700 Individual/$3,400 Family)	
	Deductible	Basic HSA and Basic HSA Out-of-Area Options: Combined with Medical** ($3,300 Individual/$6,600 Family)	
30-day	Retail – Generic	$10 after deductible	
30-day	Retail – Preferred Brand	30% after deductible	
30-day	Retail – Non-Preferred Brand	30% after deductible	
30-day	Retail or Mail – Specialty	30% after deductible	
90-day	Mail – Generic	$25 after deductible	
90-day	Mail – Preferred Brand	30% after deductible	
90-day	Mail – Non-Preferred Brand	30% after deductible	
	Out-of-Pocket Maximum (includes deductible)	Premium HSA and Premium HSA Out-of-Area Options: Combined with Medical ($5,000 Individual/$10,000 Family)	
	Out-of-Pocket Maximum (includes deductible)	Basic HSA and Basic HSA Out-of-Area Options: Combined with Medical ($6,500 Individual/$13,000 Family)	
Contact	CVS/caremark: **www.caremark.com** | **1-877-252-3485**		

*Prescription drugs apply to the out-of-pocket maximum.
**You must meet the combined Medical and Prescription Drug Family deductible if coverage level is other than *You Only*.
***Call **1-800-578-4403** for more information about your Specialty Drug costs.

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Standard and Standard Out-of-Area Medical Plan Options

If you enroll in the Standard or Standard Out-of-Area options offered under the Medical plan, you'll automatically receive prescription drug coverage under the Baker Hughes Company Prescription Drug program (the Prescription Drug program) through CVS/caremark. This program allows you to receive prescription drugs at reasonable costs by paying a copay or coinsurance.

When your prescription is filled through the CVS/caremark national network of retail pharmacies, and you present your CVS/caremark ID card, the cost for your prescription will depend on whether your prescription drug is a generic, preferred, or non-preferred brand name drug. Your cost is also based on whether you purchase your prescription drug through a retail pharmacy that is in the CVS/caremark national network, use the mail service, or use a non-network retail pharmacy. The cost for each drug category is shown below.

Prescription Drug Coverage		Standard and Standard Out-of-Area Options
Deductible		N/A
30-day	**Retail – Generic**	$10
	Retail – Preferred Brand	25% ($30 minimum/$60 maximum)
	Retail – Non-Preferred Brand	30% ($60 minimum/$100 maximum)
	Retail or Mail – Specialty	30%*
90-day	**Mail – Generic**	$25
	Mail – Preferred Brand	25% ($75 minimum/$150 maximum)
	Mail – Non-Preferred Brand	30% ($150 minimum/$250 maximum)
	Out-of-Pocket Maximum	$4,000 Individual/$8,000 Family

*Call 1-800-578-4403 for more information about your Specialty Drug costs.

The Prescription Drug program offers a combination of copays and coinsurance. You will pay a copay for generic medications at both retail locations and via the mail service. Preferred and non-preferred medications will be subject to coinsurance with minimums and maximums, at both retail locations and via the mail service. For example, if the discounted cost of your preferred prescription costs $150, your cost would be $37.50 (25% [coinsurance] x $150 = $37.50). Because $37.50 is within the range of the minimum/maximum of $30/$60, you pay exactly 25%.

To help manage the cost of prescription medications, there is an out-of-pocket maximum in place that protects you from catastrophic expenses by limiting the amount you pay out-of-pocket each year. Your prescription drug costs will contribute to the out-of-pocket maximum. Once the out-of-pocket maximum is met, the Prescription Drug program pays 100% of most eligible prescription drug expenses for the remainder of the plan year. The out-of-pocket maximum is reset at the beginning of every plan year. Please note that certain expenses will not count toward the out-of-pocket maximum.

PrudentRx Program for Standard PPO and Standard PPO Out-of-Area Plans Specialty Medications

As part of your prescription drug plan, CVS/caremark contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists Standard and Standard Out-of-Area PPO Plan members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled Standard and Standard Out-of-Area PPO Plan members who get a manufacturer copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

PrudentRx will work with you and the drug manufacturers to get copay card assistance and will manage enrollment, and renewals for those copay cards on your behalf. Even if there is no copay card program for your specialty medication, as long as it is eligible for coverage under the PrudentRx Program, your cost will be $0 for as long as you are enrolled. The table below is an example of how the program works:

Out-of-pocket cost if enrolled in PrudentRx		Out-of-pocket cost if not enrolled in PrudentRx	
Medication cost:	$1,000 for a 30-day supply	**Medication cost:**	$1,000 for a 30-day supply
Your Responsibility:	(30%)[2]: $300	**Your Responsibility:**	(30%)[2]: $300
Your out-of-pocket cost:	$0	**Your out-of-pocket cost:**	$300
Amount applied to deductible:	$0[3]	**Not eligible**	
Amount applied to out-of-pocket maximum:	$0	**Amount applied to out-of-pocket maximum:**	$300

Please note: The example assumes the medication is an "essential health benefit," which allows your out-of-pocket cost to apply to your out-of-pocket maximum. Many specialty medications are considered "non-essential health benefits."[4,5] For medications that are not essential health benefits, amounts paid by you, a manufacturer or a plan sponsor will not apply to your out-of-pocket maximum.[6]

[1]Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change. Copay assistance program may not be used with any government payor plan.

[2]Copay, copayment, or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

[3]Only amounts paid by the member apply to the deductible. Amounts paid by manufacturers or others are not applied to the deductible.

[4]A self-funded Plan may define the items and services that qualify as "essential health benefits" by referencing any definition authorized by the U.S. Department of Health and Human Services, including any available state benchmark plan. Your Plan utilizes the Utah Essential Health Benefit Benchmark Plan.

[5]There's an exception process to decide if a medication that's not an "essential health benefit" is medically necessary for a particular plan member.

[6]The out-of-pocket maximum is the total amount you must pay in a plan year for certain covered services called "essential health benefits." Once the specified out-of-pocket limit is reached, your health plan will pay 100 percent of the cost of these covered services. More information on the out-of-pocket limit is available in other sections of this SPD.

PrudentRx Will Automatically Enroll You in the Program

Participation in the program is voluntary, and to make it easier, enrollment in the Standard or Standard Out-of-Area Plan will automatically enroll you and your dependents in the program. Some manufacturers, however, require you to sign up to take advantage of the copay assistance that they provide for their specialty medications – in that case, you must call PrudentRx at **1-800-578-4403** and a PrudentRx Advocate will help you enroll in the copay assistance program for that medication. A PrudentRx Advocate will also contact you if you are required to enroll in the copay assistance program for any specialty medication that you take.

If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance program as required by a manufacturer, you will be responsible for 30% of the cost of your specialty medications. If you have any questions about the program, call PrudentRx at **1-800-578-4403**, Monday through Friday, from 8 a.m. to 8 p.m. ET. If they don't hear from you, a PrudentRx Advocate will call you to see if you have any questions about the program.

Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area Options

If you enroll in the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option offered under the Medical plan, you'll automatically receive prescription drug coverage under the Prescription Drug program through CVS/caremark. Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area options are considered high deductible health plans, subject to requirements imposed by the Internal Revenue Code.

When your prescription is filled through the CVS/caremark national network of retail pharmacies, and you present your CVS/caremark ID card, your cost for prescriptions depends on whether you have met the combined medical and prescription drug deductible. Once you have met the applicable combined deductible, the cost for your prescription will depend on whether your prescription is a generic, preferred, or non-preferred brand name drug. Your cost is also based on whether you purchase your prescription drug through a retail pharmacy that is in the CVS/caremark national network, use the mail service, or use a non-network retail pharmacy. The cost for each drug category is shown below. For a list of preventive drugs, please visit **www.caremark.com**, or call **1-877-252-3485**.

Prescription Drug Coverage		Premium HSA and Premium HSA Out-of-Area Options	Basic HSA and Basic HSA Out-of-Area Options
Deductible (does not apply to certain preventive drugs)*		Combined with Medical ($1,700 Individual/$3,400 Family**)	Combined with Medical ($3,300 Individual/$6,600 Family**)
30-day	**Retail – Generic**	$10	$10
	Retail – Preferred Brand	30% after deductible	30% after deductible
	Retail – Non-Preferred Brand	30% after deductible	30% after deductible
	Retail or Mail – Specialty	30% after deductible	30% after deductible
90-day	**Mail – Generic**	$25	$25
	Mail – Preferred Brand	30% after deductible	30% after deductible
	Mail – Non-Preferred Brand	30% after deductible	30% after deductible
	Out-of-Pocket Maximum	Combined with Medical ($5,000 Individual/$10,000 Family)	Combined with Medical ($6,500 Individual/$13,000 Family)

*For a list of preventive drugs, please visit **www.caremark.com** or call **1-877-252-3485**.

**You must meet the combined Medical and Prescription Drug Family deductible if coverage level is other than *You Only*.

The Prescription Drug program is subject to an annual combined Medical and Prescription Drug deductible. You must first satisfy the combined Medical and Prescription Drug deductible before the plan will begin to share in the cost of covered services with you. You must meet the family deductible if your coverage level is other than You Only (see the *Medical* section for information on how the Individual and Family deductible works). Once the applicable combined deductible is met, the Prescription Drug program begins to share in the cost of eligible expenses for prescription drugs in all four tiers.

To help manage the cost of prescription medications, there is an out-of-pocket maximum in place that limits the amount you pay out-of-pocket each year. Deductible expenses and those expenses incurred from paying coinsurance and copays are used to satisfy the out-of-pocket maximum. Once the applicable combined out-of-pocket maximum is met, the Prescription Drug plan pays 100% of most eligible expenses for the remainder of the plan year. The deductible and out-of-pocket maximum are reset at the beginning of every plan year. Please note that certain expenses will not count toward the out-of-pocket maximum.

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 **www.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.

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.

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.

Additional Resources

BakerHughesBenefits.com

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

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

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 **www.caremark.com** or by calling **1-800-237-2767**. Residents of Florida, Minnesota, Oklahoma, Tennessee, and West Virginia should log on to the CVS/caremark website at **www.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; or
- a 90-day supply network pharmacy; or
- an approved mail service pharmacy

Either way, you will pay mail service prices. You can locate approved participating pharmacies and mail service providers at **www.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 one refill 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 U.S. 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 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday.
- Log on to **www.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: **www.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 Advance 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.

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 coinsurance. 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.

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

Generics

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.

No Generic Substitution

- 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.
- Otherwise, 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 (which includes 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 your physician requires the brand name drug when a generic alternative is available, you are still required to pay the brand or non-preferred brand copay, however, you will not otherwise be subject to 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 **www.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 U.S. 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 ACF 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 ACF 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 **www.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 U.S. 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 Transform Diabetes Care Management Program

The Baker Hughes Company Prescription Drug program 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. In addition, TDC program members receive additional benefits.

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:

- Pharmacist counseling in person or by phone
- 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 **www.caremark.com**.

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. Residents of Florida, Minnesota, Oklahoma, Tennessee, and West Virginia should log on to the CVS/caremark website at **www.caremark.com** to locate a 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, unless 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 8:00 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 **www.caremark.com** or by calling **1-800-237-2767**.

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 federal legend 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)

AccordantCare Complex Conditions Nurse Care Management Program

What is the AccordantCare™ for complex conditions?

It's a 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 to Baker Hughes members?

It helps achieve results that matter most to Baker Hughes members. AccordantCare provides a better experience for members, which leads to better outcomes. 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 Registered Nurse ("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 RN who specializes in the Member's complex 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's plan 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: **www.Accordant.com**

Exclusions and Limitations

The Baker Hughes Company Prescription Drug Program 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 Medical 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
- 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)
- 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

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 365 days 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 reimbursement for covered expenses, CVS/caremark must receive your claim form and supporting documentation no later than 365 days 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.

Remember...

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

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 **www.caremark.com**, or by calling Customer Care at **1-877-252-3485**.

Appealing a Denied 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 prescriber 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 your prescriber describing why medicine is necessary, clinical notes, test results, or any other supporting documentation. Mail or fax appeal to:

CVS/caremark, Inc.
Prescription Claim Appeals
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: **1-866-443-1172**

Remember...

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

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 (see the *Manner and Content of Notification of Claims Decision* section of this SPD for a further general explanation of the information that must be included). If the situation meets the definition of urgent under the law, the 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 (see "*Manner and Content of Notification of Appeals Decision*" section of this SPD for a further general explanation of the information that must be included).

External Review

If your claim or appeal for prescription drug benefits is denied on the basis of medical judgment, you may request, in writing, an External Review within four months of the date you receive notice of the final adverse benefit determination.

The request should include your name and your contact information (including mailing address and daytime phone number), your ID number, and a copy of the coverage denial notice. The request for the External Review and supporting documentation may be mailed or faxed to CVS/caremark at:

CVS/caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: **1-866-689-3092**

Within five days of receiving your request for an External Review, CVS/caremark conducts a "preliminary review" to ensure the request qualifies. Within one day after completing this preliminary review, CVS/caremark notifies you, in writing, that:

- The member's request for an External Review is complete, and may proceed
- The request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or
- The request for an External Review is complete, but not eligible for review

Referral to IRO. If your request is complete, CVS/caremark assigns the request for External Review to one of the IROs with which CVS/caremark contracts. The IRO notifies you of its acceptance of the assignment. You have 10 days to provide the IRO with additional information you want the IRO to consider.

Timing of IRO's Determination. The IRO will provide you and CVS/caremark (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for the External Review.

Reversal of the Plan's Prior Decision. If CVS/caremark, acting on the Plan's behalf, receives notice from the IRO that it has reversed the prior determination of your claim, CVS/caremark immediately provides coverage or payment for the claim.

External Review Process (Expedited). If your claim is marked "urgent" by your physician, CVS/caremark processes it as an urgent care claim. In some cases, CVS/caremark may contact the physician to confirm that the claim meets the ERISA requirements for an urgent care claim, but will continue to process the claim as urgent while attempting to do so. To initiate an Expedited External Review, you or your physician should call CVS/caremark Customer Care at **1-877-252-3485**. All requests for an expedited review must be clearly identified as "urgent" at submission. The IRO must provide you and CVS/caremark, on behalf of the Plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an Expedited External Review.

For more information on Standard and Expedited External Reviews, see the *Federal External Review Program* section of this SPD.

Dental Plan

Dental Benefits At-a-Glance

Type of Plan	Voluntary dental coverage		
Who Pays the Cost	You share the cost of dental care coverage with Baker Hughes.		
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees or • Benefits-eligible part-time employees		
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer.		
Enrollment Period	• New hires and employees transferring to a position with US benefits within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if they have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not change the coverage in which you are enrolled during the Annual Enrollment period, you'll receive the same coverage you had the previous year, as long as you remain eligible.		
Dental Choices	• CIGNA Dental PPO Program		
Coverage Level	• You Only • You + Spouse or Domestic Partner • You + Children* • You + Family		
CIGNA Dental PPO Plan**	Maximum Benefit	$2,500 (excluding orthodontia)	
	Deductible	$50 per person/$100 per family	
	Type of Service	**Plan Pays**	**You Pay**
	Routine Preventive Services	100% (no deductible)	0%
	Basic Care Services	80% (after deductible)	20% (after deductible)
	Major Care Services	50% (after deductible)	50% (after deductible)
	Orthodontia (for dependent children up to age 19)	50% (subject to a $2,500 lifetime maximum)	50% (subject to a $2,500 lifetime maximum)
Contact	• CIGNA Dental PPO plan at **www.mycigna.com** or **1-800-542-4293** • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)		

*Your domestic partner must be covered under the dental plan for a domestic child to be covered.

**Please note that if you receive dental care from a non-network dentist, the amount paid will not exceed Reasonable and Customary (R&C) costs. R&C costs are the standard costs for services in a geographic area.

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Dental care is an important part of maintaining your general health, but it can be expensive. If you see your dentist regularly for routine check-ups, your dentist can often identify minor problems before they become serious and more costly. With this in mind, the coverage options offered under the Baker Hughes Company Group Dental Care Plan help protect you and your family's health by encouraging preventive and diagnostic dental care, as well as providing basic, major, and orthodontia services.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees.

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

For assistance completing spouses or domestic partners who both work at Baker Hughes coverages, please call the Baker Hughes Benefits Center at **1-866-244-3539**, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Dental Coverage Options

To ensure that your coverage fits your needs, you can choose from four different levels of coverage:

- You Only
- You + Spouse or Domestic Partner
- You + Children*
- You + Family

Remember...

The options available to you and your family are available on **BakerHughesBenefits.com** or by calling the Baker Hughes Benefits Center. Your Dental Plan coverage election is separate from your Medical plan election.

What is the Cost of these Coverage Options?

You and Baker Hughes share the cost of dental coverage provided under the Dental Plan. Your cost of coverage is determined by the level of coverage you choose. To see the Dental Plan coverage and costs, go to **BakerHughesBenefits.com** or call the Baker Hughes Benefits Center.

You pay your portion of the cost with pre-tax dollars, which means that your monthly premiums are deducted from your paycheck generally before federal and state income and Social Security taxes are withheld. The premiums are not included in your taxable income, so your taxable income is lower.

Note: New Jersey does not allow pre-tax deductions. In New Jersey, only your federal taxable income would be reduced.

Did you know?

Cigna Dental does not issue Member ID Cards. You can either log in to your mycigna.com account or download the myCigna Mobile App to view or print a member ID card for yourself and any dependents you cover on the plan.

Remember...

You must enroll in the Dental Plan to receive dental benefits. If you do not enroll, there is no default coverage for dental benefits.

*Your domestic partner must be covered under the dental plan for a domestic child to be covered.

CIGNA Dental PPO Program

If you elect the CIGNA Dental PPO Program, you and your eligible family members may generally obtain services from any licensed dentist you choose. However, if you use a dental provider who participates in the CIGNA Dental Preferred Provider Organization (PPO), you'll pay less for care because the network providers provide services at pre-negotiated fees, which are usually less than fees charged by non-network providers. If you use non-network providers, your covered expenses will be based on the Reasonable and Customary costs as determined by CIGNA.

Schedule of Benefits

Benefits	Expenses
Annual Maximum Benefit	$2,500 (excluding orthodontia. See below for orthodontia benefits)
Calendar Year Deductible (deductible is waived for preventive and diagnostic services)	
Individual	$50 per person
Family	$100 per family
Dental Expenses	
Preventive and diagnostic services	100% (no deductible)
Basic dental care services	80% (after deductible)
Major dental care services	50% (after deductible)
Orthodontic care (for dependent children up to age 19)	50% (no deductible) $2,500 lifetime maximum per dependent child

A deductible is an amount you or your family must pay each plan year before the Dental Plan begins to share in the cost of covered services with you or your covered family members.

After the deductible has been met, you share in the cost of covered services with the Dental Plan through coinsurance. When you seek care from a network dental provider, you'll pay less for care because network providers have agreed to charge based on a negotiated fee schedule. If you seek treatment from a non-network dental provider, the CIGNA Dental PPO will pay a percentage of the Reasonable and Customary (R&C) costs you incur. R&C costs are the standard costs for services in a geographic area. It is your responsibility to verify the network status of the provider with the CIGNA Total network each time you seek care.

Covered Expenses

In general, the CIGNA Dental PPO Program pays for four types of dental expenses:

- Preventive and diagnostic services
- Major dental care services
- Basic dental care services
- Orthodontic care (for dependent children up to age 19)

Preventive and Diagnostic Services

There is no deductible for preventive or diagnostic services. The Dental Plan pays 100% of the allowable charges for the following covered expenses for each covered person up to the annual maximum benefit. Below you'll find examples of some of the dental services covered and the limitations to this coverage.

Service	Limitation
All examinations, including routine	Twice in a calendar year
Routine cleanings	Twice in a calendar year
Full mouth X-rays	One complete set every 36 consecutive months
Bitewing X-rays	Twice in a calendar year
Periapical X-rays	Twice in a calendar year
Topical fluoride application	Twice in a calendar year

Basic Dental Care Services

Under the CIGNA Dental PPO Program, you must satisfy the calendar year deductible for basic dental care services. After the applicable deductible is met, the plan will pay 80% of the allowable charges for the following covered expenses for each covered person for the remainder of the plan year or until the annual maximum benefit is met.

Service	Limitation
Diagnostic X-rays, other than full mouth or bitewing	None
Fillings, other than gold	Composite filling payable; exclusions apply
Pit and fissure sealants for posterior teeth	One time application for dependent children up to age 19 for posterior teeth only (limited to one treatment per tooth, per lifetime)
Stainless steel crowns	None
Space maintainers	To replace prematurely lost teeth for dependent children up to age 19
Extractions	None
Oral surgery	None
General anesthetics, pre-medication, local anesthesia, analgesia, or conscious sedation	Paid a separate benefit only when medically or dentally necessary, as determined by the Claims Administrator, and when administered in conjunction with procedures that are covered under the Dental program
Periodontal treatment or surgery of the gums	None
Endodontic treatment of dental pulp, including root canal therapy	None
Repair or recementing of crowns, inlays, onlays, bridgework, or dentures	When performed more than six months after the installation
Relining or rebasing dentures	When performed more than six months after the installation of full or partial dentures, but limited to no more than one time in 36 months
Emergency treatment	For temporary pain relief, not the same day as any other service, except X-rays

Major Dental Care Services

Under the CIGNA Dental PPO Program, you must satisfy the calendar year deductible for major dental care services. After the applicable deductible is met, the plan will pay 50% of the allowable charges for the following covered expenses for each covered person for the remainder of the plan year or until the maximum annual benefit is met.

Service	Limitation
Fixed bridgework, partial, or full dentures	• Excludes third molars • No benefits will be paid for adjustments during the first six months after replacement
Add teeth to an existing fixed bridge, partial, or full denture	None
Replace an existing bridgework with a new bridgework	The existing bridgework is certified by the dentist or physician to be at least 5 years old at the time of replacement and cannot be repaired.
Replace an existing full denture with a new denture	The existing denture (full or partial) is certified by the dentist or physician to be at least five years old at the time of replacement and cannot be repaired
Crowns (other than stainless steel), inlays, onlays, or gold fillings to restore teeth	The cost of procedures will only be paid if: • The tooth is fractured or has major decay • The tooth cannot be restored with fillings such as amalgam, plastic, or composite resin
Replace a crown, inlay, onlay, or gold filling	Your dentist or physician must certify that the existing crown, inlay, onlay, or gold filling is at least five years old and cannot be repaired
Dental implants	Initial restorative care or replacement after five years from initial installation

Orthodontic Care

The CIGNA Dental PPO Program offers orthodontic care treatment for your eligible dependent children up to age 19, subject to a lifetime maximum of $2,500 per dependent child and includes the following services:

- Examinations
- X-rays
- Surgery
- Extractions
- Active appliance and adjustments of the appliances (only for the prevention of harmful habits)

To receive benefits for orthodontic care, your dentist must, prior to performing any services, submit in writing a complete outline of the problem, the proposed treatment of that problem, the charges for the treatment, and the length of time for completion of the treatment. This must be submitted in writing to CIGNA before services will be considered a covered expense. Failure of your child's provider to comply with these requirements will result in no benefit being paid under the Dental Plan for any services subject to such requirements.

Pre-Treatment Review

The pre-treatment review process lets you and your dentist know what the CIGNA Dental PPO Program will pay before treatment begins. If you anticipate having dental expenses of $250 or more, your dentist should submit a written treatment plan and pre-operative X-rays before a course of dental treatment begins so you can fully understand what benefits may be payable under the Dental Plan for that course of treatment.

Pre-operative X-rays should be submitted, along with a treatment plan, for multiple crowns, bridgework, or surgical extractions. The process for submitting a treatment plan is easy and convenient. Simply ask your dentist to complete and send a standard Dental Plan claim form to the following address:

Connecticut General Life Insurance Company (CIGNA)
Chattanooga Claims Office
P.O. Box 188037
Chattanooga, TN 37422-8037

By submitting the treatment plan before work begins, both you and your dentist will know in advance the benefits that are available for the prescribed treatment.

Dental Expense Timing

Some procedures are performed over a longer length of time. If you're close to meeting your $2,500 maximum benefit for the year, you may want to reconsider the timing of a procedure to receive the highest benefit possible.

Covered Expense	Date Expense Is Considered To Be Incurred
Full or partial dentures	Date of installation
Fixed bridges, crowns, inlays, or onlays	Date of installation
Periodontal surgery	Date surgery is performed

Extended Dental Benefits

If your coverage ends while you're incurring charges due to an ongoing procedure, your benefits will be considered for payment as follows:

Dentures	
Charges will be considered if:	• The impression is made before the date coverage ends; • The denture is ordered before the date coverage ends; and • The denture is placed in the mouth within 90 days from the date coverage ends.

Fixed Bridgework, Crowns, and Inlays	
Charges will be considered if:	• The tooth or teeth are prepared before the date coverage ends; • The impression is taken before the date coverage ends; • The bridgework, crown, or inlay is ordered before the date coverage ends; and • The work is seated in the mouth within 90 days from the date coverage ends.

Endodontic Treatment, Including Root Canal Therapy	
Charges will be considered if:	• The tooth is opened before the date coverage ends, and • The procedure is completed within 90 days from the date coverage ends.

PPO Exclusions and Limitations

No payment will be made under the CIGNA Dental PPO Program for expenses incurred for the following:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown, or denture within five years after the date it was originally installed unless:
  - The replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth
  - The bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits
- Any replacement of a bridge, crown, or denture that is or can be made usable according to common dental standards
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension
  - Diagnose or treat conditions or dysfunction of the temporomandibular joint
  - Stabilize periodontally involved teeth
  - Restore occlusion
- Porcelain or acrylic veneers or crowns or pontics on or replacing the upper and lower first, second, or third molars
- Bite registrations, precision or semi-precision attachments, or splinting
- Instruction for plaque control, oral hygiene, and diet
- Dental services that do not meet common dental standards
- Services that are considered to be medical services
- Services and supplies received from a hospital
- Alternate Treatment Provision is NOT included on crowns and fillings

In addition, Dental Plan benefits under the CIGNA Dental PPO Program will be reduced, so that the total payment will not be more than 100% of the charge made for the dental service when benefits are provided for that service under both the Dental Plan and any Medical plan or prepaid treatment program made available by Baker Hughes.

In addition, no payment will be made for expenses incurred by you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- For or in connection with an illness that is covered under any Workers' Compensation or similar law
- For charges made by a hospital owned or operated by, or that provides care or performs services, for the United States government, if these charges are directly related to a condition connected to military service
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges that the person is not legally required to pay

- To the extent that they're more than either the applicable contracted fee, applicable Eligible Expenses costs, or applicable scheduled amount
- For charges for unnecessary care, treatment, or surgery
- To the extent that you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.

Remember, you must enroll in the Dental Plan to receive dental benefits. If you do not enroll, there is no default coverage for dental benefits.

How Do I File a Dental Claim?

If you're covered under the CIGNA Dental PPO Program, you or your provider must submit a claim form to CIGNA when you receive dental treatment and services from a non-network provider.

The CIGNA claim form includes instructions on where and how to file a claim. 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 CIGNA as soon as possible after your treatment. You have 12 months from the date of service or treatment to file a claim for expenses incurred.

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

Connecticut General Life Insurance Company (CIGNA)
Chattanooga Claims Office
P.O. Box 188037
Chattanooga, TN 37422-8037

After you send in your claim and it has been processed by CIGNA, you'll receive an Explanation of Benefits (EOB) statement outlining the Dental Plan benefit paid with respect to your claim. You can create an online account to view claim details on **myCigna.com** and the MyCigna app. If you do not receive an EOB, contact CIGNA member services at **1-800-542-4293**.

As a claimant, you are entitled to receive written notice, within 30 days of filing your claim, whether the claim is to be allowed in full, in part, or denied. This time limit may be extended for another 15 days in special cases, but you'll be notified of the reasons for the delay. You may file claims as often as you wish. If you're paid more than you should have been reimbursed for a claim, or if a claim is paid for ineligible expenses, CIGNA may deduct the overpayment from future claims payments made to you.

To process the claim, CIGNA has the right to review a dentist's statement of treatment, study models, X-rays, and any additional evidence considered necessary as evidence on which a claim under the CIGNA Dental PPO Program may be based. In considering a claim, CIGNA has the right to require examination of you or your dependents when and as often as may be required.

What is an EOB?

An Explanation of Benefits (EOB) is a statement that is sent to you after you seek treatment or services from a dental care provider. The statement outlines your coverage, the benefits paid to your provider, and any amounts you owe for the treatment or service.

What if My Dental Claim is Denied?

If you are covered under the CIGNA Dental PPO Program and if your claim is denied in whole or in part, you can call or write to Member Services as listed on your claim form or EOB to see if CIGNA Member Services can help you resolve your issues and questions regarding the denial without you having to file a formal appeal. This procedure is voluntary. You are not required to call CIGNA Member Services before filing a formal appeal. If CIGNA Member Services cannot resolve your issues with respect to the denial of your claim for benefits over the phone, you may file a formal appeal.

Denial - Appeal

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

- **Start with Customer Service:** We are here to listen and help. If you have a concern regarding a person, a service, or contractual benefits, you may call the toll-free number on your explanation of benefits or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

  We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

- **Internal Appeals Procedure:** To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by telephone. Call or write us at the toll-free number on your explanation of benefits or claim form. Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

  We will respond in writing with a decision within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Dental Plan provisions on which the determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information, as defined below;
4. A statement describing any voluntary appeal procedures offered by the Dental Plan and your right to bring an action under ERISA section 502(a), if applicable;
5. Upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal; and
6. An explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review.

Additional Resources — CIGNA

Via Internet: **www.mycigna.com**

- Download a claim form
- Find claim status and detail
- Get an ID Card
- Find Care & Costs

Customer Service: 1-800-542-4293

Remember...

All decisions concerning exclusions and limitations under the Dental plan will be made at the sole discretion of the Claims Administrator.

Vision Plan

Vision Benefits At-a-Glance

Type of Plan	Voluntary vision coverage - High Plan and Low Plan
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees or • Benefits-eligible part-time employees
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with US benefits within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if they have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not change the coverage in which you are enrolled during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Plan Information	There are two Vision Plan options, the High Plan and the Low Plan. • The High Plan allows for frames OR contacts every calendar year. • The Low Plan allows for frames OR contacts every other calendar year. You may choose any provider, however, if you use doctors and facilities in the VSP network, your vision expenses are generally lower.
Contact	• VSP at **www.vsp.com** • VSP customer service at **1-800-877-7195** or **1-916-635-7373** (worldwide) • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

If You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees

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

If you and your spouse or domestic partner work for Baker Hughes and need assistance completing your elections, please call the Baker Hughes Benefits Center at **1-866-244-3539**. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

*A domestic partner needs to be covered in order for a domestic child to be covered.

What is the Employee's Cost of the Vision Plan?

If you decide to enroll yourself or your family in the Baker Hughes Company Vision Program (Vision Plan), you'll pay the cost of the plan you select. The cost you're responsible for is called the premium — a monthly amount determined by your elected plan and coverage level. To see your per-pay-period premium, go to **BakerHughesBenefits.com** or call the Baker Hughes Benefits Center at **1-866-244-3539**.

You pay your premium with pre-tax dollars, which means that your monthly premiums are deducted from your paycheck generally before federal and state income and Social Security taxes are withheld. Since your premiums are not included in your taxable income, your taxable income is lower. Note that domestic partners and their children are not tax dependents under IRS rules. You must pay the premium for their health benefits on an after-tax basis.

Note: New Jersey does not allow before-tax deductions. In New Jersey, only your federal taxable income would be reduced.

How Does the Vision Plan Work?

The two options offered under the Baker Hughes Company Vision Plan are funded through an insurance policy issued by VSP and are designed to pay benefits to help you and your family take care of your vision needs. By encouraging regular vision exams and helping you pay for necessary vision expenses, the Vision plan helps you maintain your vision at a reasonable cost.

For Questions Contact:

VSP operates a nationwide network of eye-care providers. Network doctors provide services at pre-negotiated fees, which are usually lower than the fees charged by non-network doctors.

Vendor	Website	Telephone
VSP	**www.vsp.com**	1-800-877-7195 or 1-916-635-7373 (worldwide)

Did you know?

If you're covered under the Vision plan, you will not receive an identification card. If you use a VSP network provider, they will submit claims on your behalf. If you use a non-network provider, you will need to pay for care at the time of service and you will need to submit a claim form for reimbursement. Claim forms are available online at **www.vsp.com**, or by calling VSP at **1-800-877-7195** or **1-916-635-7373** (worldwide).

You and the Vision plan share the cost when you receive vision care. You pay a copay or receive an allowance depending on the plan you elect and the type of service you receive. Refer to the *Vision Schedule of Benefits* section for more information.

A **copay** is the flat dollar amount you pay when you use the VSP network. For example, you will be charged a $10 copay for an annual eye examination when you visit a VSP network doctor (the Vision plan generally pays the remaining portion of the allowable cost). Copays must be paid each time a service is rendered or materials are prescribed and filled.

An **allowance** is the set dollar amount the Vision plan pays toward your eye care in a calendar year. You will be responsible for all charges over the Vision plan allowance. You'll receive 20% off the amount over your allowance through VSP network providers. Refer to the *Vision Schedule of Benefits* section.

Remember...

You must enroll into the Vision Plan to receive vision benefits. If you do not enroll, there is no default coverage for vision benefits.

Through the Vision plan, you'll save on eye exams, prescription eyeglasses (lenses and frames), and contact lenses. Additionally, you'll receive extra discounts on additional pairs of eyeglasses and sunglasses, including lens options through VSP network doctors, and discounts on laser eye surgery through VSP contracted surgery facilities. You simply make an appointment to see any eye care provider when you need eye care, keeping in mind you'll receive the most value from VSP network doctors.

If your provider is in the VSP network, you pay the applicable copay and expense based on the plan you elect and the type of service you receive. Your VSP doctor will submit a claim electronically to VSP, which will pay your doctor for eligible services.

If you choose a provider who is not in the VSP network, you must pay for care at the time of service and submit a claim form to VSP for reimbursement. The Vision plan will reimburse you at the out-of-network reimbursement level minus the copays.

All covered expenses are subject to provisions shown in the *Vision Schedule of Benefits* section.

Vision Network

VSP has a national network of participating doctors and offers low, fixed prices for services.
To locate a participating doctor:

- Ask your local doctor if he or she participates in the VSP network;
- Log on to the VSP website at **www.vsp.com** and use the doctor search feature; or
- Call VSP member services at **1-800-877-7195** or **1-916-635-7373** (worldwide).

Tip!

If you or a covered dependent are away from home (for example, a child away at school) you can use any VSP network doctor in the United States.

How the Process Works Using a VSP Preferred Provider

When you make your appointment, identify yourself as a VSP member; provide your name and confirm your date of birth. The doctor's office will contact VSP for authorization and confirm the Vision plan benefits and coverage amounts.

The cost of a routine eye examination and standard lenses (single vision, lined bifocal, lined trifocal) are covered in full under the Vision plan when provided through a VSP preferred provider or network doctor after you pay the necessary copays.

When you arrive for your appointment, you'll pay the $10 copay for your routine eye examination. If the doctor prescribes corrective lenses for prescription eyeglasses, you'll be responsible for the additional $25 materials copay (lenses and frame). You'll receive a $150 to $200 allowance toward the purchase of your frames, depending on if you elect the High Plan ($200) or the Low Plan ($150). You'll receive a 20% discount off the amount over your allowance. You will be responsible for paying any amount above the allowance.

If the doctor prescribes contact lenses for both the High Plan and the Low Plan, you will receive a $150 allowance that can be applied toward the contact lens and exam (fitting and evaluation). You'll receive a 15% discount off the cost of the contact lens exam (fitting and evaluation). You will be responsible for paying any amount above the allowance.

Using your Benefits Outside the VSP Network

If you choose a provider outside the VSP network, you are responsible for paying all charges at the time of your appointment. You will then be responsible for submitting an itemized statement of services to VSP for reimbursement under the Vision plan. The reimbursement amounts are shown on the *Vision Schedule of Benefits* section. You may contact VSP for instructions regarding your claim filing.

Example 1 - the High Plan*:

Before you make an appointment to see an eye care provider, take a look at the options you have and how the VSP process works when you choose to obtain services from a VSP preferred provider versus when you choose to obtain services outside the network.

You make an appointment to see Dr. Green for an annual eye exam and contact lens fitting.

If Dr. Green is in the VSP network...

- You make an appointment to see Dr. Green. Tell them you are covered by the Baker Hughes Vision plan administered by VSP. You may be asked for your Social Security Number.
- Dr. Green's office will contact VSP before your appointment for authorization and your Vision plan coverage amounts.
- You pay a $10 copay at the time of service for the eye exam.
- You choose $200 contact lenses. The plan has a $150 allowance, so you pay $50.

The network eye exam plus your contacts costs you $60.

If Dr. Green is a non-network provider...

- You make an appointment to see Dr. Green, knowing that non-network charges will apply.
- You must pay the total fee for service during your visit with Dr. Green – $352 ($152 eye exam; $200 contact lenses).
- You send your claim directly to VSP for processing (remember to make a copy for your records).
- VSP mails your allowance of $170 to your home address ($45 eye exam allowance and $125 contact lens allowance).

The non-network eye exam plus your contacts costs you $182.

Note: Dollar amounts are for illustrative purposes only and may not reflect actual costs.

*The High Plan allows for frames OR contacts every calendar year.

Example 2 - the Low Plan*:

Before you make an appointment to see an eye care provider, take a look at the options you have and how the VSP process works when you choose to obtain services from a VSP preferred provider versus when you choose to obtain services outside the network.

You make an appointment to see Dr. Green for an annual eye exam and contact lens fitting.

If Dr. Green is in the VSP network...

You make an appointment to see Dr. Green. Tell them you are covered by the Baker Hughes Vision plan administered by VSP. You may be asked for your Social Security Number.

Dr. Green's office will contact VSP before your appointment for authorization and your Vision plan coverage amounts.

You pay a $10 copay at the time of service for the eye exam.

You choose $200 contact lenses. The plan has a $150 allowance, so you pay $50.

The network eye exam plus your contacts costs you $60.

If Dr. Green is a non-network provider...

You make an appointment to see Dr. Green, knowing that non-network charges will apply.

You must pay the total fee for service during your visit with Dr. Green – $352 ($152 eye exam; $200 contact lenses).

You send your claim directly to VSP for processing (remember to make a copy for your records).

VSP mails your allowance of $150 to your home address ($45 eye exam allowance and $105 contact lens allowance).

The non-network eye exam plus your contacts costs you $202.

Note: Dollar amounts are for illustrative purposes only and may not reflect actual costs.

*The Low Plan allows for frames OR contacts every other calendar year.

Vision Schedule of Benefits

This is the schedule of benefits for the High Plan and the Low Plan. Please note that you may receive either one pair of glasses or contact lenses in a calendar year, not both.

Benefit	High Plan In-Network	High Plan Out-of -Network	Low Plan In-Network	Low Plan Out-of-Network
Eye Exam*	$10 copay (annual)	$45 allowance (annual)	$10 copay (annual)	$45 allowance (annual)
Lenses • Single Vision • Lined bifocal • Lined trifocal • Standard progressive	$25 copay (annual)	Allowance (annual) • $30 for single vision lenses • $50 for lined bifocal lenses • $65 for lined trifocal lenses • $50 for standard progressive	$25 copay (every other year)	Allowance (every other year) • $30 for single vision lenses • $50 for lined bifocal lenses • $65 for lined trifocal lenses • $50 for standard progressive
Frames	$200 retail frame allowance (annual) Additional $20 for featured frames (annually)	$70 allowance (annual)	$150 retail frame allowance (every other year) Additional $20 for featured frames (every other year)	$70 allowance (every other year)
Contact Lenses	$150 allowance for contacts and contact lens exam with fitting and evaluation (annual)	$125 allowance (annual)	$150 allowance for contacts and contact lens exam, including fitting and evaluation (every other year)	$105 allowance (every other year)

*Eye exams must be performed by an ophthalmologist or optometrist and must include a complete analysis of your eyes and related structures to identify diagnosis for glasses or contact lenses.

You pay additional costs for the following:

- Blended lenses
- Contact lenses, except as noted above
- Oversize lenses
- Progressive multifocal lenses
- Coating of the lens or lenses
- Photochromic lenses
- Laminating of the lens or lenses
- Frames that cost more than the allowance

Note: When you receive care or services at a VSP network doctor location, you must pay any cost above your allowances under the Vision plan, including sales tax and any non-covered expenses.

Visually Necessary

Visually necessary lenses are those needed following cataract surgery or to correct extreme visual acuity problems that cannot be corrected with eyeglasses or lenses for certain eye conditions. (The conditions covered include aphakia, anisometropia, high ametropia, nystagmus, keratoconus, and other eye conditions that make contact lenses necessary.) This benefit applies to both the High Plan and the Low Plan. Under the High Plan, you receive this benefit every 12 months. Under the Low Plan, you receive this benefit every 24 months.

When visually necessary contact lenses are obtained from a VSP network doctor, they will be covered in full minus the $25 materials copay when certain criteria are met. When visually necessary contact lenses are obtained from a provider outside the network, the Vision plan will provide an allowance toward the cost as outlined below. Coverage for visually necessary contact lenses — regardless of whether they are obtained from a VSP network doctor or not — are subject to review to determine if certain conditions are met.

	VSP Network Doctor	Non-VSP Network Doctor
Professional fees and materials*	Covered in full minus $25 materials copay	High Plan: $210 Low Plan: $210

*Under the High Plan, you receive this benefit every 12 months. Under the Low Plan, you receive this benefit every 24 months.

Exclusions

No benefits are paid for services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a +50 diopter power)
- Two pair of glasses instead of bifocals
- Lenses and frames previously paid for under the Vision plan that are lost or broken will not be replaced except at the intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye exam or corrective eyewear required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature

How Do I File a Vision Plan Claim?

If you use a VSP preferred provider or network doctor, he or she will submit claims on your behalf. You're only responsible for applicable copays and amounts over your Vision plan allowances.

If you use a provider outside the network, you must submit a claim to VSP for reimbursement. You can file a claim at **www.VSP.com** or send the Request for Reimbursment Form to VSP with the following information:

- An itemized statement of services you received
- Include your name, address, phone number, date of birth, employer name (Baker Hughes), your member identification number (last four digits of your Social Security Number); and
- If the claim is for a dependent, your dependent's name, address, phone number, and your relationship to the covered dependent (such as spouse or domestic partner or child); and
- Copies of your receipts

Send your claim to:

VSP
PO Box 495933
Cincinnati, OH 45249-59

File your claim directly with VSP as soon as possible after the date of treatment. Claims must be submitted within 12 months of the date of service. You can also file a claim online. It's secure. You can check your claim status, get paid faster, and save on paper. Go to www.vsp.com to log into your account to complete your claim form online. You can also create your online account, if you don't already have one.

Once your claim is processed and approved, you'll be reimbursed according to the *Vision Schedule of Benefits* section.

Remember...

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

What if My Vision Plan Claim is Denied?

If your claim is denied, in whole or in part, you can call VSP member services at **1-800-877-7195** to see if VSP member services can help you resolve your issues and questions regarding the denial without you having to file a formal appeal. This procedure is voluntary. You are not required to call VSP member services before filing a formal appeal. If VSP member services cannot resolve your issues with respect to the denial of your claim for benefits over the phone, you may file a formal appeal.

Appealing a Denied Claim

If you are not satisfied with the results of a decision regarding your claim, you may begin the appeals procedure as outlined below.

Initial Appeal

You or your doctor or authorized representative may initiate an appeal within 180 days of an initial determination through the VSP Member Appeals Department. Appeals may be submitted orally or in writing to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

You may review, during normal business hours, any documents held by VSP pertinent to the denial. You may submit written comments, documents, records, and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial claim. VSP will respond within the appropriate time period for the type of claim. This response will include the reasons for the decision and references to the plan provisions on which the decision was based.

Second Level Appeal

If you disagree with the resolution of your appeal, you have the right to a second level appeal. Within 60 days of receipt of VSP's final determination, you may submit your appeal along with any further documentation to the address listed above. VSP will respond within the appropriate time period for the type of claim. This response will include the reasons for the decision and references to the plan provisions on which the decision was based.

Remember...

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with Vision plan access or claim issues that you have not been able to resolve on your own. 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.

Other Remedies

If you have completed the appeals process stated above, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U. S. Department of Labor or the insurance regulatory agency for your state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) [29 USC. 1132(a)(1)(B)], you have the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those cases where the claims were not approved in whole or in part as the result of appeals and you disagree with the outcome of the appeal.

Additional Resources

Via Internet: **www.vsp.com**

- Search for providers in the VSP network
- View your personalized eye-care coverage
- Access eye health and wellness information
- Customer Service: **1-800-877-7195**

Coordination of Benefits for the Vision Plan

If you or your covered dependents have coverage under another vision plan in addition to your coverage under the Baker Hughes Company Vision plan, you may choose to receive separate services from each plan independently, or you may choose to have the plans pay for the same date of service.

If you choose to have the plans pay for the same service, one of the plans will pay the benefits first, making that plan primary. The other plans will pay benefits next. In this case, the other plans will be the secondary payer. The rules below help determine which plan pays first.

How Coordination Works

If the Baker Hughes Vision plan is primary, it will pay or provide its benefits as if the other plans do not exist.

If the Vision plan is the secondary plan, you will receive allowances (exam, lenses, and frame) that will be used to pay up to, but not more than the billed amount. Only services used on the primary benefit may be used for coordinating services on the secondary benefit. Secondary allowances are applied first to the same service or product on the primary plan. Vision benefits may only be coordinated with services provided for vision care.

How to Determine if Your Baker Hughes Company Vision Plan is Primary

When you or your covered dependents have coverage under another vision plan in addition to coverage under the Baker Hughes Company Vision plan, VSP must determine the order of assignment.

Determining Primary and Secondary Plans

When coordinating benefits, it must be determined which plan is billed first.

- The plan that covers the member as an employee is “primary”.
- The plan that covers the member as a dependent is “secondary”.
- For members with multiple employer plans, the plan covering the employee for the greatest period of time is “primary”.
- If you are a dependent child and are covered under both parents’ plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody has the primary plan, or the parent decreed by the court to be responsible has the primary plan
- If a person whose coverage is provided under a right of continuation pursuant to a federal or state law (e.g. COBRA) is also covered under another plan, the effect on benefits is as follows:
  - The plan covering the person as an employee (or as the employee’s dependent) will pay first, and
  - The plan of continuation coverage will pay second
- When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. For example, if you are a new employee as the result of an acquisition of a business by Baker Hughes and your vision plan coverage continues with your former employer for a period of time after the acquisition, your former employer’s plan will pay first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

Flexible Spending Accounts

Flexible Spending Accounts At-a-Glance

Type of Plan	Voluntary H&W benefit (Flexible Spending Accounts)
Who Pays the Cost	You pay the full cost of coverage. You can elect to have Baker Hughes set aside pre-tax money into Health Care or Dependent Care Flexible Spending Accounts based on your expected health care and dependent care costs.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees or • Benefits-eligible part-time employees
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with US benefits must enroll within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • After November 1, new hires will not be eligible to contribute to an FSA for the calendar year in which they are hired. • Employees can make changes during Annual Enrollment or if they have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you participate in an FSA, you must actively change your contribution during Annual Enrollment or your contribution amount will default to $0.
Contact	UnitedHealthcare: • **www.myuhc.com** • 1-866-743-6549

	Health Care Flexible Spending Account	**Dependent Care Flexible Spending Account**
Eligible Dependents	See the Eligible Dependents chart in the *HCFSA* section	See the Eligible Dependents chart in the *DCFSA* section
Eligible Expenses	See the chart in the *Eligible Health Care Expenses* section	Qualifying expenses that allow you and your spouse, if any, to work, look for work, or attend school full time. For examples, see the *DCFSA* section and IRS Publication 503 at **www.irs.gov**.
Minimum Contribution	$60	$300
Maximum Contribution	$3,300	• $5,000 for single taxpayers and for married taxpayers filing a joint tax return* • $2,500 for married taxpayers filing separate returns*

***Contributions cannot exceed the lesser of your or your spouse's earned income. Or, if your spouse is a full-time student or is disabled, you can contribute up to $3,000 for one dependent or $5,000 for two or more dependents.**

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Flexible Spending Accounts

The Baker Hughes Flexible Spending Accounts (FSAs) are designed to help you save on out-of-pocket health care and dependent care expenses by using pre-tax dollars to pay your share of eligible expenses.

There are two separate accounts:

- **Health Care Flexible Spending Account:** for out-of-pocket health care expenses for you and your eligible dependents
- **Dependent Care Flexible Spending Account:** for dependent care expenses, such as day care (not health care)

Remember...

Any unused amounts in your FSA will be forfeited if claims are not filed by March 31 of the following year. Eligible expenses must be incurred by December 31 of the plan year.

Health Care and Dependent Care Flexible Spending Accounts are completely separate and are designed for different types of expenses. Deposits to your Dependent Care FSA **cannot** be used to reimburse yourself for health care expenses incurred by you or your dependents. Likewise, deposits to your Health Care FSA **cannot** be used for dependent care expenses.

Participation is entirely voluntary. You can have both a Health Care FSA and a Dependent Care FSA, just one account, or no account at all. You do not have to be covered under a Baker Hughes Medical plan to take advantage of the reimbursement accounts.

Please note that the amount you elect to contribute to a Flexible Spending Account is divided by the number of pay periods in a calendar year or pay periods left in the year. If your goal amount is not equally divisible by the number of pay periods, your actual contributions may be slightly more than your goal amount. You will be reimbursed from the FSA up to the elected goal amount.

Once you make your election, you cannot change your contribution during the year unless you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). **Please note: You will not receive a debit card to pay for FSA eligible expenses.**

Eligible expenses for a plan year must be incurred by December 31 of that plan year, and claims for reimbursement of eligible expenses must be filed no later than March 31 of the following year.

Tax Savings with the Flexible Spending Accounts

In general, Flexible Spending Accounts save you money by allowing you to pay for eligible expenses with pre-tax dollars. The amount you save is determined by the income tax and Social Security tax you do not have to pay. With FSAs, you figure out how much you want to contribute for a calendar year, and the money is taken out of your paychecks in equal amounts before taxes. You do not pay federal income tax, Social Security tax, and in most cases, state income tax on the amounts you decide to contribute. Plan carefully as you decide how much to set aside for the year because you forfeit all money you don't use by the end of the year (or submit for reimbursement by the following March 31).

Health Care Flexible Spending Account

What Can the Health Care FSA Do For You?

Use the Health Care FSA to help bridge the gap between what your health care plan pays and what you pay.

- Spread the cost of services over the year. You can be reimbursed for eligible expenses before the money is in your account, up to the total amount you elect to contribute for the year
- Reduce the cost of eligible over-the-counter medicine, supplies, and materials. Use your pre-tax contributions to pay for eligible health care expenses such as your deductible, medical and prescription drug coinsurance, or other expenses not covered by your Medical, Prescription Drug, Vision, or Dental Plans. The amount you save is determined by the amount of income tax and Social Security tax you do not have to pay
- Save time with automatic filing of Medical and Prescription Drug claims. Once claims are processed by the Baker Hughes Medical and/or Prescription Drug plans, they are filed automatically with the FSA Administrator, UnitedHealthcare. You do not have to file these claims manually. Reimbursement will be sent to your home address on file with Baker Hughes, or you can set up direct deposit online at **www.myuhc.com**. If you submit a claim using the online claim form on **www.myuhc.com**, the Plan will typically reimburse you 2-3 days after the claim is processed

  If you prefer to process these types of claims manually, you can turn off the automatic claim initiation feature online at **www.myuhc.com** or by calling UnitedHealthcare at **1-866-743-6549**. Dental, vision, and other expenses will need to be filed manually with the FSA Administrator for reimbursement. **You will not receive a debit card for FSA eligible expenses.**

Important: Claims processed by the Baker Hughes Medical plan and Prescription Drug plan are filed automatically with the FSA Administrator. If you choose to file these claims manually, the automatic claim filing feature must be turned off each plan year by going to **www.myuhc.com** or by calling UnitedHealthcare at **1-866-743-6549**. You will not receive an FSA debit card to pay for FSA eligible expenses.

Eligible Dependents*

In addition to eligible expenses you incur for yourself, you may submit eligible expenses to your Health Care FSA for the following:

- Your spouse or domestic partner
- Eligible dependents

An eligible dependent is one who qualifies as a “qualifying child” or a “qualifying relative” for federal income tax purposes. The table below briefly summarizes requirements for a “qualifying child” and a “qualifying relative.”

Eligible Dependents	Qualifying Child	Qualifying Relative
Relationship to Employee	Examples include your: • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece The individual cannot be the qualifying child of any other person.	Examples include your: • Son/daughter • Grandchild • Stepchild • Nephew/niece • Brother/sister • Parent • Stepbrother/stepsister • Grandparent • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Residency Requirements	Will live with you for more than half of the year and is a US citizen or national or a resident of the US, Canada, or Mexico	Is a US citizen or national or a resident of the US, Canada, or Mexico
Age Requirement	• Younger than you, under age 27 at the end of the tax season OR • Any age if permanently and totally disabled	No requirement applicable
Support Requirement	Will not provide over half of his or her own support for the year	You will provide over half of the individual's support for the year.
Income Limitations	No limitation applicable for individual being claimed. If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	Will have gross income for the year less than $4,300
Joint Return Limitation	If married, will not file a joint federal income tax return with his or her spouse	If married, will not file a joint federal income tax return with his or her spouse

***The information provided in the table above does not include all the requirements for a "qualifying child" or a "qualifying relative" for federal income tax purposes. For more information on those requirements, see Section 152 of the Internal Revenue Code and IRS Publication 502, which are available on the IRS website at www.irs.gov.**

How the Health Care FSA Can Save You Money

Here is an example of the tax savings you can realize when you use the Health Care FSA. In this example, a person saves $500 in taxes.

	Using a Health Care FSA Pre-Tax	Paying Health Care Expenses After-Tax
Gross Annual Income Payments for expenses using pre-tax dollars (deposit in Health Care FSA)	$30,000 -$2,000	$30,000 -$0
Taxable Wages Amount of tax to pay (assumes 25%)	$28,000 -$7,000	$30,000 -$7,500
Take-Home Pay Payment for expenses using after-tax dollars	$21,000 -$0	$22,500 -$2,000
Spendable Income Additional spendable income from tax savings	$21,000 $500	$20,500 $0

Example assumes a combined federal and state tax rate of 25%. The higher your tax rate, the more you can potentially save with a Flexible Spending Account.

Consider This...

Want to see how easy it is to generate over $100 in out-of-pocket medical costs? Consider just these routine expenses:

Eligible Expense	Health Care FSA	Total
Prescription Drugs	1 formulary brand medication at $30	$30
Doctor Visits	1 network doctor visit (assuming deductible not met)	$65
Dental Care	1 filling @ $80 (you pay 20% after deductible)	$16 coinsurance after deductible
Vision Care	1 eye exam	$10 copay
Total		**$121**

If you are newly eligible for benefits, or if you have an eligible change in status see the *Can I Make Changes After I Enroll?* information located in the *General Information* section.

Afraid of the "Use it or Lose it" Requirement? Here's How You Can Avoid it … and Save Money.

If you do not use all of the money in your Health Care FSA by the end of the year, you lose what is left in your account. If you are like many people who are missing out on savings because you are afraid of the "use it or lose it" requirement, estimate conservatively. Elect to contribute only the money you are reasonably sure to use during the year.

Did you know…

If you participate in a Health Care FSA, you cannot elect to contribute to a Health Savings Account (HSA). If you elect a Health Care FSA at the beginning of the year, you cannot contribute to an HSA at any time during the same plan year even if you experience a qualified change in status.

Eligible Health Care Expenses

The IRS provides information that can help you determine which health care expenses are eligible for reimbursement. For detailed information, see IRS Publication 502, which is available on the IRS website at **www.irs.gov**.

Here are some examples of **eligible**, reimbursable health care expenses:

Medical	
• Acupuncture • Alcoholism or chemical dependency treatment • Birth control pills and devices, or sterilization • Charges that exceed a medical plan's limits, including amounts above Eligible Expense limits • Crutches (purchase or rental) • Deductibles and coinsurance • Fees charged by medical professionals for medical care including chiropractors, Christian Science practitioners, midwives, osteopaths, practical nurses, psychiatrists, psychoanalysts (medical care only), and psychologists (medical care only) • Home health care, including nurses and attendants • Lab tests and X-rays • Nursing home confinement for medical care • Nursing service by a registered nurse or licensed vocational nurse	• Physical therapy, speech therapy, occupational therapy, and other health-related therapy • Prescription drugs, if not covered by another plan • Private duty nursing • Routine physical exams and other preventive care not covered by other health plans • Smoking cessation programs and smoking cessation drugs available only by prescription • Syringes, needles, and injections • Vaccinations and immunizations • Vitamins prescribed by a physician for treatment of a medical condition • Wheelchairs and other necessary equipment for the disabled • Wigs (purchased upon the advice of a physician for the mental health of a patient with loss of hair due to medical reasons)

Vision	Hearing
• Eye exams • Eyeglasses, including tinting • Contact lenses • Contact lens solutions and products • Radial keratotomy, laser eye surgery (LASIK), or similar surgery to correct vision • Special equipment, training, and dogs for the blind	• Hearing exams • Hearing aids and repair • Special equipment, training, and dogs for the deaf

Examples of Over-the-Counter (OTC) items that do not require a prescription to qualify for FSA purchase or reimbursement:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrheal medicine
- Baby rash ointment
- Certain allowable OTC medical supplies, materials, medicines, and drugs
- Cold and flu medicine
- Eye drops
- Feminine hygiene products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Lip balm with sunscreen
- Motion sickness medicines
- Nasal sprays or drops
- Ointment for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies
- Sunscreen with SPF 15 or higher

If I purchase an OTC medicine, how do I use my FSA to pay for it?

If you buy the medicine off the shelf you will need to submit an FSA claim form, and a copy of your receipt for the medicine you purchased. Visit **www.irs.gov/publications/p502** for more detailed information about eligible expenses for reimbursement.

Ineligible Health Care Expenses

Here are some examples of **ineligible** health care expenses:

Health Care Flexible Spending Account	
• Bottled water • Cosmetic surgery (except for the correction of birth defects, accidental disfigurement, or reconstruction following mastectomy) • Cosmetics, toiletries, toothpaste • Custodial care in an institution, such as a nursing home • Electrolysis • Funeral, cremation, or burial expenses • Health club dues or exercise equipment • Household and domestic help • Items that are not medically necessary	• Licensed practical nurse (LPN) for the care of a healthy newborn • Marriage or family counseling • Maternity clothes and diaper services • Premiums for health, automobile, life, disability, or accident insurance • Social activities, such as dance lessons or classes • Special school tuition for a child with discipline or emotional problems • Uniforms • Vacation or travel taken for general health purposes • Weight loss and fitness programs for general health purposes (except in cases of morbid obesity)
Over-the-Counter	
• Bath products, cleansers, soap • Creams, lip balm without sunscreen, lipstick, lotions, moisturizers • Deodorants/antiperspirants • Foot care products • Hair care products • Hair removal products	• Medicine dispensers • Powders • Shaving and grooming products • Snoring aids • Stimulants (to stay awake) • Sunscreen below SPF 15, sunless tanning, after-sun products

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Health Care FSA coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Health Care FSA by notifying the Plan Administrator in advance and providing payment of any required contribution (i.e., contributions to the account) for the Health Care FSA. If an employee's Military Service is for a period of time of fewer than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the Health Care FSA.

An employee may continue Health Care FSA coverage under the USERRA for up to the lesser of:

- The 24 month period beginning on the date of the employee's absence from work, or
- The day after the date on which the employee fails to apply for, or return to, a position of employment

Regardless of whether an employee continues the Health Care FSA, if the employee returns to a position of employment, the employee's Health Care FSA will be reinstated.

You should call the Plan Administrator if you have questions about your rights to continue the Health Care FSA under the USERRA.

Dependent Care Flexible Spending Account

What Can the Dependent Care FSA Do For You?

The Dependent Care FSA allows you to pay for eligible expenses with pre-tax dollars so that you and your spouse (if any) can work or attend school full time. This account allows you to:

- **Reduce the cost of eligible dependent care expenses (not health care expenses).** The amount you save is determined by the amount of income tax and Social Security tax you do not have to pay
- **Help manage your dependent care expenses.** Money must be in your account before you can be reimbursed. For example: If you have made contributions to your account totaling $300, you can be reimbursed only for up to $300 worth of eligible expenses

Eligible Dependents*

You may be reimbursed under the Dependent Care Flexible Spending Account for qualifying dependent care expenses you incur for a spouse, a child, or other individual if that individual qualifies as a "qualifying individual" for federal income tax purposes. The table below briefly summarizes requirements for a spouse or domestic partner, a child, or other individual to be a "qualifying individual."

Eligible Dependents	Spouse or Domestic Partner	Qualifying Child	Other Qualifying Person
Relationship to Employee	Your spouse or domestic partner	**Examples include your:** • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece The individual cannot be the qualifying child of any other person.	**Examples include your:** • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece • Parent • Grandparent • Uncle/aunt • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Disability Criteria	Is physically or mentally not able to care for himself or herself	No disability criteria required	Is physically or mentally not able to care for himself or herself
Residency Requirement	Will live with you for more than half of the year	Will live with you for more than half of the year and is a US citizen or national or a resident of the US, Canada, or Mexico	Will live with you for more than half of the year and is a US citizen or national or a resident of the US, Canada, or Mexico
Age Requirement	No requirement applicable	Is under the age of 13 when the care is provided	No requirement applicable
Support Requirement	No requirement applicable	If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	You will provide over half of the individual's support for the year.

*The information provided in the table above does not include all the requirements for a "qualifying individual" for federal income tax purposes. For more information on those requirements, see Sections 21 and 152 of the Internal Revenue Code and IRS Publications 503 and 501, which are available on the IRS website at **www.irs.gov**.

Eligible Dependent Care Expenses

The IRS provides information that can help you determine which dependent care expenses are eligible for reimbursement. For detailed information, see IRS Publication 503, which is available on the IRS website at **www.irs.gov**.

Here are some examples of **eligible**, reimbursable dependent care expenses:

Dependent Care Flexible Spending Account

- A qualified day care center, nursery school, or summer day camp
- A housekeeper whose duties include day care
- Someone who cares for an elderly or incapacitated dependent
- A babysitter inside or outside your home
- A relative who cares for your dependents, as long as that relative is not one of your dependents for whom you can claim an exemption or one of your children under age 19

Remember, you'll need to provide a tax ID number or the Social Security Number of the care provider when you fill out your reimbursement request.

Ineligible Dependent Care Expenses

Here are some examples of **ineligible** dependent care expenses:

Dependent Care Flexible Spending Account

- Care provided by your children who are under the age of 19, or by anyone you claim as a dependent for federal income tax purposes
- Charges for the services of a care provider who has no Social Security or taxpayer identification number
- Child support payments
- Care for days not worked — including time off or holidays — or days when eligibility requirements are not met
- Education and food from first grade on
- Expenses for care received before you were covered by the Dependent Care FSA
- Food, clothing, education, transportation, or entertainment (food and education will be covered if provided by the nursery school or day care center as part of its preschool care services)
- Residential care, such as a nursing home
- Tuition or overnight camp

Important: If you do not use all of the money in your Dependent Care FSA by the end of the year, what is left in your account will be forfeited.

How Much Should You Contribute?

Estimate Your Dependent Care Expenses

If you have never used a Dependent Care FSA, estimate conservatively until you are comfortable with how it works. If you are newly eligible for benefits, or if you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).

Dependent Care FSA vs. Income Tax Credit

The payment method that is best for you depends on your individual situation. In some cases, using the Dependent Care FSA can save you more. In other cases, you may save more by taking a credit on your federal income tax return. To help you determine whether the Dependent Care FSA or the tax credit is better for your particular situation, you may want to consult a tax specialist, contact the IRS at **www.irs.gov**, or call **1-800-TAX-FORMS** and ask for Publication No. 503.

How Flexible Spending Accounts Work

Although the accounts cover different types of expenses, they generally operate in the same way:

1. When you're first hired or become eligible, and during each Annual Enrollment period, estimate your expected eligible expenses for health care and/or dependent care for the year for which you are enrolling in coverage. **You can enroll in one account or both, depending on your needs and your family's needs.**
2. Designate the amount you want to contribute.
3. The amount you choose to contribute is automatically deducted, in equal amounts, from your paychecks on a pre-tax basis throughout the year. Your contributions are then deposited into the FSAs that you select.
4. When you incur an eligible expense during the year, you file a claim form for reimbursement (eligible Baker Hughes medical and prescription drug expenses are automatically filed for you). A claim form is available online at **BakerHughesBenefits.com** or **myuhc.com**. Refer to *Filing a Reimbursement Request* below for more information.
5. Reimbursement from your Flexible Spending Accounts is based on when the eligible expense was incurred rather than when the eligible expense was paid. Expenses must be incurred by December 31 of a calendar year to be reimbursed from the FSA for such year. Claims must be filed no later than March 31 of the following year.

Important: If you do not change the contribution amount during the next Annual Enrollment period, your contribution will automatically default to $0.

Filing a Reimbursement Request

When you have eligible expenses of $25 or more, submit your claim using a UnitedHealthcare (UHC) FSA claim form and include supporting documentation (the provider's Explanation of Benefits [EOB] or detailed receipts) as proof of services rendered. Please ensure that the supporting documentation clearly indicates the applicable date or period for which the service was provided. Submit the claim form by fax or mail as instructed on the claim form or submit a claim using the online claim form. Claim forms are available at **www.myuhc.com**, **BakerHughesBenefits.com**, and on your Benefits Center account, or you can submit a claim using the **www.myuhc.com** online claim form submission feature. If you do not have access to the Internet, call UHC at **1-866-743-6549** to request a copy of the claim form.

You may file claims for reimbursement of covered expenses at any time during the year in which they are incurred and no later than March 31 of the following year. The expenses must have been incurred during the calendar year covered by the FSA.

Reimbursements are typically processed and paid via check within two to three weeks. If you prefer to receive reimbursements directly into your bank account, log on to **myuhc.com** to set up direct deposit.

Claim activity and account balance information will be provided in a monthly Health Statement, as well as in quarterly statements. You can access these statements, as well as Explanations of Benefits (EOB) for each processed claim at **myuhc.com**.

Changing Your Contribution Amounts

IRS regulations do not permit you to stop or change the amount you contribute to a Flexible Spending Account during the calendar year unless you meet one of the following conditions:

A. With regard to both a Health Care FSA and a Dependent Care FSA, one of the following changes in status events occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent
- An event that results in a change in the employment status of you, your spouse, or dependent, including termination or commencement of employment, a strike or lockout, and the commencement of or return from an unpaid leave of absence
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age or any similar circumstances, as provided under the Health Care FSA or Dependent Care FSA

B. For individuals who participate in the Health Care FSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your Health Care FSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage
- If the Health Care FSA receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child, then the Health Care FSA Plan Administrator may change your election. The new election will provide coverage for that child if the order requires you to provide coverage for the child under the HCFSA, or permit you to cancel your child's coverage under the HCFSA, if the order requires your former spouse to provide coverage and that coverage is provided

C. For individuals who participate in a Dependent Care FSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider, or
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you

You must notify Baker Hughes within 31 days of the above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code and, to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event and that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting.

Changes in contribution amounts made during the plan year are effective on the date that you notify Baker Hughes of the change in status.

Notification of Claims Decision

Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Plan Administrator will notify you of the plan's benefit determination within a reasonable time period, but not later than:

- Baker Hughes Company Health Care Flexible Spending Account Plan (the HCFSA plan): 30 days after receipt of the claim by the plan. The Plan 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 HCFSA plan and the Plan Administrator notifies you in writing or electronically before the initial 30-day period expires
- Baker Hughes Company Dependent Day Care Flexible Spending Account Plan: 90 days after receipt of the claim by the Dependent Care Flexible Spending Account plan. The Plan Administrator may extend this period for up to 90 days, as long as the extension is necessary due to matters beyond the control of the Dependent Care Flexible Spending Account plan and the Plan Administrator notifies you in writing or electronically before the initial 90-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 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.

UnitedHealthcare will review all claims in accordance with the rules established by the US Department of Labor. UnitedHealthcare's decision will be final. The table below describes the time frames in an easy-to-read format that you and UnitedHealthcare are required to follow for the HCFSA plan.

Claim Denial and Appeals	
	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal the claim denial no later than:	180 days after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Baker Hughes must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Manner and Content of Notification of Claims Decision

UnitedHealthcare 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 review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action 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 a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request; and
- 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

Remember...

If you enroll in a Baker Hughes Medical plan and contribute to a Health Care FSA, eligible medical and prescription drug claims processed by UnitedHealthcare and prescription drug claims processed by CVS/caremark will automatically be processed through the Health Care FSA. This saves you the time and paperwork associated with submitting a claim manually. If you prefer to process these types of claims manually, you can turn off the automatic claim initiation feature online at **www.myuhc.com** or by calling UHC at **1-866-743-6549**.

What if My Flexible Spending Account Claim is Denied?

If Your Claim is Denied

If you have a question or concern about a claim reimbursement determination, you may call a UnitedHealthcare customer service representative at **1-866-743-6549** to discuss, on an informal basis, your questions regarding the determination. You may also call the number on the back of your medical ID card. If the Flexible Spending Account customer service representative cannot resolve the issue to your satisfaction, you may request an appeal as described below. This procedure is voluntary. You are not required to call UnitedHealthcare customer service before filing a formal appeal.

- **Level One:** You, your eligible dependent, or authorized representative can appeal a denied FSA claim within 180 days after you receive notification of the claim denial. If you wish to request an appeal of a denied claim for reimbursement, you, your eligible dependent, or authorized representative must submit your appeal in writing to UnitedHealthcare at the following address:

  UnitedHealthcare
  FSA Appeals
  PO Box 740380
  Atlanta, GA 30374
  Fax: 1-248-733-6148

— Your appeal must include:

- The patient's name and identification number (or Social Security Number)
- A description of the claim determination that you are appealing
- The reason you believe your claim should be reimbursed; and
- Any documentation or other written information to support your appeal

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to review the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The Level One appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim.

- **Level Two:** If you are not satisfied with the Level One appeal decision, you have the right to request a second level of appeal from Baker Hughes. Your Level Two appeal request must be submitted in writing within 60 days from receipt of the Level One appeal decision to Baker Hughes at the following address:

  Baker Hughes Company
  Attn: Total Rewards H&W Department — Appeals
  575 N. Dairy Ashford Rd., Suite 100
  Houston, Texas 77079-1117

The Level Two appeal will be conducted, and you will be notified by Baker Hughes of the decision in writing within 30 days from receipt of a request for a Level Two appeal.

Baker Hughes has the exclusive right to interpret and the discretionary authority to administer the FSA plans, and these decisions are conclusive and binding.

Notice of Benefit Decision on Appeal

Every notice of a determination on appeal will be provided in writing and, if an adverse determination is made, will include:

1. Specific reasons for denial;
2. Reference to the specific plan provisions on which the decision is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information, including any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment, or other similar exclusion or limit; and
4. A statement describing your right to bring civil action in court under Section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate legal action for benefits until you have completed the Level One and Level Two appeal processes.

Any other questions about the process for requesting a review should be addressed to UnitedHealthcare at **1-866-743-6549**.

IRS Rules and Other Limitations

Federal tax law restricts your Flexible Spending Account in several important ways:

- **No transfers.** Once you designate amounts for your Health Care and Dependent Care FSAs, you may not move money between those accounts. For example, suppose you designate $400 to each account for the year (total of $800) and you actually spend $200 for health care and $600 for dependent care. The $200 of health care expenses would be reimbursed from your Health Care FSA. You could receive reimbursement for only $400 of the dependent care expenses from your Dependent Care FSA. The other $200 of dependent care expenses would not be reimbursed, and the remaining $200 in your Health Care FSA would be forfeited after the end of the calendar year
- **Forfeitures.** If you do not incur eligible expenses during the calendar year for all of the money in your account (and file reimbursement claims for all of the money in your account by March 31 of the following year), you'll lose any money left over in your account. This means that careful planning is important in determining the amount you want to put into each account
- **Changes.** You cannot stop, increase, or decrease your Flexible Spending Account contributions until the next Annual Enrollment period, except in certain situations involving a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section)

Dependent Care Flexible Spending Account

If you're single, you can use your Dependent Care FSA to care for a dependent while you work. If you're married, you can use the account if the expenses are to care for a dependent while you work and:

- To enable your spouse to work, or look for work
- To enable your spouse to study as a full-time student for at least five calendar months during the year; or
- To provide care for your dependents if your spouse is incapable of self-care

Note: If you're a highly compensated employee, your contributions to the accounts may be reduced or suspended.

What if I Go On a Leave of Absence?

Refer to the *Leave of Absence* section in this SPD for details.

When Coverage Ends

Your coverage ends on the date your employment with Baker Hughes terminates. If you leave Baker Hughes, you'll have until March 31 of the following year to submit claims for reimbursement. Your claims for qualifying expenses must be incurred through your date of termination of employment.

If you terminate employment and would like to continue participating in the HCFSA plan, you and your covered dependents may be eligible to continue participating as authorized by COBRA. This coverage can continue for the remainder of the year in which you terminate if the amounts you must pay to continue coverage are less than the remaining benefits you can receive under the HCFSA plan. However, contributions for continuation of coverage will be on an after-tax basis and include a 2% administrator fee. Participation in a Health Care FSA cannot continue past the end of the year in which your employment terminates.

If you do not elect to continue participation under COBRA coverage, only claims incurred through your date of termination of employment can be submitted for reimbursement.

Note: You cannot continue participation in the Dependent Care FSA under COBRA.

Remember...

In order to give Flexible Spending Accounts their tax-free status, the IRS provides guidance to help you determine which health care and dependent care expenses are eligible. Eligible expenses for a calendar year must be incurred by December 31 of that year and claims must be filed no later than March 31 of the following year.

Things To Consider

Health Care Flexible Spending Account

- If you contributed to a Health Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount. In addition, please remember that contributions in 2026 will be limited to $3,300
- It might be helpful to review your health care expenses in recent years. Do you have recurring, predictable expenses? Also consider any anticipated changes that might affect your out-of-pocket expenses next year, such as a new baby
- If you're changing your medical and/or dental coverage, consider how this will affect your out-of-pocket expenses such as the deductibles, coinsurance, and out-of-pocket maximums — all of which are eligible for reimbursement under the account
- If you're enrolled in a Health Savings Account (HSA), you are not eligible to participate in a Health Care FSA

Dependent Care Flexible Spending Account

- If you contributed to a Dependent Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount
- What dependent care expenses do you expect to have during the next calendar year?
- Do you have any dependents becoming ineligible this year (for example, turning age 13)?
- Will your dependent care expenses change during the summer months and holidays?

Note:

- If you claim health care expenses for reimbursement under your Health Care Flexible Spending Account, you cannot claim them as itemized deductions on your federal tax return
- Because you pay no Social Security taxes on the amounts set aside in your account, participating in the account may slightly reduce future Social Security benefits. In most cases, the tax savings from participating should be greater than any loss of Social Security benefits

Important: Because of the tax advantages provided by these accounts, they're subject to certain Internal Revenue Code and regulation limitations. It is important to plan carefully. If you do not use all of the FSA money during the year, the Internal Revenue Code and regulation requires you to forfeit the balance in your account. You cannot carry over a credit to the next year for money left in your account at the end of the year, you cannot transfer balances between the two accounts, nor can that money be refunded to you. Focus on predictable amounts of expenses when determining if this will work for you.

Additional Resources

Via Internet: **www.myuhc.com**

- Track a claim online or access your claims history
- Locate a list of eligible expenses
- Download a claim form
- Sign up for Electronic Funds Transfer/Direct Deposit
- Find more information about how FSA plans work

Customer Service: 1-866-743-6549

Health Savings Account

Health Savings Account At-a-Glance

Type of Plan	Voluntary H&W benefit (Health Savings Account)
Who Pays the Cost	You contribute to this account on a pre-tax basis, and then you can use the HSA to pay for qualified medical expenses incurred by you and your covered tax dependents. You control your HSA funds and decide whether to use them for current medical expenses or to save your HSA funds for the future. **Note: An employee does not have to provide coverage for a dependent under a Baker Hughes Medical plan to use the HSA dollars for a dependent's qualifying medical expenses. The dependent only needs to be a qualifying tax dependent.**
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees or benefits-eligible part-time employees, and • Enrolled in the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option Employees are eligible to contribute to an HSA if: • They are covered by the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option • They and their spouse or domestic partner are not contributing to or covered by a Health Care Flexible Spending Account (FSA), even if the spouse or domestic partner is covered under his or her own plan • They are not covered by another health plan including a Health Care Flexible Spending Account • They are not enrolled in Medicare • They cannot be claimed as a dependent on another taxpayer's tax return
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with US benefits and electing the applicable Medical plan within 31 days. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). You will need to re-elect your HSA contribution amount at each Annual Enrollment period or your contribution amount will default to $0. • New Hires hired on or after November 1 will not be eligible to contribute to an HSA for the calendar year in which they are hired. • Current employees can make changes to their current HSA election on or after November 1 by contacting the Baker Hughes Benefits Center at **1-866-244-3539**.
Minimum Contribution	N/A
Maximum Contribution*	• $4,400 for You Only • $8,750 for You + Spouse or Domestic Partner • $8,750 for You + Children • $8,750 for You + Family If you are age 55 or older, special catch-up contributions will allow you to contribute an extra $1,000 in 2026.
Contact	• UnitedHealthcare via **www.myuhc.com** or at **1-866-743-6549** • Optum Bank via **www.optumbank.com** or at **1-800-791-9361**

*The maximum contribution amounts listed here include the Baker Hughes contribution, if applicable (see *Employer Contribution* on the next page.).

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Employer Contribution

If you are enrolled in the Premium HSA or Premium HSA Out-of-Area Plan and if you have an open Health Savings Account, Baker Hughes will provide an annual lump sum contribution to your Health Savings Account ($500 if you elect Individual coverage, $750 if you elect You + Spouse or Domestic Partner or You + Children, or $1,000 if you elect Family coverage). If you enroll in the Basic HSA or Basic HSA Out-of-Area option, you will not receive a Baker Hughes contribution. This contribution is subject to review and change in future years.

Benefits of an HSA

An HSA works with your high deductible health plan to help you plan, save and pay for medical care.

HSAs offer triple tax savings:*

- The money you put in is not included in your taxable income for federal income tax purposes up to the limit allowed by the Internal Revenue Code
- Your savings grow tax-free
- Any money you take out to pay for qualified medical expenses is not included in your taxable income for federal income tax purposes
- An HSA is like no other savings account. With an HSA, **you are in charge**. You decide:
  - How much you will contribute to your account (subject to certain limits imposed by the Internal Revenue Code)
  - When you want to use your savings to pay for or reimburse yourself for qualified medical expenses
  - What bank will administer your account (if it is a new account, through your employment with Baker Hughes, the HSA will be set up with Optum Bank); and
  - Whether or not to invest some of your savings in mutual funds for greater potential long-term growth

The money in your HSA is always yours — there is no "use it or lose it" rule. All amounts in your HSA belong to you, and the unspent balance remains in your account until spent. Your account is portable and will not be forfeited even if you:

- Change jobs
- Change medical coverage
- Become unemployed
- Move to another state
- Get married or divorced

*State tax treatment of HSAs varies. Go to **www.myuhc.com** or consult your state's department of revenue to find out more.

Will a Health Savings Account Work For You?

You are eligible to participate in the HSA if:

- You are enrolled in the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option
- You and your spouse or domestic partner are **NOT** contributing to a Health Care Flexible Spending Account (FSA)
- You are **NOT** covered by another health plan including a Health Care Flexible Spending Account
- You are **NOT** enrolled in Medicare. Veterans with a service-related disability are now permitted to enroll in the HDHP (with no other disqualifying coverage) and make or receive HSA contributions regardless of when they received Veterans Affairs benefits; and
- You can **NOT** be claimed as a dependent on another taxpayer's tax return

Similar to the FSA, each year at Annual Enrollment you elect the amount you want to contribute to the HSA. If you do not change your election during Annual Enrollment, your contribution will default to $0. Once you elect the amount to contribute, deductions will be taken from your paycheck on a pre-tax basis.

See the following chart for a comparison of Flexible Spending Accounts versus Health Savings Accounts.

	Health Care Flexible Spending Accounts	Health Savings Accounts
Pre-Tax	Yes	
Tax-Free Interest	No	Yes
Expense Types	Most qualified medical care expenses	
Availability of funds in the account	Available on day one	Funds must accumulate before available for use
Forfeit at the end of the year	Yes	No, accumulated amounts roll over from year to year
Portable	No	Yes
Debit Card	No	Yes

You can use your HSA funds to pay for qualified medical expenses, even if an expense is not covered by your health plan. For example, few health plans cover the cost of acupuncture, but HSAs can. Your HSA dollars also apply not only to you, but also to your spouse or domestic partner and tax dependents, even if they are not covered by your high deductible health plan.

A list of qualified medical expenses is provided by the IRS, and it includes a wide range of dental, vision, and medical expenses. You should become familiar with the list and consult it as needed to determine if an expense can be paid for with your HSA. Some covered eligible expenses include:

- Deductibles and coinsurance under the Medical, Prescription Drug, and Dental Plans
- Vision care expenses, such as eye exams, glasses, contacts, and laser eye surgery
- Hearing care expenses, including exams and necessary hearing aids; and
- Certain over-the-counter medication and drugs that are purchased for medical care, including those used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body and menstrual care products

Visit **www.irs.gov/publications/p502** for more detailed information about eligible expenses for reimbursement.

Generally, you cannot use your HSA to pay for health insurance premiums, but there are exceptions. You may use your HSA to pay for:

- Individual Long-Term Care insurance policies
- COBRA coverage
- Health plan coverage while receiving unemployment benefits; and
- If age 65 or older, any health insurance except a Medicare supplement policy (A-J), such as Medigap coverage

Visit **www.irs.gov/publications/p969** for detailed IRS information about HSAs.

If You Participate in a Health Care FSA

You have the option to participate in the HSA or the Health Care Flexible Spending Account (FSA), but you cannot participate in both accounts due to limitations imposed by the Internal Revenue Code. If you elected to participate in the Health Care FSA at the beginning of the year, you cannot contribute to the HSA at any point during that plan year.

The Dependent Care FSA is provided under a separate plan from the Health Care FSA. You may be eligible to make contributions to the Dependent Care FSA whether or not you choose to participate in the HSA or Health Care Flexible Spending Account.

Fees

Baker Hughes pays the HSA set-up fee and monthly service fees for each participating employee for HSAs administered by Optum Bank. If you are not enrolled in the Medical plan but still maintain a balance in your HSA, you will be responsible for the $3.75 monthly service fee associated with the Optum Bank account. This fee will be automatically deducted from your account each month. These fees cover a debit card and an electronic statement at no additional cost. Paper statements are available on a quarterly basis for a fee of $1.50. The debit card can be used at merchant locations, with no transaction charge, for eligible purchases up to your available account balance. ATM cash withdrawals using your card to reimburse yourself for eligible expenses, are subject to a fee of $2.50 per transaction (plus any fees that may be imposed by the owner of the ATM). For more information on the other fees associated with the account, contact Optum Bank, the administrator of the HSA.

Additional Resources

Via Internet: **www.myuhc.com**

Online banking through Optum Bank is accessible 24/7 and includes:

- Account balances and transaction history
- Interest rate and payment information
- Beneficiary information
- Contribution maximum
- Account statements
- Download the Optum Bank mobile app

Customer Service: 1-866-743-6549

Note: In order to contribute pre-tax dollars through Baker Hughes to your Health Savings Account, you must be enrolled in one of the Baker Hughes high deductible health plans (Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option), however, you can make contributions to any other HSA you have up to the allowable maximum contribution.

Using the HSA

Although the accounts cover different types of expenses, they generally operate in the same way:

1. Once your account is open and deposits have been made to your account, you can start using your HSA. You are 100% vested and have total control over the funds in your account as soon as they are deposited. You decide whether to spend your HSA funds for current medical expenses or to pay the cost of those expenses out-of-pocket so you can save your HSA money for the future.
2. Your funds will earn tax-free interest. The interest rates are set by Optum Bank and are subject to change by Optum Bank without notice. Once your account balance reaches $2,000, you will have the option to invest your HSA funds into different investment fund choices. Further information on these funds is available from Optum Bank.
3. When you incur an eligible medical expense (reference the *Medical* section for information on how the Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area options work), you can, depending on your balance, use:
   - Your Health Savings Account MasterCard Debit Card℠ at a doctor's office, pharmacy, or health care facility that accepts MasterCard debit cards to pay for care at the time of service. However, you cannot spend the funds before they are deposited into the account. If you do not have the full amount to cover your expense in the account, you can pay for the expense out-of-pocket and reimburse yourself at a later date
   - Your Health Savings Account MasterCard Debit Card℠ at any ATM displaying the MasterCard logo. There are fees imposed by Optum Bank on reimbursements made by using an ATM withdrawal
   - Online bill payment at www.myuhc.com
   - Payments can also be made using HSA dollars from the UHC mobile app and the Optum Bank mobile app
4. You have access to online monthly statements at **www.myuhc.com** to track your account balance and activity. If you prefer to have statements mailed to your home, notify Optum Bank. You can opt out of electronic statements at **www.myuhc.com** or by calling Customer Service at **1-866-743-6549**.
5. At the end of every year, any unused amounts in the HSA will automatically roll over for use in the next year. In the event you terminate employment with Baker Hughes, you may take your HSA with you from employer to employer or roll into another individual HSA.
6. Keep in mind that you must be able to substantiate your medical expenses if asked by the IRS. UHC and Optum do not require any substantiation (claims or receipts) to use your HSA dollars. If you are using your HSA funds, keep your receipts in case you need to substantiate the expense later. If you withdraw funds from your HSA for reasons other than eligible medical expenses, you will have to include that amount as taxable income and pay a 20% additional tax on that amount.

Contribution Limits

	Health Savings Accounts (HSAs)	
Minimum Contribution	N/A	
Maximum Contribution (includes Baker Hughes contribution)	• $4,400 for You Only • $8,750 for You + Spouse or Domestic Partner	• $8,750 for You + Children • $8,750 for You + Family

- Your annual HSA contribution cannot exceed the maximum contribution listed above unless you are age 55 or older and making "catch-up" contributions. However, individuals who enroll during the year (after January) and remain eligible to make contributions on December 1 of that same year may contribute the full annual contribution limit allowed for that year. Individuals who make contributions under this provision must remain eligible for the 12 months following the end of the year. Otherwise, your contributions will be included as income and subject to a 10% penalty. It's your responsibility to make sure you are enrolled in an eligible plan for the 12 months following the end of the year
- Individuals 55 and older can make additional catch-up contributions until they enroll in Medicare. Catch-up contributions will allow you to contribute an extra $1,000 in 2026. **You cannot contribute to an HSA if you are enrolled in Medicare (including Part A)**
- If you have contributed an amount into your HSA that exceeds your maximum allowable contribution for the year, you may withdraw the excess amount and any earnings on the excess amount prior to the due date, including extensions, of your tax return for the year the contribution was made (which is generally the following year). There is no additional tax or other penalty on withdrawals of excess contributions that are made in a timely manner. However, you must pay income tax on your excess contributions and income tax on any earnings on the excess contribution
- If you do not withdraw the excess contribution to your HSA in a timely manner, you must pay a 6% excise tax on the excess contribution and on any earnings on the excess contribution. If in the next year you decreased your maximum contribution by the amount of your excess contribution made the year before, you do not have to pay the 6% excise tax again. If, however, you leave the excess contribution in, and do not decrease your maximum contribution by the amount of your excess contribution made the year before, you will have to pay the 6% excise tax each year the excess contributions and earnings remain in the HSA

Health Savings Account Funding Rules

When considering your annual contribution amount, keep in mind the Employer contribution is included in the annual plan maximum. If you are enrolled in the Premium HSA or Premium HSA Out-of-Area Plan and elect to participate in the Health Savings Account, Baker Hughes will provide an annual lump sum contribution to your Health Savings Account ($500 if you elect Individual coverage, $750 if you elect You + Spouse or Domestic Partner or You + Children, or $1,000 if you elect Family coverage). If you enroll in the Basic HSA or Basic HSA Out-of-Area option, you will not receive a Baker Hughes contribution.

When Your Account is Funded

When your account is funded depends on if you are a current employee or a new hire. The Company and its affiliates reserve the right to discontinue employer-funded contributions to the Health Savings Account or change the funding rules at any time.

Current Employees

The full amount of any Baker Hughes contribution will appear in your account at the time of the second paycheck of the year. You must be an active employee to receive the contribution. Your contributions will be made with each pay period, beginning with the first paycheck of the year.

If the Company does not receive an account number from Optum Bank before the final paycheck of the year, the employee will not be eligible to receive the employer contribution.

New Hires

Both your funding and any funding from Baker Hughes will not occur until after the 30-day new hire enrollment period has ended. Funding will be pro-rated based on your date of hire. Here is an example.

If You Were Hired On ...	You Must Make Your Enrollment Elections by ...	You Will Receive Your HSA Contributions ...
February 1	March 1	after March 1, as soon as is administratively feasible, with each paycheck, through the end of the year.

If Your Employment Terminates

If your employment terminates, the funds in your HSA, including the employer contribution, will continue to be owned and controlled by you. If you are rehired during the same plan year, you will not be eligible for additional employer funding upon reinstatement of your employment.

Eligible Expenses

In order to allow HSAs to retain their tax-free status, the IRS determines which medical care expenses are eligible. It is very important that you save all of your medical care receipts and records of withdrawals from your HSA for tax reporting to the IRS. Please refer to the charts in the *Flexible Spending Account* section for some examples of eligible, reimbursable medical care expenses. Consider using the Receipt Vault on **www.OptumBank.com** or on the Optum Bank Mobile App.

Ineligible Expenses

Any funds you withdraw from your HSA that are not used for qualified medical expenses will be subject to federal income tax at your income tax rate plus an additional tax of 20%. You should save all of your receipts and records of withdrawals for tax reporting to the IRS. If you use your funds for non-qualifying expenses, you must report those withdrawals accordingly. You are responsible for maintaining all records associated with your HSA — neither Baker Hughes nor Optum Bank are responsible for documenting how you use the amounts that are distributed from your HSA.

Withdrawals that were made for what you reasonably thought were qualified medical expenses, but turned out not to be, may be eligible to be returned to the HSA on or before April 15th following the year in which you mistakenly withdrew the funds. Contact Optum Bank for more information.

Please refer to the chart in the *Flexible Spending Account* section for some examples of expenses the IRS considers ineligible for reimbursement.

Important: Be sure to keep your receipts and medical records. You are responsible for saving receipts and keeping track of all expenses paid from your HSA funds, in case you need to prove to the IRS that distributions from the HSA were for qualified medical expenses.

If these records verify that you paid qualified medical expenses using your HSA, you are not required to include the amounts withdrawn to pay such expenses in your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified medical expenses, you may need to report the distribution as taxable income on your tax return. Baker Hughes and UnitedHealthcare will not verify that distributions from your HSA are for qualified medical expenses.

The IRS will likely request receipts during a tax audit. Baker Hughes, Optum Bank, UnitedHealthcare, and the Claims Administrator are not responsible or liable for the misuse of HSA funds or for the use of HSA funds for non-qualified medical expenses.

You can download an expense tracking worksheet through **www.myuhc.com** to help you maintain your records or you may use your own money management software. Consider using the Receipt Vault on **www.OptumBank.com** or on the Optum Bank Mobile App. If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and possibly an additional 20% tax. Consult your tax advisor to determine how your HSA is impacted by your unique tax situation.

What if I Go on a Leave of Absence?

If you go on an unpaid leave of absence, HSA deductions will cease. However, if you continue to be covered under the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option, you can continue to make contributions to your HSA by sending in contributions directly to Optum Bank. Contact Optum Bank directly by calling **1-866-743-6549**. Upon return from an unpaid leave, contact the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) to arrange for your contributions to resume.

Note: If you are on an unpaid leave in January when the employer seed amount is applied, your account will not receive the employer seed. Upon your return to an actively at work status, the employer seed will be applied and prorated based on your date of return.

When Coverage Ends

If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the high deductible health plan in which you were enrolled. You can use HSA funds on a tax-free basis for qualifying medical expenses incurred AFTER the establishment of your HSA, as long as these expenses are not paid or reimbursed through another health plan.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are received by you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the Medical plan and COBRA premiums while COBRA coverage is in effect.

Emotional Wellbeing Solutions (EWS) – the Employee Assistance Program

EWS At-a-Glance

Type of Plan	Voluntary Health & Welfare program
Who Pays the Cost	EWS benefits are paid by Baker Hughes and are free to all eligible employees
Employee Eligibility	All eligible employees, their dependents, and household members*
When Coverage Begins	Coverage begins on your date of hire or date of transfer
Enrollment Period	No enrollment necessary
Plan Information	Confidential counseling, legal, financial consultation, and referrals to help you respond to personal issues or concerns
Benefits	• Up to five counseling sessions per issue, per year with a licensed mental health provider either virtually or in person • Guaranteed appointments: virtual appointments in 2-days and in person appointments within 5-days • Virtual Behavioral Coaching available as an alternative to therapy. A personalized, coach-led and self-paced behavioral coaching program focusing on reducing symptoms of generalized and/or social anxiety and general depression • 24-hour, seven days a week telephonic access to in the moment crisis counseling, consultation, and referral services • Nationwide community resource referral • Legal and financial consultation services
Contact	• Online at **www.liveandworkwell.com** and enter the access code "BakerHughes" • Speak to experts at **1-855-409-7074** (24 hours a day, seven days a week) • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

**Household member is defined as an individual who physically resides in the household of an employee on a permanent basis and includes an eligible dependent of an employee even if the dependent does not reside with the employee.*

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

How EWS Works

The Baker Hughes Emotional Wellbeing Solutions Program (EWS) will provide you or your household member with unlimited telephonic in the moment support for episodic needs, virtual behavioral coaching, and up to five in person or virtual counseling sessions per issue per year for assessment and referral, or short-term therapy. EWS may refer you for outside counseling or treatment services if you need longer-term counseling, a higher level of care or a specialist. Should this occur, and you are covered under the Medical plan, you may have additional mental health and substance abuse benefits available to you through the Medical plan.

Additional Resources

Via Internet: **www.liveandworkwell.com** and enter the access code "BakerHughes"

- Learn about available services and programs
- Find information and tools to help with life's challenges

Customer Service: 1-855-409-7074

How to Use EWS

1. Log on to Optum's website at **www.liveandworkwell.com** and enter the access code "BakerHughes".
2. Call Optum's dedicated, confidential, toll-free line at **1-855-409-7074**, 24 hours a day, seven days a week.
3. Download the App "myLiveandworkwell" available in the Apple Store and Android Play.

If you are referred for outside counseling or treatment services and you are not a participant in the Medical plan, then there is no further benefit available. This is significant because outside counseling is not included with EWS. Subsequent mental health benefits not covered by EWS may be available if you are enrolled in a Medical plan option.

EWS can assist you and your household members with stress, depression, parenting issues, relationship problems, and substance abuse. You may contact EWS for a recurring or new situation at any time, as long as the eligibility criteria are met.

Services provided to help you or your household member are:

- Up to five counseling sessions per issue, per year with a licensed mental health provider either virtually or with an in-person provider
- Virtual Behavioral Coaching available as an alternative to therapy.
- Telephone counseling
- Unique online service site (**www.liveandworkwell.com**) available 24/365 providing online self-assessment tool, personalized program recommendations and, access to self-improvement support articles and education; and
- Access to convenience services designed to save you time and possibly money. Personalized research and referrals for:
  - Cleaning and domestic help
  - Home improvement and repair
  - Car maintenance and repair; and
  - Fitness and recreation opportunities near you.

Examples of some personal problems addressed are:

- Adult/elder care services
- Alcohol or drug abuse
- Cautions on prescriptions
- Child care and elder care resource referrals including Solutions for Caregivers
- Education and schooling
- Emotional problems
- Family difficulties
- Financial issues
- Financial pressures
- Grief, depression, and stress issues
- Health and medical information
- Information about self-care and illness/disease prevention
- Legal problems
- Marital difficulties

- Minor medical emergencies
- Parental difficulties
- Personal legal
- Personal safety and violence issues; and
- Separation or divorce

You don't have to pay any fees for phone counseling services, and these services are unlimited. A team of EWS professionals including masters-level counselors is available to speak with you 24 hours a day, 365 days a year. These professionals will answer your questions, listen to your concerns, and help you identify and work toward resolving the problem. In addition to helping you over the phone, the counselor may refer you to other resources in your community, such as professional, legal, or financial consultation in addition to resources specific to elder/child care needs, when appropriate. The counselor may follow up with you to make sure you received the help you needed.

EWS Additional Services

Whether you or an eligible family member is facing a difficult personal problem, a stressful work environment, or a serious concern such as depression, EWS is there to offer assistance. In addition to the five free counseling sessions described under *How EWS Works*, you can receive resources and referrals for a variety of other services. Additional EWS services include:

- Consultation and qualified resource referrals for child care, elderly parent care, and disabled dependent care
- Telephonic financial consultation; two 30 minute telephonic financial consultations per problem, per year
- Family mediation service providers for a free 30-minute telephonic or face to face consultation and referrals to local mediators whose services are available at a 25% discount
- Self-help support groups for issues such as depression and alcohol, drug, or food abuse
- Community financial assistance with debt management and budget planning; and
- Legal services, including a referral to a lawyer for either a 30-minute telephonic or face-to-face consultation. Additional legal services are available at a 25% discount

Program Costs

EWS is currently provided at no cost to employees. However, Baker Hughes reserves the right to institute an arrangement by which employees will share in or pay a portion of the cost of this benefit. All costs of administering EWS will be paid out of general assets of Baker Hughes and shall be entirely unfunded.

When Coverage Ends

You and your eligible family members may use EWS while you are employed by Baker Hughes. Coverage under this Program continues while you are on a family, medical, military, or personal leave. Coverage may continue as provided under COBRA. In the event that your position at Baker Hughes is eliminated, coverage will continue in accordance with Baker Hughes' severance policy in effect at the time of job elimination.

Protection

Protection benefits provide financial protection for you and your family in the event of an accident, disability, or death.

These benefit plans include:

- Short-Term Disability
- Long-Term Disability
- Basic Life Insurance
- Supplemental Life Insurance
- Basic Accidental Death & Dismemberment Insurance
- Voluntary Accidental Death & Dismemberment Insurance
- Business Travel Accident Insurance Plan
- Legal Plan
- Critical Illness Plan
- Accident Protection Plan

Designate a Beneficiary for your Protection Benefits.

You need to designate one or more beneficiaries for the following benefits:

- Basic Life Insurance
- Basic AD&D Insurance
- Supplemental Life Insurance
- Voluntary AD&D Insurance

Make sure you have the birth date and Social Security Numbers of your beneficiaries. If you don't designate a beneficiary, the benefit will be paid according to the terms and conditions of the plan.

You can designate a beneficiary online or via the telephone.

Via Internet: go to **BakerHughesBenefits.com**

Via Telephone: **1-866-244-3539**

It's a good idea to review your beneficiary information from time to time. If you have a qualified change in status, you may want to re-evaluate or update your beneficiary information.

Short-Term Disability

Short-Term Disability At-a-Glance

Type of Plan	Payroll practice that provides income replacement if an employee becomes disabled because of outpatient surgery, hospitalization, or is unable to work due to illness, pregnancy, the birth of a child (based on type of birth), or injury
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Short-Term Disability coverage
Employee Eligibility	Active Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary.
Coverage	100% of benefits base pay weeks 1 up to 8 weeks and 75% weeks 9 up to 26 weeks, or terms of a union agreement, if applicable. Pay is based on a 5 day, 40-hour week and clinical determination is made by Sedgwick.
Elimination Period	Benefits begin on the first day of disability due to outpatient surgery, the birth of a child or hospitalization, or after seven consecutive calendar days for illness, pregnancy complications, or injury. **Note: The elimination period can be satisfied with partial and/or total days of disability.**
Contact	• To initiate a claim: Call Sedgwick at **1-877-423-8677** or go online at **www.mysedgwick.com/bakerhughes** • Baker Hughes Benefits Website: **BakerHughesBenefits.com** • For medical or financial benefit questions, contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

What is Short-Term Disability?

Baker Hughes Short-Term Disability (STD), administered by Sedgwick, allows you to continue to receive a percentage of your benefits base pay when you're unable to work as a result of an illness or injury that occurs either on or off the job. Short-Term Disability also pays benefits when you're unable to work as a result of pregnancy or illness. If you're eligible, Baker Hughes will automatically enroll you for coverage, and your coverage will begin on your first day actively at work. This benefit does not cost you anything; Baker Hughes pays the full cost of the STD premium.

Definition: For STD, Disabled or Disability means that either:

- You're prevented from performing the material and substantial duties of your regular occupation and you aren't working in any occupation that you are qualified to do based on your level of education, training, or experience,

OR

- You're working, but due to injury or sickness, you are unable to earn more than 80% of your regular pay in any occupation for which you are qualified based on your level of education, training, or experience.

To be eligible for STD under the Baker Hughes plan, you must be under the regular care of a physician. Your physician must be someone other than you or a family member, and his or her specialty or expertise must be appropriate to treat your disability.

If you remain approved for disability benefits for more than 26 weeks (the 26-week elimination period equals 180 days total), Sedgwick may assist you in transitioning to Long-Term Disability coverage with Prudential, if eligible. See the *Long-Term Disability Plan* section for more information.

What is the Employee's Cost of Short-Term Disability?

You do not contribute anything to receive STD coverage. Baker Hughes pays 100% of the cost of the benefit.

When Does Coverage Start?

Baker Hughes provides you with STD coverage on the first day you report to work. No enrollment is necessary.

The elimination period begins on the day you become disabled. The elimination period is a period of continuous disability which must be satisfied before you begin receiving STD benefit payments. The elimination period can be satisfied with both partial and/or total days of disability. By request, you may use Personal Illness/Personal Business (PIPB) or vacation time during this period. Exempt employees will be paid during the elimination period under the permissive approach to paid time off once the STD claim has been approved.

If your disability is a result of a hospitalization, the birth of a child, or outpatient surgery, payment of the STD benefit begins on the day that you are admitted into the hospital or outpatient facility. If your disability is a result of illness, pregnancy complications, or injury, STD benefit payments will begin after seven consecutive calendar days.

Definition: Elimination Period means a period of continuous disability that must be satisfied before you will begin to receive disability benefit payments. Your elimination period begins the day you become disabled. You will not be paid STD during the Elimination Period. However, PIPB for up to 26 weeks, and/or vacation days may be requested and used concurrently during the Elimination Period. If your inactive status continues beyond 26 weeks of STD, you will be direct billed for benefit continuation.

Although coverage begins on the first day you report to work, in order to receive STD, you must initiate a claim with Sedgwick and your physician must complete the required paperwork necessary to determine approval. The paperwork must be submitted to Sedgwick on or before the medical due date provided to you on the date you initiated your claim.

STD Schedule of Benefits

Minimum benefit payment:	None
Amount of benefit:	100% of benefits base pay for weeks 1 up to 8 75% of benefits base pay for weeks 9 up to 26 (Based on clinical review by Sedgwick)
Elimination period:	None for hospitalization, the birth of a child, or outpatient surgery; 7 days for illness, pregnancy complications, or injury
Maximum period of coverage:	Based on the clinical determination made by Sedgwick, coverage may continue for up to 26 weeks (the 26-week elimination period equals 180 days total), or the date you are no longer disabled, whichever is earlier

Note: Your Short-Term Disability benefits may be reduced by other disability income benefits. Additionally, the duration of your Short-Term Disability benefits is determined by Sedgwick's clinical review. See below for an explanation of other disability income benefits.

All STD benefit payments are taxed as ordinary income. Deductions normally taken from your paycheck will continue to be deducted from your STD benefit payments. If your STD benefit payment is not enough to cover the entire cost of your benefit deductions, you will be responsible for the premium payments. You will either be direct-billed through the Baker Hughes Benefits Center or will pay the premiums through payroll arrears upon your return to work.

Other Disability Income Benefits

Your STD benefit payments will be reduced (offset) by other disability income benefits you're eligible to receive, such as:

- State disability benefits
- Social Security disability benefits for either you or your dependents
- State-mandated paid family leave regulations
- Workers' Compensation benefits; and
- Damages for loss of income that you recover from a third party as a result of your disability, such as no-fault auto insurance

Note: Employees residing in a state that provides Paid Family Leave, must contact their respective state to initiate a claim concurrently with FMLA and/or STD.

If you receive other disability income benefits in addition to STD benefits from Baker Hughes, an overpayment may result. **As a condition of receiving STD benefits, you agree to return or pay back any overpayments to Baker Hughes.**

If you are receiving Workers' Compensation benefits due to an occupational disability and the amount of your Workers' Compensation award is less than your regular pay, you may also be eligible to receive STD benefit payments.

If the amount of your other disability income benefits is greater than your regular pay, you will not receive STD benefit payments. In this situation, you will be direct billed for benefit continuation or arrears will accumulate and repayment will be due upon return to work or termination of employment if you do not return.

Note: After 26 weeks, you may be eligible to receive LTD benefit payments. Contact Prudential as soon as possible to ensure you understand the qualifications for being considered disabled under the LTD plan and to ensure prompt payment of LTD benefits. In order to maintain medical coverage, you will be direct-billed from the Baker Hughes Benefits Center.

STD and FMLA

If you have a qualified Family and Medical Leave Act (FMLA) or state-specific Family and Medical Leave absence from work that is due to your illness, you may also qualify for STD benefits. For more information on how STD and FMLA coordinate, please contact Sedgwick at **1-877-423-8677**.

Note: STD leave will run concurrently with FMLA and/or state-specific leave, if eligible. FMLA is calculated on a "rolling back" basis. The "rolling back" period applies to determine how much of the 12-week leave entitlement has not been used during the immediately preceding 12 months.

Employees residing in a state that provides Paid Family Leave, must contact their respective state to initiate a claim concurrently with FMLA and/or STD.

How to Calculate Your STD Payment

Short-Term Disability pay is based on a 5 day, 40 hour work week regardless of an employee's standard work schedule. Benefits base pay for disability is your pre-disability regular base earnings excluding any bonuses, any premium pay (such as overtime, lead pay, shift differentials, and allowances) fringe benefits, and employee benefits.

1. Calculate the regular STD benefit payment, and
2. Subtract any other disability income benefits for which you're eligible

Example - Paul:

Paul is an STD-eligible employee. He wakes one day, not feeling well and running a temperature. After notifying his boss, he doesn't report to work. Two days later, after not feeling any better, Paul visits his physician and is told that he has bacterial pneumonia and can't return to work for another three weeks. After speaking with his boss, Paul contacts Sedgwick to apply for Short-Term Disability. Sedgwick confirms the disability, approving benefits for a three-week disability duration. Paul is away from work for a total of three weeks.

Paul's regular biweekly pay when he becomes disabled is $1,800. Because his disability results from an illness, his STD benefits start after he is unable to work for seven calendar days. Paul receives $1,800 total in STD benefits.

First 7 Days	STD waiting period (If Paul is an hourly employee, he can use PIPB, no pay, or vacation during this time)
Next 7 Days	$900 weekly benefit
Final 7 Days	$900 weekly benefit
Total STD benefit payment to Paul	**$1,800**

Example - Mary:

Mary is an STD-eligible employee whose primary residence is in New York. Mary goes on maternity leave and will be out for 8 weeks. Mary's regular biweekly pay when she becomes disabled is $2,000. Because Mary lives in New York she will be eligible for the state of New York disability benefit.

Mary's disability is due to the birth of a child, her STD benefits are not subject to the elimination period and start immediately.

Mary's weekly STD benefit is $1,000.

Mary receives $170 per week from NY disability. This results in an adjusted STD benefit of $830 per week ($1,000 - $170).

Recurrent Disability

A recurrent disability is one that is related to an earlier disability for which you received the STD benefit. A recurrent disability is considered part of your earlier disability claim if, after receiving STD benefits, you:

- Return to your regular job on a full-time basis for less than 15 calendar days, and
- Perform all the regular and essential duties of your job

If you return to your regular job on a full-time basis for 15 calendar days or more and then become disabled again, this will be treated by Sedgwick as a new period of disability. If your disability is a result of an illness, injury, or pregnancy complications, you must complete another seven-day elimination period.

Light Duty and Workplace Modification

During your disability, you may be able to return to work through participation in light duty or workplace modification. During this time, you will continue to receive 100% of regular pay for time worked and up to 100% of benefits base pay for time off (STD benefits) from weeks 1 through 8. From weeks 9 through 26, you will continue to receive 100% of regular pay for time worked and up to 75% of benefits base pay for time off (STD benefits).

Note: Short-Term Disability does not pay benefits if you refuse to participate in light duty or workplace modification.

How Long Will STD Benefit Payments Continue?

STD benefit payments continue up to recovery (the 26-week elimination period equals 180 calendar days total) or whichever is earlier of the following:

- You fail to furnish proof that you're continuously "approved" by Sedgwick as disabled
- You're no longer under the regular care of a physician
- You refuse to be examined, if an examination is required
- You fraudulently misrepresent your need for disability
- You return to any work other than work approved by Baker Hughes
- You refuse to participate in light duty or workplace modification
- You die
- You cease to be disabled; or
- You cease to be covered under STD coverage

Note: If you separate from service from the Company and are on an approved disability claim at the time of separation from service, your STD benefits may continue with proper medical documentation to support your continued need for disability benefits.

Continuation of Health & Welfare Benefits While on STD

Your H&W benefits will continue while you are receiving STD benefit payments except in the event of termination of employment. Deductions will be taken as usual. If your employment with Baker Hughes is terminated while you are receiving STD benefit payments, your H&W benefits will also terminate. You may be eligible to continue your group health plan coverage through COBRA if you had coverage before your disability began. Refer to the *Benefits Rights* section for more information.

If you have questions regarding your benefits or benefit deductions while you are receiving STD benefit payments, please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

Short-Term Disability Process

Disability results from illness, pregnancy complications, or injury

Will you be off work for more than seven days?

Yes

Call Sedgwick on day 4 to initiate a STD claim.

No

Start PIPB leave and let your manager know when you'll return to work.
Absences for three or more consecutive days require a call to Sedgwick for FMLA or State Leave Purposes.

Disability results from hospitalization or outpatient surgery

Note: for FMLA and/or state disability, we require that EEs call Sedgwick on day 4 (after 3 days of time away for illness or injury).

Step 1 Call Sedgwick at **1-877-423-8677** or go online at **www.mysedgwick.com/bakerhughes**.

You will need to provide Sedgwick authorization to access your medical information by completing a Medical Authorization for Release of Information form and providing a copy to both Sedgwick and your physician.

Step 2 Sedgwick will ask you for the following information:

- Employee name, Social Security Number, date of birth, date last worked, date of hire
- Employer's name, address, and telephone number
- Manager's name and telephone number
- Physician's name and telephone number
- HR representative's name and telephone number
- Description of illness or injury
- Description of job or occupation
- Last day worked
- Estimated return to work day

Step 3 Once your claim is approved by Sedgwick, Short-Term Disability payments will be coordinated with Payroll. Short-term disability payments will continue as long as you meet the definition of disability, up to 26 weeks, whichever is earlier.

STD Exclusions

What Is Not Covered

Short-Term Disability does not pay benefits if your disability is caused by, contributed to, or resulting from:

- Committing or attempting to commit a felony
- Elective plastic surgery (complications related to plastic surgery may be a covered benefit)
- Non-medically necessary elective surgeries

In addition, benefits are not payable for any period during which:

- You are confined to a penal or correctional facility
- You are not under the care of a physician; or
- You are not eligible for coverage under Short-Term Disability

Termination of Coverage

Your STD coverage will end when:

- You do not provide requested medical information to Sedgwick
- Baker Hughes stops providing Short-Term Disability
- You no longer satisfy the requirements for being considered disabled for STD purposes
- You retire
- You cease to be eligible for coverage. You will cease to be eligible for coverage on the date you are no longer actively at work, if you are not disabled on that date; or
- You die

How Do I File a Short-Term Disability Claim?

Call Sedgwick at **1-877-423-8677** or go online at **www.mysedgwick.com/bakerhughes** on day 4 of your absence or as soon as possible thereafter to file an STD claim.

When you call to file your claim, Sedgwick will ask you for the following information:

- Name, Social Security Number and/or Employee ID, Workday ID, date of birth, date last worked, estimated return to work date, and date of hire
- Employer's name, address, and phone number
- Manager's name and phone number
- HR representative's name and telephone number
- Physician's name and phone number
- Description of illness or injury
- Description of job or occupation

Note: If you are unable to call, a family member, close friend, or your manager can make the call for you.

Sedgwick will review the requested information and determine whether your claim is approved or denied. If your claim is approved, bi-weekly STD benefit payments will be made directly to you through the Baker Hughes payroll.

Periodically, Sedgwick may request additional information about your disability. Remember, it is ultimately your responsibility to ensure all requested information is provided to Sedgwick. Your physician's failure to provide necessary medical documentation may result in a delay or suspension of your STD benefit payments.

You will not receive STD payments or pay during the elimination period until your claim is approved by Sedgwick. STD pay is paid on a biweekly basis on Baker Hughes regular pay cycles, and this timing could result in a delay in payment depending on when the claim decision is rendered.

Medical Authorization

When filing a claim for STD benefits, you **must** provide Sedgwick authorization to access your medical information by completing a Medical Authorization for Release of Information form and providing a copy to your physician.

You can obtain the Medical Authorization for Release of Information form by calling Sedgwick at **1-877-423-8677**.

Disability Claims Denial Notice

You will receive written notice of Sedgwick's claim decision. If your claim is denied, the notification will include:

- Specific reasons for the denial
- Specific provisions on which the decision is based
- A description of any additional material or information necessary for the claim to be completed, as well as an explanation of why such material or information is necessary
- A description of the review procedures and their applicable time limits
- A description of any internal rules, guidelines, protocols, or other similar criteria instrumental in the decision-making, or a statement that the decision was based on the applicable items mentioned above. In this case, Sedgwick provides you with copies of the applicable material upon request (free of charge); and
- An explanation of the scientific or clinical judgment used in the decision regarding medical necessity, experimental treatment, or similar exclusion or limit. The decision applies the terms of the benefit to your medical circumstances, or you will receive a statement that an explanation will be provided upon request (free of charge)

Appealing a Denied Disability Claim

Appeals must be in writing and should be submitted to the Appeals Unit address below:

Sedgwick
Appeals Unit
P.O. BOX 14446
Lexington, KY 40512-4446

Complete the Baker Hughes STD Appeal Form and include the following information:

- Claim Number
- Employee name
- Address
- Telephone Information
- Physician Information
- Reasons for requesting the appeal
- Additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim

The appeal decision will be communicated directly to you and/or your duly authorized representative.

You, or your authorized representative, will have 180 days after receiving notice that your disability claim is denied to appeal the decision in writing to Sedgwick, as well as submitting any information relevant to the claim (e.g., written comments, documents, records).

In addition, Sedgwick provides you with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

At the first level of appeal, the claimant submits additional proof of disability to the original claims adjuster. If this additional information changes the decision of the denial, then the claim resumes payments. If not, then the claim would go to the second step of appeals as outlined below.

A plan fiduciary, who had no role in the initial claim denial, reviews your appeal. The review is independent and will not give the original denial any special consideration.

If a medical judgment is involved, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved and who had no role in the initial claim denial.

Sedgwick notifies you of the appeal decision within 45 days after Sedgwick receives your request for review. If there are special circumstances requiring a delay, you will be notified of the final decision no later than 90 days after your request for review is received.

Special Circumstances Requiring Delay of Appeal Decision

Under normal circumstances, you will be notified in writing of the final decision within 45 days of the date your request for review is received. If there are special circumstances requiring a delay, the period can be extended (before the end of the original 45-day period) as the result of matters beyond the control of Sedgwick. Any notice for extension before the end of the original 45-day period will further explain:

- The reason for the extension and when Sedgwick expects to rule on your claim
- Standards on which the right to a benefit is based
- Unresolved issues that prevent a decision on the claim; and
- Additional information needed to resolve those issues

Please note that you will be notified of the final decision no later than 90 days after your request for review is received.

How Short and Long-Term Disability Benefits Work Together

Short-Term and Long-Term Disability benefits work together, when applicable. Short-Term Disability benefits are payable for the first 26 weeks of disability, and then, if you continue to be disabled, Long-Term Disability benefits may take over. STD and LTD have different provisions, but both are offered to protect you and your family from loss of income in the event of an injury or illness that does not allow you to work. If you are receiving STD benefit payments and continue to be eligible for disability coverage, Sedgwick automatically transitions your claim to Prudential for LTD consideration.

Long-Term Disability

Long-Term Disability At-a-Glance

Type of Plan	Welfare benefit plan that provides income replacement if an employee continues to be disabled for more than 26 weeks (the 26-week elimination period equals 180 days).
Who Pays the Cost	Baker Hughes pays 100% of the cost of Core LTD coverage. However, you pay the additional cost if you elect LTD Buy-up coverage.
Employee Eligibility	Active employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees • Union employees, if applicable
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Coverage Options	• Core coverage • Buy-up coverage
Enrollment Period	**Core coverage:** No enrollment necessary **Buy-up coverage:** • New hires and employees transferring to a position with US benefits, within 31 days. If you do not enroll, you'll default to Core coverage • Employees can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year or you will default to core coverage only
Coverage*	**Core coverage:** • If disabled, the Core coverage will pay you 50% of your pre-disability base pay earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the LTD Schedule of Benefits section for the maximum period payable if you're 62 or older when your disability occurs • Maximum monthly benefit is $15,000 per month • Mental illness is covered for up to 24 months within your lifetime • Medical coverage is continued for a maximum of 24 months if you had coverage in place and premiums are maintained while on LTD **Buy-up coverage:** • If disabled, Buy-up coverage will pay you 60% of your pre-disability base pay earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the *LTD Schedule of Benefits* section for the maximum period payable if you're 62 or older when your disability occurs • Maximum monthly benefit is $15,000 per month • Mental illness is covered for up to 24 months within your lifetime • You must be actively at work to be eligible for the LTD buy up plan. If you elect buy-up coverage while on a Leave of Absence, your new coverage will not begin until you return to an active work status • Medical coverage is continued for a maximum of 24 months if you had coverage in place and premiums are maintained while on LTD
Elimination Period	26-week elimination period (which equals 180 days total). (During this time, you may be eligible for Short-Term Disability benefits. See the *Short-Term Disability* section for details.) The LTD elimination period is the greater of the Short-Term Disability maximum benefit period or 180 days.
Contact	• For questions regarding LTD benefit payments: Call Prudential at **1-800-842-1718** • For questions regarding the plan or about your benefits while on LTD: Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) • Baker Hughes Benefits Website: **BakerHughesBenefits.com**

Note: Do not rely on the chart on the prior page alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage. This section of the SPD summarizes certain provisions of the LTD plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **BakerHughesBenefits.com**, prepared by Prudential, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

What is Long-Term Disability?

Becoming permanently disabled or having an extended disability can have devastating financial implications by taking away your ability to make a living. While some people can get by without working for a few months, few people can afford to stop working altogether for an extended period of time. That's where the Baker Hughes Company Long-Term Disability Plan (the LTD plan) can help you. The LTD plan benefit picks up generally where your Short-Term Disability (STD) benefit leaves off and offers coverage for you if you are disabled because of a qualifying illness or injury. You will receive Core LTD coverage at no cost. However, you may purchase additional LTD coverage. The LTD plan is funded by an insurance policy issued by Prudential.

Definition: Disability or Disabled means that due to illness or as a direct result of accidental injury:

- You are unable to perform the material and essential duties of your regular occupation due to your sickness or injury; and
- You are receiving regular care from a doctor, and
- You have 20% or more loss in your monthly earnings due to that sickness or injury

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury:

- You are unable to perform the duties of any gainful employment for which you are reasonably fitted by education, training or experience; and
- You are under the regular care of a doctor

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this SPD. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

Note: On each July 1, Prudential will adjust your pre-disability earnings by the lesser of the current annual percentage increase in Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) or 10%.

What is the Employee's Cost of the LTD Plan?

LTD Core coverage is available at no cost to you. If you elect additional LTD Buy-up coverage you pay the cost of the additional benefit. Your contribution is automatically deducted from your paycheck on a before-tax basis.

When Coverage Starts

Coverage starts on the first day you are actively at work if you enroll within 31 days from your date of hire. If you're either a newly hired regular full-time employee or a benefits-eligible part-time employee (scheduled to work at least 20 hours per week), you're eligible to enroll for Buy-up coverage under the LTD plan. You will automatically receive Core LTD coverage, which is effective on your first day of active work. However, you must elect additional Buy-up coverage within 31 days from your date of hire.

If you do not enroll within 31 days from your date of hire, you'll lose your right to elect Buy-up coverage until the following Annual Enrollment period or you experience a qualified change in status as defined in the *General Information* section.

When LTD Benefit Payments Start

Your LTD benefit payments will begin after a qualifying illness or injury has forced you to be away from work for 180 days and Prudential has made a determination about your claim. The Long-Term Disability elimination period is stated as the greater of the Short-Term Disability (STD) maximum benefit period or 180 days, and the elimination period can be satisfied with both partial and total days of disability. Your LTD payment will be paid by Prudential.

Disability coverage generally will be continuous from Short-Term Disability to Long-Term Disability.

Definition: Elimination Period means a period of continuous disability that must be satisfied before you will be eligible to receive disability benefits. Your elimination period begins the day you become disabled. Your elimination period for LTD benefits is the greater of 180 days or the date your STD benefits end. The LTD elimination period is stated as the greater of the STD maximum benefit period or 180 days.

LTD Schedule of Benefits

Pre-disability earnings means your gross monthly income, including field pay and 401(k) deferred compensation in effect just prior to your date of disability. It does not include income received from commissions; awards and bonuses; overtime pay; car allowance; housing allowance; lead pay; cell pay; machine pay; shift differentials; the grant, award, sale, conversion, and/or exercise of shares of stock or stock options; the contributions on your behalf to any deferred compensation arrangement or pension plan; or any other compensation from Baker Hughes.

Minimum benefit payment:	$25 per month*
Maximum benefit payment:	$15,000 per month
Amount of benefit:	Core coverage: 50% of your pre-disability earnings
Maximum period of coverage:	Up to age 65, or until you're no longer disabled, whichever is earlier. Mental and substance abuse disabilities are covered for up to 24 months in your lifetime.
Medical benefit continuation:	Maximum of 24 months if you had coverage in place and premiums are maintained while on LTD.

*Subject to overpayment and rehabilitation incentives. May continue past age 65, depending on the age of onset (see chart below).

At the onset of a disability, if you are age 62 or older, the following table will apply if you are deemed eligible for LTD due to accidental illness or injury (excluding disability due to substance abuse or mental health issues). All LTD benefit payments are made by Prudential and are taxable for federal income tax purposes. You will receive LTD payments and a W-2 from Prudential for any LTD payments.

Age at LTD Onset*	Maximum Benefit Period Core Coverage or Buy-up Coverage
Prior to age 62	Up to age 65
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*This is your age at the onset of your disability, which may be the date STD began.

Note: Your LTD benefit payments may be reduced by other disability income benefits and sources of income. See below for an explanation of other sources of income.

Evidence of Insurability (EOI)

You will not be required to provide Evidence of Insurability (EOI) to receive LTD coverage, however, pre-existing condition exclusions will apply (see the *LTD Exclusions* section).

You have a pre-existing condition for purposes of the pre-existing condition exclusion if both 1. and 2. are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 12 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available.
2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Other Disability Income Benefits and Sources of Income

Your LTD benefit payments may be reduced (offset) by other disability income benefits paid, payable, or for which there is a right under:

- The Social Security Act (including amounts for which your dependents may qualify because of your disability)
- Any Workers' Compensation or occupational disease act or law, or any other law which provides compensation for an occupational injury or sickness
- Occupational accident coverage provided by or through Baker Hughes
- Any statutory disability benefit law
- Any pension or disability plan of any other nation or political subdivision thereof (**note**: this does not include the Baker Hughes Pension Plan)
- The Railroad Retirement Act
- The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act
- The Canada Old Age Security Act; or
- Any Public Employee Retirement System plan, or any State Teachers' Retirement System plan, or any plan provided as an alternative to any of the above acts or plans

In addition, your LTD benefit payments may be reduced (offset) by the following sources of income:

- Retirement benefits paid under the Social Security Act
- Any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described in Rehabilitation Incentives. This includes but is not limited to salary, commissions, overtime pay, bonus, or other extra pay arrangements from any source
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement, or otherwise including future earnings
- Any income received for disability under a group insurance policy to which Baker Hughes has made a contribution, such as benefits for loss of time from work due to any disability
- Installment payments for permanent total disability
- A government compulsory benefit plan or program
- A self-funded plan, or other arrangement if Baker Hughes contributes toward it or makes payroll deductions for it
- Any sick pay, vacation pay or other salary continuation that Baker Hughes pays to you
- Occupational disease laws
- Laws providing for maritime maintenance and cure; or
- Unemployment insurance law or program

If you receive any of the benefits described above in addition to LTD benefit payments from Prudential, an overpayment may result. As a condition of receiving LTD benefit payments, you agree to return or pay back any overpayments, including lump-sum awards.

Important: After you have been disabled for five full months, you may be eligible for Social Security benefits. If Social Security assistance is appropriate for you, Prudential will arrange the services of an advocate — at no charge to you — to help you apply for and secure Social Security benefits.

Important: Please note that your LTD benefit payment will be offset by other disability income benefits to which you are entitled even if you do not apply for the other disability income benefits.

Family Social Security Integration

Any disability or retirement benefits paid to your dependents because of your disability or retirement will be deducted from your monthly benefit payment.

Example:

Joe earns $4,000 pre-disability earnings each month. He elected Buy-up coverage. After exhausting his STD benefits, Joe's disability is approved for LTD benefits by Prudential.

Joe's maximum LTD benefit would be $2,400 per month (60% X $4,000), less taxes.

Joe receives a Social Security award for himself of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by Prudential of $1,900 per month ($2,400 – $500).

Joe also receives a Social Security benefit for his dependents of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by Prudential of $1,400 per month ($1,900 – $500).

1. Calculate the LTD plan's regular LTD benefit payment.
2. Subtract any other income benefits for which you or your eligible dependents are eligible.

Mental Illness or Substance Abuse Limitation

If you're disabled due to a mental illness of any type, benefits will not be payable beyond 24 months in your lifetime. If you are confined to a hospital or institution at the end of the 24-month period, you may be eligible to have your benefits extended.

Definition: Mental illness means a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, substance related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

Prudential will not apply the mental illness limitation to dementia if it is a result of:

- stroke
- trauma
- viral infection
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

Recurrent Disability

A recurrent disability is a disability that is related to a prior disability for which you received a monthly LTD benefit. It's considered part of your prior disability if, after receiving LTD benefits, you return to your regular job on a full-time basis for less than 180 days and then are disabled again due to the same or a related condition. If your disability is recurrent, you will not need to satisfy a new elimination period.

If you return to your regular job for more than 181 days and become disabled again, you'll start a new disability claim and will be subject to:

- A new 26-week elimination period (which may be covered by Short-Term Disability benefits); the Long-Term Disability elimination period is stated as the greater of the Short-Term Disability period or 180 days
- A new maximum period payable; and
- Any other provisions of the LTD plan that are in effect on the date your disability recurs

Rehabilitation Incentive

If you participate in a rehabilitation program, your monthly benefit will increase by an amount equal to 10% of the monthly benefit. The increase will occur before your monthly benefit is reduced by any other income.

Work Incentive

If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any, and
- Reduced by other income as defined in the section titled *Other Disability Income Benefits and Sources of Income*
- Your monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100% of your pre-disability earnings as calculated in the definition of disability

Limit on Work Incentive

After the first 24 months following your elimination period, we will reduce your monthly benefit based on the amount you earn from working while disabled.

Family Care Incentive

If you work or participate in a rehabilitation program while you are disabled, we will reimburse you for up to $400 for monthly expenses you incur for each family member to provide:

- Care for your or your spouse's child, legally adopted child, or child for whom you or your spouse are a legal guardian and who is:
  - Living with you as part of your household
  - Dependent on you for support; and
  - Age 12 years old or under

The child care must be provided by a licensed child care provider who may not be a member of your immediate family or living in your residence.

- Care to your family member who is:
  - Living with you as part of your household
  - Chiefly dependent on you for support; and
  - Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law
- Care to your family member may not be provided by a member of your immediate family

We will make reimbursement payments to you on a monthly basis starting with the first monthly benefit payment until you have received 24 monthly benefit payments. Payments will not be made beyond the maximum benefit period. We will not reimburse you for any expenses for which you are eligible for payment from any other source. You must send proof that you have incurred such expenses.

Survivor Benefit

When Prudential receives proof that you have died, we will pay your eligible survivor a survivor benefit equal to 3 months of your gross disability payment.

The survivor benefit will be paid if, on the date of your death:

- Your disability had continued for 180 or more consecutive days; and
- You were receiving or were entitled to receive payments under the plan

Rules apply based on the eligibility of the beneficiary. Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

How Long Will LTD Benefit Payments Continue?

LTD benefit payments continue up to age 65 for Core coverage and Buy-up coverage or until the date of the following:

- You're no longer disabled
- You fail to furnish proof that you continue to be disabled
- You're no longer under the regular care of a physician
- You refuse to be examined, participate in any rehabilitative employment, or receive recommended treatment that is generally acknowledged by physicians to cure, correct, or limit the disabling condition
- Your monthly earnings exceed 80% of your pre-disability earnings
- The date benefits end as specified in the mental illness provisions
- You reach the maximum period of coverage
- You die
- You become covered under any other group long term disability plan, you will not be eligible for payments under the Prudential plan; or
- You are incarcerated as a result of a conviction

Note: If your disability or illness occurs on or after age 62, see the *LTD Schedule of Benefits* section for more details. If you become covered under any other group long term disability plan, you will not be eligible for payments under the Prudential plan.

Date Benefit Payments End

Your disability benefit payments will end on the earliest of:

- The end of the maximum benefit period
- The date benefits end as specified in the mental illness provisions
- The date you are no longer disabled
- The date you die
- The date you cease or refuse to participate in a rehabilitation program that we require and that is approved by your physician
- The date you fail to have a medical exam requested by Prudential; or
- The date you fail to provide the required proof of continuing disability

While you are disabled, the benefits described in this section will not be affected if:

- Your insurance ends, or
- The group policy is amended to change the plan of benefits for your class

Benefits Continuation

Medical

If you are under the age of 65 when your LTD claim was approved, you may continue certain Baker Hughes Medical plan options for a maximum of 24 months from the date your LTD claim is approved. If you are approved for LTD at age 65 or after, and before you terminated employment with the Company, you may continue your Medical plan option until you are no longer receiving disability benefits under the LTD plan. You will be required to pay your share of the cost for your Medical plan coverage, which will be billed to you monthly by the Baker Hughes Benefits Center. Failure to pay your premiums will result in termination of coverage. You may have the option to continue your Medical plan coverage through COBRA at termination of employment. Refer to the *Benefits Rights* section for more information on COBRA.

Basic Life

If you are under the age of 65 when your LTD claim was approved, you may continue Basic Life insurance coverage for a maximum of 24 months from the date your LTD claim is approved. If you are approved for LTD at age 65 or after, and before you terminated employment with the Company, you may continue Basic Life insurance coverage until you are no longer receiving disability benefits under the LTD plan. You'll have the option to convert your Life Insurance coverage to an individual policy at termination of employment.

Supplemental Life

If you are enrolled in the Supplemental Life insurance plan, your coverage will end when you are approved for LTD. You may be eligible to continue your coverage by converting it to an individual policy. For more information, contact Prudential at **1-800-778-3827.** If you are using a telecommunications device for the hearing impaired (TDD), call **1-800-496-1214.**

Voluntary AD&D

You will continue Voluntary AD&D coverage under premium waiver if you had coverage before your disability began and if you remain disabled.

Other Coverage

You may elect to continue Dental, Vision, and your Health Care Flexible Spending Account through COBRA if you had such coverages before your disability began. Refer to the *Benefits Rights* section for more information on COBRA.

If Employment is Terminated

If your employment with Baker Hughes terminated before you transitioned to LTD benefits, you are not eligible for continuation of Medical or Basic Life insurance benefits. In this event, you may be eligible to continue Medical coverage through COBRA and convert your Basic Life insurance coverage to an individual policy. For more information on converting your Basic Life insurance coverage, contact Prudential at **1-800-778-3827**. If you are using a telecommunications device for the hearing impaired (TDD), call **1-800-496-1214**. Refer to the *Benefits Rights* section for more information on COBRA.

Medicare Eligibility and LTD

If you continue coverage under a Baker Hughes Medical plan while you are receiving disability benefits under the LTD plan and you are, or later become, eligible to enroll for medical benefits under Medicare, you must enroll in both Parts A and B of Medicare as soon as you are eligible to enroll. Although you may be eligible for certain Baker Hughes medical benefits for up to 24 months, when/if you become eligible for Medicare, if it is before the end of the 24 month period, you will need to enroll in Medicare at that time because Medicare will become your primary medical coverage. If (1) you are eligible to enroll for medical benefits under Medicare, (2) you are not actively working for Baker Hughes, and (3) you have been receiving disability benefits from Baker Hughes plans for more than six months, the benefits you are eligible to receive under the Baker Hughes Medical plan will be determined as if Medicare was providing your primary medical coverage, regardless of whether you enroll in Medicare Parts A and B. In that case, your Baker Hughes Medical plan coverage will only pay benefits to the extent the plan provides a higher level of benefit than Medicare. The Baker Hughes Medical Plan Administrator will process your medical claims only after receiving the Medicare Explanation of Benefits. If you do not enroll in Medicare Parts A and B, the administrator will process your claims by estimating the amount Medicare would have paid and will pay only the amount that is payable under the Baker Hughes Medical plan that exceeds the amount that would have been paid by Medicare.

If you have questions regarding your benefits while you are receiving LTD benefit payments, please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

LTD Exclusions

What is Not Covered

The LTD plan does not pay benefits if your disability is caused by, contributed to, or results from:

- A pre-existing condition. A condition for which medical treatment or advice was rendered, prescribed, or recommended within 12 months prior to your effective date of coverage by the LTD plan. A condition shall no longer be considered pre-existing if it causes disability that begins after you have been covered under the LTD plan for a period of 12 months
- War, whether declared or not, or any act of war
- Active participation in a riot
- Committing or attempting to commit a felony; or
- Attempted suicide or self-inflicted injury or illness

In addition, benefits are not payable for any period during which:

- You are confined to a penal or correctional facility
- You are not under the care of a physician; or
- You are not eligible for coverage under the LTD plan

Termination of Coverage

Your LTD plan coverage will end when:

- You do not provide the requested medical information to Prudential
- You cease to be eligible for coverage
- You qualify for retirement benefits from Baker Hughes; or
- Baker Hughes terminates the LTD plan

Date Your Insurance Ends

Your insurance coverage from Prudential under the LTD plan will end on the earliest of:

For All Prudential Insurance Coverages:

- The date the group policy coverage from Prudential under the LTD plan ends; or
- The date insurance ends for your class; or
- The end of the period for which the last premium has been paid for you

For Disability Income Insurance: Long-Term Benefits:

- The date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease active work in an eligible class if you are not disabled on that date; or
- The date you retire in accordance with the date your employment ends; or
- The date your employment ends; or
- The last day of the period for which you made any contributions

How do I File a Long-Term Disability Claim?

If You Were Receiving STD Benefit Payments…

If you are already receiving STD benefit payments and continue to be eligible for disability coverage, Sedgwick automatically transitions your claim to Prudential for LTD consideration.

If You Were Not Receiving STD Benefit Payments…

If you are disabled for the duration of the 26-week LTD plan elimination period and were not receiving STD benefit payments, you must call Prudential at **1-800-842-1718** to initiate a claim for LTD benefits. The LTD elimination period is stated as the greater of the end of the STD maximum benefit period or 180 days.

Note: You are encouraged to call Prudential at the beginning of your disability to ensure you understand the qualifications for being considered disabled under the LTD plan and also to ensure prompt payment of LTD payments, should you be eligible.

Prudential may ask you for the following information:

- Company Name: Baker Hughes Company
- Company Control Number: 52656
- Employee ID (found in Workday) or Social Security number
- Address and telephone number
- Date of birth
- Job title
- Doctor's name, phone number, and fax
- Your last day worked and your first day out due to this condition
- If the absence is work-related
- The date you expect to return to work

You may need to provide Prudential with written authorization to access your medical information by completing an authorization form and providing a copy to both Prudential and your physician.

You can obtain an authorization form by calling Prudential at **1-800-842-1718**.

Note: If you are unable to call, a family member, close friend, or your manager can make the call for you.

Note: It is ultimately your responsibility to ensure all requested information is provided to Prudential. Failure of your physician to provide necessary medical documentation may result in a delay or suspension of your LTD benefit payments.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in this section. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of this SPD and your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656**.

If you are unable to access this website and want to receive a printed copy of these requirements or have any questions, call Prudential at **1-866-439-9026**.

Responding to Your Disability Claim

Prudential will notify you in writing about whether your claim has been approved or denied within a reasonable period of time, but not later than 45 days of receiving your claim. This period can be extended for up to another 30 days if you are notified (before the end of the original 45-day period) that the extension is necessary due to matters beyond the control of the LTD plan. The 30-day extension period can be extended for up to an additional 30 days if you are notified (before the end of the first 30-day extension period) that the extension is necessary due to matters beyond the control of the LTD plan. Any notice for an extension will explain:

- The reason for the extension and when Prudential expects to rule on your claim, and
- Additional information needed to resolve those issues

If an extension is required because you need to provide the information necessary to resolve claim issues, you will have 45 days from the time you receive the extension notice to provide the additional information. If you do not provide the requested information on or before the end of such 45-day period, your benefit claim will be denied by Prudential.

Disability Claims Denial Notice

You will receive written notice of Prudential's claim decision under the LTD plan. If your claim is denied, the notification will include:

- the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the LTD plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits
- references to the specific plan provisions on which the benefit determination was based
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals
- a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and
- copies of any internal rules or guidelines relied upon in making this determination, if applicable

Appealing a Denied Disability Claim

Appeals must be in writing and must be submitted to the claim department address below. You have a right to appeal the decision. If you choose to do so, your appeal must be made in writing by you or your authorized representative, and submitted within 180 days of the date of receipt of the letter.

Note: employment may not be protected during the LTD appeal process.

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480
Philadelphia, PA 19176
Phone: **800-842-1718**
Fax: **877-889-4885**

You should include the following information in writing:

- Your name, control number, and Social Security number (or claim number)
- The reasons that you disagree with the determination
- Medical evidence or information to support your position such as:
  - Copies of therapy treatment notes
  - Any additional treatment records from physicians
  - Actual test results (e.g. EMG, MRI)

You may submit with your appeal any other written comments, documents, records, or information related to your claim.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Your written claim appeal should be submitted to the Appeals Review Unit at the address listed above.

A determination on your appeal will be made within 45 days of the receipt of your appeal request. This period may be extended by 45 days, if special circumstances require an extension. You will receive written notice of the extension, the reason for the extension, and the date by which the Appeals Review Unit expects to render a decision, within the initial 45-day period. However, if the Appeals Review Unit requests additional information, the extension may be delayed until you provide the requested information.

If our decision to deny benefits is upheld at the first level of appeal, you or your authorized representative may file a voluntary second appeal. You are entitled to receive upon request and at no cost, sufficient information to make a decision about filing this appeal. The same time frame for the first appeal will apply to the second appeal.

If ERISA Applies

After completion of the first level of appeal, you may also file a lawsuit under the Employee Retirement Income Security Act (ERISA). ERISA allows you to file suit for policy benefits and reasonable attorney's fees. Your decision on whether to file a second appeal will not affect your rights to sue under ERISA.

Disability Appeal Denial Notice

Prudential will send you a written notice of Prudential's decision under the LTD plan regarding your appeal of a denied disability claim. If your appeal is denied in whole or in part, the notification will include:

- the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the LTD plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits
- references to the specific plan provisions on which the determination was based
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request
- Prudential's review procedures and applicable time limits
- a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request
- copies of internal rules or guidelines relied upon in making this determination, if applicable and
- a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitation period expires for the claim at issue

You and Prudential can also seek other voluntary alternative dispute resolution options, such as mediation. Contact your local US Department of Labor office and your State insurance regulatory agency to find out what resources are available.

If Prudential fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in court.

Note: All benefits and coverages described are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this SPD and the insurance policies, the insurance policies will always govern.

Basic Life Insurance

Basic Life At-a-Glance

Type of Plan	Welfare plan that provides Basic Life insurance
Premium Contributions	Baker Hughes pays 100% of the cost of your coverage. No premium contributions are required from you for this coverage.
Employee Eligibility	Employees on US-based payroll who work not less than 20 hours per week
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary. However, if you wish to limit your coverage to $50,000 to avoid imputed income, you may do so within 31 days of your date of hire or transfer to a position with US benefits. You can also make changes during Annual Enrollment or if you have a qualified status change (see the *Can I Make Changes After I Enroll?* information in the *General Information* section).
Coverage Options	• Coverage equal to 2x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000). • Coverage is reduced by 50% the first of the year following your 70th birthday. • You may limit your coverage to $50,000 to avoid imputed income. If you limit your coverage to $50,000 to avoid imputed income then decide to revert to 2X your annual benefits base pay, you will have to submit evidence of insurability.
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Basic Life plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan by accessing your account from **BakerHughesBenefits.com**, prepared by Prudential, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Group Insurance Certificate and this SPD. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

Your Basic Life Insurance Coverage

Employee life insurance provides valuable financial protection for your family. If you die, your life insurance benefit can replace your income for a period of time and also help your family pay for expenses incurred as a result of your death. Because life insurance is such an important benefit, Baker Hughes provides Basic Life insurance coverage under the Baker Hughes Life insurance program (the Basic Life plan) at no cost to you, and no enrollment is necessary. Basic Life insurance coverage provides peace of mind for you and basic financial security to you or your beneficiaries in the event you die.

What is the Employee's Cost of the Basic Life Plan?

No premium contributions are required from you for this coverage.

When Does Coverage Begin?

The Basic Life plan provides you with Basic Life insurance coverage on the first day you are actively at work. No enrollment is necessary.

Definition: Actively at Work means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business or at other places Baker Hughes business requires you to travel.

How Does the Basic Life Plan Work?

Basic Life insurance is provided to all eligible employees at no cost to you. Your benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefit programs. This **does not** include overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later. Coverage increases due to changes in your benefits base pay are effective the following January 1. All increases are subject to the actively-at-work requirements.

If you die while covered by the Basic Life plan, your beneficiaries will receive a benefit based on your annual benefits base pay and age, as follows:

Your Age When You Die	Benefit Amount
Under Age 70	2x benefits base pay or $50,000 if coverage is capped to avoid imputed income, • Rounded to the next higher $1,000 (if not already a multiple thereof), and • Minimum $50,000; maximum $500,000
Age 70 or Over	Coverage is reduced by 50% the first of the year following your 70th birthday.

Imputed Income

If your Basic Life insurance coverage is greater than $50,000, the value of this employer-paid coverage in excess of $50,000 is considered "imputed income" and subject to income tax. To avoid imputed income, you can elect to reduce your benefit by capping your Basic Life insurance coverage at $50,000 during an election period. The imputed income is added to your total annual compensation reported to the Internal Revenue Service (IRS). It appears on your W-2 statement and is taxable at your regular income tax rate.

Example:

Jose is 30 years of age and receives Basic Life insurance coverage of 2x his annual benefits base pay, which is $60,000. Imputed income is calculated on the value of $10,000 (or the difference between his coverage and $50,000) and equals approximately 40 cents per month. This amount will be included on his W-2 statement as taxable income.

Tip!

If you have previously capped your coverage to avoid imputed income, you may remove the cap from the benefit during any Annual Enrollment period or during certain qualified changes in status, so long as you provide satisfactory Evidence of Insurability.

Survivor Support Representatives

The Baker Hughes Benefits Center has dedicated Survivor Support Representatives to assist you or your dependents in submitting a claim for death benefits to the insurance carrier.

Survivor Support Representatives can be reached by calling **1-866-244-3539**, Option 4 , Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Naming a Beneficiary

You must name a beneficiary for your Basic Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A Beneficiary **means a person chosen, on a form approved by Prudential, and submitted to Prudential before your death, under a Prudential Group Contract to receive some or all of the insurance benefits when you die.**

Note: When naming a beneficiary, you may:

- Name one or more beneficiaries. If you select more than one beneficiary, you must choose the percentage of benefits that are to be paid to each beneficiary
- Name a beneficiary that you cannot change in the future without his or her written consent (This is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Prudential at **1-800-524-0542** to obtain the form. Once you have completed the form, you will need to provide it to the Baker Hughes Benefits Center
- If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise. If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you

Beneficiary Rules

The rules in this section apply to insurance payable under a Prudential Group Contract on account of your death, when that coverage states that they apply. But these rules are modified by any burial expenses rule in the Schedule of Benefits for the Prudential Group Contract and, if there is an assignment, by the following sections of this SPD: *Limits on Assignments*; and *Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract*. You have the right to choose a Beneficiary for each coverage under a Prudential Group Contract providing benefits to you.

If there is a Beneficiary for the insurance under a coverage provided through a Prudential Group Contract, it is payable to that Beneficiary. Any amount of insurance under a coverage, such coverage for which there is no Beneficiary at your death will be payable to the first of the following:

1. Surviving spouse or domestic partner
2. Surviving child(ren)/child(ren) of domestic partners in equal shares
3. Surviving parents in equal shares
4. Surviving siblings in equal shares
5. Estate

This order will apply unless otherwise provided in the *Limits on Assignments* section.

You may change the Beneficiary at any time without the consent of the present Beneficiary. The Beneficiary change form must be filed through the **Baker Hughes Benefits Center**. The change will take effect on the date the form is signed. But it will not apply to any amount paid by Prudential before Prudential receives the form. If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise. If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you.

Limits on Assignments

You may assign your insurance under a coverage provided under a Prudential Group Contract. Unless the Schedule of Benefits for the Prudential Group Contract states otherwise, insurance under any coverage providing death benefits or periodic benefits on account of disability may be assigned only as a gift assignment. Any rights, benefits or privileges that you have as an Employee may be assigned. This includes any right you have to choose a Beneficiary or to convert to another contract of insurance. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Baker Hughes Benefits Center. This paragraph applies only to insurance for which you have the right to choose a Beneficiary, when that right has been assigned. If an assigned amount of insurance becomes payable on account of your death and, on the date of that death, there is no Beneficiary chosen by the assignee, it will be payable to:

(1) the assignee, if living; or

(2) the estate of the assignee, if the assignee is not living. It will not be payable as stated in the Beneficiary Rules

Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract

This Section applies to all coverages provided through a Prudential Group Contract, providing Employee death benefits.

If you are eligible for insurance under the Group Contract on the Group Contract's effective date you will have no rights, benefits or privileges under any such coverage if, on the day before that date, all the following were true:

(1.) You were insured for group life insurance under another group contract. That contract was issued by Prudential or another insurance carrier to cover employees of the employer

(2.) Your group life insurance under the other group contract ended

(3.) An irrevocable and absolute gift assignment made by you was in effect. It was made before the other contract ended. That assignment was of all your rights, benefits and privileges of the group life insurance under the other group contract. Those rights were owned by the assignee or the assignee's successor. The owner of those rights of the group life insurance under the other group contract on the day before the Prudential Group Contract's effective date will be the owner of the rights, benefits, and privileges you would have had under a coverage if this section did not apply. This includes, but is not limited to, any right of assignment you would have had under the Limits on Assignments section above. The term "assignee" as used in that section includes such an owner. The term "group life insurance", as used above, means only group life insurance provided under a group contract in effect on the day before the date the employer became included under the Group Contract

If You Become Terminally Ill

If you become terminally ill while covered under the Basic Life plan, you may apply for an accelerated benefit. Subject to approval by the Basic Life insurance provider, Prudential, this allows you to receive the full or a partial amount of your Basic Life insurance benefit before you die.

Definition: Terminally Ill means that due to accident or sickness, you are expected to have less than 24 months to live.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Prudential that your life expectancy, because of sickness or accident, is 24 months or less. That evidence must include certification by a physician. Prudential reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Prudential's physician will prevail. Prudential retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

Conditions

Your right to be paid under this option is subject to these terms:

- To elect this option, you must use the claim form provided by Prudential and follow the instructions on the claim form. If you do not have a claim form, contact the **Baker Hughes Benefits Center** at **1-866-244-3539** Option 4 to speak to a Survivor Support Representative, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.
- You must furnish a certification by a doctor that your life expectancy is 24 months or less. You should furnish the *Attending Physician's Certification* part of your claim form to your doctor and have your doctor complete the form
- Your life insurance must not be assigned

Terminal illness proceeds will be made available to you on a voluntary basis only. You are not eligible for this benefit if you elect the benefit involuntarily solely because:

- You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise
- You are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The maximum is the amount equal to your Basic Life insurance coverage (which cannot exceed $500,000 when combined with Supplemental Life). If you die before all payments have been made, Prudential will pay the remainder to your named beneficiaries.

In no event will the amount of the accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Basic Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Basic Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force.

If you elect to receive accelerated benefits, Prudential will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit.

Accelerated Benefit Amount Calculation and Payment

Prudential will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender, and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you unless you validly assign them otherwise. If you die before all payments have been made, Prudential will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Prudential.

Filing a Basic Life Claim

To claim benefits, your beneficiary who is entitled to benefits in the case of your death (or you, in the case of an accelerated benefit), the claimant, must contact the **Baker Hughes Benefits Center** at **1-866-244-3539,** Option 4 to speak to a Survivor Support Representative. The Survivor Support Representative will mail the applicable forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but no later than 365 days from the date of the covered person's death, to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic Life plan are fully-insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Claims Procedures

Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

(i) the views of your treating providers and vocational professionals who evaluated you

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

(iii) an award of Social Security Administration disability benefits

(b) references to the specific plan provisions on which the benefit determination was based

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Appeals of Adverse Determination: Filing an Appeal

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in the section above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination. Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time.

A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period. Prudential will provide you, free of charge and prior to an adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

(i) the views of your treating providers and vocational professionals who evaluated you

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

(iii) an award of Social Security Administration disability benefits

(b) references to the specific plan provisions on which the benefit determination was based

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Notice of Benefit Decision on Appeal

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in the section above, you may make a second, voluntary appeal, although you are not required to do so. You may submit with your second, voluntary appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second, voluntary appeal within 45 days of the receipt of your second, voluntary appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period.

However, if the period of time is extended due to your failure to submit information necessary to decide the second, voluntary appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second, voluntary 45-day appeal review period.

Your decision to submit a benefit dispute to this second, voluntary level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second, voluntary level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second, voluntary level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending. If the claim on second, voluntary appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial.

The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse appeal determination letter. If a decision on second, voluntary appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on the second, voluntary appeal.

Legal Action Following Appeals

If your claim for benefits and any required appeal are denied (or not decided within the time periods discussed above), you may file suit as discussed in the section *Benefits Rights.* If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained in the certificate of coverage/insurance provided by Prudential, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the amount payable under the Basic Life plan is paid to your beneficiaries by Prudential. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse or domestic partner; otherwise
- Your naturally born or legally adopted children or domestic partner's children in equal shares; otherwise
- Your surviving parents in equal shares; otherwise
- Your siblings in equal shares; otherwise
- Your estate.

The benefit will be paid in a single sum or by any other method agreeable to Prudential and your beneficiaries. Prudential will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Prudential based on current short-term market rates, or the minimum required by state law, whichever is greater.

When Does Coverage End?

Right to Apply for Coverage Under the Portability Plan

You will have the right to apply for term life coverage under the Portability Plan if you meet all of these tests:

1. Your Basic Life coverage ends for any reason other than:
   a. your failure to pay, when due, any contribution required for it; or
   b. the end of your employment on account of your retirement; or
   c. the end of the coverage for all employees when such coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.
2. You meet the Active Work Requirement on the day your insurance ends.
3. You are less than age 80.
4. Your Amount of Insurance is at least $20,000 under the Basic Life coverage on the day your insurance ends.

Portability Application Period

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. The Portability Application Period is the 31 day period after your Basic Life coverage ends. But, if you have the right to convert your insurance under the Basic Life coverage to an individual contract, it is the longer of:

1. The 31 day period after your coverage ends; and
2. The number of days during which you have the right to convert your insurance under the coverage to an individual life insurance contract as shown in the coverage.

Effect of Conversion Privilege

The right to elect coverage under the Portability Plan is provided in lieu of the conversion privilege described in the Basic Life coverage, except as follows:

1. You may convert your amount of insurance under the Basic Life coverage in excess of the maximum for term life coverage under the Portability Plan. This maximum is the lesser of 5 times your annual Earnings and $1,000,000.

2. You may convert your insurance if you elected coverage under the Portability Plan, but Prudential decided that your evidence of insurability was not satisfactory.

If you elect to convert all of your insurance under the Basic Life coverage to an individual contract, you may not elect to apply for coverage under the Portability Plan. If, during the Portability Application Period, you apply for coverage under the Portability Plan and then elect to convert all of your insurance under the Basic Life coverage to an individual contract, your coverage under the Portability Plan will not become effective. The right to elect coverage under the Portability Plan does not affect your coverage under the Death Benefit During Conversion Period provision of the Basic Life coverage.

Terms and Conditions of the Portability Plan

The form, amount, first premium, and effective date will be as stated below.

Form and Amount: The form of term life coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Basic Life coverage under the Group Contract. Amount: Not more than your amount of insurance under the Basic Life coverage when your insurance ends, but not less than $20,000. The maximum amount of term life insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000. First Premium: The first premium is due to Prudential within 31 days of the date the first bill is issued. Effective Date: The day after the Portability Application Period ends.

If the Basic Life Plan is Terminated

If the Basic Life plan ends, you may convert to an individual policy as stated above. However, the converted policy will be limited to the lesser of:

- The amount of Basic Life insurance coverage you had under the Basic Life plan (less any life insurance amount you become eligible for under another group policy within 31 days after the Basic Life plan ends), and
- $10,000

The converted policy will be effective 31 days after the group insurance provided under the policy terminates. If you should die during the conversion period, the amount of Basic Life insurance you could have converted under the policy will be paid to your beneficiary.

Converting or Porting Your Coverage

For more information, or to convert or port your coverage, contact Prudential at **1-800-778-3827.** If you are using a telecommunications device for the hearing impaired, call **1-800-496-1214.**

Supplemental Life Insurance

Supplemental Life At-a-Glance

Type of Plan	Voluntary Supplemental Life insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who work not less than 20 hours per week.
Eligible Dependents	• Spouse or domestic partner • Qualified dependent child
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer (must be actively at work). If changes are made during Annual Enrollment, coverage goes into effect the following January 1.
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year. Note: You may need to provide Evidence of Insurability (EOI) for yourself and your spouse or domestic partner (if spouse or domestic partner coverage is elected).
Coverage Options	• Employee: Coverage equal to 1x to 8x annual benefits base pay (up to a maximum of $6 million) multiplied and then rounded to the next higher $1,000, if not already a multiple thereof. There is a $250,000 coverage option for employees making less than $31,250. Coverage is reduced by 50% the first of the year following your 70th birthday. • Spouse or domestic partner: You can choose from the following options: — $25,000 — $150,000 — $50,000 — $200,000 — $75,000 — $250,000 — $100,000 • Children: $10,000 for each eligible dependent
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Supplemental Life plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document by accessing your account from **BakerHughesBenefits.com** prepared by Prudential and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and this SPD. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this SPD. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

Your Supplemental Life Insurance Coverage

You may purchase additional life insurance coverage for yourself and coverage for your spouse or domestic partner and your eligible dependents. The Baker Hughes Company Supplemental Life insurance program (the Supplemental Life plan) provides you with an additional benefit if you, your spouse or domestic partner, or your dependents were to die.

What is the Employee's Cost of the Supplemental Life Plan?

You pay for the full cost of this coverage through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within 31 days of becoming eligible for coverage, your coverage begins on your first day of active work if you are a new hire or existing employee transferring to a position with US benefits; or the following January 1 if you enroll during the Annual Enrollment period and are actively at work. If you elect coverage that requires Evidence of Insurability (EOI), you will be covered at the highest level of coverage possible without EOI pending a decision by the provider, Prudential.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees.

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

The chart below outlines acceptable and unacceptable Supplemental Life coverage elections for couples* who both work at Baker Hughes. For assistance completing spouses or domestic partners who both work at Baker Hughes coverages, please call the **Baker Hughes Benefits Center** at **1-866-244-3539**. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Supplemental Life Coverage Options	Employee A	Employee B	Employee A	Employee B	Employee A	Employee B
Supplemental Life	elected	elected	elected	elected	waived	elected
Supplemental Spouse Life*	elected	elected	waived	waived	waived	elected
Supplemental Child Life	elected	elected	waived	waived	waived	elected
Baker Hughes Policy	Unacceptable[1]		Acceptable[2]		Acceptable[3]	

Note 1: ***The Baker Hughes Health and Protection Plan does not allow Dual Coverage.*** Spouses or domestic partners cannot each elect Supplemental Life, Supplemental Spouse Life and Supplemental Child Life coverage.

Note 2: Married employees or domestic partners who both work at Baker Hughes may not elect Supplemental Spouse Life if the other has elected Supplemental Life on themselves.

Note 3: Either spouse or domestic partner can elect Supplemental Life, Supplemental Spouse and Child Life coverage. ***However, both spouses or domestic partners cannot cover a dependent under child life.***

Definition: Actively at Work means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business or at other places Baker Hughes business requires you to travel.

*Includes domestic partnerships

How Does the Supplemental Life Benefits Base Pay Plan Work?

Supplemental Life insurance is available to all eligible employees. However, you must enroll and pay the full cost of this benefit. Just like Basic Life insurance, your Supplemental Life insurance benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefits programs. Benefits base pay does not include overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay and age are used as part of the premium calculation.

Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

If you die while covered by the Supplemental Life plan, your beneficiaries will receive a benefit based on your elected amount or approved EOI coverage amount. If a spouse or domestic partner or a dependent dies while covered by the Supplemental Life plan, you will receive a benefit based on the amount of coverage elected during enrollment or approved EOI coverage amount.

Coverage Level	Benefit Options You May Elect
Employee Under Age 70	Coverage equal to 1x to 8x annual benefits base pay multiplied and then rounded to the next higher $1,000 if not already a multiple thereof up to a maximum of $6 million. There is a $250,000 coverage option for employees making less than $31,250.
Employee Age 70 or Over	Coverage is reduced by 50% the first of the year following your 70th birthday.
Spouse or Domestic Partner	• $25,000 • $75,000 • $125,000 • $200,000 • $50,000 • $100,000 • $150,000 • $250,000 Note: The amount of spouse or domestic partner coverage cannot exceed 100% of your combined Basic and Supplemental Life insurance.
Dependent Children	$10,000 per covered child

Evidence of Insurability

If you enroll in Supplemental Life insurance coverage within 31 days of first becoming eligible, you may elect coverage up to the guarantee issue amounts without providing Evidence of Insurability (EOI). Guarantee issue is the maximum amount of insurance an employee or spouse or domestic partner can receive without EOI when first eligible under the Supplemental Life plan, provided enrollment is made in a timely manner within the initial enrollment period.

The guarantee issue amounts are as follows:

- **Employee Supplemental Life:** $250,000
- **Spouse or Domestic Partner Life:** $25,000
- **Child Life:** $10,000 (EOI does not apply regardless of when election is made)

Example:

Tom is a new hire whose annual benefits base pay is $100,000, and he elects three times salary. Tom is covered up to the guarantee issue amount of $250,000 until a decision is made on his EOI. If approved, he will receive the full benefit amount he elected of three times ($300,000) coverage. If the EOI is denied, coverage will remain at the guarantee issue amount of $250,000.

If you do not enroll in coverage when first eligible, you will be required to submit EOI for any future enrollment.

If you enroll in coverage when first eligible and then elect to increase your coverage during future enrollments, EOI will generally be required for amounts above the guarantee issue or when increasing coverage by more than one level. All coverage increases are subject to the actively-at-work requirements. Refer to the chart below for additional details.

Remember...

If you do not elect coverage as a new hire or when you first transfer to a position with US benefits and decide to elect Supplemental Life insurance during a future enrollment period, you will be required to provide Evidence of Insurability for yourself and your spouse or domestic partner (if elected) for any amount of coverage elected.

Providing EOI Documentation

	Election Period	Election	EOI Required?
Employee	During the new hire enrollment period or newly eligible enrollment period	Any election less than or equal to the guarantee issue of $250,000	No
		Any election above the guarantee issue of $250,000	Yes
	After the new hire enrollment period or newly eligible enrollment period	Any election for one multiple that does not exceed the guarantee issue of $250,000	No
		Any election for more than one multiple	Yes
Spouse or Domestic Partner	During the new hire enrollment period or newly eligible enrollment period	Any election up to the guarantee issue of $25,000	No
		Any election above the guarantee issue of $25,000	Yes
	After the new hire enrollment period or newly eligible enrollment period	Any election amount, including new elections	Yes
		Any election from "No Coverage" to any elected amount	Yes
Dependent Children	No EOI required for coverage		No

Providing EOI Documentation

If you are required to provide Evidence of Insurability, you will be directed to Prudential's EOI Connect website to provide additional information. Until a decision has been made on your coverage, you or your spouse or domestic partner will be covered at the highest level of coverage possible without EOI. If EOI is approved, the Supplemental Life and/or Spouse or Domestic Partner Life insurance coverage at the higher coverage level will become effective on the day the EOI decision is made, or according to the Supplemental Life plan rules as long as you remain eligible and are actively at work. If the election requiring EOI was made during Annual Enrollment, the coverage will be effective the later of the date the EOI decision was made, or January 1 following Annual Enrollment. If an exam or tests are required to complete the EOI process, Prudential will arrange for the needed services at no cost to you.

Naming a Beneficiary

You must name a beneficiary for your Supplemental Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A **Beneficiary** means a person chosen, on a form approved by Prudential and submitted to Prudential before your death, to receive some or all of the insurance benefits when you die.

Note: When naming a beneficiary you may:

- Name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the percentage of benefits that are to be paid to each beneficiary
- Name a beneficiary that you cannot change in the future without his or her written consent (this is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Prudential at 1-800-524-0542 to obtain the form to submit to the Baker Hughes Benefits Center
- You're automatically the beneficiary for your dependent's (spouse or domestic partner and children) Supplemental Life insurance benefits
- If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise
- If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you

Beneficiary Rules

The rules in this section apply to insurance payable under a Prudential Group Contract on account of your death, when that coverage states that they apply. But these rules are modified by any burial expenses rule in the Schedule of Benefits for the Prudential Group Contract and, if there is an assignment, by the following sections of this SPD: *Limits on Assignments*; and *Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract*. "Beneficiary" means a person chosen, on a form approved by Prudential and submitted to Prudential before your death, to receive some or all of the insurance benefits. You have the right to choose a Beneficiary for each coverage under a Prudential Group Contract providing benefits to you. If there is a Beneficiary for the insurance under a coverage provided through a Prudential Group Contract, it is payable to that Beneficiary. Any amount of insurance under such coverage for which there is no Beneficiary at your death will be payable to the first of the following: your

1. surviving spouse or domestic partner
2. surviving child(ren)/domestic partner's child(ren) in equal shares
3. surviving parents in equal shares
4. surviving siblings in equal shares
5. estate.

This order will apply unless otherwise provided in the Limits on Assignments. You may change the Beneficiary at any time without the consent of the present Beneficiary. The Beneficiary change form must be filed through the Baker Hughes Benefits Center. The change will take effect on the date the form is signed. But it will not apply to any amount paid by Prudential before Prudential receives the form. If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise. If you and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before you.

Limits on Assignments

You may assign your insurance under a coverage provided under a Prudential Group Contract. Unless the Schedule of Benefits for the Prudential Group Contract states otherwise, insurance under any coverage providing death benefits or periodic benefits on account of disability may be assigned only as a gift assignment. Any rights, benefits or privileges that you have as an Employee may be assigned. This includes any right you have to choose a Beneficiary or to convert to another contract of insurance. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Baker Hughes Benefits Center. This paragraph applies only to insurance for which you have the right to choose a Beneficiary, when that right has been assigned. If an assigned amount of insurance becomes payable on account of your death and, on the date of that death, there is no Beneficiary chosen by the assignee, it will be payable to:

1. the assignee, if living; or
2. the estate of the assignee, if the assignee is not living. It will not be payable as stated in the Beneficiary Rules

Effect of Gift Assignment of Rights of Group Life Insurance Under Another Group Contract

This section applies to all coverages provided under a Prudential Group Contract providing Employee death benefits. If you are eligible for insurance under the Group Contract on the Group Contract's effective date you will have no rights, benefits, or privileges under any such coverage if, on the day before that date, all the following were true:

1. You were insured for group life insurance under another group contract. That contract was issued by Prudential or another insurance carrier to cover Employees of the Employer
2. Your group life insurance under the other group contract ended
3. An irrevocable and absolute gift assignment made by you was in effect. It was made before the other contract ended. That assignment was of all your rights, benefits, and privileges of the group life insurance under the other group contract. Those rights were owned by the assignee or the assignee's successor. The owner of those rights of the group life insurance under the other group contract on the day before the Prudential Group Contract's effective date will be the owner of the rights, benefits, and privileges you would have had under a coverage if this section did not apply. This includes, but is not limited to, any right of assignment you would have had under the Limits on Assignments section above. The term "assignee" as used in that section includes such an owner. The term "group life insurance", as used above, means only group life insurance provided under a group contract in effect on the day before the date became included under the Group Contract

If You Become Terminally Ill

If you become terminally ill while covered under the Supplemental Life plan, you may apply for an accelerated benefit. Subject to approval by the insurance provider, Prudential, this allows you to receive the full or a partial amount of your Supplemental Life insurance benefit before you die. If you elect the option to accelerate payment of death benefits under the Prudential Group Contract, the amount of your Supplemental Life coverage will be reduced by the Terminal Illness Proceeds described below. Any portion of your death benefit that remains after this election will be payable when Prudential receives proof of death. Payment of the remaining death benefit will be considered full settlement of the death benefit. Any such reduction under your Supplemental Life coverage will not apply to your Accidental Death and Dismemberment Insurance, if any. You will not be required to pay an additional contribution if you elect the option to accelerate payment of death benefits under the Prudential Group Contract. You will not be charged an Accelerated Payment Fee.

Definition: "**Terminally Ill"** means that due to sickness or accident, you are expected to have less than 24 months to live.

Definition: "Terminally Ill Employee": is an employee whose life expectancy is 24 months or less.

Definition: "Terminal Illness Proceeds": is amount of Supplemental Life that you may elect to place under the Supplemental Life coverage. The Terminal Illness Proceeds are equal to 100% of the amount in force on your life on the date Prudential receives the proof that you are a Terminally Ill Employee, but not more than $500,000. However, the Terminal Illness Proceeds may be reduced if, within 24 months after the date Prudential receives such proof, a reduction on account of age would have applied to the amount of your Supplemental Life coverage. In that case, the amount of the Terminal Illness Proceeds may not exceed the amount of such insurance after applying the reduction.

Option: If you become a Terminally Ill Employee while insured under the Supplemental Life provision or while your death benefit protection is being extended under the Supplemental Life coverage provision, you may elect to have the Terminal Illness Proceeds placed under this option. That election is subject to the conditions set forth below.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Prudential that your life expectancy, because of sickness or accident, is 24 months or less. That evidence must include certification by a physician. Prudential reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Prudential's physician will prevail. Prudential retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

Conditions

Your right to be paid under this option is subject to these terms:

- To elect this option, you must use the claim form provided by Prudential and follow the instructions on the claim form. If you do not have a claim form, contact the **Baker Hughes Benefits Center** at **1-866-244-3539**, Option 4 to speak to a Survivor Support Representative, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST
- You must furnish a certification by a doctor that your life expectancy is 24 months or less. You should furnish the *Attending Physician's Certification* part of your claim form to your doctor and have your doctor complete the form
- Your life insurance coverage must not be assigned
- Terminal Illness Proceeds will be made available to you on a voluntary basis only. You are not eligible for this benefit if you elect the benefit involuntarily solely because:
  - You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise
  - You are required by a government agency to use this option in order to apply for, get, or keep a government benefit or entitlement

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The maximum is the amount equal to your Supplemental Life insurance coverage (which cannot exceed $500,000 when combined with Basic Life). If you die before all payments have been made, Prudential will pay the remainder to your named beneficiaries.

In no event will the amount of the Supplemental Life plan accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Supplemental Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Supplemental Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force and premiums will be reduced accordingly.

If you elect to receive accelerated benefits, Prudential will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit under the Supplemental Life plan.

Accelerated Benefit Amount Calculation and Payment

Prudential will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender, and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you, unless you validly assign them otherwise. If you die before all payments have been made, Prudential will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Prudential.

Amount Due But Unpaid at Your Death

If you elect monthly installments and you die before all payments have been made, Prudential will pay your Beneficiary or Beneficiaries determined under the Beneficiary Rules in one sum. That sum will be the total of the payments that remain.

Conditions: Your right to be paid under this option is subject to these terms:

1. To elect this option, you must use the claim form provided by Prudential and follow the instructions on the claim form. If you do not have a claim form, contact the Baker Hughes Benefits Center.
2. You must furnish a certification by a doctor that your life expectancy is 24 months or less. You should furnish the Attending Physician's Certification part of your claim form to your doctor and have your doctor complete the form.
3. Your Supplemental Life insurance must not be assigned.
4. Terminal Illness Proceeds will be made available to you on a voluntary basis only. You are not eligible for this benefit if you elect the benefit involuntarily solely because:
   a. You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise.
   b. You are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement.

Effect on Insurance: This benefit is in lieu of the benefits that would have been paid on your death with respect to the Terminal Illness Proceeds. When you elect this option, the total amount of Supplemental Life insurance otherwise payable on your death, including any amount under an extended death benefit, will be reduced by the Terminal Illness Proceeds. Also, any amount you could otherwise have converted to an individual contract will be reduced by the Terminal Illness Proceeds. If you are contributing for your Supplemental Life insurance, the amount of your contribution will be adjusted based on the amount of Supplemental Life insurance remaining in force. If your Supplemental Life insurance is reduced by any amount paid under the Prudential Group Contract, that reduction will not apply to the Accidental Death and Dismemberment Insurance, if any.

Remember...

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

Filing a Supplemental Life Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**, Option 4 to speak to a Survivor Support Representative. The Survivor Support Representative will mail the applicable forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but no later than 365 days from the date of the covered person's death, to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Supplemental Life plan are fully-insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Survivor Support Representatives

The Baker Hughes Benefits Center has dedicated Survivor Support Representatives to assist you or your dependents in submitting a claim for death benefits to the insurance carrier.

Survivor Support Representatives can be reached by calling **1-866-244-3539**, Option 4, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Claims Procedures

Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

  (i) the views of your treating providers and vocational professionals who evaluated you

  (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

  (iii) an award of Social Security Administration disability benefits

(b) references to the specific plan provisions on which the benefit determination was based

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.

Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in the section above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge. A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time.

A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

Prudential will provide you, free of charge and prior to an adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date. If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

- the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,
- references to the specific plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- a description of Prudential's review procedures and applicable time limits,
- a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and
- a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed deniedon appeal.

Notice of Benefit Decision on Appeal

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in the section above, you may make a second, voluntary appeal, although you are not required to do so. You may submit with your second, voluntary appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential shall make a determination on your second, voluntary appeal within 45 days of the receipt of your second, voluntary appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the second, voluntary appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second, voluntary 45-day appeal review period.

Your decision to submit a benefit dispute to this second, voluntary level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second, voluntary level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second, voluntary level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on second, voluntary appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse appeal determination letter. If a decision on second, voluntary appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on the second, voluntary appeal.

Legal Action Following Appeals

If your claim for benefits and any required appeal are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in the certificate of coverage/insurance provided by Prudential, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the amount payable under the Supplemental Life plan is paid to your beneficiaries by Prudential. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse or domestic partner; otherwise
- Your naturally born or legally adopted children or domestic partner's children in equal shares; otherwise
- Your surviving parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate

The benefit will be paid in a single sum or by any other method agreeable to Prudential and the beneficiaries. Prudential will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Prudential based on current short-term market rates, or the minimum required by state law, whichever is greater.

Note: Supplemental Life benefits for the employee and covered dependents will not be paid to the beneficiary if you or the covered dependent spouse or domestic partner commits suicide within 24 months of electing coverage.

When Does Coverage End?

Right to Apply for Coverage Under the Portability Plan

You will have the right to apply for term life coverage under the Portability Plan if you meet all of these tests:

1. Your Optional Employee Term Life Coverage ends for any reason other than:
   a. your failure to pay, when due, any contribution required for it; or
   b. the end of your employment on account of your retirement; or
   c. the end of the coverage for all employees when such coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days
2. You meet the Active Work Requirement on the day your insurance ends
3. You are less than age 80
4. Your Amount of Insurance is at least $20,000 under the Optional Employee Term Life Coverage on the day your insurance ends

Portability Application Period

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. The Portability Application Period is the 31 day period after your Optional Employee Term Life Coverage ends. But, if you have the right to convert your insurance under the Optional Employee Term Life Coverage to an individual contract, it is the longer of:

1. The 31 day period after your coverage ends; and
2. The number of days during which you have the right to convert your insurance under the coverage to an individual life insurance contract as shown in the coverage.

Effect of Conversion Privilege

The right to elect coverage under the Portability Plan is provided in lieu of the conversion privilege described in the Basic Employee Term Life Coverage, except as follows:

1. You may convert your amount of insurance under the Optional Employee Term Life Coverage in excess of the maximum for term life coverage under the Portability Plan. This maximum is the lesser of 5 times your annual Earnings and $1,000,000.
2. You may convert your insurance if you elected coverage under the Portability Plan, but Prudential decided that your evidence of insurability was not satisfactory. If you elect to convert all of your insurance under the Optional Employee Term Life Coverage to an individual contract, you may not elect to apply for coverage under the Portability Plan. If, during the Portability Application Period, you apply for coverage under the Portability Plan and then elect to convert all of your insurance under the Optional Employee Term Life Coverage to an individual contract, your coverage under the Portability Plan will not become effective. The right to elect coverage under the Portability Plan does not affect your coverage under the Death Benefit During Conversion Period provision of the Optional Employee Term Life Coverage.

Terms and Conditions of the Portability Plan

The form, amount, first premium, and effective date will be as stated below.

Form and Amount: The form of term life coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Optional Employee Term Life Coverage under the Group Contract. Amount: Not more than your amount of insurance under the Optional Employee Term Life Coverage when your insurance ends, but not less than $20,000. The maximum amount of term life insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000. First Premium: The first premium is due to Prudential within 31 days of the date the first bill is issued. Effective Date: The day after the Portability Application Period ends.

Converting or Porting Your Coverage

For more information or to convert or port your coverage, contact Prudential at **1-800-778-3827**. If you are using a telecommunications device for the hearing impaired, call **1-800-496-1214**.

Basic AD&D Insurance

Basic AD&D At-a-Glance

Type of Plan	Welfare plan providing Accidental Death & Dismemberment insurance.
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Basic AD&D insurance.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary
Coverage Options	Coverage equal to 1x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000). This coverage amount is referred to as the principal sum by the insurance provider.
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or 1-847-883-0945 (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Basic AD&D plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan by accessing your account from **BakerHughesBenefits.com** prepared by Prudential and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES

There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate and this SPD. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate and this SPD. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 52656.

Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can provide you financial protection in addition to the protection you have through life insurance. Basic Accidental Death & Dismemberment coverage is provided under the Baker Hughes Accidental Death & Dismemberment program (the Basic AD&D plan).

Both Life and AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a death benefit; however, AD&D only pays if the cause of death was accidental
- AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses

You do not contribute anything to receive Basic AD&D insurance coverage. It is paid 100% by Baker Hughes.

The Basic AD&D plan provides you with Basic AD&D insurance coverage on the first active day of work. No enrollment is necessary.

Basic AD&D insurance coverage provides financial protection for your family if you die accidentally. The Basic AD&D plan also pays a benefit to you if you lose a limb, lose your sight or hearing, or become paralyzed as the result of an accident. Basic AD&D plan benefits are payable in addition to benefits from Basic Life insurance, Voluntary Accidental Death & Dismemberment insurance, and the Business Travel Accident insurance plan (if applicable).

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy which is in force and is the direct cause of loss.

Survivor Support Representatives

The Baker Hughes Benefits Center has dedicated Survivor Support Representatives to assist you or your dependents in submitting a claim for death benefits to the insurance carrier.

Survivor Support Representatives can be reached by calling **1-866-244-3539**, Option 4, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

The amount of your Basic AD&D plan benefit is based on the type of loss that you suffer, as shown in the following chart. No benefit will be payable for a loss which is not shown in this chart:

Basic AD&D

Your accidental death, dismemberment, paralysis, or other covered loss

You or your dependent contacts the **Baker Hughes Benefits Center** and request to speak to a Survivor Support Representative

Once the Benefits Center Survivor Support Representative has been contacted and the claim has been processed and approved by the insurance provider, a benefit will be paid to you or your beneficiaries

Naming a Beneficiary

You need to name a beneficiary for your Basic AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Remember...

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

If you do not name a beneficiary under the Basic AD&D insurance plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that is to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (This is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Prudential at 1-800-524-0542 to obtain the form. Once you have completed the form, you will need to provide it to the Baker Hughes Benefits Center.

How Does the AD&D Process Work?

What Losses are Covered by Basic AD&D Insurance?

The amount of your Basic AD&D plan benefit is based on the type of loss that you suffer, as shown in the following chart. No benefit will be payable for a loss which is not shown in this chart:

Loss: which occurs within 365 days of accident	% of Principal Sum
• Life • Sight in both eyes • Speech and hearing in both ears • Both hands or both feet • One hand and one foot • One hand or one foot and sight of one eye • Quadriplegia	100%
• Triplegia • Paraplegia • One arm or one leg (by severance, above the elbow or above the knee)	75%
• Sight of one eye • Speech • Hearing in both ears • One hand or one foot • Hemiplegia	50%
• Thumb and index finger of the same hand • Uniplegia • Four fingers of the same hand • Hearing in one ear • Loss of use* (which occurs within 365 days of accident) of one hand, or one foot, or one arm, or one leg	25%
• All toes on one foot	13%
• Big toe	5%
• Coma	The lesser of 2% per month and $1,000 up to 100 months; after 100 months a lump sum equal to 100% of the Amount of Insurance minus the amount already paid for
• Exposure and Disappearance Benefit**	% of Principal sum consistent with type of loss

** Loss of use: The total and permanent loss of function.*
***For the purposes of the coverage: 1) Exposure to the elements will be considered an accidental bodily Injury. Exposure to the elements means exposure to severe hot or cold weather that results in actual significant physical injury including sun stroke, heat stroke, and frostbite. 2) It will be presumed that the person has suffered a loss of life if the person's body has not been found within one year of disappearance, stranding, sinking, or wrecking of any vehicle in which the person was an occupant.*

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

Example:

Assuming that your maximum AD&D benefit is $50,000, the following benefit amounts would apply to the losses listed:

Type of Accidental Loss	Benefit
• Life • Both hands, both feet, the sight of both eyes, or any combination • One hand and one foot • One hand or one foot and the sight of one eye • Speech and hearing	$50,000
• One hand, one foot, or the sight of one eye • Speech or hearing (in both ears)	$25,000
• Thumb and index finger of the same hand	$12,500

If you suffer multiple losses as the result of one accident, only the single largest benefit will be payable. For example, if you lost a hand, your thumb, and index finger (on the other arm), you would receive a maximum benefit of $25,000.

If a covered loss occurs as a result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amount, which when totaled, exceeds the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Defining Loss

Loss means your:

- Loss of life;
- Total and permanent Loss of Sight;
- Total and permanent Loss of Speech;
- Total and permanent Loss of Hearing;
- Permanent loss of arm or leg by severance at or above the elbow or the knee;
- Permanent loss of hand or foot by severance at or above the wrist or ankle;
- Permanent loss of thumb and index finger of the same hand or permanent loss of four fingers on the same hand by severance at or above the point at which they are attached to the hand;
- Permanent loss of all toes on the same foot or the big toe by severance at or above the point at which they are attached to the foot;
- Loss of use of hand, foot, arm, or leg;
- Loss of use due to quadriplegia, triplegia, paraplegia, hemiplegia, or uniplegia
- Loss due to coma

- Loss of Sight means total and permanent loss of sight. Corrected visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees.
- Loss of Speech means total and permanent loss of speech that continues for at least 12 consecutive months following the covered accident.
- Loss of Hearing means a hearing loss of greater than 70 decibels at all frequencies or there is less than 50% speech discrimination at 70 decibels on an audiogram.
- Quadriplegia means the total and permanent paralysis of both upper and both lower limbs.
- Paraplegia means the total and permanent paralysis of both lower limbs.
- Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.
- Triplegia means the total and permanent paralysis of three limbs.

- Uniplegia means the total and permanent paralysis of one limb.
- Loss of Use means total and permanent loss of function.
- Coma means a persistent vegetative state in which there is no response to external stimuli as determined by the person's doctor and begins within 365 days after the accident and continues for 31 consecutive days. It is total, continuous, and permanent at the end of the 31-day period. Benefits will begin after the 31-day period.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

Basic AD&D Losses Not Covered

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's suicide or attempted suicide, while sane or insane.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's Intentionally self-inflicted Injuries, or any attempt to inflict such injuries.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's sickness, whether the loss results directly or indirectly from the sickness.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's medical or surgical treatment of sickness, whether the Loss results directly or indirectly from the treatment.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's bacterial or viral infection. But, this does not include:

- pyogenic infection resulting from an accidental cut or wound; or
- bacterial infection resulting from accidental ingestion of a contaminated substance.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person taking part in any riot or insurrection.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, a war, or any act of war, except as provided by the War Risk Hazard provision. War means declared or undeclared war and includes resistance to armed aggression. Terrorism is not considered an act of war.

Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious, or social objectives.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, while the insured person is serving on full-time active duty for more than **30 days** in any armed forces. But this does not include Reserve or National Guard active duty for training.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's travel or flight in any vehicle used for aerial navigation, except as provided by any hazard provision, if:

- the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
- the person is performing as a pilot or a crew member of any aircraft; or
- the person is riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of Baker Hughes or any of its subsidiaries or affiliates. This includes getting in, out, on or off any such vehicle.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's commission of or attempt to commit an assault or a felony.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the loss occurred, regardless of whether the person:

- was operating a motor vehicle; and
- was convicted of an alcohol related offense.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured's doctor.

Note: Specific exclusion wording may vary by situs, as required by state filings.

Additional Basic AD&D Benefits

Air Bag

If you die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Basic AD&D plan will pay an amount equal to the lesser of 10% of the amount of insurance; and $10,000 if:

a. The person is a driver or passenger in an automobile;

b. The person is wearing a seat belt in the manner prescribed by the vehicle's manufacturer,

c. The actual use of a seat belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s); the automobile is equipped with a factory-installed air bag; and

d. A properly functioning air bag; was deployed for the seat that the person occupied.

Seat belt means passive restraint device for an adult that meets published federal safety standards, is installed by the automobile's manufacturer or replaced by an organization sanctioned by the automobile's manufacturer, and is not altered or replaced after that installation, or federally approved, properly installed child safety seat.

Bereavement and Trauma Counseling

The Basic AD&D Benefit applies if you require Bereavement and Trauma Counseling Sessions because you suffer a loss. It is payable for Bereavement and Trauma Counseling Sessions that are held within one year after the date of the accident causing the loss. The benefit pays an amount equal to the lesser of (1) the actual cost charged for counseling sessions, and (2) $100. This benefit is payable for up to 50 sessions.

Car Jacking

The Basic AD&D plan will pay a benefit if you suffer a loss while covered that is the result of a Carjacking of an automobile in which you are driving or riding.

The benefit payable is equal to the lesser of 5% of the Amount of Insurance on the person; and $10,000.

Funeral Expense

If you suffer an accidental bodily Injury that results in a loss of life within 365 days of an accident the Basic AD&D plan will pay a funeral expense benefit up to $2,000.

The Basic AD&D plan benefit pays an amount equal to the lesser of:

a. The amount of the Funeral Expenses;

b. 2.5% of the amount of Insurance on the person; and

c. $2,000.

Hearing Aids and Prosthetics

The Basic AD&D plan pays a benefit for hearing aids and prosthetic devices if you suffer a loss while covered under the plan and the loss requires you to use a hearing aid or a prosthetic device. It is payable if:

a. The hearing aid was obtained within one year of the accident that results in the loss and was prescribed by a doctor; or

b. The prosthetic device was obtained within one year of the loss and was prescribed by a doctor

The benefit payable is equal to the least of

1. The actual cost to the person for the hearing aid or the prosthetic device;
2. 5% of the amount of insurance on the person; and
3. $10,000.

Home Alteration & Vehicle Modification

If an accidental injury causes a loss that requires home alteration or vehicle modification the Basic AD&D plan will pay an amount equal to the least of:

1. the actual cost charged for the alteration or modification;
2. 10% of the amount of insurance on the person; and
3. $10,000

This additional benefit for home alteration and vehicle modification expense only applies once during a person's lifetime.

Medical Premium

The Basic AD&D plan pays a benefit for monthly medical premiums if you suffer a loss while covered under the plan and:

a. You suffer an accidental bodily Injury that results in a loss within 365 days of an accident; and

b. The accidental bodily Injury: (i) results in your having to take a leave of absence from your job with Baker Hughes; or (ii) ends your employment with Baker Hughes.

c. You choose to continue membership in the Baker Hughes medical plan beyond the time that it would otherwise end

The Basic AD&D plan will pay an amount equal to the lesser of 3% of your amount of insurance and $500.

This benefit will be paid monthly until the first of these occurs:

1. Your continued membership in the Baker Hughes medical plan ends.
2. You become covered under any other group medical plan.
3. The benefit has been paid for 12 consecutive months.

Proof of enrollment in the Baker Hughes medical plan and of continued medical premium contribution must be given to Prudential.

Additional Benefit for Monthly Medical Premium for your Dependent Spouse, Domestic Partner or Dependent Child

The Basic AD&D plan will pay your qualified dependent spouse, domestic partner or qualified dependent child for monthly medical premiums if you die accidentally. This additional benefit for monthly medical premiums is payable for your qualified dependent spouse, domestic partner or child who:

a. Is insured for dependents insurance under the coverage on the date of your death; and

b. Elects to continue membership in the Baker Hughes medical plan.

The benefit pays the lesser of:

1. 3% of your amount of insurance; and
2. $500.

This benefit will be paid monthly until the first of these occurs:

1. Your spouse, domestic partner, or child's continued membership in the Baker Hughes medical plan ends.
2. Your spouse, domestic partner, or child becomes covered under any other group medical plan.
3. The benefit has been paid for 12 consecutive months.

Proof of enrollment in the Baker Hughes medical plan and of continued medical premium contribution must be given to Prudential.

Mortgage Payment

The Basic AD&D plan will pay a monthly mortgage benefit up to $1,500 if you suffer an accidental bodily Injury that results in a loss of life. The plan will pay your surviving spouse or domestic partner if all criteria below is met:

a. You suffer an accidental bodily Injury that results in a Loss of life within 365 days of an accident.

b. You have a surviving spouse or domestic partner at the time of your death.

c. Your surviving spouse or domestic partner is a co-borrower on your mortgage.

d. You have an outstanding balance on your mortgage at the time of your death.

Your surviving spouse or domestic partner must give Prudential your mortgage loan number, along with the name and telephone number of your mortgage company.

The Basic AD&D plan pays the lesser of the amount of your monthly Mortgage payment; and $1,500.

This benefit will be paid monthly until the first of these occurs:

1. Your spouse or domestic partner dies.
2. Your mortgage is paid in full.
3. Your house is sold.
4. The benefit has been paid for 24 consecutive months.

Proof of the amount of monthly mortgage payment must be given to Prudential.

A mortgage payment means a loan that is secured by your house. The term includes any property taxes and insurance that may be included in the monthly payment.

Parental Care

This additional benefit for parental care only applies if you suffer a loss of life. This additional benefit is payable for each of you or your dependent spouse's or domestic partner's parents or grandparents, who was or will be claimed as a dependent on your federal income tax return for the calendar year before or during which you suffer the loss of life; and:

a. is dependent on you for more than 50% of the cost of:

   i. residing in a nursing care facility;

   ii. home health care;

   iii. enrollment in a day care program; or

b. resides in your home.

The Basic AD&D plan pays an amount equal to the lesser of 5% of your amount of insurance and $10,000

Rehabilitation Expense

The Basic AD&D plan pays a benefit if you suffer a loss while covered under the plan and a doctor determines that rehabilitation is necessary to aid you in returning to the normal activities of a person of the same age and gender. Rehabilitation Expense includes: (1) the expense for treatment by a rehabilitation therapist who is licensed, registered and/or certified to provide such treatment; and (2) the expense of confinement in a health care facility for rehabilitation.

The Basic AD&D Plan will pay an additional benefit:

1. 10% of your Amount of Insurance; and
2. $500.

This benefit will be paid monthly until the first of these occurs:

1. A doctor determines that you no longer need rehabilitation.
2. You fail to furnish any required proof of your continuing need for rehabilitation.
3. You fail to submit to a medical exam by doctors named by Prudential, at Prudential's expense, when and as often as Prudential requires.
4. The benefit has been paid for 12 consecutive months.

Seat Belt

If you die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Basic AD&D plan will pay an additional benefit of 10% of the amount of insurance to a maximum of $50,000 as long as:

- The insured is a driver or passenger in an automobile; and
- The insured is wearing a seat belt in the manner prescribed by the vehicle's manufacturer; and
- The actual use of a seat belt at the time of the injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).
- The loss was not the result from driving or riding in any automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

Seat belt means passive restraint device for an adult that meets published federal safety standards, is installed by the automobile's manufacturer or replaced by an organization sanctioned by the automobile's manufacturer, and is not altered or replaced after that installation, or a federally approved, properly installed child safety seat.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental
- The direct cause of a loss; and
- Occurs while a person is insured under the policy issued by Prudential under the Basic AD&D plan, which is in force

Accidental bodily injury does **not** include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease
- Bursitis
- Chondromalacia
- Shin splints
- Stress fractures
- Tendinitis; and
- Carpal tunnel syndrome

Spouse or Domestic Partner Tuition Reimbursement Expense

The Basic AD&D plan will reimburse your spouse or domestic partner up to $10,000 for spouse or domestic partner employment training expense if you die accidentally while you are covered under the plan, and your surviving spouse or domestic partner incurs employment training expense within 12 months following the date of your death.

This additional benefit is payable for the person who:

a. is your spouse or domestic partner on the date of your death; and

b. enrolls in any professional or trades program within 12 months after the date of your death for the purposes of obtaining an independent source of support or enriching that spouse's or domestic partner's ability to earn a living.

Additional benefit amount to be paid is an amount equal to the least of:

1. the actual annual tuition charged for the program;
2. 10% of your Amount of Insurance; and
3. $10,000

This benefit is payable annually for up to 2 consecutive years.

The benefit amount for spouse or domestic partner employment training expense will be paid to your spouse or domestic partner who incurs the expense. The benefit amount for your spouse or domestic partner employment training expense is payable in addition to any other applicable benefit amounts under the Voluntary AD&D plan. If there is no dependent spouse or domestic partner eligible for this benefit, a benefit amount of $1,000 will be paid.

Tuition Reimbursement for Your Dependent Child

This Basic AD&D will plan will pay up to $10,000 annually for a dependent child education expense if you die accidentally while you are covered under the plan, and your dependent child incurs eligible expenses within 12 months following the date of your death.

This additional benefit is payable for each dependent child less than age 26 who:

a. wholly depends on you for support and maintenance on the date of your death; and

b. is enrolled as a full-time student in a school on the date of your death; or

c. is at the 12th grade level on the date of your death and becomes a full-time student in a school within 365 days after that date.

Additional Amount Payable under this Additional Benefit

An amount equal to the least of:

1. the actual annual tuition, exclusive of room and board, books and fees, charged by the school;
2. 10% of your amount of insurance; and
3. $10,000.

This benefit is payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 26.

If there is no dependent child eligible for this benefit, a benefit of $1,000 will be paid.

Child Care Expenses for Your Dependent Child

This additional benefit under the plan will provide child care expense of an amount equal to the least of the actual cost charged by a child care center per year, not to exceed 5% of your amount of insurance and $5,000 if you die accidentally while you are covered under the plan, and your dependent child is under the age of thirteen years for whom child care expenses are incurred within 365 days of your death.

Child care expense means the actual incurred costs for the care and supervision of your dependent child who is less than age 13.

The Basic AD&D plan will reimburse child care expenses for each eligible dependent child. The benefit is payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 13. Benefits for childcare expenses will be paid to the person or institution appearing to Prudential to have assumed the main support of your dependent children.

In the event of a common accident, only one benefit amount for childcare expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for childcare expense is payable in addition to any other applicable benefit amounts payable under your Voluntary AD&D insurance coverage.

Filing a Basic AD&D Claim

To claim benefits under the Basic AD&D plan, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**, Option 4 to speak to a Survivor Support Representative.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of loss. The claimant may also request a claim form and mail the completed forms with the required documentation to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the form carefully, answer the required questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic AD&D plan are fully-insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Claims Procedures

Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan.

A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

a. The specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

b. references to the specific plan provisions on which the benefit determination was based,

c. a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

d. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

e. a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

f. a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific, or clinical judgment for the determination will be provided free of charge upon written request, and

g. copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.

Appeals of Adverse Determination: Filing an Appeal

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in the section above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

Prudential will provide you, free of charge and prior to an adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

a. the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

b. references to the specific plan provisions on which the determination was based,

c. a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

d. a description of Prudential's review procedures and applicable time limits,

e. a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and

f. a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Notice of Benefit Decision on Appeal

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in the section above, you may make a second, voluntary appeal, although you are not required to do so. You may submit with your second, voluntary appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second, voluntary appeal within 45 days of the receipt of your second, voluntary appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the second, voluntary appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second, voluntary 45-day appeal review period.

Your decision to submit a benefit dispute to this second, voluntary level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second, voluntary level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second, voluntary level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on second, voluntary appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse appeal determination letter. If a decision on second, voluntary appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on the second, voluntary appeal.

Legal Action Following Appeal

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed in the *Benefits Rights* section. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this SPD, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Basic AD&D policy will be paid in a lump sum to beneficiaries designated by you within 365 days after the accident causing the loss.

All benefits, except for loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- Your spouse or domestic partner; otherwise
- Your children or domestic partner's children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate

When Does Coverage End?

Your coverage under the Basic AD&D plan will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Right to Apply for Coverage Under the Portability Plan

You will have the right to apply for accident coverage under the Portability Plan if you meet all of these tests:

1. Your Accidental Death and Dismemberment coverage ends for any reason other than:
   a. your failure to pay, when due, any contribution required for it; or
   b. the end of your employment on account of your retirement; or
   c. the end of the coverage for all employees when such coverage is replaced by group Accidental Death and Dismemberment insurance from any carrier for which you are or become eligible within the next 31 days.
2. You meet the Active Work Requirement on the day your insurance ends.
3. You are less than age 80.
4. Your Amount of Insurance is at least $20,000 under the Accidental Death and Dismemberment coverage on the day your insurance ends.

Portability Application Period

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. The Portability Application Period is the 31-day period after your Accidental Death and Dismemberment coverage ends.

Terms and Conditions of the Portability Plan

The form, amount, first premium, and effective date will be as stated below.

- **Form:** The form of accidental death and dismemberment coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Accidental Death and Dismemberment Coverage under the Group Contract.
- **Amount:** Not more than your amount of insurance under the Accidental Death and Dismemberment coverage when your insurance ends, but not less than $20,000. The maximum amount of Accidental Death and Dismemberment insurance under the Portability Plan is the lesser of 5 times your annual earnings and $1,000,000.
- **First Premium**: The first premium is due to Prudential within 31 days of the date the first bill is issued.
- **Effective Date:** The day after the Portability Application Period ends.

Porting Your Coverage

For more information, or to port your coverage, contact Prudential at **1-800-778-3827.** If you are using a telecommunications device for the hearing impaired, call **1-800-496-1214.**

Voluntary AD&D Insurance

Voluntary AD&D At-a-Glance

Type of Plan	Voluntary Accidental Death & Dismemberment insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in *General Information*). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Level	• You Only • You + Family • No Coverage
Coverage Options	**Employee Coverage:** You can elect from 1x, 2x, 3x, 4x, or 5x your annual salary, up to a maximum of $4 million. **Employee + Family Coverage**: Based on the employee coverage levels above, if you elect family coverage, the spouse or domestic partner and children benefit is as follows: • Spouse or domestic partner only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse or domestic partner and children — 40% of employee coverage amount for your spouse or domestic partner and 10% of employee coverage amount, up to $20,000 per child
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Voluntary AD&D plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan by accessing your account from **BakerHughesBenefits.com** prepared by Prudential and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in the Group Insurance Certificate and this SPD. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Group Insurance Certificate and this SPD. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 52656.

Your Voluntary Accidental Death & Dismemberment (AD&D) Insurance

Voluntary Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can give you financial protection in addition to the protection you have through life insurance. Voluntary Accidental Death & Dismemberment coverage is provided under the Baker Hughes Company Voluntary Accidental Death & Dismemberment program (the Voluntary AD&D plan).

What is the Difference Between Supplemental Life and Voluntary Accidental Death & Dismemberment (AD&D) Insurance?

Both Supplemental Life and Voluntary AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a benefit if you or a covered family member dies. However, Voluntary AD&D only pays if the cause of death was accidental
- Voluntary AD&D premiums are lower because the incidence of accidental death is much lower than that of death from natural causes
- Voluntary AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses

Voluntary AD&D insurance should not be considered a substitute for Supplemental Life insurance; however, it can provide valuable additional protection, especially at younger ages when responsibilities are greatest and availability of funds is not.

Who Pays the Cost of the Voluntary AD&D Plan?

If you decide to enroll yourself, or yourself and your dependents, in the Voluntary AD&D plan, you'll pay the full cost through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within the specified time frame in Voluntary AD&D insurance coverage, your coverage begins on your first active day of work if you're a new hire or an existing employee transferring to a position with US benefits, or the following January 1 if you enroll in the Plan during the Annual Enrollment period.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees

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

What Losses are Covered by Voluntary AD&D Insurance?

The chart below outlines acceptable and unacceptable Voluntary AD&D coverage elections for couples* who both work at Baker Hughes. For assistance completing spouses or domestic partners who both work at Baker Hughes coverages, please call the Baker Hughes Benefits Center at 1-866-244-3539. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Voluntary AD&D Coverage Options	Employee A	Employee B	Employee A	Employee B	Employee A	Employee B
Voluntary AD&D	elected	elected	elected	elected	waived	elected
Voluntary AD&D Family (Spouse or Domestic Partner)	elected	elected	waived	waived	waived	elected
Voluntary AD&D Family (Child(ren))	elected	elected	waived	waived	waived	elected
Voluntary AD&D Family (Spouse or Domestic Partner and Child(ren))	elected	elected	waived	waived	waived	elected
Baker Hughes Policy	Unacceptable[1]		Acceptable[2]		Acceptable[3]	

Note 1: ***The Baker Hughes Health and Protection Plan does not allow Dual Coverage.*** Spouses or domestic partners cannot each elect Voluntary AD&D, Voluntary AD&D Family (Spouse or Domestic Partner), Voluntary AD&D Family (Child(ren)) and Voluntary AD&D Family (Spouse or Domestic Partner and Child(ren)).

Note 2: Married employees and domestic partners who both work at Baker Hughes cannot elect Voluntary AD&D Family (Spouse or Domestic Partner) coverage on the other.

Note 3: Either spouse or domestic partner can elect Voluntary AD&D, Voluntary AD&D Family (Spouse or Domestic Partner), Voluntary AD&D Family (Child(ren)), and Voluntary AD&D Family (Spouse or Domestic Partner & Child(ren)) coverage. ***However, both spouses or domestic partners cannot cover a dependent under Voluntary AD&D Child(ren).***

How Does Voluntary AD&D Insurance Work?

If you choose to participate in the Voluntary AD&D plan, the plan pays a benefit to you or your beneficiaries if you or a covered family member suffer accidental death, dismemberment, paralysis, or other covered losses.

Schedule of Benefits for Voluntary AD&D Insurance	
Employee Coverage	You can elect from 1x, 2x, 3x, 4x, or 5x your annual salary, up to a maximum of $4 million.
Employee + Family Coverage	Based on the employee coverage levels above, if you elect family coverage, the spouse or domestic partner and children benefit is as follows: • Spouse or domestic partner only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse and children — 40% of employee coverage amount for your spouse or domestic partner and 10% of employee coverage amount, up to $20,000 per child

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy which is in force and is the direct cause of loss.

Voluntary AD&D Enrollment Process

Voluntary AD&D

Enroll in coverage

Name your beneficiaries

You or your dependent's accidental death, dismemberment, paralysis, or other covered loss

You or your dependent contacts the **Baker Hughes Benefits Center** and request to speak to a Survivor Support Representative

Once the Baker Hughes Benefits Center Survivor Support Representative has been contacted and the claim has been processed and approved by the insurance provider, a benefit will be paid to you or your beneficiaries

Note: You're automatically the beneficiary for your dependent's loss-of-life benefits.

Naming a Beneficiary

You need to name a beneficiary for your Voluntary AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

If you do not name a beneficiary under the Voluntary AD&D plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that is to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (This is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact **Prudential** at **1-800-524-0542** to obtain the form. Once you have completed the form, you will need to provide it to the **Baker Hughes Benefits Center.**

Remember...
It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

How Does the Voluntary AD&D Process Work?

What Losses are Covered by Voluntary AD&D Insurance?

The amount of your Voluntary AD&D plan benefit is based on the type of loss that you or your covered dependent suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

Loss which occurs within 365 days of accident	% of Principal Sum
• Life • Sight in Both Eyes • Speech and Hearing in Both Ears • Both Hands or Both Feet • One Hand and One Foot • One Hand or One Foot and Sight of One Eye • Quadriplegia	100%
• Triplegia • One Arm or One Leg (by severance, above the elbow or above the knee) • Paraplegia	75%
• Sight of One Eye • Speech • Hearing in Both Ears • One Hand or One Foot • Hemiplegia	50%
• Uniplegia • Thumb & Index Finger of the Same Hand • Four Fingers of the Same Hand • Loss of Use* (which occurs within 365 days of accident) of One Hand, One Foot, One Arm, or One Leg • Hearing in One Ear	25%
• All Toes on One Foot	13%
• Big Toe	5%
• Coma	The lesser of 2% per month and $1,000 up to 100 months; after 100 months a lump sum equal to 100% of the Amount of Insurance minus the amount already paid for coma
• Exposure and Disappearance Benefit**	% of Principal sum consistent with type of loss

**Loss of use: The total and permanent loss of function.*

***For the purposes of the coverage: 1) Exposure to the elements will be considered an accidental bodily Injury. Exposure to the elements means exposure to severe hot or cold weather that results in actual significant physical injury including sun stroke, heat stroke, and frostbite. 2) It will be presumed that the person has suffered a Loss of life if the person's body has not been found within one year of disappearance, stranding, sinking, or wrecking of any vehicle in which the person was an occupant.*

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, which when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Survivor Support Representatives

The Baker Hughes Benefits Center has dedicated Survivor Support Representatives to assist you or your dependents in submitting a claim for death benefits to the insurance carrier.

Survivor Support Representatives can be reached by calling **1-866-244-3539**, Option 4, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Defining Loss

Loss means your:

- Loss of life
- Total and permanent loss of sight
- Total and permanent loss of speech
- Total and permanent loss of hearing
- Permanent loss of arm or leg by severance at or above the elbow or the knee
- Permanent loss of hand or foot by severance at or above the wrist or ankle
- Permanent loss of thumb and index finger of the same hand or permanent loss of four fingers on the same hand by severance at or above the point at which they are attached to the hand
- Permanent loss of all toes on the same foot or the big toe by severance at or above the point at which they are attached to the foot
- Loss of use of hand, foot, arm, or leg
- Loss of use due to quadriplegia, triplegia, paraplegia, hemiplegia, or uniplegia
  - Loss due to coma
  - Loss of Sight means total and permanent loss of sight. Corrected visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees.
  - Loss of Speech means total and permanent loss of speech that continues for at least 12 consecutive months following the covered accident.
  - Loss of Hearing means a hearing loss of greater than 70 decibels at all frequencies or there is less than 50% speech discrimination at 70 decibels on an audiogram.
  - Quadriplegia means the total and permanent paralysis of both upper and both lower limbs.
  - Paraplegia means the total and permanent paralysis of both lower limbs.
  - Hemiplegia means the total and permanent paralysis of the upper and lower limbs on one side of the body.
  - Triplegia means the total and permanent paralysis of three limbs.
  - Uniplegia means the total and permanent paralysis of one limb.
  - Loss of Use means total and permanent loss of function.
  - Coma means a persistent vegetative state in which there is no response to external stimuli as determined by the person's doctor and begins within 365 days after the accident and continues for 31 consecutive days. It is total, continuous, and permanent at the end of the 31-day period. Benefits will begin after the 31-day period.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

Voluntary AD&D Losses Not Covered

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's suicide or attempted suicide, while sane or insane.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's sickness, whether the loss results directly or indirectly from the sickness.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's bacterial or viral infection. But, this does not include:

- a pyogenic infection resulting from an accidental cut or wound; or
- a bacterial infection resulting from accidental ingestion of a contaminated substance.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person taking part in any riot or insurrection.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, a war, or any act of war, except as provided by the War Risk Hazard provision. War means declared or undeclared war, and includes resistance to armed aggression. Terrorism is not considered an act of war.

Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious, or social objectives.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, while the insured person is serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's travel or flight in any vehicle used for aerial navigation, except as provided by any hazard provision, if:

- the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
- the person is performing as a pilot or a crew member of any aircraft; or
- the person is riding as a passenger in an aircraft owned, operated, controlled, or leased by or on behalf of Baker Hughes or any of its subsidiaries or affiliates.

This includes getting in, out, on or off any such vehicle.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's commission of or attempt to commit an assault or a felony.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the loss occurred, regardless of whether the person:

- was operating a motor vehicle; and
- was convicted of an alcohol related offense.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison, or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured's doctor.

Note: Specific exclusion wording may vary by situs, as required by state filings.

Additional Voluntary AD&D Benefits

Air Bag

If you or a covered dependent die as the result of a private passenger automobile accident and that person was wearing a seat belt at the time, the Voluntary AD&D plan will pay an amount equal to the lesser of 10% of the amount of insurance; and $10,000 if:

a. The person is a driver or passenger in an automobile;

b. The person is wearing a seat belt in the manner prescribed by the vehicle's manufacturer,

c. The actual use of a seat belt at the time of the Injury is verified in an official report of the accident, or is certified in writing by the investigating official(s);

d. The automobile is equipped with a factory-installed air bag; and

e. A properly functioning air bag was deployed for the seat that the person occupied.

Seat belt means passive restraint device for an adult that meets published federal safety standards, is installed by the automobile's manufacturer or replaced by an organization sanctioned by the automobile's manufacturer; and is not altered or replaced after that installation; or (2) federally approved, properly installed child safety seat.

Bereavement & Trauma Counseling

The Voluntary AD&D benefit applies if you require Bereavement and Trauma Counseling Sessions because you suffer a loss. It is payable for Bereavement and Trauma Counseling Sessions that are held within one year after the date of the accident causing the loss. The benefit pays an amount equal to the lesser of (1) the actual cost charged for counseling sessions, and (2) $100. This benefit is payable for up to 50 sessions. The Bereavement & Trauma Counseling expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Car Jacking

The Voluntary AD&D plan will pay a benefit if you or a covered dependent suffer a loss while covered that is the result of a carjacking of an automobile in which the person is driving or riding.

The benefit payable is equal to the lesser of 5% of the amount of insurance on the person and $10,000.

Child Care Expense

If you enroll in Voluntary AD&D insurance coverage under the plan, the plan will provide child care expense of an amount equal to the least of the actual cost charged by a child care center per year, not to exceed 5% of your amount of insurance and $5,000 if you die accidentally while you and your eligible dependents are covered under the plan, and your dependent child is under the age of thirteen years for whom child care expenses are incurred within 365 days of your death.

Child care expense means the actual incurred costs for the care and supervision of your dependent child who is less than age 13.

The Voluntary AD&D plan will reimburse child care expenses for each eligible dependent child. The benefit is payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 13.

Benefits for child care expenses will be paid to the person or institution appearing to Prudential to have assumed the main support of your dependent children.

In the event of a common accident, only one benefit amount for child care expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for child care expense is payable in addition to any other applicable benefit amounts payable under your Voluntary AD&D insurance coverage.

Education Expense

To claim benefits under the Voluntary AD&D plan, if you or your beneficiary who is entitled to benefits enroll in Voluntary AD&D insurance coverage and elect to cover your eligible dependents, the plan will reimburse education expense up to $10,000 annually for each eligible dependent up to the $40,000 maximum benefit amount per child if you die accidentally while you and your eligible dependents are covered under the plan, and:

- Wholly depends on you for support and maintenance on the date of your death; and
- Is enrolled as a full-time student in a school on the date of your death; or
- Is at the 12th grade level on the date of your death and becomes a full-time student in a school within 365 days after that date.

Education expense payments for each eligible dependent child will be available. However, the total annual payment for each dependent child will not exceed the $10,000 annual benefit amount for education expense. In no event will the total payment exceed the maximum benefit amount of $40,000.

The education expense payment is limited to four consecutive years for each eligible dependent child.

If, on the date of your death while covered under the Voluntary AD&D plan, you have coverage for a dependent child, but do not have any dependent children eligible for education expense payments, the plan will pay the alternate benefit amount of $1,000. If the alternate benefit amount is paid, then no further payments for education expense will be paid.

In the event of a common accident, only one benefit amount for education expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for education expense shall be paid to the person who incurs the expense. The alternate benefit amount in lieu of education expense reimbursement shall be paid to the named beneficiary.

The benefit amount for education expense is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Funeral Expense

If you or a covered dependent suffer an accidental bodily Injury that results in a loss of life within 365 days of an accident the Voluntary AD&D plan will pay a funeral expense benefit up to $2,000.

The benefit pays an amount equal to the lesser of:

a. The amount of the Funeral Expenses;

b. 2.5% of the amount of Insurance on the person; and

c. $2,000.

Hearing Aids and Prosthetics

The Voluntary AD&D plan pays a benefit for hearing aids and prosthetic devices if you or a covered dependent suffer a loss while covered under the plan and the loss requires you to use a hearing aid or a prosthetic device. It is payable if:

a. The hearing aid was obtained within one year of the accident that results in the loss and was prescribed by a doctor; or

b. The prosthetic device was obtained within one year of the loss and was prescribed by a doctor

The benefit payable is equal to the least of:

1. The actual cost to the person for the hearing aid or the prosthetic device;
2. 5% of the amount of insurance on the person; and
3. $10,000.

Home Alteration & Vehicle Modification

If an accidental injury causes a loss that requires home alteration or vehicle modification the Voluntary AD&D plan will pay an amount equal to the least of:

1. the actual cost charged for the alteration or modification;
2. 10% of the Amount of Insurance on the person; and
3. $10,000

This additional benefit for Home Alteration and Vehicle Modification Expense only applies once during a person's lifetime

Medical Premium

The Voluntary AD&D plan pays a benefit for monthly medical premiums if you suffer a loss while covered under the plan and:

a. You suffer an accidental bodily Injury that results in a Loss within 365 days of an accident; and

b. The accidental bodily Injury:

   i. Results in your having to take a leave of absence from your job with Baker Hughes; or

   ii. Ends your employment with Baker Hughes.

c. You choose to continue membership in the medical plan beyond the time that it would otherwise end

The Voluntary AD&D will pay an amount equal to the lesser of 3% of your amount of insurance and $500.

This benefit will be paid monthly until the first of these occurs:

1. Your continued membership in the Baker Hughes medical plan ends.
2. You become covered under any other group medical plan.
3. The benefit has been paid for 12 consecutive months.

Additional Benefit for Monthly Medical Premium for your Dependent Spouse, Domestic Partner, or Dependent Child

This additional benefit for monthly medical premiums is payable for your qualified dependent spouse, domestic partner, or child who:

a. Is insured for dependents insurance under the coverage on the date of your death; and

b. Elects to continue membership in your Employer's medical plan.

The benefit pays the lesser of:

1. 3% of your amount of insurance; and
2. $500.

This benefit will be paid monthly until the first of these occurs:

1. Your spouse, domestic partner, or child's continued membership in the Baker Hughes medical plan ends.
2. Your spouse, domestic partner, or child becomes covered under any other group medical plan.
3. The benefit has been paid for 12 consecutive months.

Mortgage Payment

The Voluntary AD&D plan will pay a monthly mortgage benefit up to $1,500 If you suffer an accidental bodily Injury that results in a loss of life. The plan will pay your surviving spouse or domestic partner if all criteria below is met:

a. You suffer an accidental bodily Injury that results in a Loss of life within 365 days of an accident.

b. You have a surviving spouse or domestic partner at the time of your death.

c. Your surviving spouse or domestic partner is a co-borrower on your mortgage.

d. You have an outstanding balance on your mortgage at the time of your death.

Your surviving spouse or domestic partner must give Prudential your mortgage loan number, along with the name and telephone number of your mortgage company.

The Voluntary AD&D pays the lesser of the amount of your monthly mortgage payment; and $1,500.

This benefit will be paid monthly until the first of these occurs:

1. Your spouse or domestic partner dies.
2. Your mortgage is paid in full.
3. Your house is sold.
4. The benefit has been paid for 24 consecutive months.

A mortgage payment means a loan that is secured by your house. The term includes any property taxes and insurance that may be included in the monthly payment.

Parental Care

This additional benefit for parental care only applies if you suffer a loss of life. This additional benefit is payable for each of you or your dependent spouse or domestic partner's parents or grandparents, who were or will be claimed as a dependent on your Federal Income Tax return for the calendar year before or during which you suffer the Loss of life and is dependent on you for more than 50% of the cost of:

a. Residing in a nursing care facility;

b. Home health care or enrollment in a day care program; or

c. Resides in your home.

The Voluntary AD&D plan pays an amount equal to the lesser of:

a. 5% of your Amount of Insurance; and

b. $10,000

Common Accident

If you and your qualified dependent spouse or domestic partner suffer a loss of life due to a common accident the Voluntary AD&D plan will pay a benefit if all of the below are met:

a. Your qualified dependent spouse or domestic partner is insured for dependents insurance under the coverage on the date of the accident that results in your spouse's or domestic partner's Loss of life.

b. You and your spouse or domestic partner both suffer a loss of life as a result of the same accident.

c. You have a surviving qualified dependent child on the date of the accident

The Common Accident benefit will pay an amount equal to the lesser of:

a. the difference between:

- the amount of insurance payable under the Coverage for your Loss of life; and
- the amount of Insurance payable under the Coverage for your spouse's or domestic partner's loss of life; and

b. $100,000.

Child's Loss

The Voluntary AD&D plan will pay up to $10,000 should a qualified dependent child suffer a loss and:

a. That loss is not a loss of life.

b. That child is insured for dependents Insurance under the coverage on the date of the accident that results in that loss.

The benefit pays an amount equal to the lesser of the amount payable for that Child's Loss; and $10,000.

This benefit is not payable if the child dies within 90 days of the accident.

But, if the child sustains more than one Loss from the same accident, the amount will be equal to 100% of the amount payable for the one largest amount payable as a result of the child's Loss

Critical Period

This additional benefit only applies if either: (a) you suffer a loss of life; or (b) your qualified dependent spouse or domestic partner suffers a loss of life. If you suffer a loss of life, it is payable during the Critical Period following your death. If your spouse or domestic partner suffers a loss of life, it is payable during the Critical Period following your spouse's or domestic partner's death.

This benefit is only payable if these tests are met:

a. On the date of your or your spouse's or domestic partner's loss of life, your spouse or domestic partner is insured for dependents Insurance under the Coverage.

b. The person who suffers the loss has a surviving spouse or domestic partner or surviving dependent child on the date of death.

An amount equal to 1.5% of the amount of insurance on the person for each of the 12 months immediately following the person's death.

Rehabilitation Expense

The Voluntary AD&D plan pays a benefit if you or your covered family member suffers a loss while covered under the plan and a doctor determines that rehabilitation is necessary to aid you in returning to the normal activities of a person of the same age and gender. Rehabilitation expense includes: (1) the expense for treatment by a rehabilitation therapist who is licensed, registered, and/or certified to provide such treatment; and (2) the expense of confinement in a health care facility for rehabilitation.

The benefit pays an amount equal to the lesser of 10% of your amount of insurance and $500 for a maximum of 12 months as long as you remain eligible. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Voluntary AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Seat Belt Coverage

If you or a covered dependent die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Voluntary AD&D plan will pay an amount equal to the lesser of 10% of the Amount of Insurance on the person to a maximum of $50,000 as long as:

- The insured is a driver or passenger in an automobile; and
- The insured is wearing a seat belt in the manner prescribed by the vehicle's manufacturer; and
- The actual use of a seat belt at the time of the injury is verified in an official report of the accident, or is certified in writing by the investigating official(s).

A loss is not covered if the loss was the result from driving or riding in any automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

Seat belt means passive restraint device for an adult that meets published federal safety standards, is installed by the automobile's manufacturer or replaced by an organization sanctioned by the automobile's manufacturer, and is not altered or replaced after that installation, or a federally approved, properly installed child safety seat.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental
- The direct cause of a loss; and
- Occurs while a person is insured under the policy issued by Prudential under the Basic AD&D plan, which is in force

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease
- Bursitis
- Chondromalacia
- Shin splints
- Stress Fractures
- Tendinitis; and
- Carpal Tunnel Syndrome

Spouse or Domestic Partner Tuition Reimbursement Expense

The Voluntary AD&D plan will reimburse your spouse or domestic partner up to $10,000 for spouse or domestic partner employment training expense if you die accidentally while you are covered under the plan, and your surviving spouse or domestic partner incurs employment training expense within 12 months following the date of your death.

This additional benefit is payable for the person who:

(a) is your spouse or domestic partner on the date of your death; and

(b) enrolls in any professional or trades program within 12 months after the date of your death for the purposes of obtaining an independent source of support or enriching that spouse's or domestic partner's ability to earn a living.

Additional benefit amount to be paid is an amount equal to the least of:

(1) the actual annual tuition charged for the program;

(2) 10% of your amount of insurance; and

(3) $10,000.

This benefit is payable annually for up to 2 consecutive years.

The benefit amount for spouse or domestic partner employment training expense will be paid to your spouse or domestic partner who incurs the expense. The benefit amount for spouse or domestic partner employment training expense is payable in addition to any other applicable benefit amounts under the Voluntary AD&D plan. If there is no dependent spouse or domestic partner eligible for this benefit, a benefit amount of $1000 will be paid.

Filing a Voluntary AD&D Claim

To claim benefits under the Voluntary AD&D plan, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**, Option 4 to speak to a Survivor Support Representative. The Survivor Support Representative will mail the applicable forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the form carefully, answer the required questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Voluntary AD&D plan are fully insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Claims Procedures

Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed.

However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

a. the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

b. references to the specific plan provisions on which the benefit determination was based,

c. a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

d. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

e. a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request; and

f. copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.

Appeals of Adverse Determination Filing an Appeal

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period.

However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

Prudential will provide you, free of charge and prior to an adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

a. the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

b. references to the specific plan provisions on which the determination was based,

c. a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

d. a description of Prudential's review procedures and applicable time limits,

e. a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

f. copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

g. a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Notice of Benefit Decision on Appeal

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in the section above, you may make a second, voluntary appeal, although you are not required to do so.

You may submit with your second, voluntary appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second, voluntary appeal within 45 days of the receipt of your second, voluntary appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the second, voluntary appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second, voluntary 45-day appeal review period.

Your decision to submit a benefit dispute to this second, voluntary level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second, voluntary level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second, voluntary level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on second, voluntary appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse appeal determination letter. If a decision on second, voluntary appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on the second, voluntary appeal.

Legal Action Following Appeal

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed in the *Benefits Rights* section. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this SPD, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Voluntary AD&D policy will be paid in a lump sum to the beneficiaries designated by you if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- Your spouse or domestic partner; otherwise
- Your children or the children of your domestic partner, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate

When Does Coverage End?

Your coverage under the Voluntary AD&D plan will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Right to Apply for Coverage Under the Portability Plan

You and your qualified dependents may become covered for similar coverage under the portability plan when the Voluntary Accidental Death and Dismemberment coverage for you and your covered dependents ends. You will have the right to apply for accident coverage for yourself or a qualified dependent under the Portability Plan if you meet all of these tests:

1. Your Voluntary Accidental Death and Dismemberment Coverage ends for any reason other than:
   a. your failure to pay, when due, any contribution required for it; or
   b. the end of your employment on account of your retirement; or
   c. the end of the coverage for all employees when such coverage is replaced by group accident insurance from any carrier for which you are or become eligible within the next 31 days
2. You meet the Active Work Requirement on the day your insurance ends.
3. You are less than age 80.
4. Your Amount of Insurance is at least $20,000 under the Voluntary Accidental Death and Dismemberment Coverage on the day your insurance ends.

Portability Application Period

You have the right to apply for coverage under the Portability Plan during the Portability Application Period. The Portability Application Period is the 31-day period after your Voluntary Accidental Death and Dismemberment Coverage ends.

Terms and Conditions of the Portability Plan

The form, amount, first premium, and effective date will be as stated below.

- **Form:** The form of term life coverage that Prudential then makes available under the Portability Plan. The terms and conditions of that coverage will not be the same as the Voluntary Accidental Death and Dismemberment Coverage under the Group Contract.

- **Amount:** Not more than your amount of insurance under the Voluntary Accidental Death and Dismemberment Coverage when your insurance ends, but not less than $20,000. The maximum amount of Accidental Death and Dismemberment insurance under the Portability Plan is the lesser of 5 times your annual Earnings and $1,000,000 minus the amount ported under Basic Accidental Death and Dismemberment coverage.
- **First Premium:** The first premium is due to Prudential within 31 days of the date the first bill is issued.
- **Effective Date:** The day after the Portability Application Period ends.

Porting Your Coverage

For more information or to port your coverage, contact Prudential at **1-800-778-3827.** If you are using a telecommunications device for the hearing impaired, call **1-800-496-1214.**

Business Travel Accident Insurance Plan

Business Travel Accident Insurance Plan At-a-Glance

Type of Plan	Welfare plan that provides Business Travel Accident insurance for employees traveling on Company business
Who Pays the Cost	Baker Hughes pays 100% of the cost of your business travel insurance.
Employee Eligibility	All employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	No enrollment necessary. You are automatically covered when traveling on business for Baker Hughes.
Coverage Options	• Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof subject to a minimum principal sum of $50,000 and a maximum principal sum of $3 million. Your coverage amount is referred to as the principal sum by the insurance provider (and for purposes of this *Business Travel Accident* insurance section) • Maximum for spouse or domestic partner during relocation in connection with the relocation of the employee is $25,000, provided that all travel is authorized by, and at the expense of, Baker Hughes • Maximum for eligible dependent children during relocation in connection with the employee is $10,000, provided that all travel is authorized by, and at the expense of, Baker Hughes
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide)

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Business Travel Accident plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Federal Insurance Company ("Chubb") and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan by accessing your account from **BakerHughesBenefits.com** prepared by Chubb and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Chubb, the certificate of coverage/insurance will prevail in all instances.

Your Business Travel Accident Insurance

The Baker Hughes Company Business Travel Accident program (the Business Travel Accident plan) is designed to provide you accident insurance when traveling on authorized Baker Hughes business. "Baker Hughes business" means all circumstances arising from or occurring while you are traveling on assignment by or at the direction of Baker Hughes, including relocation. Relocation means assignment to a new regular place of employment that is more than 50 miles from the prior place of employment.

What is the Employee's Cost of the Business Travel Accident Plan?

You do not contribute anything to receive Business Travel Accident insurance coverage. It is paid 100% by Baker Hughes.

When Does Coverage Begin?

Baker Hughes provides you with Business Travel Accident insurance coverage on the first day of active work. No enrollment is necessary. You must be traveling on authorized Baker Hughes business to receive a benefit.

How Does the Business Travel Accident Insurance Plan Work?

With the Business Travel Accident insurance plan, you have the following coverage:

Schedule of Benefits for Business Travel Accident Insurance	
Employee	Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof subject to a minimum principal sum of $50,000 and a maximum principal sum $3 million.
Spouse or Domestic Partner	Maximum for spouse or domestic partner during relocation in connection with the relocation of the employee is $25,000.
Dependent Children	Maximum for dependent children during relocation in connection with the employee is $10,000.

The coverage amount is referred to as the principal sum by the insurance provider. If you suffer accidental death, dismemberment, paralysis, or other covered losses while traveling on authorized Baker Hughes business or during relocation for a Baker Hughes assignment, the plan will pay a benefit that is a percentage of the principal sum, depending on the type of covered loss. The plan will also pay a benefit if your spouse or domestic partner, or dependent children suffer accidental death, dismemberment, paralysis, or other covered losses.

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy issued by Chubb under the Business Travel Accident plan which is in force and is the direct cause of loss and with respect to a spouse or domestic partner, or dependent child, if it occurs while with the employee during a relocation due to a Baker Hughes assignment.

Note: The Business Travel Accident plan does not cover you while you're routinely commuting to/from work.

What Losses are Covered by Business Travel Accident Insurance?

The amount of your Business Travel Accident insurance benefit is based on the type of loss that you, your spouse or domestic partner, or dependent children suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $15 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Note: The maximum benefit payable for one accident cannot exceed 100% of five times your benefits base pay or $3 million, whichever is less.

In the event you incur more than one loss in any one accident, only the single largest benefit is payable for all injuries.

Example:

If you lose a thumb and index finger on the same hand and hearing (in both ears), you would receive 50% of your principal sum.

Defining Loss

- Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by the insurance provider
- Loss of foot means complete severance through or above the ankle joint, even if the foot is later reattached
- Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least 3 fingers and the thumb on the same hand, even if the fingers and/or thumb are later reattached
- Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a physician
- Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident
- Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician
- Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician
- Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician
- Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints of the thumb and index finger of the same hand, even if one or both are later reattached
- Paraplegia means complete and irreversible loss of all motion and all practical use of both legs, that lasts longer than 365 days, as determined by a physician
- Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs, that lasts longer than 365 days, as determined by a physician
- Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg, that lasts longer than 365 days, as determined by a physician
- If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage, at the time of the accident
- If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by the Plan

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

Business Travel Accident Exclusions

What Is Not Covered

- The Business Travel Accident program and the coverage provided by the program does not apply to any: accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in, or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft, or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth, or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide, or intentionally self-inflicted injury
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, at the time of an accident. Intoxication is defined by the laws of the jurisdiction where such accident occurs
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of a narcotic at the time of an accident. This exclusion does not apply if any narcotic or controlled substance is taken and used as prescribed by a physician
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss when:
  - The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury, or loss, or
  - There is any other legal prohibition against providing insurance of any accident, accidental bodily injury, or loss

Additional Business Travel Accident Benefits Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days after the accident and remains in a coma for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for a coma, prescribed and supervised by a physician within the first 30 days following the accident, the Business Travel Accident insurance plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% of the loss-of-life benefit amount, whichever is earlier. The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal benefit amount is paid in full
- The date of recovery or death

If you or a covered family member dies within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Psychological Therapy Expense

The Business Travel Accident insurance plan pays a benefit if a physician determines the need for you or a covered family member to have psychological therapy after suffering a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Rehabilitation Expense

The Business Travel Accident insurance plan pays a benefit if you or a covered family member suffers a loss covered under the plan which prevents the insured person from performing all the duties of his or her regular occupation and requires rehabilitation, as determined by a physician approved by the insurance provider.

The benefit pays for Reasonable and Customary (R&C) rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Seat Belt and Occupant Protection Device Coverage

If you or a covered family member dies as the result of a private passenger automobile accident and the insured person was wearing a seat belt at the time, the Business Travel Accident insurance plan will pay an additional benefit of 10% for seat belt and 10% for occupant protection device. The overall maximum additional benefit for both is 20% of the principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident
- The insured person was an occupant of the private passenger automobile
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer

If it cannot be determined if the insured person was wearing a seat belt at the time of the accident, a limited alternate benefit of $2,000 will be paid in addition to the accidental loss-of-life benefit.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer's instructions.

The plan will also pay a benefit for an occupant protection device if you or a covered family member is positioned in a seat protected by a properly deployed occupant protection device. An occupant protection device means either an airbag, which inflates for added protection to the head and chest areas or any other personal safety restraint system other than a seat belt recognized by the U.S. National Highway Transportation Safety Board. The occupant protection device benefit will only be paid if a benefit is paid for seat belt coverage, other than the alternate benefit amount.

Verification of actual use of the seat belt and proper operation of the occupant protection device at the time of an accident must be part of an official report of such accident or be certified, in writing, by an investigating police officer.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental
- The direct cause of a loss; and
- Occurs while a person is insured under this policy, which is in force

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease
- Bursitis
- Chondromalacia
- Shin splints
- Stress fractures
- Tendinitis; and
- Carpal tunnel syndrome

Filing a Business Travel Accident Claim

To claim benefits under the Business Travel Accident program, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**, Option 4 to speak to a Survivor Support Representative. The Survivor Support Representative will mail the applicable forms to the claimant.

To initiate the claims process, the claimant must complete the required forms at the **Chubb United States Claim Center** at **chubbclaims.com/ace/us-en/welcome.aspx** and submit them along with any required documentation as soon as reasonably possible, but in no event later than 365 days from the date of loss. The claimant may also request a claim form and email the completed forms with the required documentation. Contact information is as follows:

Chubb A & H Claims
Email: **ChubbAandHClaims@chubb.com**
Phone: **1-800-336-0627** (within the US)
1-302-476-6194 (outside the US)

The claimant should read the instructions on the site carefully, answer the required questions, and attach all documentation prior to submitting.

After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Business Travel Accident insurance plan are fully insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Survivor Support Representatives

The Baker Hughes Benefits Center has dedicated Survivor Support Representatives to assist you or your dependents in submitting a claim for death benefits to the insurance carrier.

Survivor Support Representatives can be reached by calling **1-866-244-3539**, Option 4.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 90 days of Chubb receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period for an additional period of up to 90 days. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The notice shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the additional information requested is not provided to Chubb within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial
- Reference to the pertinent plan provisions upon which the denial is based
- A description of any additional information the claimant is required to provide to complete the claim and an explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim denial, without regard to whether the advice was relied upon in making the claim denial, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request to Chubb, and
- A statement that, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, that such rule, guideline, protocol or other similar criterion, a copy thereof will be provided free of charge upon written request to Chubb

Appealing the Denial of a Claim

The claimant or an authorized representative may appeal any denial of a claim for benefits. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send the written appeal to the following address:

Chubb A&H Claims
PO Box 816
Portland, ME 04104
Attn: Diane Basa - AVP Claims
Phone: 1-800-336-0627

Upon receipt of the claimant's written appeal, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's 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 determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent plan provisions on which the denial was based
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits; and
- A statement of the right to sue in federal court under Section 502(a) of ERISA

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision, and
- Explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, if applicable
- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits, and
- A description of any applicable contractual limitations period that applies to your right to bring a civil action under section 502(a) of ERISA, including the calendar date on which the contractual limitation period expires for the claim at issue

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to bring a civil action under the Employee Retirement Income Security Act (ERISA).

No legal action may be brought to recover on the policy until sixty (60) days after Chubb has been given complete Proof of Loss. No such action may be brought after three (3) years from the time complete Proof of Loss is required to be given. No such action may be brought unless there has been full compliance with all of the terms of the policy.

In no case will Chubb be liable for benefits that are not payable under the terms of the policy or that exceed the applicable Benefit Amounts or limits of insurance of the policy.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Business Travel Accident policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for your loss-of-life, will be paid to you. Benefits for your loss-of-life will be paid to the Basic Life beneficiary designated by you. If no such designation has been established, then the benefits will be paid to the first surviving class in the following order:

- Your spouse or domestic partner; otherwise
- Your children or children of your domestic partner, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate

When Does Coverage End?

Your coverage under the Business Travel Accident policy will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Legal Benefit

The Legal Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan providing access to legal advice and assistance.
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees Note: Domestic partners and their children are not eligible for coverage under the Legal Plan.
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Family* • No Coverage Note: Domestic partners and their children are not eligible for coverage under the Legal Plan.
Contact	• LegalEASE: **1-888-416-4313** and reference Baker Hughes Company or your Member ID number • LegalEASE Legal Corner: **legalcorner.legaleaseplan.com** • LegalEASE website: **https://www.legaleaseplan.com/bakerhughes**

Note: This benefit summary is intended to highlight the Legal Plan's benefits and should not be relied on to determine coverage. Please refer to the certificate of coverage issued upon enrollment for a more complete explanation of your coverage. If this benefit summary conflicts with the certificate of coverage, the certificate of coverage will prevail.

Overview

The LegalEASE plan can ease the biggest stresses - finding and paying for legal expertise when you need it most. The LegalEASE plan provides benefits for both in-network and out-of-network assistance with your personal legal matters; from complex litigation, such as divorce and bankruptcy, to the more basic, such as drafting a lease agreement or updating a will.

What is the Employee's Cost of the Plan?

If you decide to enroll yourself or your family in the LegalEASE plan, you'll pay the cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your coverage level.

When Does Coverage Begin?

If you elect the LegalEASE plan, coverage begins on the first active day of work if you're a new hire or an existing employee transferring to a position with US benefits, or on January 1 if you elect it during Annual Enrollment.

*Does not apply to domestic partnerships.

What is Covered by the Legal Plan?

The chart below summarizes a few of the popular services offered under the plan, and the maximum benefits when you seek coverage in- or out-of-network.

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Advice and Consultation			
Document Review (up to 6 pages)	Unlimited	Covered	$60
Financial Helpline			N/A
Initial Law Office Consultation	One hour per calendar quarter		$60/consultation
Legal Helpline; Online Legal Access	Unlimited		N/A
Consumer Matters			
Document Preparation (e.g., simple deed, promissory note, consumer dispute correspondence, installment sales agreement, simple affidavit, lease agreement, timeshare agreement)	One use per year (One of each document)	Covered	$60/document
General Power of Attorney	One use per year		Employee – $40/document Family member – $60/document
Life Insurance Claims	Covered subject to managed case rules		Up to $2,000
Small Claims Court Representation	Up to 2 hours		$120
Consumer Dispute	One use per year		$595
Will, Codicil, Trust, and Probate			
Living Trust Document	One use per year	Covered	$310
Living Will, Health Care Power of Attorney			$55
Probate of Small Estate	Up to 2 hours		$120
Will or Codicil (includes member, spouse, family member)	One per year per person		$90/document
Residential Matters			
Tenant Dispute	Covered subject to managed case rules	Covered	Up to $2,000
Purchase of Primary Residence, including Document Preparation and Closing	One per year		$490
Refinancing Primary Residence			$385
Sale of Primary Residence			$365

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Financial Matters			
Bankruptcy Chapter 7 or 13	Up to defined in-network or out-of-network maximums	Up to $750	Up to $680
Debt Collection Defense	One use per year	Covered up to $700	
• Pre-litigation defense activities			$425
• Trial defense			$595
Identity Theft – Prevention/Recovery Assistance • Initial consultations with trained specialists (consultations can also be online) • Recovery document preparation/ review by a local attorney • Personal ID recovery package	Four per year	Covered	Not covered
Tax Audit Representation	Up to $2,000		Up to $2,000
Family Law			
Divorce/Separation – Uncontested	Up to 10 hours	Covered	$595
Divorce – Contested **Consent/Default Divorce**	Up to $2,000		Up to $2,000
Uncontested Guardianship/ Conservatorship	One use per year	Covered	$400
Juvenile Court Proceedings		Covered	$470
Name Change			$255
Uncontested Government Agency Adoptions		Covered	$300
Uncontested Stepparent Adoptions		Covered	$300
Civil/Criminal Defense			
Civil Litigation Defense	One use per year/up to $2,000	Covered	Up to $2,000
Criminal Defense	One use per year	Debt Collection Defense	$215
• Administrative proceeding (regarding suspension or revocation of license)		Covered	$255
• Misdemeanor defense • Traffic Tickets except driving under influence, vehicular homicide, or violations related to a commercial driver's license		Covered	Up to $2,000

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Miscellaneous Law Office Services			
Miscellaneous Law Office Services			
• Legal Services for any non-excluded legal matter not specifically covered in the Schedule of Benefits	Up to 10 hours per year	Covered	$60 an hour
• Discounted Legal Services for any non-excluded legal matter	N/A	25% discount on Participating Attorney's hourly rates	N/A

Note: Do not rely on this chart alone. It merely summarizes your benefits. Call the Baker Hughes Benefits Center at **1-866-244-3539** or LegalEASE at **1-888-416-4313** for a more complete explanation of your coverage.

Elder Parent Coverage

Parents of the plan member and the member's spouse are eligible for certain benefits under the Legal Plan if the member elected "Family" coverage. The benefits specified below extend not only to the member's parents and the member's spouse's biological parents, but to their step-parents and adoptive parents, as well.

Elder Parent Coverage includes:

- Legal Advisor Helpline – Advice and consultation with a plan attorney by toll-free telephone
- Financial Helpline – Financial consultation by toll-free telephone
- Simple Will preparation – One simple Will per eligible parent, per year
- Living Will preparation – One living Will per eligible parent, per year

Identity Theft Recovery Assistance Coverage

Coverage includes a basic Identity Theft HelpLine Service for covered members, their spouse and children, including stepchild, legally adopted child, child placed in the home for adoption and foster child, up to age 19, and from age 19 up to 26 years if they are primarily dependent upon the member for support, regardless of whether they are full-time students, married, or eligible for group health plan coverage.

Identity Theft Assistance Coverage includes:

- Advice and Consultation: half hour telephonic consultations (4 per year) with a Trained Identity Theft Recovery Specialist
- Personal Recovery Kit: designed to walk the member or family member step-by-step through the process of recovery
- Simple Recovery Letter preparation by plan attorney: a plan attorney will draft the simple affidavits to submit to specific agencies and organizations needed to establish the theft of the identity and prevent further loss of identity and credit rating
- Review of necessary recovery legal documents: up to 6 pages each

LegalEASE Legal Corner

The Legal Corner is a comprehensive web resource for employees to get help navigating legal resources and local attorneys. The Legal Corner is included as part of the LegalEASE Legal Plan and offers self-search web-based services. This valuable web resource is accessible for all employees, whether or not they're enrolled in the legal plan. You can browse legal resources, read articles around different areas of law, and access an online directory for help from a Network Attorney.

Although employees who are not Legal Plan Members may not have all the paid-in-full or partially paid legal coverages as Members do, you can still get an initial consultation (up to 30 minutes) at no charge with a Plan Attorney if the attorney is located near you. If you choose to retain the attorney, you'll receive a discounted hourly rate of 15%.

The Legal Corner Offers

- An interactive directory that connects you to a Plan Attorney with expertise specific to your legal matter
- A help center full of resources designed to navigate common individual or family legal issues including articles and videos
- Access to review and print sample legal documents

For more information go to **legalcorner.legaleaseplan.com** or call **1-888-416-4313**.

Exclusions

The following benefits are excluded:

- Appellate court proceedings, class actions, interventions, derivative action, and amicus curiae filings.
- The preparation and filing of individual, partnership or estate tax returns, appellate or administrative proceedings related to tax returns, litigation before the US Tax Court, US Court of Claims or any other federal, state, or other courts with respect to tax matters
- Matters relating to securities, trademark or patent matters; business or commercial interests, including, but not limited to, professional, partnership, and/or corporate matters; matters involving the law or laws of jurisdictions other than the United States and its territories; any matters involving a government (domestic or foreign) entity or agency; farm-related issues; matters involving commercial or rental property transactions, including the purchase, sale, or lease of investment or income-producing property. A two-family house, whether or not used by the Member as his or her primary residence, is deemed an investment or income-producing property
- Legal services which are fully paid for or provided at no cost by any governmental agency, organization or insurance company
- Matters that the attorney deems frivolous, spurious, harassing, or unethical (collectively referred to as "frivolous") or otherwise prohibited by the Model Rules of Professional Conduct of the state in which the attorney is licensed
- Costs associated with covered legal services, including but not limited to, all fines, court costs, penalties, sanctions, expert witness fees, bonds, bail bonds, attorney fees, exhibits, deposition costs, filing fees, transcripts, postage, telephone, photocopying, recording fees, messengers, judgments, jury fees, court reporter fees, investigative costs, and all other incidental and out-of-pocket legal and litigation costs
- Any services on behalf of a Family Member against the interests of the Member
- Any employment-related matter. This includes, but is not limited to, any dispute involving the Member's Employer or its affiliates, their officers or directors, the Member's employee benefit plans, credit unions, programs, or arrangements sponsored by an employer, or cases involving workers' compensation, unemployment compensation, sexual harassment, age discrimination, etc.
- Any dispute or proceeding against the following persons or entities, their officers, directors, employees, or agents: any person or entity involved in the sale of the group policy; Administrator or its subsidiaries; Policyholder; Member's Employer; Virginia Surety Company, Inc. its parents, subsidiaries or any affiliated or successor company, plan underwriter or reinsurer; Plan Sponsor; or any Participating and/or Non-Participating Attorney, if the dispute or proceeding pertains to services provided under the group policy / Certificate of Coverage
- Except regarding LegalEASE Helpline and Financial Helpline services, benefits will not be provided in connection with pre-existing matters, which includes any matter where the Member and/or Family Member is on notice as to a pending legal dispute or has previously contacted an attorney
- Where there are specific hours or dollar amounts provided in the Contract, or where a maximum is set under the Managed Case Rules, the Member will be responsible for all attorney fees incurred which exceed the maximum. Additional exclusions related to each benefit are included in the Covered Services.

Contacting a Legal Plan Representative

Prior to receiving any legal services, you must first contact the LegalEASE call center at **1-888-416-4313** or by logging on to **legaleaseplan.com**. Reference Baker Hughes Company or your Member ID number when calling. Member services is available from 7:30 a.m. to 7:30 p.m., CST. A Personal Member Service Representative will match you to an available network attorney. You may choose to use a network attorney and receive the network benefits of the plan, or pay more when you go out-of-network. No matter your decision, you should contact the Legal Plan prior to incurring any legal expenses.

When Does Coverage End?

Coverage in the Legal Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The plan terminates
- You do not make the required contributions

If you are interested in continuing your coverage once your employment with Baker Hughes ends, or are currently involved in a legal matter before any of the above occur contact LegalEASE directly.

When Coverage Ends

If you become ineligible to participate in the Legal Plan through the Company, you will receive a letter to continue coverage after you leave the Company. You must contact LegalEASE within 60 days from the date your coverage ended to elect to continue coverage.

Critical Illness Plan

Critical Illness Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for critical illness.
Who Pays the Cost	You pay the full cost of coverage, which is determined by your age and coverage level.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee must be actively at work on the effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year
Coverage Options	• You Only • You + Spouse or Domestic Partner • You + Children * • You + family
Maximum Benefit Amount	**Low Plan** • Employee: $15,000 • Spouse or Domestic Partner: $15,000 • Child: $7,500 **High Plan** • Employee: $30,000 • Spouse or Domestic Partner: $30,000 • Child: $15,000
Wellness Benefit	$50 per plan year.
Contact	UnitedHealthcare Specialty Benefits: **1-800-444-5854** Website: **www.myuhcfp.com** (you can use your UHC website user id and password) Support email: **fpcustomersupport@uhc.com** Group Number: 305735 Customer service team is available Monday through Friday from 8 a.m. to 6 p.m. EST.

Note: This section of the SPD summarizes certain provisions of the Critical Illness plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by UnitedHealthcare, and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **BakerHughesBenefits.com**, prepared by UnitedHealthcare, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by UnitedHealthcare, the certificate of coverage/insurance will prevail in all instances. Please read the full disclosure document posted on BakerHughesBenefits.com or call UHC at 1-800-444-5854 for more details. If this benefit summary conflicts with the certificate of coverage issued upon enrollment, the certificate of coverage shall prevail.

Overview

The UnitedHealthcare Critical Illness protection plan provides a lump sum payment if the covered person is diagnosed with certain specified diseases or has certain specified surgeries for the first time after insurance takes effect.

Critical Illness insurance coverage helps offset expenses not reimbursed by other types of insurance such as copays, deductibles, mortgage payments, child care, and other household expenses. This supplemental insurance option complements your existing medical and disability income insurance coverage by providing you with a lump-sum payment upon diagnosis of a covered illness.

Coverage is guaranteed provided the employee is actively at work on the coverage effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.

*Including children of your domestic partner. Your domestic partner must be covered under the plan to add your domestic partner's children.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees

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

If you and your spouse work for Baker Hughes and need assistance completing your elections, call the Baker Hughes Benefits Center at **1-866-244-3539**, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Covered Conditions

Cancer Conditions	Initial Benefit Amount	Reoccurrence Benefit Amount
Non-Invasive Cancer	25%	100%
Invasive Cancer	100%	100%
Skin Cancer	$250	100%
Functional Loss Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Coma	100%	100%
Loss of Hearing	100%	NONE
Loss of Sight	100%	NONE
Loss of Speech	100%	NONE
Paralysis	100%	100%
Severe Brain Damage	100%	100%
Infectious Disease Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Infectious Disease Minor	25%	100%
Infectious Disease Major	25%	100%
Coronavirus	$1,000	100%
Organ Failure Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Bone Marrow Disease	100%	100%
Chronic Renal (Kidney) Failure	100%	NONE
Heart Failure	100%	NONE
Major Organ Failure (Liver, Lung, Pancreas, Small Bowel)	100%	100%
Neurological Disease Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Alzheimer's Disease	25%	NONE
Amyotrophic Lateral Sclerosis	25%	NONE
Huntington's Disease	25%	NONE
Multiple Sclerosis	25%	NONE
Parkinson's Disease	25%	NONE

Advanced Neurological Disease Conditions	Initial Benefit Amount	Reoccurrence Benefit Amount
Advanced Alzheimer's Disease	25%	NONE
Advanced Parkinson's Disease	25%	NONE
Vascular Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Coronary Artery Disease (Major)	100%	100%
Coronary Artery Disease (Minor)	25%	100%
Heart Attack (Myocardial Infarction)	100%	100%
Ruptured Aneurysm	100%	100%
Stroke	100%	100%
Sudden Cardiac Arrest	100%	100%
Additional Conditions	**Initial Benefit Amount**	**Reoccurrence Benefit Amount**
Benign Brain Tumor	50%	100%

Critical Illness Protection Plan Example

Say you enroll in the $15,000 coverage and you or a covered dependent has a heart attack. If you are enrolled in the Premium HSA option:

Critical Illness	Benefit Impact
Your estimated out-of-pocket costs (deductible, coinsurance) would be:	$5,000
The Critical Illness plan would pay an Initial Benefit of:	$15,000
If the same person had another heart attack, the Recurrence Benefit would be:	$15,000

Wellness Benefit

If a covered person takes one of the screening/prevention measures listed below while insured under the Plan and after the insurance has been in effect for 30 days, UHC will pay a $50 health screening benefit upon submission of proof that such measure was taken. UHC will pay one health screening benefit per covered person per calendar year upon receipt by the Plan of adequate documentation to support the performance of any test for the covered individual.

The screening/prevention measures for which a health screening benefit may be paid includes:

- Antibody or Serology testing
- At-Home Screening tests for Colon Cancer (such tests must be approved by the Food and Drug Administration)
- Biopsy
- Blood Test for Cholesterol
- Blood test for triglycerides
- Biometric Screenings
- Bone Density scans
- Bone marrow testing
- Breast ultrasound
- Breast MRI
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray

- Colonoscopy
- Complete Blood Count
- Doppler screening for carotids
- Doppler screening for peripheral vascular disease
- Doppler Screening for abdominal aorta
- Echocardiogram
- Electrocardiogram
- Endoscopy
- Fasting blood glucose test
- Fasting plasma glucose (FPG)
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Hemoglobin A1C (HbA1c)
- HPV Testing
- Lipid Panel
- Mammography
- Monoclonal Antibody Therapy
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thinprep pap test
- Thermography
- Serum cholesterol test to determine level of HDL and LDL
- Virtual Colonoscopy
- Wellness Fair Screening
- Whole Body

This benefit will be paid as long as the policy is in force and you and your dependents remain insured under this benefit. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments you and/or your dependents receive under the policy.

Interaction with Wellness Benefit: If you have purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare, the Wellness Benefit for any Health Screening Test is payable only once per plan year for each person insured under this benefit, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different Health Screening Test issued under a separate policy.

How to file a Wellness claim: You can access a Wellness Claim form either on **BakerHughesBenefits.com** or by logging into your UnitedHealthcare Specialty Benefits **account**.

Return To:

UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466
Telephone: **1-800-539-0038**
Fax: **1-888-505-8550**

Filing a Critical Illness Claim

Notice of Claim

Written notice of a claim must be given to UnitedHealthcare by you or your authorized representative, within 30 days after the date of death or the date of loss. If it is not possible, written notice must be given as soon as it is reasonably possible to do so. Contact UnitedHealthcare at 1-800-444-5854 to obtain a claim form. The claim form is also located on **BakerHughesBenefits.com** or the UnitedHealthcare Specialty Benefits **website**. If you do not receive the form from UnitedHealthcare within 20 days of your request, submit your written proof of claim to UnitedHealthcare without waiting for the form. Written proof should establish facts about the claim such as nature of illness and extent of the claim.

Filing a Claim

You must fill out the claim form and then give it to your physician who should fill out the section of the form. The completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits by regular mail, email, or fax as indicated below.

Mail:

UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466
Phone: **1-800-539-0038**
Email: **FPCustomerSupport@uhc.com** (email is unsecured unless you are a registered Cisco user)
Fax: **1-888-505-8550**

Proof of Claim

Proof of Claim may include the following:

1. A completed claim form;
2. A certified copy of the death certificate (if applicable);
3. Your enrollment form;
4. Your Beneficiary designation (if applicable);
5. All medical information, including reports of diagnostic testing and photocopies of medical records, including histories;
6. Physical, mental, or diagnostic examinations and treatment notes;
7. The names and addresses of all:
   a. Physicians or other qualified medical professionals you have consulted;
   b. Hospitals or other medical facilities in which you have been treated; and
   c. Pharmacies which have filled your prescriptions within the past three years;
8. Your signed authorization for UnitedHealthcare to obtain and release medical, employment, and financial information (if applicable);
9. Documentation of your hours worked;
10. Proof of any employer approved Leave of Absence; or
11. Any additional information required by UnitedHealthcare to adjudicate the claim.

All proof submitted must be satisfactory to UnitedHealthcare.

You and Baker Hughes must fill out the applicable designated section of the claim form and then give it to your attending physician. The physician should fill out their section of the form and send it directly to UnitedHealthcare.

Time of Claim Payment

UnitedHealthcare will pay a claim for a covered loss immediately upon or no later than 2 months after Proof of Claim is received. However, if special circumstances require an extension, UnitedHealthcare will provide you or your authorized representative with:

1. A description of any further proof needed to complete the claim; and
2. An explanation of why such material is needed.

UnitedHealthcare will pay benefits for a covered loss upon receipt of all proper Proof of Claim. If UnitedHealthcare has not paid the claim when due and has not denied it for valid reasons, the benefit due will accrue interest at the rate of 1.5% per month until the claim is paid.

Payment of Claim

All benefits are payable to you. If you die before a benefit is paid, UnitedHealthcare will pay any amount due in accordance with the Beneficiary provision otherwise in the following order, to your:

1. Legal spouse or domestic partner;
2. Natural or legally adopted children in equal shares;
3. Parents;
4. Brothers and sisters; or
5. Estate.

Overpayment of Claim

UnitedHealthcare has the right to recover any over payments due to fraud or claims processing error. You must reimburse UnitedHealthcare in full. UnitedHealthcare will determine the method by which the repayment is to be made. UnitedHealthcare has the right to recover overpayment from your spouse or domestic partner if living, otherwise your child under the age 26 or estate.

Legal Action

You or your dependent, if applicable, may not bring suit to recover a claim until 60 days after you have given UnitedHealthcare written proof of loss. No suit may be brought more than three years after the date of loss.

Claims Denial Process for Critical Illness Insurance

If you disagree with UnitedHealthcare's decision, in whole or in part, and wish to appeal it, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to a full and fair review of the decision. Your request for review must be in writing and must be received by UnitedHealthcare within 180-days from the date that you receive your denial letter or UnitedHealthcare's decision will be final. Forward your appeal request, along with any comments or additional information that you feel would assist in UnitedHealthcare's review of or substantiate your claim.

UnitedHealthcare will review your letter and accompanying information with the other information in your file, and will notify you of the appeal determination within 45-days of receipt of your request, unless special circumstances require an extension of that time. If there are special circumstances, UnitedHealthcare will notify you in writing and request any additional information that is required, and of the revised time frames for their decision.

How to send UnitedHealthcare information:

Mail: UnitedHealthcare Insurance Company
Address: PO Box 7466, Portland, ME 04112-7466
Fax: **1-888-505-8550**
Email: **FPCustomerSupport@uhc.com** (unsecured unless you are a registered Cisco user)

Please refer to the certificate of coverage insurance for further information regarding filing a claim or appeal of a denied claim or related legal action.

When Does Coverage End?

Coverage in the Critical Illness plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The date you die
- The plan terminates
- You do not make the required premium payments

When Coverage Ends

If you become ineligible to participate in Critical Illness coverage through Baker Hughes, you will receive a letter from the **Baker Hughes Benefits Center**. The letter will offer you the option to continue coverage outside the group plan at the same premium rates through Portability. To elect to continue your coverage, you must contact the UHC Portability Department at 1-877-683-8601 within 31 days from the date your coverage ended. Coverage continued under Portability terminates at age 75.

Portability: How to Port Your Coverage

You may elect to port your or your dependents' insurance prior to the date your insurance under the Policy ends.

You may not port your insurance if:

1. You fail to pay any required premium;
2. You are on an approved leave of absence;
3. The Policy terminates;
4. You are or become insured under another group critical illness policy;
5. You are older than the Portability Policy Age Limit shown in the Schedule;
6. You reside outside of the United States;
7. You reside in a state where the insurance is not available; or
8. You are actively in military service or entering active military service.

Electing Portability

To elect to continue you and your dependent's insurance, you must:

1. Submit a written request to UnitedHealthcare; and
2. Pay the first month's premium; within 31 days of the date your insurance ends.

The following combinations may be ported:

1. You only;
2. You and your spouse or domestic partner only;
3. You and your children only; or
4. You and all your dependents.

No other combinations of ported insurance amounts will be allowed. You must continue to pay the cost of your and your dependent's ported insurance.

Your surviving dependents may port their insurance if you die. However, your surviving spouse or domestic partner must port in order for your surviving children to port. If there is no surviving spouse or domestic partner, no children will be allowed to port.

The portability insurance will end on the earliest of the date:

1. You fail to pay the required premium;
2. You become insured under any other critical illness insurance policy;
3. You no longer reside in the United States; or
4. You attain any Portability Policy Age Limit shown in the Schedule.

If you are rehired after you port your insurance, you must cancel the ported insurance to re-enroll under the Policy.

Portability, ported, or port means you and your dependents may continue insurance under the Policy that would otherwise terminate due to certain conditions.

Portability Premium Contribution

The rate will be the group's current rate for your or your dependents' class for the first 12 months of portability. However, the required premium including any part previously paid by Baker Hughes must be paid.

After the first 12 months, the rate may change to a portability rate which may be higher.

Exclusions

The Critical Illness plan will not pay a benefit for a Critical Illness contributed to or caused by:

1. Intentional self-inflicted Injury, this exclusion does not apply to the *Mental Health Disorder Hospital Confinement Benefit* if covered under this Policy;
2. Attempted suicide, this exclusion does not apply to the *Mental Health Disorder Hospital Confinement Benefit* if covered under this Policy;
3. Active participation in a riot, felony, assault, or illegal occupation;
4. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
5. Loss sustained while on active duty as a member of the armed forces of any nation except during any time period insurance is extended under the continuation during Leave of Absence provision;
6. Intoxication or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for you by a physician and taken as prescribed.

UnitedHealthcare also will not pay a benefit for a Critical Illness that was diagnosed outside of the United States or Canada, unless the diagnosis was confirmed by a physician practicing within the United States or Canada.

For the purpose of these exclusions, intoxication means being under the influence as defined by applicable state law as determined by:

1. The blood alcohol content; or
2. The results of other means of testing blood alcohol content or the content of other substances.

Accident Protection Plan

Accident Protection Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for accidents
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee must be actively at work on the effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year
Plan Options	Low Plan and High Plan. The Low Plan offers a lower benefit amount compared to the High Plan.
Coverage Options	You have the option of enrolling in the High plan or the Low plan at the following coverage levels: • You Only • You + Spouse or Domestic Partner • You + Children* • You + family
Medical Expense Benefit	$100 per plan year.
Contact	UnitedHealthcare Specialty Benefits: **1-800-444-5854** Website: **www.myuhcfp.com** (you can use your UHC website user id and password) Support email: **fpcustomersupport@uhc.com** Group Number: 305735 Customer service team is available Monday through Friday from 8 a.m. to 6 p.m. EST.

Note: This section of the SPD summarizes certain provisions of the Accident Protection Plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by UnitedHealthcare, and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan by accessing your account from **BakerHughesBenefits.com**, prepared by UnitedHealthcare, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by UnitedHealthcare, the certificate of coverage/insurance will prevail in all instances. Please read the full disclosure document posted on BakerHughesBenefits.com or call UHC at 1-800-4444-5854 for more details. If this benefit summary conflicts with the certificate of coverage issued upon enrollment, the certificate of coverage shall prevail.

Overview

The UnitedHealthcare Accident Protection Plan will pay money back to you if you have a covered injury and need medical care. You can choose between the Low and High Plans and select your coverage tier during enrollment. The amount you receive is based on the plan enrolled in and the covered expenses, which may include emergency room services, surgeries, recovery care and more. You can use the money to help pay your health plan deductible and other out-of-pocket costs. Or, use it to make up for lost wages, to help pay your mortgage or rent, and more.

Once UnitedHealthcare verifies your claim request as a covered injury, the benefit payment will be sent directly to you, giving you the freedom to use it however you choose.

*Including children of your domestic partner. Your domestic partner must be covered under the plan to add your domestic partner's children.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees

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

If you and your spouse or domestic partner work for Baker Hughes and need help completing your elections, call the **Baker Hughes Benefits Center** at **1-866-244-3539**, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Base Benefits for Covered Expenses (Per Accident)

These are the base benefits for the Accident Protection Plan. The payment amount is what the plan will pay directly to you when your claim is submitted and approved.

Plan Benefits	Low Plan	High Plan
Initial Care		
Ground Ambulance	$200	$400
Air Ambulance	$750	$1,500
Emergency Room Treatment	$100	$200
Physician Office/Urgent Care (per visit)	$100	$200
Hospital Care		
Hospital Admission	$1,000	$2,000
Hospital Confinement	$125	$225
Hospital ICU Admission	$1,500	$3,000
Hospital ICU Confinement	$200	$400
Follow Up Care		
Appliances Benefit		
Wheelchair	$200	$400
Knee Scooter	$200	$400
Knee Immobilizer	$200	$400
Lumbar Spine Brace	$200	$400
Walking Boot	$200	$400
Walker	$200	$400
Crutches	$200	$400
Leg Brace	$200	$400
Cervical Collar	$200	$400
Cane	$50	$100
Ankle Brace	$50	$100
Ankle Boot	$50	$100
Air Cast	$50	$100
Follow up Physician Visit	$50	$100
Major Diagnostic Exam	$100	$200

Plan Benefits	Low Plan	High Plan
Minor Diagnostic Exam	$100	$200
Prosthetic		
One Device	$500	$1,000
Two or More Devices	$1,000	$2,000
Rehabilitation Facility (per day/Up to 30 days)	$75	$150
Rehabilitation Therapy (per visit/up to 10 Visits)	$25	$50
Common Injuries		
Abdominal/Thoracic Surgery		
Surgery to repair	$1,000	$2,000
Exploratory without repair	$100	$200
Cranial Surgery	$200	$400
Eye Surgery		
Removal of foreign body	$100	$200
Surgical Repair	$200	$400
Hernia Surgery	$200	$400
Arthroscopic Surgery	$200	$400
Non-Specific Surgery		
General Anesthesia	$200	$400
Conscious Sedation	$100	$200
Tendon / Ligament / Shoulder Cartilage / Rotator Cuff / Knee Cartilage Surgery		
Surgery to repair one	$300	$600
Surgery to repair more than one	$600	$1,200
Exploratory without repair	$150	$300
Burns		
2nd Degree (at least 36% of body surface)	$450	$900
3rd Degree (9 to 34 sq. inches)	$900	$1,800
3rd Degree (35 or more sq. inches)	$6,000	$12,000
Concussion	$150	$300
Coma	$6,000	$12,000
Lacerations		
Greater Than 15 cm	$400	$600
5 cm - 15 cm	$250	$500
Less Than 5 cm	$50	$100
Not Requiring Sutures	$30	$60
Paralysis		
Quadriplegia	$10,000	$20,000

Plan Benefits	Low Plan	High Plan
Hemiplegia	$5,000	$10,000
Paraplegia	$5,000	$10,000
Ruptured / Herniated Disc	$500	$1,000
Emergency Dental Work		
Crown(s)	$100	$200
Extraction(s)	$100	$200
Medical Supplies / Over-the-counter(one time per plan year)	$10	$20
Family Child Daycare (per day up to 30 days)	$30	$45
Lodging (per day up to 30 days)	$100	$200
Transportation (for special treatment more than 100 miles away, maximum of 3 trips per accident)	$250	$500
Fractures		
Skull (Depressed, except bones of face or nose)	$4,000 / $2,000	$8,000 / $4,000
Sternum	$4,000 / $2,000	$5,000 / $2,500
Hip, Thigh (Femur)	$4,000 / $2,000	$8,000 / $4,000
Skull (Simple, except bones of face or nose)	$2,000 / $1,000	$4,000 / $2,000
Leg (from top of tibia to ankle joint)	$2,000 / $1,000	$4,000 / $2,000
Pelvis (Excluding Coccyx)	$3,000 / $1,500	$6,000 / $3,000
Vertebrae (body of)	$3,000 / $1,500	$6,000 / $3,000
Sacral / Sacrum	$750 / $375	$1,500 / $750
Face or Nose (except teeth)	$1,000 / $500	$2,000 / $1,000
Upper Arm (Elbow to Shoulder)	$1,500 / $750	$3,000 / $1,500
Upper Jaw (except Alveolar process)	$1,000 / $500	$2,000 / $1,000
Ankle	$1,000 / $500	$2,000 / $1,000
Foot (except Toes)	$1,000 / $500	$2,000 / $1,000
Forearm, Hand, Wrist (except Fingers)	$1,000 / $500	$2,000 / $1,000
Kneecap	$1,000 / $500	$2,000 / $1,000
Lower Jaw (except Alveolar process)	$1,000 / $500	$2,000 / $1,000
Shoulder Blade or Collarbone	$1,400 / $700	$2,800 / $1,400
Vertebral Process	$1,000 / $500	$2,000 / $1,000
Rib(s)	$600 / $300	$1,200 / $600
Coccyx	$300 / $150	$600 / $300
Finger or Toe	$300 / $150	$400 / $200
Dislocations		
Hip	$3,000 / $1,500	$6,000 / $3,000

Plan Benefits	Low Plan	High Plan
Elbow	$1,000 / $500	$2,000 / $1,000
Ankle	$2,000 / $1,000	$4,000 / $2,000
Collar Bone (Sternoclavicular)	$1,000 / $500	$2,000 / $1,000
Foot (except toes)	$2,000 / $1,000	$4,000 / $2,000
Hand	$800 / $400	$1,600 / $800
Kneecap (Patella)	$2,000 / $1,000	$4,000 / $2,000
Lower Jaw	$400 / $200	$800 / $400
Shoulder Blade	$500 / $250	$1,000 / $500
Wrist	$500 / $250	$1,000 / $500
Collarbone (Acromioclavicular separation)	$800 / $400	$1,600 / $800
Finger or Toe	$200 / $100	$400 / $200
Organized Sporting Activity Injury	Increases amounts payable under Follow Up Care and Common Injuries sections by 25%	
Additional Benefits		
Medical Expense Benefit	$100	

This information does not replace your official plan documents. Please see your official plan documents for all coverage details, which includes limitations and exclusions.

Medical Expense Benefit

UnitedHealthcare will pay the covered Medical Expenses incurred for you or your dependent's injuries due to a covered accident provided that:

1. The payment will not exceed the maximum benefit amount shown for this benefit in the schedule for all such expenses incurred as the result of any one covered accident;
2. The expenses are incurred for treatment received within 90 days of the covered accident.

The term covered medical expenses means expenses which are:

1. Incurred for treatment in:
   a. A hospital
   b. A physician's office;
   c. Urgent Care Center; or
   d. Hospital Emergency Room; and
2. Not in excess of those which the physician or facility has indicated a willingness to accept as evidenced by its agreements with insurers, fee for service plans, or similar programs.

UnitedHealthcare will not pay for any expenses that you or your dependent are not legally required to pay.

How to File a Medical Expense Benefit Claim

You can access a Wellness Claim form either on **BakerHughesBenefits.com** or by logging into your UnitedHealthcare Specialty Benefits **account**.

Mail: UnitedHealthcare Specialty Benefits
Address: PO Box 7466, Portland, ME 04112-7466
Telephone: **1-800-539-0038**
Fax: **1-888-505-8550**

Filing an Accident Protection Claim

Notice of Claim

Written notice of a claim must be given to UnitedHealthcare by you or your authorized representative within 30 days after the date of death or the date of loss. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include the claimant's name, the Policyholder's name and the Policy number. The Notice of Claim must be submitted to UnitedHealthcare. Please call UnitedHealthcare at **1-800-444-5854** for additional information.

Claim Forms

Contact UnitedHealthcare at **1-800-444-5854** to obtain a claim form. The claim form is also located on **BakerHughesBenefits.com** or the UnitedHealthcare Specialty Benefits **website**. If you contact UnitedHealthcare and request a claim form, they will send you or your dependent the claim forms within 20 days. If the forms are not received from UnitedHealthcare within 20 days of your or your dependent's request, written proof of claim should be sent to UnitedHealthcare without waiting for the form. You or your dependent will satisfy the proof of claim requirement if written proof of the occurrence, nature, and extent of the loss are sent to UnitedHealthcare. The completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits by regular mail, email, or fax as indicated below.

Mail:
UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466
Phone: **1-800-539-0038**
Email **FPCustomerSupport@uhc.com** (email is unsecured unless you are a registered Cisco user)
Fax: **1-888-505-8550**

Proof of Claim

Written Proof of Claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of Claim may include the following:

1. A completed claim form;
2. A certified copy of the death certificate (if applicable);
3. Your Enrollment form;
4. Your beneficiary designation (if applicable);
5. All medical information, including reports of diagnostic testing and photocopies of medical records, including histories;
6. Physical, mental, or diagnostic examinations and treatment notes;
7. The names and addresses of all:
   a. Physicians or other qualified medical professionals you have consulted;
   b. Hospitals or other medical facilities in which you have been treated; and
   c. Pharmacies which have filled your prescriptions within the past three years;
8. Your signed authorization for UnitedHealthcare to obtain and release medical, employment, and financial information (if applicable);
9. Documentation of your hours worked;
10. Proof of any Employer approved Leave of Absence; or
11. Any additional information required by UnitedHealthcare to adjudicate the claim.

All proof submitted must be satisfactory to UnitedHealthcare.

You and Baker Hughes must fill out the applicable designated section of the claim form and then give it to your attending physician. The physician should fill out their section of the form and send it directly to UnitedHealthcare.

In some cases, you will be required to give UnitedHealthcare authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim. UnitedHealthcare will deny your claim or stop making your payments if the appropriate information is not submitted.

Time of Claim Payment

Benefits for loss covered are paid upon receipt of Proof to UnitedHealthcare. UnitedHealthcare will pay any daily benefit due:

- On a monthly basis, after proof of loss is received, while the loss and UnitedHealthcare liability continue; or
- Immediately after UnitedHealthcare receives the proof following the end of their liability

UnitedHealthcare will pay any other benefit immediately after proof of claim is received. However, if special circumstances require an extension, UnitedHealthcare will provide the Claimant with:

- A description of any further proof needed to perfect the claim; and
- An explanation of why such material is needed

Benefits for a covered loss will then be paid upon receipt of all proper proof of claim.

Payment of Claim

Loss of Life benefits are payable in accordance with the Beneficiary designation in effect at the time of your death. If there is no Beneficiary, or the Beneficiary is not living at the time of your death, benefits are payable to your survivors, in equal shares, in the first of the following classes to have a survivor at your death:

- Spouse or domestic partner
- Children or children of domestic partner
- Parents
- Brothers and sisters

If there is no survivor in these classes, payment will be made to your estate. You are the beneficiary for your covered dependents. Except as otherwise noted for specified additional benefits that may be included in the Policy, all other benefits due and not assigned will be paid to you, if living. Otherwise, the benefits will be paid according to the above. If a benefit is payable to your estate, to a minor or to someone who is not competent to give a valid release, UnitedHealthcare has the right to pay up to $1,000 to any relatives whom they consider entitled. Any amount UnitedHealthcare pays in good faith releases UnitedHealthcare from further liability, but only for the amount paid.

Overpayment of Claim

UnitedHealthcare has the right to recover any over payments due to:

- Fraud; and
- Any error that you, UnitedHealthcare, or the Baker Hughes Benefits Center make in processing a claim

You must reimburse UnitedHealthcare in full. UnitedHealthcare will determine the method by which the repayment is to be made:

- Your Beneficiary if living, or
- Your Estate

Legal Action

You may not bring suit to recover under this provision until 60 days after you have given UnitedHealthcare written proof of claim. No suit may be brought more than three years after the date of loss.

Claims Denial Process for Accident Protection Insurance

If you disagree with UnitedHealthcare's decision, in whole or in part, and wish to appeal it, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to a full and fair review of the decision. Your request for review must be in writing and must be received by UnitedHealthcare within 180-days from the date that you receive your denial letter or UnitedHealthcare's decision will be final. Forward your appeal request, along with any comments or additional information that you feel would assist in UnitedHealthcare's review of or substantiate your claim.

UnitedHealthcare will review your letter and accompanying information with the other information in your file and will notify you of the appeal determination within 45-days of receipt of your request, unless special circumstances require an extension of that time. If there are special circumstances, UnitedHealthcare will notify you in writing and request any additional information that is required, and of the revised time frames for their decision.

How to send UnitedHealthcare information:

Mail: UnitedHealthcare Insurance Company
Address: PO Box 7466
Portland, ME 04112-7466
Fax: **1-888-505-8550**
Email: **FPCustomerSupport@uhc.com** (unsecured unless you are a registered Cisco user)

Please refer to the certificate of coverage/insurance for further information regarding filing a claim or appeal of a denied claim or related legal action.

When Does Coverage End?

Coverage in the Accident Protection Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The date you die
- The plan terminates
- You do not make the required contributions

When Coverage Ends

If you become ineligible to participate in Accident Protection coverage through Baker Hughes, you will receive a letter from the **Baker Hughes Benefits Center**. The letter will offer you the option to continue coverage outside the group plan at the same premium rates through Portability. To elect to continue your coverage, you must contact the UHC Portability Department at **1-877-683-8601** within 31 days from the date your coverage ended. Coverage continued under Portability terminates at age 75.

Portability: How to Port Your Coverage

You may elect to port your or your dependents' insurance prior to the date your insurance under the Policy ends.

You may not port your insurance if:

1. You fail to pay any required premium;
2. You are on an approved leave of absence;
3. The Policy terminates;
4. You are or become insured under another group accident policy;
5. You are older than the Portability Policy Age Limit shown in the Schedule;
6. You reside outside of the United States;
7. You reside in a state where the insurance is not available; or
8. You are actively in military service or entering active military service.

Electing Portability

To elect to continue you and your dependent's insurance, you must:

1. Submit a written request to UnitedHealthcare; and
2. Pay the first month's premium; within 31 days of the date your insurance ends.

The following combinations may be ported:

1. You only;
2. You and your spouse or domestic partner only;
3. You and your children only; or
4. You and all your dependents.

No other combinations of ported insurance amounts will be allowed. You must continue to pay the cost of your and your dependent's ported insurance.

Your surviving dependents may port their insurance if you die. However, your surviving spouse or domestic partner must port in order for your surviving children to port. If there is no surviving spouse or domestic partner, no children will be allowed to port.

The portability insurance will end on the earliest of the date:

1. You fail to pay the required premium;
2. You become insured under any other accident insurance policy;
3. You no longer reside in the United States; or
4. You attain any Portability Policy Age Limit shown in the Schedule.

If you are rehired after you port your insurance, you must cancel the ported insurance to re-enroll under the Policy.

Portability, ported, or port means you and your dependents may continue insurance under the Policy that would otherwise terminate due to certain conditions.

Portability Premium Contribution

The rate will be the group's current rate for your or your dependents' class for the first 12 months of portability. However, the required premium including any part previously paid by Baker Hughes must be paid.

After the first 12 months, the rate may change to a portability rate which may be higher.

Exclusions

UnitedHealthcare will not cover any loss caused or contributed by:

1. Disease, bodily, or mental infirmity, or medical or surgical treatment of these (except pyogenic infections through an accidental wound);
2. Suicide or intentionally self-inflicted Injury;
3. Active participation in a riot;
4. Committing or attempting to commit a crime, or participating or attempting to participate in a crime;
5. Taking part in the commission of an assault or being engaged in an illegal activity;
6. An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
7. Use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, unless prescribed for you by a physician and taken as prescribed;
8. Driving or in physical control of a motor vehicle while Intoxicated;
9. Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping, base jumping, or using off-road vehicles that are not registered for use on-road based on applicable state law;
10. Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test;
11. Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
12. Travel or flight in, or descent from any aircraft, except if employment duties require you to be a pilot and/or passenger in a privately owned aircraft, or as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
13. Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
14. Injury arising out of or in the course of any occupation or employment for pay or profit, or any injury or sickness for which you or your dependent are entitled to benefits under any Workers' Compensation Law, Employers' Liability Law, or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule; or
15. An accident that occurs outside of the United States.

In addition to the exclusions shown above, no payment will be made for Treatment received outside of the United States.

Hospital Indemnity Protection Plan

Hospital Indemnity Protection Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for hospital care or confinement.
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee must be actively at work on the effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.
Enrollment Period	• New hires and employees transferring to a position with US benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or during the year if they have a qualified change in status (see the *Can I Make Changes After I Enroll?* information located in the General Information section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year as long as you remain eligible.
Coverage Options	• You Only • You + Spouse or Domestic Partner • You + Children * • You + family
Maximum Daily Benefit Amount	**Low Plan** • $100 to $500 **High Plan** • $200 to $1,000
Contact	UnitedHealthcare Specialty Benefits: **1-800-444-5854** Website: **www.myuhcfp.com** (you can use your UHC website user id and password) Support email: **fpcustomersupport@uhc.com** Group Number: 305735 Customer service team is available Monday through Friday from 8 a.m. to 6 p.m. EST.

Note: This section of the SPD summarizes certain provisions of the Hospital Indemnity Protection Plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by UnitedHealthcare, and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **BakerHughesBenefits.com**, prepared by UnitedHealthcare, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by UnitedHealthcare, the certificate of coverage/insurance will prevail in all instances. Please read the full disclosure document posted on **BakerHughesBenefits.com** or call UnitedHealthcare at **1-800-444-5854** for more details. If this benefit summary conflicts with the certificate of coverage issued upon enrollment, the certificate of coverage shall prevail.

Overview

The UnitedHealthcare Hospital Indemnity Protection Plan provides a lump sum payment if the covered person receives hospital care or is confined to a hospital after coverage takes effect.

Hospital Indemnity insurance complements your existing medical and disability income insurance coverage by providing you with a lump-sum payment upon receiving hospital care, such as an ER visit, one-day surgery, or several days of hospital confinement.

Coverage is guaranteed provided the employee is actively at work on the coverage effective date. If the employee is not actively at work, the coverage will be effective the day the employee returns to active status.

*Including children of your domestic partner. Your domestic partner must be covered under the plan to add your domestic partner's children.

You and Your Spouse or Domestic Partner Both Work at Baker Hughes

If both you and your spouse or domestic partner work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse or domestic partner as your dependent (or vice versa), or
- Both choose to enroll in benefits as employees

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

If you and your spouse work for Baker Hughes and need assistance completing your elections, call the **Baker Hughes Benefits Center** at **1-866-244-3539**, Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Covered Conditions

Low Plan	
Covered Benefits	**Daily Benefit Amount**
Hospital Admission Benefit (up to 365 days/plan year)	$500
Daily Hospital Confinement Benefit (up to 365 days/plan year)	$100
Daily Intensive Care Unit Confinement Benefit (up to 365 days/plan year)	$100
Intensive Care Unit Admission Benefit (up to 365 days/plan year)	$500
Newborn Benefit (1 day/plan year)	$100
Mental and Nervous Disorder Treatment Benefit (Inpatient) (up to 30 days/plan year)	$100
Rehabilitation Therapy Benefit (Inpatient) (up to 30 days/plan year)	$100
Short Stay and Observation Benefit (up to 23 hours/plan year)	$100
High Plan	
Covered Benefits	**Daily Benefit Amount**
Hospital Admission Benefit (up to 365 days/plan year)	$1,000
Daily Hospital Confinement Benefit (up to 365 days/plan year)	$200
Daily Intensive Care Unit Confinement Benefit (up to 365 days/plan year)	$200
Intensive Care Unit Admission Benefit (up to 365 days/plan year)	$1,000
Newborn Benefit (1 day/plan year)	$200
Mental and Nervous Disorder Treatment Benefit (Inpatient) (up to 30 days/plan year)	$200
Rehabilitation Therapy Benefit (Inpatient) (up to 30 days/plan year)	$200
Short Stay and Observation Benefit (up to 23 hours/plan year)	$200

Hospital Indemnity Protection Plan Example

Say you enroll in the Hospital Indemnity High Plan and you or a covered dependent are in the hospital emergency room for observation. If you are enrolled in the Premium HSA option:

Hospital Indemnity	Benefit Impact
Your estimated out-of-pocket costs (ER copay) would be	$100
The Hospital Indemnity Protection Plan would pay an Initial Benefit of	$200
You will have a credit remaining to apply toward other expenses related to your hospital visit	$100

Wellness Benefit

If a covered person takes one of the screening/prevention measures listed below while insured under the Plan and after the insurance has been in effect for 30 days, UHC will pay a $50 health screening benefit upon submission of proof that such measure was taken. UHC will pay one health screening benefit per covered person per calendar year upon receipt by the Plan of adequate documentation to support the performance of any test for the covered individual.

The screening/prevention measures for which a health screening benefit may be paid are:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray

This benefit will be paid as long as the policy is in force and you and your dependents remain insured under this benefit.

The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments you and/or your dependents receive under the policy.

Interaction with Wellness Benefit: If you have purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare, the Wellness Benefit for any Health Screening Test is payable only once per plan year for each person insured under this benefit, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different Health Screening Test issued under a separate policy.

How to file a Wellness claim: You can access a Wellness Claim form either on **BakerHughesBenefits.com** or by logging into your UnitedHealthcare Specialty Benefits account.

What is the Employee's Cost of the Plan?

If you decide to enroll in the Hospital Indemnity Protection plan, you'll pay the full cost of the plan. The cost you're responsible for is called the premium.

Premium Rate Change: Your premiums and the premiums for your covered dependents may change when your premium is due, if rates are changed under the policy.

Filing a Hospital Indemnity Claim

Notice of Claim

Written notice of a claim must be given to UnitedHealthcare by you or your authorized representative, within 30 days after the date of the date of the hospital visit or confinement. If it is not possible, written notice must be given as soon as it is reasonably possible to do so. Contact UnitedHealthcare at 1-800-444-5854 to obtain a claim form. The claim form is also located on **BakerHughesBenefits.com** or the UnitedHealthcare Specialty Benefits **website**. If you do not receive the form from UnitedHealthcare within 20 days of your request, submit your written proof of claim to UnitedHealthcare without waiting for the form. Written proof should establish facts about the claim such as nature of illness and date of the hospital visit.

Filing a Claim

You must fill out the claim form and then give it to your physician who should fill out the section of the form. The completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits by regular mail, email, or fax as indicated below.

Mail:

UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321
Phone: **1-800-539-0038**
Email: **FPCustomerSupport@uhc.com** (email is unsecured unless you are a registered Cisco user)
Fax: **1-888-505-8550**

Written proof of claim must be filed within 90 days after the date of the hospital visit or confinement. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of Claim

Written proof of claim must be filed within 90 days after the date of the hospital visit or confinement. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include, at the claimant's expense:

- The date of diagnosis;
- A completed claim form signed by the claimant and physician(s) including documentation furnished by the physician and supported by clinical, radiological, histological, pathological, and/or laboratory evidence of hospitalization. If the claim is for your spouse or domestic partner, then your spouse or domestic partner must also sign the claim form; and
- The name and address of any hospital or medical facility where treatment was received and any physician who provided treatment prior to the diagnosis

In the event of death, an autopsy confirmation identifying the cause of death:

- Will be required for myocardial infarction; and
- May also be required for other hospitalizations where allowed by law

Payment of Claim

All benefits are payable to you. If you die before a benefit is paid, UnitedHealthcare will pay any amount due to your beneficiary if you designated a beneficiary, otherwise in the following order:

1. Legal spouse or domestic partner;
2. Natural or legally adopted children in equal shares; or
3. Estate.

Overpayment of Claim

UnitedHealthcare has the right to recover any over payments due to fraud or claims processing error. You must reimburse UnitedHealthcare in full. UnitedHealthcare will determine the method by which the repayment is to be made. UnitedHealthcare has the right to recover overpayment from your spouse or domestic partner if living, otherwise your child under the age 26 or estate.

Legal Action

You or your dependent, if applicable, may not bring suit to recover a claim until 60 days after you have given UnitedHealthcare written proof of loss. No suit may be brought more than three years after the date of loss.

Claims Denial Process for the Hospital Indemnity Protection Plan

If you disagree with UnitedHealthcare's decision, in whole or in part, and wish to appeal it, under the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to a full and fair review of the decision. Your request for review must be in writing and must be received by UnitedHealthcare within 180-days from the date that you receive your denial letter or UnitedHealthcare's decision will be final. Forward your appeal request, along with any comments or additional information that you feel would assist in UnitedHealthcare's review of or substantiate your claim.

UnitedHealthcare will review your letter and accompanying information with the other information in your file, and will notify you of the appeal determination within 45-days of receipt of your request, unless special circumstances require an extension of that time. If there are special circumstances, UnitedHealthcare will notify you in writing and request any additional information that is required, and of the revised time frames for their decision.

How to send UnitedHealthcare information:

Mail: UnitedHealthcare Insurance Company
Address: PO Box 7466, Portland, ME 04112-7466
Fax: **1-888-505-8550**
Email: **FPCustomerSupport@uhc.com** (unsecured unless you are a registered Cisco user)

Please refer to the certificate of coverage insurance for further information regarding filing a claim or appeal of a denied claim or related legal action.

When Does Coverage End?

Coverage in the Hospital Indemnity Protection Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The date you die
- The plan terminates
- You do not make the required premium payments

When Coverage Ends

If you become ineligible to participate in Hospital Indemnity coverage through Baker Hughes, you will receive a letter from the **Baker Hughes Benefits Center**. The letter will offer you the option to continue coverage outside the group plan at the same premium rates through Portability. To elect to continue your coverage, you must contact the UHC Portability Department at **1-877-683-8601** within 31 days from the date your coverage ended. Coverage continued under Portability terminates at age 75.

Portability: How to Port Your Coverage

You may elect to port your or your dependents' insurance prior to the date your insurance under the Policy ends.

You may not port your insurance if:

1. You fail to pay any required premium;
2. You are on an approved leave of absence;
3. The Policy terminates;
4. You are or become insured under another group accident policy;
5. You reside outside of the United States or its territories;
6. You reside in a state where the insurance is not available; or
7. You are actively in military service or entering active military service.

Electing Portability

To elect to continue your and your dependent's insurance, you must:

1. Submit a written request to UnitedHealthcare; and
2. Pay the first month's premium within 31 days of the date your insurance ends.

The following combinations may be ported:

1. You only;
2. You and your spouse or domestic partner only;
3. You and your children only; or
4. You and all your dependents.

No other combinations of ported insurance amounts will be allowed. You must continue to pay the cost of your and your dependent's ported insurance.

Your surviving dependents may port their insurance if you die. However, your surviving spouse or domestic partner must port in order for your surviving children to port. If there is no surviving spouse or domestic partner, no children will be allowed to port.

The portability insurance will end on the earliest of the date:

1. You fail to pay the required premium;
2. You become insured under any other hospital indemnity policy; or
3. You attain the Portability Policy Termination Age shown in the below.

If you are rehired after you port your insurance, you must cancel the ported insurance to re-enroll under the Policy.

Portability, ported, or port means you and your dependents may continue insurance under the Policy that would otherwise terminate due to certain conditions.

Portability Premium Contribution

The rate will be the group's current rate for your or your dependents' class for the first 12 months of portability. However, the required premium including any part previously paid by Baker Hughes must be paid. After the first 12 months, the rate may change to a portability rate which may be higher.

Eligibility Age Limit

The covered person must be under age 70 to apply for portability. To include dependent coverage, the covered dependent must also be under age 70.

Portability Termination Age

A covered person's and dependent's portability coverage will terminate on the first day of the month following the date the covered person or dependent attains age 75. If the covered person's portability coverage terminates, the dependent's coverage also terminates.

Exclusions

The Hospital Indemnity Protection Plan will not pay a benefit for a hospital visit or confinement if it is due to:

1. An act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. Loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the *Continuation During Leave of Absence* provision;
3. Any intentionally self-inflicted Injury;
4. Active participation in a riot;
5. Committing or attempting to commit a felony, or participating or attempting to participate in a felony;
6. Taking part in the commission of an assault or being engaged in an illegal activity;
7. Use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a physician; this exclusion does not apply to the Drug and Alcohol Treatment Benefit (Inpatient) if covered under this Policy;
8. Cosmetic or elective surgery;
9. Treatment received outside the United States or its territories;
10. The reversal of a tubal ligation or vasectomy;
11. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law;
12. Participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
13. A newborn child's routine nursing or routine well baby care during the initial confinement in a hospital;
14. Driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway;
15. Mental and nervous disorders; this exclusion does not apply to the Mental and Nervous Disorder Treatment Benefit (Inpatient) if covered under this Policy;
16. Dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an Injury; or (b) correct a disorder of normal bodily function; and
17. Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Pet Insurance

Pet Insurance Benefits At-a-Glance

Type of Plan	Voluntary pet insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on US-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins Enrollment Period	Your date of hire, date of transfer, or anytime after. New hires and employees transferring to a position with US benefits can enroll anytime. There is no default coverage for employees who do not enroll. Employees can make changes anytime including during Annual Enrollment or if they have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).
Plan Information	MetLife Pet Insurance provides reimbursement for vet wellness visits, accidents, illnesses, and more. You can customize your pet insurance to meet your needs while protecting your pet's health and well-being when you enroll in benefits.
Contact	Call Center Hours Monday-Friday, 8am-9pm EST Saturday-Sunday, 10am-7pm **Phone:** 1-800-GETMET8 **Fax:** 877-281-3348
How to Enroll	Enroll anytime during the year at **metlife.pathfactory.com/bakerhughes**.

Pet Insurance Overview

Pet insurance is coverage for your pets that can help you be prepared for unexpected vet costs. With MetLife Pet Insurance, you customize pet insurance to meet your needs. Coverage can include illness, accident, and preventive care coverage. The services covered depends on the coverage you select when you enroll.

When Coverage Starts

Accident coverage and optional Preventive Care coverage begin on the effective date of your policy. Illness coverage begins 14 days later.

Types of Plans

Category	Options
Benefit Limits	$500 to $25,000 (in $1,000 increments) OR unlimited annual limit1 option (Benefit allowance resets each year for the life of the pet)
Deductibles	$0 to $2,500 annually ($0-$750 in $50 increments and $1,000, $1,250, $1,500, $2,000, and $2,500)
Reimbursements	50% to 100%[2]
Routine Wellness	Included or waived
How to Enroll	Enroll anytime during the year at **metlife.pathfactory.com/bakerhughes**.

1 Not available/applicable in LA

2 Reimbursement options include: 50%, 70%, 80%, 90% and 100%

How Pet Insurance Works

You can visit any US licensed vet, emergency clinic, or specialist and you and your veterinarian can determine the best treatment plan and medical course of action for your pet. Once you have received and paid your bill, you send it to MetLife by using MetLife's mobile app, online portal, email, fax, or mail, and they'll process your claim, usually within 10 days. You receive reimbursement[2] by check or direct deposit if the claim expense is covered under the policy.

Cost and Paying for Coverage

Each pet's premium will be unique based on your pet's age and breed, your location, and the coverage amount you select when you enroll.

You pay your premiums directly to MetLife. You do not pay them through payroll deductions. You will set up automatic payments through MetLife's online portal or call center. In addition to your premiums, the fees below may apply.

Enrollment Fee

- An enrollment fee will be charged to a policyholder for the first policy year[3].
- The enrollment fee is added to the bill/deduction for the first month's payment.

Administration/Installment Fee

- An administration/installment fee is charged anytime a policyholder is paying premium monthly. The fee is per month[1].
- The administration/installment fee is waived if the full-year premium is paid up front.

Submitting Claims

To file a claim, send MetLife the following information:

- Completed MetLife claim form
- Invoice and itemized receipt
- Include medical records and vet notes (if it's your first claim with MetLife, provide medical records from the past 12 months)

Email to: **Pet_Submit_Claim@metlife.com** or mail to:

MetLife Pet Insurance
Claims Department
400 Missouri Avenue, Suite 105
Jeffersonville, IN 47130

Exclusions

Previously covered pre-existing conditions may not be covered. To learn more about what is not covered, go to **metlifepetinsurance.com/coverage-exclusions**.

[1] Not available/applicable in LA

[2] Reimbursement options include: 50%, 70%, 80%, 90% and 100%

[3] Enrollment fee not applicable in Georgia, Kansas, Maine, Michigan, Nebraska, New York, and Ohio

Baker Hughes

Benefits Rights

Important Benefits Rights

Please read this section carefully. It contains information concerning the Baker Hughes Health & Welfare 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 benefits that Baker Hughes provides and how you may receive them. However, your participation in any of the benefit plans is not a guarantee of continued employment. The Company reserves the right to retain employees at its own discretion, regardless of benefits offered to them. Nothing in this SPD should be interpreted as a limitation of or restriction on that right. Also, in general, you cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit under any Baker Hughes Health & Welfare benefit program.

Importance of a Current Address

Because benefit-related information may be mailed to you, you must notify your local human resources representative of any change to your current address. Otherwise, you may not receive important information about your benefits.

If you provided a personal email address in Workday, you will also need to update your email address should it change.

Remember, if you terminate employment and are entitled to benefits under a Baker Hughes Health & Welfare benefit plan, you must keep the **Baker Hughes Benefits Center** informed of your current mailing address. If not, your benefits related information may not reach you.

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 Baker Hughes group health plans described in this SPD (the Health Plans) are 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 Baker Hughes self-funded and fully insured Health Plans.

The Health Plans, and Baker Hughes Company (as 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 Health Plans' business associates (organizations that have a contract with Baker Hughes Company to provide certain services, such as legal, actuarial, accounting, consulting, or data aggregation of financial circumstances) must also observe HIPAA's privacy rules. Furthermore, the Health Plans 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 they have 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 Health Plans May Use Your Protected Health Information

In order to manage your health effectively, the Health Plans are 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 a Health 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 Health Plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, when a Health Plan contacts you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Health Plan.

Your Protected Health Information may also be disclosed to certain designated employees of Baker Hughes Company (as Plan Sponsor) and its affiliates 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/dis-enrollment data – information on whether you participate in the Health Plan or whether you have enrolled or dis-enrolled from a Plan option (e.g., HMO), and
- Summary health information – summaries of claims from which names and other identifying information have been removed for purposes of obtaining premium bids from service or other providers or modifying, amending, or terminating a Health Plan

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 Health Plans, 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 Health Plans 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 Health Plans 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 Health Plans 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 Health Plans are prohibited from using or disclosing your Protected Health Information when it is considered genetic information for underwriting purposes except to the extent that a Health Plan is an issuer of long-term care policies.

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 on the previous pages, the Health Plans are 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 group Health Plan has already undertaken an action in reliance upon your authorization.

- **Psychotherapy notes.** Save for certain limited exceptions, the Health Plans must obtain authorization for any use or disclosure of your psychotherapy notes
- **Marketing.** The Health Plans 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 Health Plans 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 575 N Dairy Ashford Rd., Suite 100, Houston, Texas, 77079-1117.

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 Health Plans use or maintain an electronic health record of your Protected Health Information, you may obtain a copy in an electronic format, and, if you choose, direct the Health Plans to transmit a copy to a party you designate. The Health Plans may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, the Health Plans 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 Health Plans 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 us to provide an accounting).

Restriction: You have the right to ask a Health Plan to restrict how your Protected Health Information is used and disclosed for treatment, payment, and health care operations. You may also ask the Health 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 Health 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 if the request is determined to be reasonable and will not materially interfere with the operation of the Health 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 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 Health Plan.

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.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Health 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
HIPAA Privacy Officer
575 N. Dairy Ashford Rd., Suite 100,
Houston, Texas 77079-1117
Tel: **1-713-439-8600**

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

The Health Plans maintain a formal 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 the Baker Hughes Benefits website (**BakerHughesBenefits.com**). The Health Plans are 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 Health Plans reserve 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 Health Plans will provide individuals with a revised notice on **BakerHughesBenefits.com**.

Contact your local human resources representative, the Corporate Benefits Department, or 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 Health Plan and Baker Hughes Company 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 employee 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 Health 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 Health Plan for the purposes for which the disclosure was made when no longer needed; and
- Ensure an adequate separation between the Health Plan and the Company.

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

Special Enrollment Rights

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

Special Enrollment Due to Loss of Other Medical Coverage

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

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

Special Enrollment Due to Acquisition of a Dependent

If you are enrolled in one of the Health Plans described in this SPD and during the year you acquire a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, your dependent will be eligible for special enrollment in the Health Plans, if the dependent meets the definition of an eligible dependent.

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

You must request special enrollment within 31 days after the applicable marriage, domestic partnership, birth, adoption, or placement for adoption. Enrollments following a marriage, domestic partnership, birth, adoption, or placement for adoption will be effective as of the date of the marriage, domestic partnership, birth, adoption, or placement for adoption.

Note: over aged dependents cannot be added to the plan during a special enrollment period, as described above.

Special Enrollment for Certain Changes in Medicaid or CHIP Coverage

If you or your eligible dependent are eligible to enroll in one of the Health Plans described in this SPD but are not enrolled, you or your eligible dependent will be entitled to enroll for coverage under the plan if:

- You or your eligible dependent were covered under a Medicaid plan or under a state child health plan and that coverage was terminated because you or your eligible dependent lose eligibility for that coverage, or
- You or your eligible dependent become eligible under a Medicaid plan or under a state child health plan for assistance with your premium payments due under one of the Health Plans described in this SPD

However, you must request enrollment in the plan not later than 60 days after the date of termination of the Medicaid plan or state child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

Some states have a Medicaid plan or a child health plan (CHIP) that can help pay for employer-provided group health plan coverage like that provided by the Health Plans described in this SPD. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health plan premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact that program to find out if premium assistance is available to you.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state's Medicaid or CHIP program to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for coverage under the plan.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical plan options described in this SPD 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 Medical options and the Claim Administrators that offer mastectomy coverage under the 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 coinsurance provision consistent with those established for other benefits under the applicable option offered under the Medical plan option.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Subrogation and Reimbursement

The Plan and each health and welfare plan offered under the Plan has a right to subrogation and reimbursement. For each health and welfare plan offered under the Plan that is funded through an insurance policy, a health maintenance organization ("HMO") or dental maintenance organization ("DMO"), the terms of the applicable insurance policy, HMO contract or DMO contract will set forth the plan's right to subrogation and reimbursement. For each health and welfare plan offered under the Plan that is funded by the Company and/or its affiliates (each, a "Baker Hughes funded plan") the subrogation and reimbursement rights of the Baker Hughes funded plan are set forth in this section of the SPD. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs, and beneficiaries and their estates and beneficiaries, unless otherwise stated.

Subrogation applies when a plan offered under the Plan has paid Benefits for a Sickness or Injury for which any third party may be, or is allegedly, responsible. The right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under a plan offered under the Plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits. The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any Benefits you receive for that Sickness or Injury from the plan. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under a plan offered under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you so received from the plan to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury, or damages
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury, or damages
- An employer in a workers' compensation case or other matter alleging liability
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers, or third-party administrators
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party
- Any person or entity that is liable for payment to you on any equitable or legal liability theory

You agree as follows:

- You will cooperate with the Plan and the Company in protecting a plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable
  - Providing any relevant information requested by the plan
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim
  - Responding to requests for information about any accident or injuries
  - Making court appearances
  - Obtaining the plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses
  - Complying with the terms of this section

Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan.

If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

Each Baker Hughes funded plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- These subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs, and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent
- No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right
- Regardless of whether you have been fully compensated or made whole, the Baker Hughes funded plan may collect from you 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, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights
- Benefits paid by the Baker Hughes funded plan may also be considered to be Benefits advanced
- If you receive any payment from any party as a result of Sickness or Injury, and the plan alleges some or all of those funds are due and owed to the plan, you, your legal counsel and/or your other representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account
- By participating in and accepting Benefits from the Baker Hughes funded plan, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets to the extent of the amount of plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the plan (within the meaning of ERISA) with respect to such amounts 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, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights
- The Baker Hughes funded plan's rights to recovery will not be reduced due to your own negligence
- By participating in and accepting Benefits from the Baker Hughes funded plan, you agree to assign to the plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits, and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily
- The Baker Hughes funded plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the plan is governed by a six-year statute of limitations
- You may not accept any settlement that does not fully reimburse the plan, without its written approval
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Baker Hughes funded plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation
- The provisions of this section apply to each Dependent child covered under a plan and to the parents, guardian, and other representatives of such Dependent child, who incurs a Sickness or Injury caused by a third party or otherwise described herein. If a parent or guardian or other representative may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim
- If a third-party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Baker Hughes funded plan, the provisions of this section continue to apply, even after you are no longer covered
- In the event that you do not abide by the terms of the Baker Hughes funded plan pertaining to reimbursement, the Baker Hughes funded plan may terminate Benefits to you, your dependents or the participant employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to your failure to abide by the terms of the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan
- The plan and all Administrators administering the terms and conditions of these subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan

Right of Recovery

The Plan also has the right to recover Benefits it has paid on your or your Dependent's behalf that were:

- Made in error
- Due to a mistake in fact
- Advanced during the time period of meeting the calendar year Deductible, or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery. If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan

Overpayment and Underpayment of Benefits

If you are covered under a Baker Hughes funded benefit plan described in this SPD 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 a Baker Hughes funded benefit plan described in this SPD 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 a Baker Hughes funded benefit plan described in this SPD pays with respect to benefits for 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 the 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 Baker Hughes funded benefit plan. If the refund is due from another person or organization, the covered person agrees to assist the Baker Hughes funded benefit plan in obtaining the refund, when requested.

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

As a participant in certain of the Baker Hughes Health & Welfare benefit programs, you are entitled to certain rights and protections under 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 participant with a copy of this summary annual report

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or domestic partner, 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 welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare 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 initiate arbitration under the Plan's arbitration provisions (or file suit in a federal court to the extent allowed under the terms of the Plan or otherwise required by ERISA). In such a case, the arbitrator or 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 initiate arbitration under the Plan's arbitration provisions (or file suit in a federal court to the extent allowed under the terms of the Plan or otherwise required by ERISA). 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 initiate arbitration under the Plan's arbitration provisions (or file suit in a federal court to the extent allowed under the terms of the Plan or otherwise required by ERISA). If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may initiate arbitration under the Plan's arbitration provisions (or file suit in a federal court to the extent allowed under the terms of the Plan or otherwise required by ERISA). The arbitrator or court will decide who should pay arbitration/court costs and legal fees. If you're successful, the arbitrator or court may order the person you have sued to pay these costs and fees. If you lose, the arbitrator or 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 **www.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 publications hotline of the Employee Benefits Security Administration.

COBRA

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, go to **BakerHughesBenefits.com**. You may also call the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide).

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 you and your qualifying family members the opportunity to temporarily extend the coverage you and your dependents had under the Baker Hughes group health plans described in this SPD (the group health plans) 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. While a domestic partner is not covered by COBRA, the group health plans offered by Baker Hughes voluntarily extend certain coverage to a qualifying domestic partner who is covered by the plan in a fashion comparable to certain COBRA continuation coverage.

COBRA coverage can become available to you when you would otherwise lose your coverage under the group health plans. It can also become available to other members of your family who are covered under the group health plans 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 a group health plan on the day prior to a COBRA qualifying event listed below. Otherwise, the individual has no rights to elect COBRA coverage. However, once you, your spouse, domestic partner, or other dependent gains coverage under COBRA (or comparable coverage for domestic partners), you, your covered spouse, domestic partner, or dependent may elect to add eligible dependents according to the same provisions that apply to active employees covered under the group health plans.

COBRA Qualifying Events

If you're an active employee covered by a group health plan, you may elect COBRA coverage if your coverage under the plan is lost because:

- Your hours of employment are reduced, or
- Your employment terminates (other than for gross misconduct)

If you're a covered spouse or domestic partner of a covered active or former employee, you may elect COBRA coverage (or comparable coverage for domestic partners) for yourself if your coverage under the group health plan is lost for any of these reasons:

- Your spouse or domestic partner dies
- Your spouse's or domestic partner's hours of employment are reduced or employment terminates (other than for gross misconduct)
- You are divorced or legally separated from your spouse
- Your domestic partnership is terminated; or
- Your spouse or domestic partner becomes entitled to coverage under Medicare

If you're a covered dependent child of a covered active or former employee, you may elect COBRA coverage for yourself if your coverage under the group health plan is lost for any of these reasons:

- The covered employee dies
- The covered employee's hours of employment are reduced or employment terminates (other than for gross misconduct)
- Your parents divorce or legally separate
- Your parents terminate a domestic partnership
- You cease to qualify as a dependent child of the covered employee under the group health plan; or
- The covered employee 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.

Special Rules Apply if You Take a Leave Under FMLA

Taking a leave under the FMLA (see the *Leave of Absence* section) is not a qualifying event under COBRA. However, a COBRA qualifying event will occur on the last day of the FMLA leave if:

- You (or your dependent) are covered under the group health plan on the day before the FMLA leave begins
- You do not return to employment with Baker Hughes at the end of the FMLA leave; and
- You (or your dependent) would otherwise qualify for COBRA coverage

If the above requirements are met, COBRA coverage would continue for up to 18 months from the last day of your FMLA leave.

Type of Coverage Available Under COBRA

Continuation of coverage under the Medical, Dental, and Vision plans and Emotional Wellbeing Solutions (the EAP), and limited continued participation in your Health Care Flexible Spending Account that is available under COBRA is the same coverage provided to covered active persons on the day before the COBRA qualifying event. If coverage under one of the group health plans is modified for covered active employees, 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 active employees have to add or eliminate coverage of family members or to switch to another applicable benefit option under the group health plans.

COBRA Eligibility

To receive continuation coverage under COBRA (or comparable coverage for domestic partners), you or a family member **must** notify the **Baker Hughes Benefits Center** when a covered employee and spouse divorce or legally separate, when a covered employee and domestic partner terminate their partnership, when a dependent child of the covered employee ceases to qualify as a dependent child under the group health plan, or when a covered employee or covered dependent becomes disabled. You, or your spouse or domestic partner, 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 you and/or your spouse or domestic partner, or dependents will not be entitled to receive COBRA continuation coverage (or comparable coverage for domestic partners). After the **Baker Hughes Benefits Center** is notified that a COBRA qualifying event has occurred, you and your qualifying dependents will be notified of your rights (via mail) to elect COBRA coverage (or comparable coverage for domestic partners) and provided with application materials. You then have 60 days from the post-mark date of those materials to call the **Baker Hughes Benefits Center** to make COBRA elections and comparable domestic partner elections. Covered employees may elect COBRA coverage on behalf of their spouses or comparable domestic partner coverage on behalf of their domestic partners, and parents may elect COBRA coverage on behalf of their children.

You do not have to provide Evidence of Insurability to elect COBRA or comparable domestic partner coverage. Once you or your dependents are receiving COBRA coverage or comparable domestic partner coverage, if you change your marital status or if you, your spouse or domestic partner, 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 group health plans 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 active employees 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 children 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 you to continue your coverage under a group health plan for up to the periods described below (other than the Health Care Flexible Spending Account to which special rules described in the section titled *Special COBRA Rules for the Health Care Flexible Spending Account* apply):

If You Experience One of these Qualifying Events	Coverage May be Elected for	Up to a Maximum of
Your death	Your spouse or domestic partner, and/or dependent children	36 months
Your divorce or legal separation	Your spouse and/or dependent children	
Your termination of your domestic partnership	Your domestic partner and the children of your domestic partner*	
Your children are no longer eligible for benefits under the group health plan	Your child	
Your eligibility for Medicare benefits	Your spouse or domestic partner, and/or dependent children	
Your termination of employment (unless terminated for gross misconduct) or a reduction of work hours	You, your spouse or domestic partner, and/or dependent children	• 18 months generally • 29 months, if you, your spouse or domestic partner, or your child covered under the group health plan qualify for Social Security disability benefits due to a disability that existed the day of the qualifying event or began within the first 60 days of COBRA coverage or comparable domestic partner coverage and lasts at least until the end of the 18-month period of COBRA coverage or comparable domestic partner coverage • 36 months for a spouse or domestic partner, and children, if another qualifying event (other than bankruptcy of your employer) occurs during the initial 18-month or 29-month coverage period, as applicable, the second qualifying event would have caused the spouse or domestic partner, or dependent child to lose coverage under the group health plan had the first qualifying event not occurred and notice of the second qualifying event is properly given by the spouse or domestic partner, or dependent child to the group health plan administrator • 36 months for the spouse or domestic partner, and children, if you were entitled to receive Medicare within 18 months before your termination of employment or reduction of work hours

*Your domestic partner needs to be enrolled in order for a domestic partner's child who cannot qualify as your dependent to be enrolled

To be "disabled" for COBRA (or comparable domestic partner coverage) purposes, you or your spouse or domestic partner, or dependent child must qualify for Social Security disability benefits and must have been disabled at the time of the qualifying event or become disabled within the first 60 days of COBRA (or domestic partner) coverage. To receive the up to 11-month extension of the applicable continuation coverage period as a result of a qualifying disability, you or your spouse or domestic partner, or dependent child must notify the **Baker Hughes Benefits Center** at **1-866-244-3539** of the disability before the end of the initial 18-month coverage period. If you recover (are no longer disabled) you must notify the **Baker Hughes Benefits Center** 30 days after the date you are determined to no longer be disabled. If you recover within the initial 18-month coverage period, and within 60 days after the date the Social Security Administration determination is made, you may keep your COBRA coverage for the remainder of the 18-month period. Should you recover in the 19th through the 28th month, your COBRA coverage will cease at the end of the month in which you're determined to no longer be disabled. If a person becomes eligible for COBRA or comparable domestic partner coverage as a result of more than one qualifying event, the maximum 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 group health plans only to the extent required by COBRA except as permitted by the Plan Administrator.

Ending COBRA or Comparable Domestic Partner Coverage

Your COBRA or comparable domestic partner 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 pay the premium for your coverage in a timely manner
- You become entitled to Medicare after making your coverage election
- You become covered under another group health plan or
- The maximum required COBRA or domestic partner coverage period expires

Cost of COBRA Coverage

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

You or your eligible dependents will be charged 100% of the total cost for COBRA or comparable domestic partner coverage plus a 2% administration fee. You'll receive information about the cost of COBRA or comparable domestic partner 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 timely premium payments.

However, if you elect COBRA or comparable domestic partner coverage due to termination of employment or reduction in work hours and then you qualify for Social Security disability benefits, your premium will be increased to 150% of the premium amount after 18 months of coverage. Please note that premiums for COBRA and comparable domestic partner coverage are subject to change. However, participants will be notified of any rate change.

If you elect COBRA or comparable domestic partner coverage and timely 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 or comparable domestic partner coverage, 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 and comparable domestic partner coverage ends and **cannot thereafter be reinstated**.

Special COBRA Rules for the Health Care Flexible Spending Account

Under COBRA, you may also be entitled to elect to continue making contributions to your Health Care Flexible Spending Account, but only if your contributions for the remainder of the plan year are less than the maximum amount of eligible health care expenses that can be reimbursed for the remainder of the plan year. For example, if you elected to set aside $1,200 in your Health Care Flexible Spending Account, you file a claim for $1,000 in March and then terminate April 1, the maximum benefit available for the rest of the year is only $200. However, the maximum amount the plan could require as payment would be approximately $900. Therefore, you would not be eligible under COBRA to continue participating in your Health Care Flexible Spending Account after your employment ended.

Under COBRA, your contributions to your Health Care Flexible Spending Account must be made on an after-tax basis and will be subject to an additional 2% administrative fee. You cannot continue making contributions to your Health Care Flexible Spending Account pursuant to COBRA for any plan year following the plan year in which your COBRA qualifying event occurs. If you choose not to continue making contributions to your account when you leave Baker Hughes, you can still be reimbursed for expenses incurred before you left, but you cannot be reimbursed for expenses incurred after you leave Baker Hughes.

If You Return to Work with Baker Hughes Before COBRA Coverage Ends

If you return to work as an employee while you're on COBRA coverage, you may elect to participate in the group health plan as an active employee. Upon your return to active coverage, you and all of your covered dependents will not be subject to any pre-existing medical condition limitations for medical conditions.

Coverage Options Besides COBRA Coverage

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's or domestic partner's employer's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at **www.healthcare.gov**.

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 Baker Hughes group health plans are 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 (QMCSO) is issued with respect to your child, that child will be eligible for coverage as required by the order.

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 a group health plan, and satisfies all of the following:

1. The order recognizes or creates a child's right to receive group health plan 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 Baker Hughes group health 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 employee 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 or notice is a QMCSO
- Determine if the order or notice is qualified, and
- Notify the eligible employee and the representative of each child covered by the order or notice of the determination and, if the order or notice is determined to be qualified, provide the representative of the child covered by the order or notice with a full explanation of the benefits under the applicable plans

Participants and beneficiaries under the Baker Hughes group health plans can obtain, without charge, a copy of the plans' QMCSO procedures from the **Baker Hughes Benefits Center** by calling the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the US) or **1-847-883-0945** (worldwide) between 7:00 a.m. and 7:00 p.m. Central Time, Monday through Friday.

The Plan Administrator is responsible for deciding whether a court order or national medical support notice satisfies the conditions of a QMCSO.

Baker Hughes

Important Plan Information

Plan Administration and Funding

The Baker Hughes Health & Welfare benefit programs described in this SPD are administered and funded in different ways. Some of the plans are funded through insurance with participant and/or Company contributions as described in the separate sections of this SPD. Others are funded wholly by participant 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 administration of the Baker Hughes Health & Welfare benefit programs described in this SPD. By participating in one of the plans, 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
Phone: **1-713-439-8600**

Note: The Short-Term Disability plan is not covered by ERISA.

Claims Administrator

For some of the Baker Hughes Health & Welfare benefit programs described in this SPD, Baker Hughes Company has delegated authority to third party administrators to administer benefit claims under the plan. The Claims Administrator for each benefit plan is listed on the following pages. Subject to Baker Hughes Company's overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret plan provisions and is the named fiduciary to determine benefit claims.

Cost of Administering the Plans

Baker Hughes intends to pay certain expenses of administering the Baker Hughes Health & Welfare benefit programs described in this SPD except for the Vision Plan, the Supplemental Life Plan, Voluntary AD&D Plan, Critical Illness insurance Plan, the Accident Protection Plan, the Hospital Indemnity Protection Plan, the Legal Plan, and Pet Insurance, which are paid wholly by the employee.

Contributions to the Plans

Baker Hughes offers some welfare benefit programs that are fully insured. For these plans, the insurance company designates the Benefits Administrator and provides the benefit and determines the premiums to be paid.

The Baker Hughes Health & Welfare benefit programs described in this SPD are individually identified by name and number as shown in the following table. Each of those plans, other than the Short-Term Disability plan which is not subject to ERISA, are offered under the Plan. The records of each plan are kept on a calendar-year basis.

Claims Administrators

Plan	
Plan Administrator and Sponsor	Baker Hughes Company Attn: Total Rewards H&W Department 575 N. Dairy Ashford Rd., Suite 100 Houston, Texas 77079-1117 For information call **1-713-439-8600**
Plan Sponsor's Employer Identification Number (EIN)	76-0207995
Plan Name	Baker Hughes Company Welfare Benefits Plan
Plan Number	501
Plan Year	The plan year begins January 1 and ends December 31.
Agent For Service of Legal Process	Baker Hughes Company Chief Legal Officer 575 N. Dairy Ashford Rd., Suite 100 Houston, Texas 77079-1117

Plan	Medical Plan
Plan Name	Baker Hughes Company Comprehensive Major Medical Plan
Plan Type	Welfare plan providing comprehensive medical benefits
Type of Administration	Self insured
Plan Number	701368
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Prescription Drug Plan
Plan Name	Baker Hughes Company Prescription Drug program
Plan Type	Welfare plan providing prescription medication benefits
Type of Administration	Self insured
Plan Number	1424
Benefit Administrator	CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Plan	Dental Plan
Plan Name	Baker Hughes Company Group Dental Care Plan
Plan Type	Welfare plan providing comprehensive dental benefits
Type of Administration	Self insured
Plan Number	3215512
Benefit Administrator	CIGNA 1111 Market Street Chattanooga, TN 37402

Plan	Vision Plan
Plan Name	Baker Hughes Company Vision Program
Plan Type	Welfare plan providing comprehensive vision benefits
Type of Administration	Fully insured
Plan Number	12210899
Benefit Administrator	Vision Service Plan 12222 Merit Drive, Suite 1410 Dallas, TX 75251

Plan	Flexible Spending Accounts
Plan Name	Baker Hughes Company Health Care Flexible Spending Account Plan and Baker Hughes Company Dependent Day Care Flexible Spending Account Plan
Plan Type	Welfare plan for the use of pre-tax money for health and dependent care costs
Type of Administration	Self insured
Plan Number	705742
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Health Savings Account
Plan Name	Health Savings Accounts
Plan Type	Welfare plan accumulating pre-tax money for medical expenses if you participate in an HDHP
Plan Number	701368
Benefit Administrator	Optum Bank P.O. Box 271629 Salt Lake City, UT 84127-1629

Plan	Emotional Wellbeing Solutions
Plan Name	Baker Hughes Company Employee Assistance Program
Plan Type	Welfare service providing referral services
Type of Administration	Fully insured
Plan Number	BAHC
Benefit Administrator	Optum Headquarters 13625 Technology Drive Eden Prairie, MN 55344

Plan	Short-Term Disability
Plan Type	Payroll practice providing income replacement
Type of Administration	Self insured
Plan Number	88110
Benefit Administrator	Sedgwick P.O. Box 14030 Lexington, KY 40512-4030

Plan	Long-Term Disability
Plan Name	Baker Hughes Company Long-Term Disability Program
Plan Type	Welfare plan providing long-term disability benefits
Type of Administration	Fully insured
Plan Number	52656
Benefit Administrator	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176

Plan	Basic and Supplemental Life insurance
Plan Names	Baker Hughes Company Life Insurance Program Baker Hughes Company Supplemental Life Insurance Program
Plan Type	Welfare plan providing Basic and Supplemental Life insurance
Type of Administration	Fully insured
Plan Number	52656
Benefit Administrator	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176

Plan	Basic and Voluntary Accidental Death & Dismemberment
Plan Names	Baker Hughes Company Accidental Death & Dismemberment Program Baker Hughes Company Voluntary Accidental Death & Dismemberment Program
Plan Type	Welfare plan providing Basic and Voluntary Accidental Death & Dismemberment insurance
Type of Administration	Fully insured
Plan Number	52656
Benefit Administrator	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176

Plan	Business Travel Accident Insurance
Plan Name	Baker Hughes Company Business Travel Accident Program
Plan Type	Welfare plan providing Business Travel Accident insurance
Type of Administration	Fully insured
Plan Number	6477-59-66
Benefit Administrator	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700

Plan	Legal Plan
Plan Type	Voluntary plan providing legal advice and assistance
Plan Number	602482
Benefit Administrator	LegalEase 5850 San Felipe, Suite 600 Houston, TX 77057

Plan	Pet Insurance
Plan Type	Voluntary Welfare benefit plan that provides benefits coverage for pets
Plan Number	98046
Benefit Administrator	MetLife Pet Insurance Claims Department 400 Missouri Avenue, Suite 105 Jeffersonville, IN 47130

Plan	Critical Illness
Plan Type	Voluntary Welfare benefit plan that provides benefits for critical illness
Plan Number	305735
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Accident Protection Plan
Plan Type	Voluntary Welfare benefit plan that provides benefits for accidents
Plan Number	305735
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Hospital Indemnity Protection Plan
Plan Type	Voluntary Welfare benefit plan that provides benefits for hospital stays
Plan Number	305735
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

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 the benefit programs described in this SPD and maintain control over the operation and administration of the Plan and the benefit programs described in this SPD.

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 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 Plan. 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 Plan, including without limitation, the authority to determine any person's right to Continuation Coverage under a group health plan offered under the Plan. Except to the extent that a benefit program is insured by a third party or provided by an HMO or a DMO, the Plan Administrator will have the exclusive right and discretionary authority to interpret the terms and provisions of the Plan and the benefit programs described in this SPD and to determine any and all questions arising under the Plan or under any of 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 Plan 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 Plan 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 Plan or any benefit programs described in this SPD (Benefit Programs) other than a benefit program that is insured by a third party or provided by 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.

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 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 Company 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 Company 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 USC. Sections 1-16 (or replacement or successor statute). Nothing in the Plan 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 Plan or under any benefit program described in this SPD or any claim of breach of fiduciary duty under ERISA will be solely and exclusively 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 solely and exclusively 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 Plan and the benefit programs offered under the Plan will 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 Plan or any program offered under the Plan 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. Any attempted conveyance, transfer, assignment, mortgage, pledge, or encumbrance of Plan 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 Employers, 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.)

Remember...

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with access or claim issues that you have not been able to resolve after initial contact with the Claim Administrator's customer service. The participant Advocacy service is available for the following benefit plans:

- All Medical plans
- Prescription Drug plan
- Dental plan
- Vision plan
- Health Care Flexible Spending Account
- Health Savings Account
- Emotional Wellbeing Solutions

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.

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 under the Plan (which was mailed to your last address 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 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 this SPD is 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 Baker Hughes Company.

Benefit Administrators and Claims Payers

Baker Hughes Company 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 Company intends to continue the Plan and the Baker Hughes Health & Welfare benefit programs described in this SPD, Baker Hughes reserves the right to terminate or amend all or any of those plans in whole or in part at any time and for any reason. Baker Hughes Company's right to amend or terminate those plans 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. If a plan is so 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 plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination.

Baker Hughes Company reserves the right to modify, amend, or terminate a plan, in whole or in part, if changes in the law or other conditions make it necessary.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and Baker Hughes and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide covered health services to covered persons.

Baker Hughes and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Baker Hughes and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Baker Hughes's employees nor are they employees of UnitedHealthcare. Baker Hughes and UnitedHealthcare are not responsible for any act or omission of any provider.

Baker Hughes is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage)
- The timely payment of the service fee to UnitedHealthcare
- The funding of Benefits on a timely basis
- Notifying you of the termination or modifications to the Plan

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare, the Claims Administrator, for each covered person who selects a network provider within the group to perform or coordinate certain health services. The network providers receive this monthly payment 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
- 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.

Baker Hughes

Glossary of Terms

Glossary of Terms

Term	Definition	Section
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.	All plans
Actively at Work or Active Work	Has the meaning set forth in the applicable insured program portion of this SPD.	Protection
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.	All plans
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 • 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).	Medical
Ancillary Services	Items and services provided at a Network facility that are any of the following: • Related to emergency medicine, anesthesiology, pathology, radiology, neonatology, and whether or not provided by a Physician or non-Physician practitioner, including those 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	Medical
Air Ambulance	Medical transport by rotary wing air ambulance or fixed wing air ambulance each as defined in 42 CFR 414.605.	Medical
Annual Enrollment Period	The period each year during the fall when a US-payroll based full-time or benefits-eligible, part-time employee is eligible to change Plan benefit coverage elections.	All plans
Assisted Reproductive Technology	The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve pregnancy. Examples of such procedures are: • In Vitro Fertilization (IVF) • Gamete Intrafallopian Transfer (GIFT) • Pronuclear Stage Tubal Transfer (PROST) • Tubal Embryo Transfer (TET) • Zygote Intra Fallopian Transfer (ZIFT)	Medical
Autism Spectrum Disorder	A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities, and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.	Medical
Beneficiary	A person, trust, or estate named in writing by the participant to receive benefits provided by the Plan if the participant dies. The designation must be on file with Baker Hughes Company, at the time of death to be effective.	Protection
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.	All plans
Benefits Base Pay	Base salary including any before-tax contributions made through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Benefits base pay is determined as of October of the prior year, or the date of hire, whichever is later.	All plans
Birthing or Birthing Center	A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that 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, or • 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	Medical

Term	Definition	Section
Birthing or Birthing Center (continued)	— 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 that is part of a hospital, as defined herein, will be considered a birthing center for the purposes of the Plan.	Medical
Brand Name Drug	Drugs manufactured under a registered trade name or trademark.	Prescription Drug
Cellular Therapy	Administration of living whole cells into a patient for the treatment of disease.	Medical
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.	Medical
Claims Administrator	The person designated by Baker Hughes Company to administer claims under a benefit program described in this SPD.	All plans
COBRA	The provisions of ERISA and the Internal Revenue Code enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, that allows employees and qualifying dependents to continue their group health plan coverage for a specified length of time on the occurrence of certain events.	Group health plans
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.	Medical, Dental, Prescription Drug
Company	Baker Hughes Company and its affiliated companies that have adopted the Plan.	All plans
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.	Medical
Contribution	The amount that the employee or Employer pays toward the cost of coverage in a plan described in this SPD.	All plans
Coordination of Benefits	You and your dependents may have health coverage under a Baker Hughes provided plan and another plan. In such cases, subject to applicable law, coordination of benefit rules determine which plan is primary — meaning, which plan pays first and to what extent.	Health
Copayment (or Copay)	The charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services. Please note that 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.	Prescription Drug, Vision
Covered Expenses	The items of expense for which benefits may be paid are called covered expenses.	All plans

Term	Definition	Section
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 • Provided to a Covered Person who meets the Plan's eligibility requirements, as described under the eligibility provisions in *Am I Eligible?* • Not otherwise excluded in this SPD under *Exclusions and Limitations*	Medical
Covered Person	A person who is eligible for and enrolled in coverage under a Baker Hughes Health & Welfare plan described in this SPD upon satisfying the eligibility and participation requirements.	All plans
Custodial Care	Services that: • Are non-health related, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or • Are health-related that do not seek to cure, or that 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	Medical
Date of Disability	The date that it is determined your injury or sickness impairs your ability to perform your regular occupation.	STD, LTD
Deductible	The amount you must pay for covered expenses in a plan year before the plan begins to share in the cost of covered services.	Medical, Prescription Drug, Dental
Definitive Drug Test	Test to identify specific medications, illicit substances, and metabolites, and is qualitative or quantitative to identify possible use or non-use of a drug.	Medical
Dental Care Provider	A dentist, dental hygienist, physician, practitioner, or nurse whose profession is the care of teeth and surrounding tissue.	Dental
Dental Plan	Baker Hughes Company Group Dental Care Plan	Dental
Dentist	A person acting within the scope of his or her license, holding the degree of Physician of Medicine (M.D.), Physician of Dental Surgery (D.D.S.), or Physician of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state of jurisdiction where the services are rendered.	Dental
Designated Diagnostic Provider	A provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.	Medical
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 **www.myuhc.com** or the telephone number on your ID card.	Medical
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Healthcare Services through live audio with video technology or audio only.	Medical

Term	Definition	Section
Disability Earnings	The benefit amount you earn after disability begins. It does not include Social Security, sick pay, salary continuance payments, or any other disability payment you receive as a result of your disability. Any lump-sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.	STD, LTD
Domestic Partner	A person of the same or opposite sex with whom the Employee has an established domestic partnership.	All plans except the Legal Plan
Domestic Partner's Child(ren)	Domestic partner's child(ren) includes: • A participant domestic partner's biological children; • A participant domestic partner's adopted children; • A participant domestic partner's foster children; • Any child for whom a participant domestic partner is the legal guardian; • Any child placed in an Employee's and a participant domestic partner's home for legal adoption; or • Children named in a qualified order (QMCSO) requiring a participant domestic partner to provide coverage.	All plans except the Legal Plan
Domestic Partnership	A relationship between an Employee and one other person of the same or opposite sex. All of the following requirements apply to both persons: • You have entered into a state-recognized same- or opposite-gender civil union or registered domestic partnership; or • You have not entered into a state-recognized same-or opposite-gender civil union or registered domestic partnership, and you and your partner: — Are at least 18 years of age and mentally competent to consent to a contract — Are financially interdependent — Are each other's sole domestic partners — Are living together and share the common necessities of life — Are not so closely related that marriage would otherwise be prohibited — Are not legally married to, or the domestic partner of, another person either under statutory or common law	All plans except the Legal Plan
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	Medical
Eligible Expenses	For Covered Health Services, incurred while the Medical plan is in effect, Eligible Expenses are determined by UnitedHealthcare or as required by law. 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 generally 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	Medical
Elimination Period	A period of continuous disability that must be satisfied before you will begin to receive disability benefit payments.	STD, LTD
Emergency or True Emergency	A serious medical condition or symptom resulting from injury, sickness, 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	Medical

Term	Definition	Section
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 USC. 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 USC. 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 USC. 1395dd(e)(3)) • Emergency Health Services include items and services otherwise covered under the Medical 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.	Medical
Emergency Room	A hospital or alternate facility providing Emergency Health Services.	Medical
Emotional Wellbeing Solutions (the EAP)	Emotional Wellbeing Solutions is the Employee Assistance Program (EAP). This is a confidential counseling, legal and financial consultation and referral service available to all employees and their household members. The program is accessed by a dedicated toll-free number or website and puts employees in touch with master's-degreed counselors (up to 8 sessions per issue or concern, per year) and legal services (telephone consultation and referral only) at no charge.	Emotional Wellbeing Solutions
ERISA	Employee Retirement Income Security Act of 1974, as amended.	All plans, except STD
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.	Prescription Drug

Term	Definition	Section
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 Claims Administrator 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 as appropriate for the proposed use in any of the following: — *AHFS Drug Information (AHFS DI)* under therapeutic uses section; — Elsevier Gold Standard's Clinical Pharmacology under the indications section; — *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb. — *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B. • 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). • 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. • Only obtainable, with regard to outcomes for the given indication, within research settings. 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, 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 may, at their 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 determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.	Medical, Prescription Drug, Vision, Dental
External Review	A review of an adverse benefit determination by an IRO described in the Federal External Review Program section.	Medical
FMLA	Family and Medical Leave Act of 1993. The act generally requires employers with 50 or more employees to provide eligible employees with up to 12 weeks of unpaid, job-protected leave each year for births, adoptions, foster care placement, illness, and injury.	All plans
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	All plans
Gainful Employment	The performance of any occupation for wages, remuneration, or profit, for which you are qualified by education, training, or experience on a full-time or part-time basis, for the Employer or another employer, and which Baker Hughes approves and for which Baker Hughes reserves the right to modify approval in the future.	STD, LTD

Term	Definition	Section
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 one's 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	Medical
Gene Therapy	Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.	Medical
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.	Prescription Drug

Term	Definition	Section
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.	Medical
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.	Medical
Gestational Carrier	A gestational carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.	Medical
Health & Welfare Benefit Programs	The Baker Hughes Health & Welfare benefit programs described in this SPD.	All plans
Health Care Provider	A physician, practitioner, nurse, hospital, or specialized facility.	Medical
Home Health Care Agency	A program or organization authorized by law to provide health care services in the home.	Medical
Hospice Care Team	A group of trained medical personnel, homemakers, and counselors.	Medical
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.	Medical, STD, LTD
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.	Medical, STD, LTD, and Critical Illness
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	Medical,
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.	Medical
Intensive Outpatient Program(s)	A structured outpatient treatment program. 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.	Medical

Term	Definition	Section
Intermediate Care	Mental health or substance use treatment that encompasses the following: • Care at a residential treatment facility • Care at a partial hospitalization/day treatment program; or • Care through an intensive outpatient program	Medical
Kindbody - Reproductive Resource Services	A program made available to you by Baker Hughes. Kindbody provides: • Specialized clinical consulting services for you and your enrolled dependents that provide education on infertility treatment options, and • Access to specialized network facilities and physicians for infertility services	Medical
Leave of Absence	An authorized absence from an employee's normal work schedule.	All plans
Lifetime	The period of time during which covered participants may receive certain benefits of the plan (or any prior or successor plan of the plan sponsor).	All plans
Material and Substantial Duties	The necessary functions of your regular occupation that cannot be reasonably omitted or altered.	STD, LTD
Maximum Benefits	The maximum amount that Baker Hughes 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.	All plans
Maximum Period Payable	As shown in the Schedule of Benefits, the longest period of time that Baker Hughes will make payments to you for any one period of disability.	STD, LTD
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 **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UHCprovider.com**	Medical
Medical plan	Baker Hughes Company Comprehensive Major Medical Plan	Medical
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 USC. Sections 1394, et seq. and as later amended.	Medical, STD and LTD

Term	Definition	Section
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 Mental Disorders* published by 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 Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.	Medical
Mental Health/ Substance-Related and Addictive Disorders Delegate	The organization or individual designated by Baker Hughes Company who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.	Medical
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 Mental Disorders* published by 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 Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.	Medical
Military Service	Service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service pertaining to the military.	All plans
Monthly Benefit and Maximum Period Payable	That benefit and those periods shown in the **Schedule of Benefits** that apply to you.	LTD
Net LTD Monthly Benefit	Your gross Long-Term Disability monthly benefit less any deductible sources of income.	LTD
Network	When used to describe a provider of health care services, 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 participate in the network. This does not include providers who have agreed to discount their services. 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.	Medical, Prescription Drug, Vision, Dental
Network Provider	A physician, hospital, pharmacy, or other health care provider who participates in the network and 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.	Medical, Prescription Drug, Dental and Vision
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 31st of the following calendar year	Prescription Drug
Non-Network Provider	A physician, hospital, or other health care provider that does not have a network agreement in effect with the Claims Administrator at the time services are rendered.	Medical, Prescription Drug, Dental and Vision
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.	Prescription Drug

Term	Definition	Section
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.	Medical
Oral Surgery	Necessary procedures for surgery in the oral cavity, including pre-operative and post-operative care.	Dental
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.	Medical
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	All plans
Out-of-Area	Refers to a geographic area where the Medical plan does not offer sufficient network access to contracted providers. Eligibility for out-of-area plans is determined by the employee's home ZIP/postal code on file with the Company.	Medical
Out-of-Pocket Maximum	The maximum amount of network coinsurance you pay each plan year for covered services. 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	Medical, Prescription Drug
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; or • An ambulatory surgical facility and the stay is less than 24 consecutive hours	Medical
Partial Hospitalization/Day Treatment/High Intensity Outpatient	A structured ambulatory program that may be a free-standing or hospital-based program and that provides services for at least 20 hours per week.	Medical
Pharmaceutical Product(s)	US Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a physician.	Medical and Prescription Drug

Term	Definition	Section
Physician	Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed and qualified by law. **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.	All plans
Placed for Adoption	The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.	General Information
Plan	Baker Hughes Company Welfare Benefits Plan	All plans
Plan Administrator	Baker Hughes Company or its designee	All plans
Plan Sponsor	Baker Hughes Company	All plans
Plan Year	January 1 through December 31, the 12-month period of time on which the plan's records are maintained.	All plans
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.	Prescription Drug
Pregnancy	Includes all of the following: • Prenatal care • Postnatal care • Childbirth • Any complications associated with pregnancy	Medical, STD, and Hospital Indemnity Protection Plan
Presumptive Drug Test	Test to determine the presence or absence of drugs or a drug class in which the results are indicated as a negative or positive result.	Medical
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.	Prescription Drug
Preventive Care	Services that contribute to the prevention of a condition or disease, such as: annual well woman, well man, and well child exams.	Medical, Dental
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.	Medical, Prescription Drug
Qualified Beneficiary	A qualified beneficiary is an individual who, on the day before a qualifying event, has Baker Hughes Medical, Dental, Vision, Emotional Wellbeing Solutions (the EAP), and/or Health Care Spending Account coverage. A qualified beneficiary can be: • The covered employee • The covered spouse or domestic partner of a covered employee • The covered dependent child of a covered employee • A newborn or newly adopted child or a child placed for adoption who is added to a former employee's COBRA coverage within 31 days of birth, adoption, or placement for adoption; and/or • A covered spouse or dependent dropped in anticipation of a divorce or legal separation (upon receiving notice of the divorce or legal separation, COBRA continuation coverage will be made available effective on the date of the divorce or legal separation) • A covered domestic partner and dependent dropped as a result of dissolution of domestic partnership (upon receiving affidavit of dissolution, COBRA continuation coverage will be made available effective on the date of the dissolution)	COBRA

Term	Definition	Section
Reasonable and Customary	Reasonable and Customary (R&C) is the standard cost for a service in a geographic area. When a member utilizes a non-network provider for services, R&C costs are the basis for determining the amount considered by the plan. The member may be responsible for any amounts above R&C, in addition to any other plan responsibility, such as deductible and/or coinsurance.	Medical, Dental
Recognized Amount	The amount on which a copayment, coinsurance, or applicable deductible is based under applicable law for the below listed 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 or other providers, 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. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in section 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in section 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.	Medical
Regular Occupation	The occupation that you are performing for income or wages on your date of disability. It is not limited to the specific position you held with the Company.	STD, LTD
Rehabilitative Employment	Any gainful employment undertaken by you while receiving monthly benefits under the plan. Any planned vocational rehabilitation training program operated or sponsored by a private, nonprofit organization which regularly provides vocational rehabilitation training for disabled persons and approved by the Claims Administrator prior to your participating in it.	LTD
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.	Medical

Term	Definition	Section
Residential Treatment	A program of Mental Health Services or Substance-Related and Addictive Disorders Services that 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.	Medical
Residential Treatment Facility	A Hospital or facility, licensed and operated as required by law, that provides Residential Treatment.	Medical
Retail Network Pharmacy	A pharmacy which contracts with the Claims Administrator for the Prescription Drug plan to fill or refill your prescription when you present a valid Prescription Drug program ID card.	Prescription Drug
RRS	See Reproductive Resource Services (RRS).	Medical
Secretary	As that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).	Medical
Semi-Private Room	A room with two or more beds. When an inpatient stay in a semi-private room is a covered expense, 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.	Medical
Sickness	Physical illness, disease, or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive Disorders.	STD, LTD
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law.	Medical
SPD	This Summary Plan Description, which describes the benefit programs offered under the Baker Hughes Company Welfare Benefits Plans.	All plans
Specialty Pharmaceutical Product	Pharmaceutical Products that are generally high-cost biotechnology drugs used to treat patients with certain illnesses.	Prescription Drug
Spouse	An individual to whom you are legally married (or a domestic partner as defined in this section).	All plans
Substance-Related and Addictive Disorders Services	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 Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.	Medical
Surgery	Any operative procedure performed in the treatment of an injury, disease, or illness by instrument or cutting procedure through any natural body opening or incision.	All plans
Surrogate	A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg, the surrogate is biologically (genetically) related to the child.	Medical

Term	Definition	Section
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.	Medical
Therapeutic Donor Insemination (TDI)	Insemination with a donor sperm sample for the purpose of conceiving a child.	Medical
Total Disability or Totally Disabled	An employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a dependent's, or retired person's, inability to perform the normal activities of a person of like age and sex.	LTD
Transitional Living	Mental health services and substance-related and addictive disorder services that are provided through facilities, group homes, and supervised apartments that provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, that are either: • Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery. • Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).	Medical
Unproven Services	Health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical or behavior health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-designed system reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials. • Individual well-designed randomized controlled trials. • Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case control studies cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies. The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator 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 **www.myuhc.com** and **liveandworkwell.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) the Claims Administrator 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, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.	Medical
Urgent Care Center	An entity that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.	Medical
War	The term war means declared or undeclared war or any armed conflict resisted by any country.	Protection Plans

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