




## Standard Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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> *: \$800 Individual / \$1,600 Family <u>Non-Network</u> *: \$800 Individual / \$1,600 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 <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 <u>deductible</u> .
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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$4,000 Individual / \$8,000 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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	40% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	40% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	No charge	40% <b>coinsurance</b>	Pre-authorization required out-of- <b>network</b> 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- <u>network</u> or \$300 penalty.
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></b>	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)
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<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.
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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Cosmetic Surgery</li> </ul> | <ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
|---|---|---|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Chiropractic care</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul> |
|---|--|---|

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

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

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

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

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

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

**Language Access Services:**

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

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 Deutsch, ruf 1-866-743-6549 uff.

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

Samoa (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 <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

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

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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





## Standard Plan Out-of-Area




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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> *: \$800 Individual / \$1,600 Family <u>Non-Network</u> *: \$800 Individual / \$1,600 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 <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 <u>deductible</u> .
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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$4,000 Individual / \$8,000 Family For <u>out-of-network providers</u> *: \$4,000 Individual / \$8,000 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 <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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	20% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	No charge	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	No charge	No charge	Pre-authorization required for Sleep Studies or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	20% <b>coinsurance</b>	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)	
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a></b>	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)
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.
<b>If you are pregnant</b>	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).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<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)	
	<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.
<b>If your child needs dental or eye care</b>	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> .)		
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>

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

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

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

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

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

**Language Access Services:**

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

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, kwiiijigo 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.

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

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## 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 <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,100
<u>What isn't covered</u>	
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 <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
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 <u>plan's</u> overall <u>deductible</u>	\$800
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
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](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$5,000 Individual / \$10,000 Family For out-of- <u>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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	40% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	40% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Pre-authorization required out-of- <b>network</b> 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- <u>network</u> or \$300 penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a>	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.
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> 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- <u>network</u> for inpatient facility or \$300 penalty.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> 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>	
<b>If you need help recovering or have other special health needs</b>	<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- <u>network</u> 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.
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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, á'gang 1-866-743-6549.

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

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## 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 <u>plan's</u> overall <u>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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

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

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

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



## Premium HSA Out-of-Area Plan




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bakerhughesbenefits.com](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$5,000 Individual / \$10,000 Family For <u>out-of-network providers</u> *: \$5,000 Individual / \$10,000 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 <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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	20% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	No charge	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Pre-authorization required for Sleep Studies or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	20% <b>coinsurance</b>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a>	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.
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.
<b>If you are pregnant</b>	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)	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<p><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).</p>
	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.
	<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:

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

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

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

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

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

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

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

**Language Access Services:**

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

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, kwijigoo 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.

Samoa (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.

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

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## 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 <u>plan's</u> overall deductible	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$1,700
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
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](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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> *: \$3,300 Individual / \$6,600 Family <u>Non-Network</u> *: \$3,300 Individual / \$6,600 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> : \$6,500 Individual / \$13,000 Family For out-of- <u>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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	40% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	40% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	40% <b>coinsurance</b>	Pre-authorization required out-of- <b>network</b> 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- <u>network</u> or \$300 penalty.
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a>	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.
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> 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- <u>network</u> for inpatient facility or \$300 penalty.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of- <u>network</u> 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>	
<b>If you need help recovering or have other special health needs</b>	<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- <u>network</u> 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> .)		
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>

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

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

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

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

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

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

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

**Language Access Services:**

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

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, kwíijigo 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, á'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 <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
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](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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> *: \$3,300 Individual / \$6,600 Family <u>Non-Network</u> *: \$3,300 Individual / \$6,600 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$6,500 Individual / \$13,000 Family For out-of- <u>network providers</u> *: \$6,500 Individual / \$13,000 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 <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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Virtual visit - In <b>network</b> 0% co-ins after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply. No virtual visit coverage for out-of- <b>network</b> .
	<b>Specialist</b> visit	20% <b>coinsurance</b>	20% <b>coinsurance</b>	If you receive services in addition to office visit, additional <b>deductibles</b> or co-ins may apply.
	<b>Preventive care/screening/immunization</b>	No charge	No charge	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.
If you have a test	<b>Diagnostic test</b> (x-ray, blood work)	20% <b>coinsurance</b>	20% <b>coinsurance</b>	Pre-authorization required for Sleep Studies or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <b>coinsurance</b>	20% <b>coinsurance</b>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com/bakerhughes">www.caremark.com/bakerhughes</a>	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.
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.
<b>If you are pregnant</b>	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)	
	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>	
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.
	<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:

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

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

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

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

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

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

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

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

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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, á'gang 1-866-743-6549.

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

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## 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 <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	
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)

■ The <u>plan's</u> overall deductible	\$3,300
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
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](http://www.bakerhughesbenefits.com) or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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> *: \$100 Individual / \$300 Family Non- <u>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 <u>plan</u> 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 <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network provider</u> *: \$2,500 Individual / \$7,500 Family For out-of- <u>network providers</u> *: \$2,500 Individual / \$7,500 Family per calendar year *Out-of-pockets 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 <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 <b>network provider</b> ?	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-866-743-6549 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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
		<b>Network Provider</b> (You will pay the least)	<b>Out-of-Network Provider</b> (You will pay the most)	
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	10% <b>coinsurance</b> <b>deductible</b> does not apply	30% <b>coinsurance</b>	Virtual visit - In <b>network</b> 10% cost share by a Designated Virtual <b>Network Provider</b> . No virtual visit coverage for out of <b>network</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-insurance may apply.
	<b>Specialist</b> visit	10% <b>coinsurance</b> <b>deductible</b> does not apply	30% <b>coinsurance</b>	If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or co-insurance may apply.
	<b>Preventive care/screening/immunization</b>	No charge	30% <b>coinsurance</b>	You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for. Non- <b>network deductible/coinsurance</b> 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 <a href="http://www.myuhc.com">www.myuhc.com</a>	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)	
<b>If you need immediate medical attention</b>	<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
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	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.
	Physician/surgeon fees	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <u>coinsurance</u> <u>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.
	Inpatient services	10% <u>coinsurance</u> <u>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.
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	
	Childbirth/delivery professional services	10% <u>coinsurance</u> <u>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 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).
<b>If you need help recovering or have other special health needs</b>	<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 deductible</u> does not apply	30% <u>coinsurance</u>	<p><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.</p> <p>Spinal Manipulation is limited to 24 visits per calendar year.</p> <p>Cardiac rehabilitation is limited to 36 visits per calendar year.</p> <p>Pulmonary rehabilitation is limited to 20 visits per calendar year.</p> <p>Occupational, Physical, Speech therapy are limited to 60 visits each per calendar year.</p> <p>Aural Rehabilitation therapy is limited to 30 visits per calendar year.</p>
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<p><u>Habilitation Services</u> are provided and limits are combined with Rehabilitation Service above.</p> <p>No limits apply for treatment of Autism Spectrum Disorder Services.</p> <p><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.</p>
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> medical <u>deductible</u> does not apply	30% <u>coinsurance</u>	<p>Limited to 120 days per calendar year.</p> <p><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.</p>

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> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Weight loss programs</li> </ul>

**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/](http://www.HealthCare.gov/) or call 1-800-318-2596.

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

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

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

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

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

**Language Access Services:**

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

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 Deutsch, ruf 1-866-743-6549 uff.

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

Samoa (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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
<u>What isn't covered</u>	
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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
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 <u>plan's</u> overall <u>deductible</u>	\$100
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

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