



2026 Legal Notices

Contents

- Medicaid and Children's Health Insurance Program Employer Notice
- Notice of Privacy Practices
- Notice of Special Enrollment Rights
- Coverage for Maternity Hospital Stay
- The Women's Health and Cancer Rights Act
- Illinois Disclosure
- Family Medical and Leave Act
- Summary of Benefits and Coverage – Standard Plan
- Summary of Benefits and Coverage – Standard Out-of-Area Plan
- Summary of Benefits and Coverage – Premium HSA Plan
- Summary of Benefits and Coverage – Premium HSA Out-of-Area Plan
- Summary of Benefits and Coverage – Basic HSA Plan
- Summary of Benefits and Coverage – Basic HSA Out-of-Area Plan
- Summary of Benefits and Coverage – Hawaii Options PPO Plan

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dftr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTICE OF PRIVACY PRACTICES BAKER HUGHES

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

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

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

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

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

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: The Corporate Health and Welfare Benefits Department of Baker Hughes, 575 N. Dairy Ashford Rd., Energy Center II, Houston, Texas 77079, 1-866-244-3539 or 1-847-883-0945 (worldwide).

EFFECTIVE DATE

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

OUR RESPONSIBILITIES

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans must take steps to protect the privacy of your "protected health information." Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) your past, present, or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present, or future payment for the provision of health care to you. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will mail a revised Notice to your address that we have on record or provide you with a copy of the revised Notice at a designated location at your workplace or we may provide you with information about the change to the Notice with instructions for accessing the revised Notice.

Primary Uses and Disclosures of Protected Health Information

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

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

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

- **Treatment**

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

- **Payment**

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

- **Health Care Operations**

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

- ***Business Associates***

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

- ***Other Covered Entities***

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

- ***Plan Sponsor***

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

- ***Security Breaches***

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

- **Genetic Information**

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

Potential Impact of State Law

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

Other Possible Uses and Disclosures of Protected Health Information

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

- **Required by Law**

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

- **Public Health Activities**

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

- **Health Oversight Activities**

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

- **Abuse or Neglect**

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

- **Legal Proceedings**

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

- **Law Enforcement**

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

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

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

Required Disclosures of Your Protected Health Information

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

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

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

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

Other Uses and Disclosures of Your Protected Health Information

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

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

Your Rights With Respect to Your PHI

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

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

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

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

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

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

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

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

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

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

COMPLAINTS

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

The HIPAA Privacy Officer/Executive Counsel - Labor & Employment
Baker Hughes
575 N. Dairy Ashford Rd.
Energy Center II
Houston, Texas 77079

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

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

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

Special Enrollment Rights

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

Special Enrollment Due to Loss of Other Medical Coverage

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

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Special Enrollment Due to Acquisition of a Dependent

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

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

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

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Standard Plan, deductible of \$800 individual/\$1,600 family with 20% coinsurance; Premium HSA, deductible of \$1,700 individual/\$3,400 family with 20% coinsurance; Basic HSA, deductible of \$3,300 individual/\$6,600 family with 20% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator 1-866-743-6549.

Employer Name:	Baker Hughes
Employer State of Situs:	Texas
Name of Issuer:	UHC - Medical CVS - Pharmacy
Plan Marketing Name:	Baker Hughes' Standard PPO, Premium HSA and Basic HSA Medical Plans
Plan Year:	2026

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Partial, subject to \$20,000 medical and \$10,000 Rx lifetime Maximum
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes

23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must:**

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must:**

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing:**

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**



WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME





Standard Plan



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: \$800 Individual / \$1,600 Family Non-Network*: \$800 Individual / \$1,600 Family Per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider: \$4,000 Individual / \$8,000 Family For out-of-network providers: \$0 Individual / \$0 Family per calendar year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	Pre-authorization required <u>out-of-network</u> for Sleep Studies or \$300 penalty.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and Outpatient Private Duty Nursing. Pre-authorization required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for costs over \$1,000 out-of- <u>network</u> or will not be covered.
	<u>Hospice services</u>	No charge	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility or \$300 penalty.
	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
- Adult routine vision exam (i.e. refraction) - Cosmetic Surgery	- Dental Care (Adult) - Long-term care	- Routine foot care - Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture • Bariatric Surgery • Chiropractic care	• Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing
---	--	---

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alilis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,960

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000



Standard Plan Out-of-Area



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: \$800 Individual / \$1,600 Family Non-Network*: \$800 Individual / \$1,600 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: \$4,000 Individual / \$8,000 Family For out-of-network providers*: \$4,000 Individual / \$8,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	Pre-authorization required for Sleep Studies or \$300 penalty.
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and Outpatient Private Duty Nursing. Pre-authorization required for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1,000 or will not be covered.
	<u>Hospice services</u>	No charge	No charge	Pre-authorization required before admission for an inpatient stay in a hospice facility or \$300 penalty.
	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.)			
• Adult routine vision exam (i.e. refraction)	• Dental Care (Adult)		• Routine foot care
• Cosmetic Surgery	• Long-term care		• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Acupuncture			• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery	• Hearing aids		• Private-duty nursing
• Chiropractic care	• Infertility treatment		

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,960

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture

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

- The plan's overall deductible \$800
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This **EXAMPLE** event includes services

like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000



Premium HSA Plan



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$1,700 Individual / \$3,400 Family <u>Non-Network</u> *: \$1,700 Individual / \$3,400 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$5,000 Individual / \$10,000 Family For <u>out-of-network providers</u> : \$0 Individual / \$0 Family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required <u>out-of-network</u> for Sleep Studies or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network or \$300 penalty.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com/bakerhughes	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$150 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and Outpatient Private Duty Nursing. Pre-authorization required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	re-authorization required for costs over \$1,000 out-of- <u>network</u> or will not be covered.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility or \$300 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
• Adult routine vision exam (i.e. refraction)	• Dental Care (Adult)		• Routine foot care
• Cosmetic Surgery	• Long-term care		• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Acupuncture			• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery	• Hearing aids		• Private-duty nursing
• Chiropractic care	• Infertility treatment		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

<https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alilis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,960

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900



Premium HSA Out-of-Area Plan



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: \$1,700 Individual / \$3,400 Family Non-Network*: \$1,700 Individual / \$3,400 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: \$5,000 Individual / \$10,000 Family For out-of-network providers*: \$5,000 Individual / \$10,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for Sleep Studies or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com/bakerhughes	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.
	<u>Specialty drugs</u> (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for certain services or \$300 penalty.
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and <u>Outpatient Private Duty Nursing</u> . Pre-authorization required for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1,000 or will not be covered.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required before admission for an inpatient stay in a hospice facility or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

<u>Services Your Plan Generally Does NOT Cover</u> (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.)				
• Adult routine vision exam (i.e. refraction)	• Dental Care (Adult)			• Routine foot care
• Cosmetic Surgery	• Long-term care			• Weight loss programs
<u>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</u>				
• Acupuncture	• Hearing aids			• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery	• Infertility treatment			• Private-duty nursing
• Chiropractic care				

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,960

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900



Basic HSA Plan



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: \$3,300 Individual / \$6,600 Family Non-Network*: \$3,300 Individual / \$6,600 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider: \$6,500 Individual / \$13,000 Family For out-of-network providers: \$0 Individual / \$0 Family per calendar year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

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



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required <u>out-of-network</u> for Sleep Studies or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network or \$300 penalty.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com/bakerhughes	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Specialty drugs (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$150 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of-network for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and Outpatient Private Duty Nursing. Pre-authorization required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required for costs over \$1,000 out-of- <u>network</u> or will not be covered.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility or \$300 penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
• Adult routine vision exam (i.e. refraction)	• Dental Care (Adult)		• Routine foot care
• Cosmetic Surgery	• Long-term care		• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Acupuncture			• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery	• Hearing aids		• Private-duty nursing
• Chiropractic care	• Infertility treatment		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

<https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alilis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,260

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,820

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800



Basic HSA Out-of-Area Plan



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network*: \$3,300 Individual / \$6,600 Family Non-Network*: \$3,300 Individual / \$6,600 Family per calendar year. *Deductibles cross-apply	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network provider*: \$6,500 Individual / \$13,000 Family For out-of-network providers*: \$6,500 Individual / \$13,000 Family per calendar year *Out-of-pockets cross-apply	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for <u>out-of-network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for Sleep Studies or \$300 penalty.
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com/bakerhughes	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u>	<u>Copay</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Preferred brand drugs (Tier 2)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	Non-preferred brand drugs (Tier 3)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of-Network may be eligible for reduced reimbursement.
	<u>Specialty drugs</u> (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 90 visits per calendar year combined for <u>Home Health Care</u> and <u>Outpatient Private Duty Nursing</u> . Pre-authorization required for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 40 visits each per calendar year for Physical, Occupational and Speech Therapy. Pulmonary and Cardiac Rehabilitation therapy is unlimited.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	60 days per calendar year. Pre-authorization required or \$300 penalty.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for costs over \$1,000 or will not be covered.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required before admission for an inpatient stay in a hospice facility or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Child routine vision exam is not covered.
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

<u>Services Your Plan Generally Does NOT Cover</u> (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.)				
• Adult routine vision exam (i.e. refraction)	• Dental Care (Adult)			• Routine foot care
• Cosmetic Surgery	• Long-term care			• Weight loss programs
<u>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</u>				
• Acupuncture	• Hearing aids			• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery	• Infertility treatment			• Private-duty nursing
• Chiropractic care				

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,260

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,820

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

This **EXAMPLE** event includes services

like:

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

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

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800



Hawaii Options PPO Plan



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> *: \$100 Individual / \$300 Family <u>Non-Network</u> *: \$100 Individual / \$300 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the out-of-pocket limit for this plan?	For <u>network provider</u> *: \$2,500 Individual / \$7,500 Family For <u>out-of-network providers</u> *: \$2,500 Individual / \$7,500 Family per calendar year * <u>Out-of-pockets</u> cross-apply	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visit - In <u>network</u> 10% cost share by a Designated <u>Virtual Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply.
	<u>Specialist</u> visit	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Non- <u>network deductible/coinsurance</u> may not apply to certain services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for Sleep Studies or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$30 <u>copay</u>	Retail: \$10 <u>copay</u>	Retail: up to a consecutive 31-day supply. Mail order: 90- day supply.
	Preferred brand drugs (Tier 2)	Retail: \$30 <u>copay</u> Mail Order: \$90 <u>copay</u>	Retail: \$30 <u>copay</u>	Certain drugs may have a <u>preauthorization</u> requirement or may result in a higher cost. If you use a non- <u>network</u> Pharmacy, you are responsible for any amount over the <u>allowed amount</u> .
	Non-preferred brand drugs (Tier 3)	Retail: \$50 <u>copay</u> Mail Order: \$150 <u>copay</u>	Retail: \$50 <u>copay</u>	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	<u>Specialty drugs</u> (Tier 4)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for certain services, or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Physician/surgeon fees	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Emergency room care</u>	10% <u>coinsurance deductible</u> does not apply	10% <u>coinsurance deductible</u> does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Prior authorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Physician/surgeon fees	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	None
	Outpatient services	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Prior authorization</u> required non- <u>network</u> for certain services, or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
If you need mental health, or substance abuse services	Inpatient services	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Prior authorization</u> required non- <u>network</u> for inpatient facility or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Office visits	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	
	Childbirth/delivery professional services	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Childbirth/delivery facility services	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Limited to 150 visits per calendar year including home infusion therapy. <u>Prior Authorization</u> required non- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$400 penalty per incident applies not to exceed \$1,000 per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year. Spinal Manipulation is limited to 24 visits per calendar year. Cardiac rehabilitation is limited to 36 visits per calendar year. Pulmonary rehabilitation is limited to 20 visits per calendar year. Occupational, Physical, Speech therapy are limited to 60 visits each per calendar year. Aural Rehabilitation therapy is limited to 30 visits per calendar year.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Habilitation Services</u> are provided and limits are combined with Rehabilitation Service above. No limits apply for treatment of Autism Spectrum Disorder Services. <u>Preauthorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> medical <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 120 days per calendar year. <u>Preauthorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for DME over \$1,000, or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	<u>Preauthorization</u> required before admission for an Inpatient Stay in a hospice facility non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
If your child needs dental or eye care	Children's eye exam	10% <u>coinsurance</u>	30% <u>coinsurance</u>	1 visit every 12 months per calendar year. Combined <u>network</u> and non- <u>network</u> .
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
• Acupuncture • Cosmetic Surgery • Dental Care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
• Adult routine vision exam (i.e. refraction) • Bariatric Surgery	• Chiropractic care • Hearing aids	• Infertility treatment • Weight loss programs	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Additionally, a consumer assistance program can help you file your appeal. Contact 1-877-292-6272. A list of

states with Consumer Assistance Programs is available at: <https://www.dol.gov/ebsa/healthreform> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov/ or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deitsch, ruf 1-866-743-6549 uff.

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

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-743-6549.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-743-6549.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-743-6549.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

- The plan's overall deductible \$100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services

like:

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

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,360

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services

like:

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

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$120

Mia's Simple Fracture

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

- The plan's overall deductible \$100
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services

like:

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

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

The plan would be responsible for the other costs of these EXAMPLE covered services