



Standard Plan



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$1,000 Individual / \$2,000 Family <u>Non-Network</u> *: \$1,000 Individual / \$2,000 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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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 network provider ?	Yes. See www.myuhc.com or call 1-866-743-6549 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual visit - In network 0% co-ins after deductible by a Designated Virtual Network Provider . If you receive services in addition to office visit, additional deductibles or co-ins may apply. No virtual visit coverage for out-of- network .
	Specialist visit	20% coinsurance	40% coinsurance	If you receive services in addition to office visit, additional deductibles or co-ins may apply.
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	Pre-authorization required out-of- network for certain services 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.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	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 Mail Order: Not covered	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 Mail Order: Not covered	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 Mail Order: Not covered	30% (30 day supply only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$150 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> .
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

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 hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
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- <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.
If you are pregnant	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>	
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- <u>network</u> 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. Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders.
	<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"> • Cosmetic Surgery • Dental Care | <ul style="list-style-type: none"> • Long-term care • Routine foot care | <ul style="list-style-type: none"> • Routine vision exam (i.e. refraction) • Weight loss programs |
|---|---|---|

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, 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>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100



Standard Plan Out-of-Area



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$1,000 Individual / \$2,000 Family <u>Non-Network</u> *: \$1,000 Individual / \$2,000 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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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 out-of- <u>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 network provider ?	Yes. See www.myuhc.com or call 1-866-743-6549 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<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>	
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. Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders.

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>	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>	No charge	No charge	Pre-authorization required 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> .)		
• Cosmetic Surgery • Dental Care	• Long-term care • Routine foot care	• Routine vision exam (i.e. refraction) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture • Bariatric Surgery-1 per lifetime max through Carrum Health • Chiropractic care	• Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüijigo 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, â'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>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <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>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100



Premium HSA Plan



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$1,900 Individual / \$3,800 Family Non- <u>Network</u> *: \$1,900 Individual / \$3,800 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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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 network provider ?	Yes. See www.myuhc.com or call 1-866-743-6549 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual visit - In network 0% co-ins after deductible by a Designated Virtual Network Provider . If you receive services in addition to office visit, additional deductibles or co-ins may apply. No virtual visit coverage for out-of- network .
	Specialist visit	20% coinsurance	40% coinsurance	If you receive services in addition to office visit, additional deductibles or co-ins may apply.
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Pre-authorization required out-of- network for certain services 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.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$150 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

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

Excluded Services & Other Covered Services:

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

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">• Acupuncture• Bariatric Surgery-1 per lifetime max through Carrum Health• Chiropractic care | <ul style="list-style-type: none">• Hearing aids• Infertility treatment | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing |
|--|--|---|

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (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>	\$1,900
■ <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>	\$1,900
<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	\$4,060

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>	\$1,900
■ <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>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,900
■ <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
--------------------	---------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100



Premium HSA Out-of-Area Plan



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$1,900 Individual / \$3,800 Family Non- <u>Network</u> *: \$1,900 Individual / \$3,800 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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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> *: \$5,000 Individual / \$10,000 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.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for out-of- <u>network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.

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>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for certain services or \$300 penalty.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

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 hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<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>	
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.

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>	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. Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders.
	<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.
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"> • Cosmetic Surgery • Dental Care | <ul style="list-style-type: none"> • Long-term care • Routine foot care | <ul style="list-style-type: none"> • Routine vision exam (i.e. refraction) • Weight loss programs |
|---|---|---|

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"> • Acupuncture | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |
|---|---|--|

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwíijigo 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.

_____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>	\$1,900
■ <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>	\$1,900
<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	\$4,060

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>	\$1,900
■ <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>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,900
■ <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>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100



Basic HSA Plan



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

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$3,500 Individual / \$7,000 Family <u>Non-Network</u> *: \$3,500 Individual / \$7,000 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Virtual visit - In <u>network</u> 0% co-ins after <u>deductible</u> by a Designated Virtual <u>Network Provider</u> . If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply. No virtual visit coverage for out-of- <u>network</u> .
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional <u>deductibles</u> or co-ins may apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<u>Coinsurance</u> applies after <u>deductible</u> . Out-of- <u>Network</u> may be eligible for reduced reimbursement.

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>Specialty drugs</u> (Tier 4)	Retail: 30% <u>coinsurance</u> Mail Order: 30% <u>coinsurance</u>	Retail: 30% <u>coinsurance</u> Mail Order: Not covered	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	\$150 <u>copay</u> then <u>coinsurance</u> after <u>deductible</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-authorization required out-of- <u>network</u> or \$300 penalty.
	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- <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.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <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	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).
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- <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. Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders.
	<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.

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>	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> .)		
• Cosmetic Surgery • Dental Care	• Long-term care • Routine foot care	• Routine vision exam (i.e. refraction) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture • Bariatric Surgery-1 per lifetime max through Carrum Health • Chiropractic care	• Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about

your rights, this notice, or assistance, contact: 1-866-743-6549 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (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>	\$3,500
■ <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>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,800
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,360

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>	\$3,500
■ <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>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,920

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <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 or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$3,500 Individual / \$7,000 Family Non- <u>Network</u> *: \$3,500 Individual / \$7,000 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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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 *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 network provider ?	Yes. See www.myuhc.com or call 1-866-743-6549 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$25 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<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> Mail Order: Not covered	<u>Coinsurance</u> applies after <u>deductible</u> . 30 day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for certain services or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required or \$300 penalty.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain services or \$300 penalty. EWS offers up to 5 visits per issue per year at no cost.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-authorization required for inpatient facility or \$300 penalty.
If you are pregnant	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>	
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. Visits limits do not apply for the treatment of mental illness or substance-related & addictive disorders.
	<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.

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>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.
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> .)		
• Cosmetic Surgery • Dental Care	• Long-term care • Routine foot care	• Routine vision exam (i.e. refraction) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Acupuncture • Bariatric Surgery-1 per lifetime max through Carrum Health • Chiropractic care	• Hearing aids • Infertility treatment	• Non-emergency care when traveling outside the U.S. • Private-duty nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about

your rights, this notice, or assistance, contact: 1-866-743-6549 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

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

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

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

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

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

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <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>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,800
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,360

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>	\$3,500
■ <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>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,920

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <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
--------------------	---------

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 or call 1-866-244-3539. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-743-6549 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>Network</u> *: \$100 Individual / \$300 Family <u>Non-Network</u> *: \$100 Individual / \$300 Family per calendar year. * <u>Deductibles</u> cross-apply	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <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> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <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 <u>out-of-network providers</u> *: \$2,500 Individual / \$7,500 Family per calendar year * <u>Out-of-pockets</u> cross-apply	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <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 network provider ?	Yes. See www.myuhc.com or call 1-866-743-6549 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance deductible does not apply	30% coinsurance	Virtual visit - In network 10% cost share by a Designated Virtual Network Provider . No virtual visit coverage for out of network . If you receive services in addition to office visit, additional copays, deductibles , or co-insurance may apply.
	Specialist visit	10% coinsurance deductible does not apply	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles , or co-insurance may apply.
	Preventive care/screening/immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. Non- network deductible/coinsurance 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 certain services or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myuhc.com	Generic Drugs (Tier 1)	Retail: \$10 <u>copay</u> Mail Order: \$30 <u>copay</u>	Retail: \$10 <u>copay</u> Mail Order: Not covered	Retail: up to a consecutive 31-day supply. Mail order: 90- day supply.
	Preferred brand drugs (Tier 2)	Retail: \$35 <u>copay</u> Mail Order: \$105 <u>copay</u>	Retail: \$35 <u>copay</u> Mail Order: Not covered	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: \$70 <u>copay</u> Mail Order: \$210 <u>copay</u>	Retail: \$70 <u>copay</u> Mail Order: Not covered	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	<u>Specialty drugs</u> (Tier 4)	Retail: N/A Mail Order: N/A	Retail: N/A Mail Order: N/A	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	<u>Preauthorization</u> required non- <u>network</u> for certain services, or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Physician/surgeon fees	10% <u>coinsurance deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Emergency room care</u>	10% <u>coinsurance deductible</u> does not apply	10% <u>coinsurance deductible</u> does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	<u>Prior authorization</u> required non- <u>network</u> or penalty of \$400 per incident per calendar year will apply, not to exceed \$1,000 per calendar year.
	Physician/surgeon fees	10% <u>coinsurance</u> <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	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>	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.
If you are pregnant	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).
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Limited to 150 visits per calendar year including home infusion therapy. <u>Prior Authorization</u> required non- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$400 penalty per incident applies not to exceed \$1,000 per calendar year.

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

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

Excluded Services & Other Covered Services:

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

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griege in 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

