Health & Welfare

2020 Summary Plan Description

Baker Hughes

This document describes the health and welfare plans offered by Baker Hughes Company, LLC under the Baker Hughes Company Welfare Benefits Plan as of January 1, 2020. Please note that the information presented is only a summary. It replaces all previously published Health & Welfare Summary Plan Descriptions. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern these plans are contained in the plan documents or group insurance contracts. If, in our efforts to make the plans easy to understand, any of the plan provisions have been omitted or misstated, the official plan documents or insurance contracts must remain the final authority. The legal documents also govern the administration of the plans and payment of benefits. In the case of any dispute, the information in the plan documents or contracts will prevail. To request a copy of the plan documents for a Baker Hughes Health & Welfare benefit program described herein, write to:

Baker Hughes Company, LLC
Attn: Total Rewards H&W Department
17021 Aldine Westfield
Houston, TX 77073

(Please provide your name and mailing address.)

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

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

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

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

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

About Your Baker Hughes Summary Plan Description

This Health & Welfare (H&W) benefits document, called a Summary Plan Description (SPD), gives you information about benefits offered at Baker Hughes effective January 1, 2020. It describes important features of each benefit plan, services that are covered, and how your benefits are paid.

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

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

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

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

- Medical plan
- Wellness
- Prescription Drug plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account*
- Employee Assistance Program
- Short-Term Disability
- Long-Term Disability
- Basic Life insurance
- Supplemental Life insurance
- Basic Accidental Death & Dismemberment insurance
- Voluntary Accidental Death & Dismemberment insurance
- Business Travel Accident insurance
- Legal Plan
- Critical Illness plan
- Accident plan

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

Who Do I Call?

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

Contact the Baker Hughes Benefits Center Regarding:

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

Contact Your Human Resources Department Regarding:

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

Contact the Administrator or Insurance Company Regarding:

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

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

Additional Resources

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

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

Customer Service: 1-866-743-6549

Accessing Your Account

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

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

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

Baker Hughes Benefits Center

1-866-244-3539 (within the U.S.)

1-847-883-0945 (worldwide)

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

Contacts

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

Baker Hughes Benefit Plan	Provider	Phone Number	Website
Enrollment, Eligibility, Summary Plan Descriptions, and Advocacy	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Medical	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Prescription Drug	CVS/caremark	1-877-252-3485	www.caremark.com
Dental	Cigna	1-800-542-4293	www.mycigna.com
Vision	VSP	1-800-877-7195 or 1-916-635-7373 (worldwide)	www.vsp.com
Flexible Spending Accounts	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Health Savings Account	Optum Bank	1-866-743-6549 or 1-866-802-8572 (worldwide) 1-800-791-9361	www.optumbank.com
Employee Assistance Program (EAP)	Optum	1-855-409-7074	www.liveandworkwell.com
Short-Term Disability	Sedgwick	1-877-423-8677	www.claimlookup.com client number 8504
Long-Term Disability	Prudential	1-800-842-1718	mybenefits.prudential.com
Life and Accidental Death & Dismemberment (AD&D)	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Legal Plan	Legal Access Plans LLC	1-888-416-4313	www.legaleaseplan.com/bakerhughes
Critical Illness Plan	UnitedHealthcare (UHC)	1-800-444-5854	N/A
Accident Plan	UnitedHealthcare (UHC)	1-800-444-5854	N/A
401(k) Plan and Pension Plan	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Baker Hughes Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	BakerHughesBenefits.com

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Am I Eligible?

Employee Eligibility

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

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

Eligible Employees Do Not Include:

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

Remember...

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

Are My Dependents Eligible?

If you're an eligible employee as defined above, you may cover your eligible dependents under your Baker Hughes H&W plans. Eligible dependents include:

Family Member	Eligibility Requirements
Your Spouse	• Your legal spouse of opposite or same gender, including common-law in states recognizing common-law marriage, or a legally separated spouse in states recognizing legal separation.
Your Children	• Your dependent children up to age 26, regardless of whether they are married, full-time students, or eligible for other group health plan coverage, or • Your unmarried dependent children up to any age who are supported by you because of mental or physical disability; the disability must have occurred during the period in which they were eligible dependents under the Health & Welfare plans (up to age 26).

Eligible Children Include:

- Your biological children
- Your adopted children and children placed for adoption
- Your stepchildren
- Foster children in your care
- Any children for whom you have legal custody
- Any children for whom there is a Qualified Medical Child Support Order (QMCSO)

Eligible Dependents Do Not Include:

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

Special Note on Dependent Children

Please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) if there are any changes to your dependents' status. Your dependent will lose eligibility on his or her 26th birthday, and coverage will be terminated on the last day of the month in which he or she turns 26.

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

Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** to enroll your newborn. You will be required to provide dependent verification documents.

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

Coverage for a Disabled Dependent Child

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

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

Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.

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

If Eligibility for Benefits Coverage is Denied — How to Appeal

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

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

  Baker Hughes Company, LLC
  Attn: Total Rewards H&W
  Appeals Department
  17021 Aldine Westfield
  Houston, TX 77073

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

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

If Both You and Your Spouse Work at Baker Hughes

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

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

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

Retroactive Cancellation of Coverage

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

How Do I Enroll?

New Hires

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

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

Your Default Coverage

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

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

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

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

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

Annual Enrollment

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

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

Online — BakerHughesBenefits.com	By phone — Baker Hughes Benefits Center
To access your benefits account online, from **BakerHughesBenefits.com**, click on *Enroll, Change, or Review Benefits*. The first time you access the enrollment system, you will need to create a new user ID and password. • If you are inside the Baker Hughes network, select Health & Protection Benefits - single sign-on from Baker Hughes Intranet. • If you are outside the Baker Hughes network, select Health & Protection - access with login and password.	**Call the Baker Hughes Benefits Center** 1-847-883-0945 (worldwide) 1-866-244-3539 (within the U.S.) Representatives are available Monday through Friday from 7 a.m. to 7 p.m. CST. If you're a new hire or an existing employee transferring to a position with U.S. benefits, you can enroll via the telephone after you receive your first paycheck.

Tip!

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

If You Do Not Enroll

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

Remember...

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

Tip!

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

Deduction Authorization

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

Baker Hughes accepts no liability or responsibility for paying any employee portion of premiums. Paychecks are prepared bi-weekly (26 paychecks in 2020). Most payroll benefit deductions are collected semi-monthly from the first two paychecks of each month (26 deductions per year). Depending upon timing of plan election, payroll deduction of retroactive premiums may be necessary. If during the course of employment with Baker Hughes, you are approved for a Leave of Absence (LOA), understand that you will be required to pay employee contributions for coverage in place prior to leave. Payment of these premiums for continuation of coverages will be deducted from your paycheck. If you are not receiving pay during the leave, the benefit deductions will go into arrears and will be deducted from your regular pay upon your return to work. Upon termination of employment, it may be necessary for Baker Hughes to deduct the remainder of any employee contributions for the current month's coverages, in addition to any outstanding amounts.

Identification Cards

After you enroll, your Medical and Prescription Drug Plan Administrator will send identification cards to your address on file at Baker Hughes. Your ID card shows the type of plan, your coverage, and other information to help your physician, pharmacist, or health care provider verify your eligibility or submit your claim. If you don't receive a card or you would like additional cards, contact:

Remember...
Members of the Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area plans will receive a combined ID card for both Medical and Prescription Drug coverage.

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

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

Can I Make Changes After I Enroll?

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

The benefit changes that are permitted must generally be made within **31 days** of the qualifying change in status or the coverage you had before the change will remain in effect for the full plan year (certain exceptions apply).

Approved IRS Changes in Status Include:

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

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

How Do I Make Approved Changes After I Enroll?

The approved changes must be made within the time frame specified above. To make the approved changes, access your account online or contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide), Monday through Friday, 7 a.m. to 7 p.m. Central Time.

Tip!

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

When Does My Coverage Begin?

Newly Hired or Transferred Employee

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

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

Rehired Employees

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

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

Current Employee

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

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

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

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

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

When Does My Coverage End?

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

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

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

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

Rescission of Coverage

Once an individual is enrolled and covered under one of the following Medical plans:

- Standard plan
- Standard Out-of-Area plan
- Premium HSA plan
- Premium HSA Out-of-Area PPO plan
- Basic HSA plan
- Basic HSA Out-of-Area plan

Your coverage under one of these Medical plans may not be rescinded retroactively unless such individual was enrolled in the Medical plan either:

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

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

If You Retire

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

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

If You Become Disabled

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

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

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

Leave of Absence

Coverage Continuation

The federal Family and Medical Leave Act of 1993 (FMLA) provides for continuation of coverage during an eligible leave of absence, and reinstatement of coverage following a return to active status.

During a business-related unpaid personal leave, or the unpaid portion of leave, the Company will maintain any H&W benefits the employee had prior to taking the leave, excluding the Dependent Care Flexible Spending Account and Health Savings Account. For other personal unpaid leaves, the Company will maintain any H&W benefits the employee had prior to taking the leave, excluding Short-Term Disability, Long-Term Disability, Dependent Care Flexible Spending Account, and Health Savings Account. In addition, the employee may discontinue certain other benefits while on unpaid leave by contacting the **Baker Hughes Benefits Center** within 31 days of the leave. If you are not receiving pay during a Company-approved leave, you will be direct billed through the Baker Hughes Benefits Center. If you do not pay the required premiums within the specified timeframe, your coverage will be terminated.

If you are enrolled in a Health Savings Account (HSA), deductions will cease. However, if you continue to be covered under the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area Plan, you can continue to make contributions to your HSA by sending contributions directly to Optum Bank. Contact Optum Bank directly at **1-866-743-6549** for more information.

At the end of the initial 12-week FMLA leave period (if the leave continues), or when your employment otherwise terminates (whichever comes first), you and your covered dependents may be eligible for COBRA continuation coverage for Medical, Dental, and Vision coverage, and the Health Care Flexible Spending Account. Your cost is 100% of the gross premium plus a 2% administration fee.

Paid Leave

Your H&W coverage will be continued during an eligible leave.

During a paid leave of absence your portion of the cost of your H&W coverage during the leave of absence will be deducted from your paycheck.

Unpaid Leave

You may take an unpaid leave for up to 12 weeks in the applicable 12-month period, if:

- Your leave qualifies as a leave of absence under FMLA, and
- You are an eligible employee under the terms of that Act.

The employee is not receiving pay from Baker Hughes during the leave, you will be direct billed from the **Baker Hughes Benefits Center**.

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

Changing or Revoking Coverage Due to Unpaid Leave

You have the option to drop or change certain H&W coverage when you take an unpaid personal leave, an unpaid leave under the Family and Medical Leave Act of 1993, or a military leave by contacting the **Baker Hughes Benefits Center** within 31 days of your leave. For more information on allowable changes, contact a **Baker Hughes Benefits Center** representative at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide).

Reinstatement of Canceled Coverage Following Unpaid Leave

When you return to work after your unpaid leave, you may reinstate the coverage you elected to stop, as well as the Dependent Care Flexible Spending Account and the HSA. You must contact the **Baker Hughes Benefits Center** within 31 days of your return from unpaid FMLA leave to reinstate your coverage. If you are on an unpaid leave in January when the employer seed amount is applied, your account will not receive the employer seed. Upon your return to an actively at work status the employer seed will be applied and prorated based on your date of return.

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

Military Leave Continuation and Your Rights Under USERRA

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

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

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

Only Medical, Dental, and Vision coverage continues while you are on an approved military leave. You will be direct billed through the Baker Hughes Benefits Center.

Health

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

- Medical plan
- Wellness
- Prescription Drug plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account
- Limited Purpose Health Reimbursement Account
- Employee Assistance Program

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

Baker Hughes

Medical Plan

Medical Benefits At-a-Glance

Type of Plan	Voluntary medical coverage
Who Pays the Cost	You share the cost of medical coverage with Baker Hughes.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days of becoming eligible for coverage. If you do not enroll, you'll be given default coverage. • Employees can change their Medical plan election during Annual Enrollment or during the year if they have a qualified change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year as long as you remain eligible.
Medical Choices	• Basic HSA Plan • Standard Plan • Premium HSA Plan • Basic Out-of-Area Plan • Standard Out-of-Area Plan • Premium HSA Out-of-Area Plan **Note:** Your home zip/postal code on file with Baker Hughes determines the plan options available to you.
Coverage Level	• You • You + Children • You + Spouse • You + Family
Contact	• UnitedHealthcare: www.myuhc.com or 1-866-743-6549 • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Medical Plan Features At-a-Glance

Plan Feature	Standard [1], [4], [5] (Choice Plus Network)	Premium HSA[2], [4], [5] (Choice Plus Network)	Basic HSA[2], [4], [5] (Choice Plus Network)
Deductible	$750 Individual $1,500 Family	$1,500 Individual $3,000 Family[2]	$3,250 Individual[2] $6,500 Family[2]
Coinsurance	80% in-network; 60% of Eligible Expenses out-of-network		
Physician Office Visit	60% of Eligible Expenses out-of-network		
Virtual Visits	60% of Eligible Expenses out-of-network		
Emergency Room	60% of Eligible Expenses out-of-network		
HSA Employer Contribution	N/A	You Only: $500[3] You + Spouse/You + Children: $750[3] You + Family: $1,000[3]	N/A
Preventive Care	60% of Eligible Expenses out-of-network		
Out-of-Pocket Maximum (only in-network coinsurance applies)	$4,000 Individual $8,000 Family (includes deductible)	$5,000 Individual[2] $10,000 Family (includes deductible)[2]	$6,500 Individual[2] $13,000 Family (includes deductible)[2]

Plan Feature	Standard Out-of-Area PPO (Options PPO Network)	Premium HSA[2] Out-of-Area (Options PPO Network)[2]	Basic HSA Out-of-Area (Options PPO Network)
Deductible	$750 Individual/$1,500 Family	$1,500 Individual/$3,000 Family	$3,250 Individual/$6,500 Family
Coinsurance	80% in-network; 80% of Eligible Expenses out-of-network		
Physician Office Visit	Subject to deductible and coinsurance (Emergency Room copay does not apply to out-of-area plan.)		
Virtual Visits	N/A for Out-of-Area (subject to deductible and coinsurance)		
Emergency Room	Subject to deductible and coinsurance (Emergency Room copay does not apply to out-of-area plan.)		
HSA Employer Contribution	N/A	You Only: $500[3] You + Spouse/You + Children: $750[3] You + Family: $1,000[3]	N/A
Preventive Care	100%		
Out-of-Pocket Maximum (only in-network coinsurance applies)	$4,000 Individual $8,000 Family (includes deductible)	$5,000 Individual $10,000 Family (includes deductible)	$6,500 Individual $13,000 Family (includes deductible)

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

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

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

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

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

Medical Choices

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

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

- Standard Plan
- Premium HSA Plan
- Basic HSA Plan

OR

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

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

These plans utilize the UHC Options PPO network. If you are eligible for an out-of-area plan, that means there are too few UHC providers, facilities, and/or hospitals in your area. As a result, you can use any provider for your health care. Your medical expense reimbursements are subject to the plan deductible, coinsurance, and Eligible Expense cost limitations. Eligible Expenses are determined by UHC's reimbursement policy guidelines. You will be responsible for any costs in excess of what are considered Eligible Expenses. For a complete definition of Eligible Expenses, please see page 37.

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

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

- You Only
- You + Spouse
- You + Children
- You + Family

As a newly hired employee or a transfer to a benefits-eligible position, you must enroll within the first 31 days of your date of hire or transfer. **If you do not make an enrollment election, you'll be covered by the Standard Plan (or Standard Out-of-Area Plan, as appropriate) with** *You Only* **coverage**. Default coverage may be different for employees transferring to U.S. benefits (contact the Baker Hughes Benefits Center for assistance).

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

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

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

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

Medical Plan Options

1

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

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for specialist visit
- You are required to meet the deductible before the plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services are covered at 80% in-network or 60% out-of-network after the deductible is met. Out-of-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see page 37.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible network expenses
- Prescription drug costs apply to the out-of-pocket maximum.

2

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

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for a specialist visit
- You are required to meet the combined Medical and Prescription Drug deductible before the plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services covered at 80% in-network or 60% out-of-network after the deductible is met. Non-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see page 37.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible in-network expenses

3

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

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for a specialist visit
- You are required to meet the combined Medical and Prescription Drug deductible before the plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services covered at 80% in-network or 60% out-of-network after the deductible is met. Non-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see page 37.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible in-network expenses

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

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

Three Medical Plans

1. The **Standard Out-of-Area option** pays 80% for eligible health care expenses after the deductible. Services are subject to the Claims Administrator's Eligible Expenses determination. For non-network services, you are required to submit a claim form for reimbursement. Please note that when you search for providers, you will need to access UHC's Options PPO network.

2. The **Premium Out-of-Area HSA option** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums, but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect a Health Savings Account (HSA). The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. When you elect the Premium HSA option, you may also elect to open a Health Savings Account (HSA). If you do, Baker Hughes will automatically deposit money in your HSA. This Employer contribution is subject to review and change in future years. See the *Health Savings Account* section for more information. The plan pays 80% for eligible health care expenses after you meet the combined Medical and Prescription Drug deductible. Services are subject to the Claims Administrator's Eligible Expenses determination. For non-network services, you are required to submit a claim form for reimbursement. Please note that when you search for providers, you will need to access UHC's Options PPO network.

3. The **Basic HSA Out-of-Area option** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums, but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect a Health Savings Account (HSA). The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. When you elect the Basic HSA option, you may also elect to open a Health Savings Account (HSA). See the *Health Savings Account* section for more information. The plan pays 80% for eligible health care expenses after you meet the combined Medical and Prescription Drug deductible. Services are subject to the Claims Administrator's Eligible Expenses determination. For non-network services, you are required to submit a claim form for reimbursement. Please note that when you search for providers you will need to access UHC's Options PPO network.

Out-of-Area PPO Coverage Example

If you have out-of-area coverage and need to see a physician, take a look at your options and how the out-of-area process works. When you have out-of-area coverage, you may choose any physician. In this example, you would be enrolled in You Only coverage in the Standard Out-of-Area option and you would have already met your $750 deductible. You decide to see Dr. Brown, a non-network provider.

You make an appointment to see Dr. Brown. (You have already met your $750 deductible.)

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

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

UnitedHealthcare determines the Eligible Expenses.

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

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

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

Tip!

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

What is the Cost of these Plans?

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

You pay your portion of the cost with pre-tax dollars, which means that your monthly premiums are deducted from your paycheck before federal and state income taxes and Social Security taxes are calculated and withheld. The premiums are not included on your W-2 form as taxable wages, so your taxable income is lower.

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

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

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

Understanding UHC Networks

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

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

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

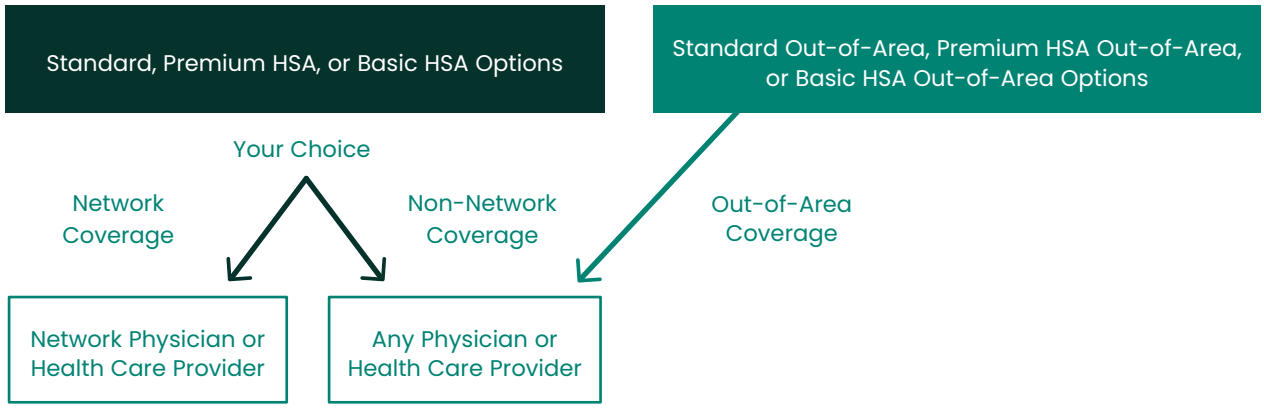
If you are a new hire or are considering enrolling in a Medical plan option for the first time, you may determine the network health care providers available in your area online at **www.myuhc.com** or by calling UHC at **1-866-743-6549**.

Tip!

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

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

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



Tip!

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

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

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

How do I know if my Physician is a Regular Physician or Specialist?

Regular physicians include general practitioners, family practitioners, internists, and pediatricians. They are primarily responsible for your health care and preventive exams. When necessary, they will also work with you to select a specialist, however, a referral to see a specialist is not required.

A specialist is a physician that has further education in a particular field of medicine. Examples of specialists include neurologists, cardiologists, orthopedists, oncologists, obstetricians, and gynecologists.

Tip!

Use network providers when possible. You generally have lower out-of-pocket costs for most services when you go to a network provider.

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

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

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

UnitedHealth Premium℠ Program

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

UnitedHealth Premium – Physician and Facility Designation Program

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

UnitedHealth Premium – Hospital Comparison Program

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

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

Additional Resources

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

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

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

Customer Service: 1-866-743-6549

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

How do the Medical Options work?

With the Medical plan, you make an appointment when you need care without the need for a referral. The Medical plan provides both network and non-network coverage; however, you will obtain a greater cost savings by utilizing a network provider. **It is your responsibility to verify the network status of the provider with UHC each time you seek care.** Many providers will accept UHC administered coverage and file claims on your behalf, but not all providers are contracted with UHC.

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

Remember...

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

Preferred Method

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

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

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

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

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

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

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

   In this case, UHC will review your claim and reimburse you up to the Eligible Expense limits. Your reimbursement will be sent to you along with an explanation of how your claim was processed. **Please see page 37** for a complete definition of Eligible Expenses.

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

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

Out-of-Pocket Expenses and Your Bottom Line

The Medical plan options may differ by:

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

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

Deductibles

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

Deductible	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plan	Basic HSA and Basic HSA Out-of-Area Plans
Individual	$750*	$1,500**	$3,250**
Family	$1,500*	$3,000**	$6,500**

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

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

Important Note about the Choice Plus and UHC Out-of-Area PPO Network Deductibles

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

Family Deductible: The family deductible can be satisfied by two or more covered family members, even if each covered family member does not satisfy the individual deductible amount. However, no one individual can contribute more than the single deductible amount to the family deductible. Once you reach your family deductible, the plan shares in the cost of covered services for all enrolled family members for the remainder of the plan year.

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

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

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

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

Coinsurance

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

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

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

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

Network Out-of-Pocket Maximum

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

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

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

Remember...

Under the Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area options, you must meet the combined medical and prescription drug family out-of-pocket maximum if your coverage level is other than You Only.

Important Note about the Standard Plan and Standard Out-of-Area Plan Out-of-Pocket Maximum:

Individual Out-of-Pocket Maximum: The combined medical and prescription drug individual out-of-pocket maximum for these plans applies separately to you and each of your covered family members. When one person meets his or her individual annual out-of-pocket maximum in a plan year, the plan pays 100% of eligible in-network expenses for that individual for the remainder of the plan year.

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

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

Individual Out-of-Pocket Maximum: The combined medical and prescription drug individual out-of-pocket maximum only applies if you elect *You Only* coverage. When you meet the individual out-of-pocket maximum in a plan year, the plan pays 100% of eligible in-network medical and prescription drug expenses for the remainder of the plan year. If you elect anything other than *You Only* coverage, you must meet the family out-of-pocket maximum before the plan will begin to pay 100% of eligible in-network expenses.

Family Out-of-Pocket Maximum: The combined medical and prescription drug family out-of-pocket maximum applies if you elect to cover dependents. The family out-of-pocket maximum can be satisfied by one or more covered family members. Once the family out-of-pocket maximum is met, the plan pays 100% of eligible, in-network medical and prescription drug expenses for all enrolled family members for the remainder of the plan year. The plan will not begin to pay 100% of eligible in-network expenses for any enrolled members until the family out-of-pocket maximum has been met.

Annual and Lifetime Maximums

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

Important

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

Service	Limitation
Acupuncture	20 visits per calendar year
Chiropractic, Speech, Physical, or Occupational Therapy	40 visits per calendar year
Home Health Care	90 visits per calendar year
Infertility Services	$10,000 lifetime maximum
Nutrition Counseling	Up to 10 visits annually; non-preventive
Skilled Nursing or Extended Care Facilities	60-day limit per calendar year

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

Shared Savings Program

The Shared Savings Program is a program in which UnitedHealthcare may obtain for the Medical plan a discount to a non-network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes plan provisions or administrative practices conflict with the scheduled rate and a different rate is determined by UnitedHealthcare. In this case, the non-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, you should call the number on your ID card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare.

Accessing Benefits

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-network providers who have agreed to discounts negotiated from their charges on certain claims for covered health services. Refer to the definition of the Shared Savings Program on the previous page for details about how the Shared Savings Program applies.

Eligible Expenses

Baker Hughes has delegated to UHC the discretion and authority to decide whether a treatment or supply is a covered health service and how Eligible Expenses will be determined and otherwise covered under the Medical plan. UHC determines Eligible Expenses for covered health services as outlined below.

Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines. UHC develops these guidelines at its discretion, after evaluating and validating all provider billings using one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; and
- As determined by medical staff and outside medical consultants pursuant to any other appropriate source or determination that UHC accepts.

For network benefits, Eligible Expenses are based on the following:

- When covered health services are received from a network provider, Eligible Expenses are UHC's contracted fees with that provider.
- When covered health services are received from a non-network provider as a result of an emergency or as arranged by UHC, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment, or any deductible. The plan will not pay excessive charges or amounts you are not legally obligated to pay.

For non-network benefits, Eligible Expenses are determined as follows:

- Negotiated rates agreed to by the non-network provider and either UHC or one of UHC's vendors, affiliates or subcontractors, at UHC's discretion, or
- If rates have not been negotiated, then one of the following amounts:

When covered health services are...	...Eligible Expenses are:
Other than pharmaceutical products • For Standard, Premium HSA, and Basic HSA: • For Standard Out-of-Area, Premium HSA Out-of-Area, and Basic HSA Out-of-Area options:	Determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. Determined based on available data sources of competitive fees in that geographic area.
Mental health services and substance use disorder services	• Reduced by 25% for covered health services provided by a psychologist • Reduced by 35% for covered health services provided by a masters level counselor
Pharmaceutical products • For Standard, Premium HSA, and Basic HSA options: • For Standard Out-of-Area, Premium HSA Out-of-Area, and Basic HSA Out-of-Area options:	Determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, UHC uses an available gap methodology to determine a rate for the service as follows:

- For services other than Pharmaceutical Products, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk, and resources of the service. If the relative value scale(s) currently in use become no longer available, UHC will use a comparable scale(s). UHC and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UHC's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
- For Pharmaceutical Products, UHC uses gap methodologies that are similar to the pricing methodology used by CMS and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UHC based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UHC updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Important

Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Medical Schedule of Benefits

	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area	Non-Network	Network or Out-of-Area	Non-Network	Network or Out-of-Area	Non-Network
Deductible (applies to out-of-pocket maximum)	$750 Individual $1,500 Family*		$1,500 Individual $3,000 Family**		$3,250 Individual $6,500 Family**	
Out-of-Pocket Maximum (only network and out-of-area coinsurance applies; non-network coinsurance does not apply)	$4,000 Individual $8,000 Family (includes deductible)	None	$5,000 Individual $10,000 Family** (includes deductible)	None	$6,500 Individual $13,000 Family** (includes deductible)	None

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

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

Important

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

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

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Acupuncture (up to 20 visits per calendar year)	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Allergy Care	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Diagnosis						
— Injections only	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Ambulance	100%; no deductible	100%; no deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
— True emergency						
— Non-emergency	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Birthing Center	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Chiropractic, Physical, or Occupational Therapy (Only Spinal Manipulation applies to limit)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Colonoscopy Procedure (diagnostic) **— Outpatient Surgery** (diagnostic office visits subject to deductible and coinsurance)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area options	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Congenital Heart Disease (see *Covered Expenses* section for additional details)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Durable Medical Equipment (items over $1,000 require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Emergency Room (Subject to $100 copay. Copay is waived if admitted.) **— True emergency**	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
— Non-emergency	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Gender Dysphoria	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Home Health Care (up to 90 visits per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospice	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospital Care **— Inpatient and outpatient**	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Immunizations Child and adult immunizations (routine and travel immunizations covered)	100%; no deductible	60% of Eligible Expenses after deductible	Network Routine: 100% Network Travel: 80% after deductible	60% of Eligible Expenses after deductible	Network Routine: 100% Network Travel: 80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area options	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Infertility Services — **Must enroll in the Fertility Solutions program** — **Infertility services must be received at designated Center of Excellence (COE)** — **Lifetime maximum benefit of $10,000 under Medical plan**	80% after deductible for COE only	Not covered	80% after deductible for COE only	Not covered	80% after deductible for COE only	Not covered
Injections	100%; no deductible	60% of Eligible Expenses after deductible	80%; no deductible	60% of Eligible Expenses after deductible	80%; no deductible	60% of Eligible Expenses after deductible
Laboratory Services — **Office setting, outpatient hospital, or independent lab**	100%; no deductible	60% of Eligible Expenses; after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— **Inpatient hospital**	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Maternity Care (you or a covered dependent)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Mental Health — **Inpatient or outpatient** (inpatient and intermediate care services require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Nutrition Counseling (up to 10 visits annually; non-preventive)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Physician's Services — Office settings	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Preventive Care (i.e., annual well woman, well man, and well child services; annual mammogram, annual physical, and colonoscopy)	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible
Anesthesiologist Services	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Second/Third Surgical Opinions (voluntary)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Skilled Nursing Facility/ Inpatient Rehabilitation Facility (up to 60 days per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Speech Therapy (up to 40 visits per calendar year) Certain exclusions apply; contact UHC Care Coordination℠ for a pre-determination	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Substance Use Disorder — Inpatient or outpatient (inpatient and intermediate care services require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
TMJ Non-surgical; excluding prescription drugs	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Transplant Services Designated Provider	100% designated provider only	60% of Eligible Expenses after deductible	80% after deductible designated provider only	60% of Eligible Expenses after deductible	80% after deductible designated provider only	60% of Eligible Expenses after deductible
— **Travel/lodging** ($10,000 lifetime maximum) — **Lodging allowance** ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child — $200 maximum applies) — **Organ search and procurement** (except bone marrow, limited to $25,000)	Covered	All services covered, except for travel and lodging	Covered	All services covered, except for travel and lodging	Covered	All services covered, except for travel and lodging
Other Network (not designated provider)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— **Travel/lodging** ($10,000 lifetime maximum) — **Lodging allowance** ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child — $200 maximum applies) — **Organ search and procurement** (except bone marrow, limited to $25,000)	Not Covered		Not Covered		Not Covered	
Urgent Care	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Virtual Visits	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	Not covered
Wigs (limited to $1,000 per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Medical Schedule of Benefits

Services	Standard and Standard Out-of-Area Plans		Premium HSA and Premium HSA Out-of-Area Plans		Basic HSA and Basic HSA Out-of-Area Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
X-ray Services (excluding major services such as MRIs, CT scans, PET scans, nuclear scans, etc.) **— Office setting or outpatient hospital**	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
X-ray – Major Services (i.e., MRIs, CT scans, PET scans, nuclear scans, etc.) **— Office setting or outpatient hospital**	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
All Other Eligible Coverage	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Maximum Benefit Aggregate lifetime maximum for all benefits while covered under the Medical plan option	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

*Services received from a non-network provider are subject to Eligible Expense costs. Please see page 37 for a complete definition of Eligible Expenses.

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

Adding It All Up

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

Services	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plans	Basic HSA and Basic HSA Out-of-Area Plans
Deductible	$750/$1,500	$1,500/$3,000*	$3,250/$6,500*
Hospital Charge (in-network)	$4,000	$4,000	$4,000
Joe pays	$750 (Individual deductible applies)	$1,500 (Individual deductible applies)	$3,250 (individual deductible applies)
Amount to apply to coinsurance	$3,250	$2,500	$750
Plan option pays	$2,600 (80% coinsurance)	$2,000 (80% coinsurance)	$600 (80% coinsurance)
Joe's coinsurance	$650 (20% coinsurance)	$500 (20% coinsurance)	$150 (20% coinsurance)
Joe's cost for claim	$1,400	$2,000	$3,400

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

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

Services	Standard and Standard Out-of-Area Plans	Premium HSA and Premium HSA Out-of-Area Plans	Basic HSA and Basic HSA Out-of-Area Plans
Deductible	$750/$1,500	$1,500/$3,000*	$3,250/$6,500*
Hospital Charge (in-network)	$7,000	$7,000	$7,000
Joe pays	$750 (Individual deductible applies)	$3,000 (Family deductible applies)	$6,500 (family deductible applies)
Amount to apply to coinsurance	$6,250	$4,000	$500
Plan option pays	$5,000 (80% coinsurance)	$3,200 (80% coinsurance)	$400 (80% coinsurance)
Joe's coinsurance	$1,250 (20% coinsurance)	$800 (20% coinsurance)	$100 (20% coinsurance)
Joe's cost for claim	$2,000	$3,800	$6,600

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

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

Emergency at or Away From Home

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

For an Emergency Room visit that **is not considered to be a true emergency** (non-emergency), any covered expenses incurred are paid based on whether the facility is network or non-network.

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

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

Tip!

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

What if I am Admitted to a Hospital?

If you're admitted to the hospital through the Emergency Room, your visit will be subject to any applicable deductible and coinsurance, however, the $100 copay will be waived. If you're admitted to a non-network hospital, you must be transferred to a network facility (unless you're in an out-of-area plan) once your condition is stabilized in order to continue to receive benefits at the network level. Otherwise, your covered charges would be paid on a non-network basis.

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

Medical Coverage Outside the U.S.

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

Preventive Health Services

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

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

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

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

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

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

A list of the immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be found online as follows:

- For persons aged 0 through 18:
  http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
- For persons aged 19 or older:
  http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf
- For persons aged 4 months through 18 years who start late or who are more than one month behind:
  http://www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. A list of these services can be found at:
  https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3
- With respect to women, to the extent not described in the first bullet, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. A list of these services can be found at:
  https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=2

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

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

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

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

  — Which pump is the most cost-effective, or

  — The timing of an acquisition.

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

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

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

Examples of preventive health services are listed below:

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

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

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

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

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

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

Nutrition Counseling

The Medical plan also provides a nutrition counseling benefit. Participants may receive up to 10 nutrition counseling sessions per calendar year (this limit applies to non-preventive nutritional counseling services only). Coverage details for each Medical plan option are provided in the *Medical Schedule of Benefits*.

Pregnancy Coverage

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

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

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

Newborn Coverage

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

Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** to enroll your newborn. You will be required to provide dependent verification documents.

Immunizations

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

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

What if I Have a Pre-Existing Condition?

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

UHC Care Coordination℠ Program

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

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

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

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

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

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

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

Prior Authorization Requirements

For the **Standard, Premium HSA,** and **Basic HSA options**, network providers are generally responsible for obtaining prior authorization before they provide these services to you. However, there are some network benefits for which you are responsible for obtaining prior authorization from *Care Coordination*SM. When you choose to receive certain covered services from non-network providers, you are responsible for notifying *Care Coordination*SM before you incur these covered services. If you fail to obtain prior authorization from *Care Coordination*, a $300 penalty will apply.

For the **Standard Out-of-Network, Premium HSA Out-of-Network,** and **Basic HSA Out-of-Network options**, you are responsible for obtaining prior-authorization from *Care Coordination*SM before you receive certain covered network or non-network services. If you fail to obtain prior authorization from *Care Coordination*, a $300 penalty will apply.

For all Medical plan options:

- We urge you to confirm with Care CoordinationSM that the services you plan to receive are covered services, even if not included in the section above. That is because in some instances certain procedures may not meet the definition of a covered expense. By calling before you receive treatment, you can check to see if payment or reimbursement under the Medical plan for the service is subject to limitations or exclusions.
- For mental health/substance use disorder services, you are responsible for notifying the Mental Health/Substance Use Disorder Administrator before receiving inpatient or intermediate care; the Mental Health/Substance Use Disorder Administrator must pre-authorize and oversee all such treatment.
- Prior authorization is required for all inpatient stays.

Emergency Services

Emergency services are services required to stabilize or initiate treatment in an emergency. Emergency services must be received on an outpatient basis at a hospital or alternate facility.

For purposes of this provision, emergency illness or injury means a serious medical condition or symptom resulting from injury, illness, or mental illness that both:

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

Please remember that if you are admitted to a hospital as a result of an emergency, you must obtain prior authorization from *Care Coordination*SM within two business days or as soon as reasonably possible. If you do not obtain prior authorization from *Care Coordination*SM, benefits for the hospital inpatient stay will be subject to a $300 penalty. Benefits will not be reduced for outpatient emergency services.

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

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

Covered Expenses

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

Covered expenses include those shown on the Medical Schedule of Benefits and:

Ambulance

Emergency
The Medical plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers emergency health services.

Ambulance service by air is covered in an emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, the Medical plan may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.

The Medical plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities when the transport is:

- From a non-network hospital to a network hospital;
- To a hospital that provides a higher level of care that was not available at the original hospital;
- To a more cost-effective acute care facility; or
- From an acute facility to a sub-acute setting.

Non-Emergency
Non-emergency service is defined as transportation by professional ambulance, other than an air ambulance, to and from a medical facility. The Medical plan only covers these services when you require transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat you.

Non-Emergency Air (airplane or helicopter)
The Medical plan does not cover non-emergency air service via airplane or helicopter. The only exception is when you require transport to a hospital or from one hospital to another because:

- The first hospital does not have the required services and/or facilities to treat you, and ground ambulance transportation is not medically appropriate because of the distance involved, or
- You have an unstable condition requiring medical supervision and rapid transport.

Note: Prior authorization is required for non-emergency ambulance service. If you fail to obtain prior authorization, a $300 penalty will apply.

Cellular and Gene Therapy
Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office. Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

Clinical Trials

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and that meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders that are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and that meets any of the following criteria in the bulleted list below.

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

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

Congenital Heart Disease

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

- Congenital heart disease surgical interventions
- Interventional cardiac catheterizations
- Fetal echocardiograms
- Approved fetal interventions

CHD services other than those listed above are excluded from coverage, unless determined by *Care Coordination*SM to be a proven procedure for the involved diagnoses. Unproven, investigational, or experimental services are not covered.

Covered CHD services may be received from a network provider or through the Congenital Heart Disease Resource Services program (United Resource Network).

Contact *Care Coordination*SM at the telephone number on your ID card for information about CHD services. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Diabetes Services

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

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

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

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

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

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

Durable Medical Equipment (DME) and Prosthesis

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

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

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

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Enteral Feeding

- Charges for enteral/nutritional formula as a sole source of nutrition provided through a feeding tube rather than through oral ingestion, or to treat inborn errors of metabolism, such as phenylketonuria

Facility/Hospital

- Hospital care for room, board, and general nursing care (including charges for the nursery care of a newborn child)
  - Semi-private room charge; if a private room is used, the difference between the hospital's private and semi-private room rate is excluded from covered expenses. If the hospital does not have semi-private rooms, the difference between the hospital's daily charge and the prevailing rate in area hospitals for semi-private rooms is excluded from covered expenses.
  - Intensive care room charge while confined as an inpatient
  - Charges for other hospital services and supplies required for treatment, except those by outside agencies, and supplies not used while confined in the hospital as an inpatient
- Services and supplies required for outpatient, non-surgical treatment provided by a hospital or facility and used while at the hospital or facility
- Services and supplies required for treatment provided by a hospital or facility and used while at the facility as an outpatient for a surgical operation or for treatment of bodily injuries
- Care in a convalescent, skilled nursing, or extended care facility if admitted immediately after a hospital stay of at least five consecutive days (limited to 60-day maximum per calendar year), for:
  - Room, board, and general nursing care — except that the difference between the facility's semi-private room rates and private room rates will be excluded from covered expenses. If the facility does not have semi-private rooms, that part of the facility's daily charge above the area facilities' prevailing rate for semi-private rooms is excluded from covered expenses; and
  - Charges for medical services and supplies required for treatment provided by the facility and used while in the facility as an inpatient.
- In addition, for non-network benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).

Gender Dysphoria

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided under Section 15, Outpatient Prescription Drugs
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
  - The treatment plan is based on identifiable external sources including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

Important: Please remember for non-network benefits, you must notify UnitedHealthcare the Claims Administrator as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.

Please call the phone number that appears on your ID card. Without notification, benefits will be subject to a $300 reduction.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises.

If you fail to obtain prior authorization as required, benefits will be subject to a $300 reduction.

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The covered person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
- The covered person must provide documentation of the following for genital surgery:
  - A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
    - Persistent, well-documented Gender Dysphoria.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must 18 years or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
    - Voice lessons and voice therapy.

Habilitative Services

Benefits are available for habilitative services for covered persons when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, vocational training, and residential treatment are not habilitative services. A service that does not help the covered person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the covered person to achieve demonstrable progress, the plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn, or improve skills and abilities for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthesis* in this section. Other than as described under Habilitative Services above, please note that the plan will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from injury, stroke, or cancer.

Hearing

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

- Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician. Benefits are provided for the hearing aid and for charges for associated fitting and hearing.
- If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the plan will pay only the amount that the plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.
- Benefits do not include bone-anchored hearing aids. Bone anchored hearing aids are a covered health service for which benefits are available under the applicable medical/surgical covered health services categories in this section except for covered persons who have either of the following:
  - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid, or
  - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Home Health Care

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

Prior Authorization Requirement

For non-network benefits, you must obtain prior authorization from the Claims Administrator five business days before receiving services or as soon as is reasonably possible for nutritional foods and skilled nursing. If you fail to obtain prior authorization as required, a $300 penalty will apply.

Hospice

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

Prior Authorization Requirement

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

Infertility Services and Fertility Solutions (FS) Program

Therapeutic services for the treatment of Infertility when provided by or under the direction of a Physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- ICSI - (intracytoplasmic sperm injection).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Embryo transportation related network disruption.
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty.
- Electroejaculation.
- Pre-implantation Genetic Diagnosis (PGD) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.

Treatment for the diagnosis and treatment of the underlying cause of Infertility is covered as described in the SPD. Benefits for diagnostic tests are described under, Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits.

Benefits for certain Pharmaceutical Products, including specialty Pharmaceutical Products, for the treatment of Infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under Injections in a Physician's Office.

Enhanced Benefit Coverage

- **Embryo biopsy for Pre-implantation Genetic Screening** (PGS) used to select embryos for transfer in order to increase the chance for conception.
- **Donor Coverage**: The plan will cover associated donor medical expenses, including collection and preparation of ovum and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.
- **Fertility Preservation for Medical Reasons** - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Additional Benefit Coverage

- **Single female or female without a male partner**. Certain Covered Health Services may be available to female Covered Persons without a male partner. The plan will cover the treatment of the female factor causing infertility and therapeutic donor insemination upon the female Covered Person's meeting the definition of Infertility. Coverage is limited to six attempts of insemination for each female Covered Person. The Plan will cover the Reciprocal IVF or Partner IVF transfer of any resulting embryos to the Covered Person from whom the oocytes were NOT derived. See also the Exclusions and Limitations for Gestational Carrier or Surrogate.
- **Single male or male without a female partner**. Certain Covered Health Services may be available to male Covered Persons without a female partner. The plan will cover the diagnosis and treatment of the male factor causing infertility, including collection and preparation of sperm, and the medications associated with the collection and preparation of sperm. See also the *Exclusions and Limitations* for Gestational Carrier or Surrogate.

Eligibility

To be eligible for infertility services benefits, you must have a diagnosis of infertility. To meet the definition of infertility, you must meet one of the following::

- You are not a able to become pregnant after thee following periods of time of regular unprotected intercourse or therapeutic donor insemination:
  - One year, if you are a female under 35.
  - Six months, if you are a female age 35 or older.
- You are a female and have failed to achieve pregnancy due to impotence/sexual dysfunction.
- You are a female and have infertility that is not related to voluntary sterilization.
- You are male and have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities, including the surgical recovery of sperm).
- Not be a child dependent, except when undergoing fertility preservation in preparation for gonadotoxic treatment.
- **Single female or Female member without a male partner (Reciprocal or Partner IVF)**. Certain Covered Health Services may be available to female Covered Persons without a male partner. The plan will cover the treatment of the female factor causing infertility and therapeutic donor insemination upon the female Covered Person's meeting the definition of Infertility and reciprocal in vitro fertilization (Reciprocal IVF or Partner IVF). Coverage is limited to six attempts of insemination for each female Covered Person. The Plan will cover the Reciprocal IVF or Partner IVF transfer of any resulting embryos to the Covered Person from whom the oocytes were NOT derived.
- **Single male or male without a female partner**. Certain Covered Health Services may be available to male Covered Persons without a female partner. The plan will cover the diagnosis and treatment of the male factor causing infertility, including collection and preparation of sperm, and the medications associated with the collection and preparation of sperm.

The waiting period may be waived if you have a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

The plan covers in-network services limited to $10,000 per covered person during the entire period you are covered under the Medical plan. There are separate medical and prescription drug lifetime maximum benefits. The plan does not provide a benefit for infertility services received from an out-of-network provider or facility.

Note: Benefits for diagnostic services are covered as outlined under the Medical Schedule of Benefits, and do not count toward the $10,000 lifetime maximum for infertility services.

Prior Authorization Requirement

You must enroll with the Fertility Solutions program as soon as possible. If you fail to enroll with a Fertility Solutions nurse as required, you will be responsible for paying all charges and no benefits will be paid.

Fertility Solutions Program

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates available to you by the plan sponsor. The program provides:

- Specialized clinical consulting services to employees and enrolled dependents to educate on infertility treatment options.
- Access to specialized network facilities and physicians for infertility services.
- The plan pays benefits for the infertility services described above when provided by designated providers participating in the Fertility Services program. The program provides education, counseling, infertility management, and access to a national network of premier infertility clinics.

If you do not live within a 60-mile radius of a COE, you will need to contact a Fertility Solutions case manager to determine a network facility prior to starting treatment. For infertility services and supplies to be considered covered health services, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services. You or a covered dependent may:

- Be referred to Fertility Solutions by UHC
- Call the telephone number on your ID card
- Call Fertility Solutions directly at **1-866-774-4626**

Tip!

To take part in the Fertility Solutions program, call a nurse at **1-866-774-4626**. The Medical plan will only pay benefits under the Fertility Solutions program if Fertility Solutions provides the proper authorization to the provider performing the services (even if you self-refer to a provider in that network).

Lab, X-Ray, and Diagnostic — Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.
- Benefits include:
  - The facility charge and the charge for supplies and equipment.
  - Physician services for radiologists, anesthesiologists, and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
  - Presumptive Drug Tests and Definitive Drug Tests.
    - Limited to 18 Presumptive Drug Tests per year.
    - Limited to 18 Definitive Drug Tests per year.

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

Prior Authorization Requirement

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

Licensed Medical Providers

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

Mental Health and Substance Use Disorder Services

Mental Health Services

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

Benefits include the following services:

- Diagnostic evaluations and assessment
- Treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, therapeutic group, and provider-based case management services
- Crisis intervention

Benefits include the following levels of care:

- Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds)

Prior Authorization Requirement

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

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

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

Neurobiological Disorders – Autism Spectrum Disorder Services

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

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

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a covered health service for which benefits are available under the applicable medical covered health services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds)
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Crisis intervention
- Provider-based case management services

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

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

Prior Authorization Requirement

For non-network benefits, please remember:

- A scheduled admission for neurobiological disorders – autism spectrum disorder (including an admission for services at a residential treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including emergency admissions) you must provide notification as soon as is reasonably possible.
- In addition, for non-network benefits, you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization include: partial hospitalization/day treatment; intensive outpatient treatment programs; psychological testing; extended outpatient treatment visits, with our without medication management; intensive behavioral therapy, including applied behavior analysis (ABA)

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

Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

- Inpatient treatment
- Residential treatment
- Partial hospitalization/day treatment
- Intensive outpatient treatment
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Crisis intervention
- Provider-based case management services

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

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

Prior Authorization Requirement

For non-network benefits for a scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.

A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

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

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

Morbid Obesity Surgery

The Medical plan provides a benefit for surgical treatment of morbid obesity. You are eligible for this benefit if you meet the following criteria:

- Are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4;
- Have a minimum Body Mass Index (BMI) of 40 or > 35 with at least 1 co-morbid condition present;
- Have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation;
- Have a 6-month physician supervised diet documented within the last 2 years.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Limitations include:

- One surgery per lifetime unless complications arise;
- Excess skin removal is not covered, unless medically necessary;
- You must enroll in the Bariatric Resource Services (BRS) program through Optum; and
- You must use a Bariatric Center of Excellence (COE).

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

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

Prior Authorization Requirement

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

Neonatal Resource Services

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

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

You or a covered dependent may also:

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

To receive NICU benefits, you are not required to visit a designated facility. If you receive services from a facility that is not a designated facility, the Medical plan pays benefits as described under *Covered Expenses.*

Orthopedic Health Support Program

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond. This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre- and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.
- Access to Designated Providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

If you are considering any of the above surgeries you must contact an Orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the Travel and Lodging Assistance Program, refer to the provision below. Note: The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with transplant services received by a Designated Provider.

Pharmaceutical Products - Outpatient

The Plan pays for pharmaceutical products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

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

If you require certain pharmaceutical products, including specialty pharmaceutical products, UnitedHealthcare may direct you to a Designated Dispensing Entity with whom UnitedHealthcare has an arrangement to provide those pharmaceutical products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, hospital-affiliated pharmacy, or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your pharmaceutical product from a Designated Dispensing Entity, network benefits are not available for that Pharmaceutical Product.

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

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

Physician Fees

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

Sterilization

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

Temporomandibular Joint (TMJ) Services

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

- Diagnosis: Examination, radiographs, and applicable imaging studies and consultation.
- Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

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

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

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

Transplantation Services

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

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

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

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

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

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

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

Travel and Lodging

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

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

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

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

Virtual Visits

Virtual visits for covered health services include the diagnosis and treatment of low acuity medical conditions for covered persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work). You'll be connected to a doctor who is licensed to deliver care in the state that you are in at the time of your visit.

Network Benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by visiting **www.myuhc.com** or by calling the telephone number on your ID card.

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss. Any combination of Network Benefits and Non-Network Benefits is limited to $1,000 per calendar year.

Exclusions and Limitations

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

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

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

Alternate Treatments

- Aromatherapy
- Hypnotism
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- Holistic or homeopathic care

Ambulance

- Transportation for convenience

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service
- Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Dehumidifiers
  - Humidifiers
- Devices and computers to assist in communication and speech
- Home remodeling to accommodate a health need such as, but not limited to, ramps and swimming pools

Dental

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

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

Drugs

Certain new pharmaceutical products and/or new dosages from the date as determined by the Claims Administrator's designee, but no later than December 31 of the following calendar year. This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment).

Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered by directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered persons for self-infusion.

If you have a life-threatening sickness or condition, under such circumstances, benefits may be available for the new pharmaceutical product.

Durable Medical Equipment and Prosthetics

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

Experimental or Investigational Services

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

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

Exceptions:

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

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

Foot Care

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

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

**This exclusion does not apply to preventive foot care for covered persons who are at risk of neurological or vasculardisease arising from diseases such as diabetes.

Gender Dysphoria

Cosmetic procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Home Health Care

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

Medical Supplies and Appliances

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings;
  - Ace bandages; or
  - Gauze and dressings.
- Powered and non-powered exoskelton devices;
- Diabetic supplies (for which benefits are provided as described under the *Covered Expenses, Diabetes* section); and
- Tubings, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment.

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

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

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

Nutrition

- Megavitamin and nutrition-based therapy
- Nutrition counseling for either individuals or groups, including weight loss programs, health clubs, and spa programs other than as provided under the Medical plan's nutrition provisions
- Intracellular micronutrient testing
- Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism
- Hyper-alimentation or total parenteral nutrition, except as provided under the *Covered Expenses* section

Orthotics

- Cranial orthotics (helmets) unless there is documentation of severe nonsynostotic positional plagiocephaly, and when there is the likelihood of ocular and oral complications as a consequence of the persistent plagiocephaly deformity;
- Braces or orthotics solely for the purpose of reshaping a body part for cosmetic reasons; and
- Braces, orthotics, or equipment used specifically as safety items or to affect performance primarily in sport-related activities.

Physical Appearance

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

Providers

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

This exclusion does not apply to mammography testing.

Reproduction

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

Services Provided Under Another Plan

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

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

Transplants

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

Travel

- Travel or transportation expenses, even though prescribed by a physician, except related to transplants

Unproven Services

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

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

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

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

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

Vision and Hearing

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

All Other Exclusions

- Health services and supplies that are not listed as a covered expense
- Charges that exceed Eligible Expense limits
- Education or training, except as provided under the *Covered Expenses* section
- Food supplements, except as provided under the *Covered Expenses* section
- Equipment or supplies made or used for physical fitness, athletic training, or general health upkeep
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Medical plan when:
  - Required solely for purposes of education, sports or camp, insurance, marriage or adoption;
  - Related to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the Medical plan ends, including health services for medical conditions arising before the date your coverage under the Medical plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Medical plan
- In the event that a non-network provider waives coinsurance and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the coinsurance and/or annual deductible are waived
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a physical congenital anomaly; speech therapy to treat stuttering, stammering, or other articulation disorders is not covered; speech therapy to treat learning disabilities or developmental delay is not covered
- Outpatient rehabilitation services, spinal treatment, or supplies including, but not limited to, spinal manipulations by a chiropractor or other physician, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring

- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Overall treatment that is intended to maintain a current state and is not effective at treating an existing medical condition
- Weight reduction or control (however, where there is a diagnosis of morbid obesity, or severe obesity with co-morbidities, the expense for surgery will be covered)
- Custodial care
- Domiciliary care
- Private duty nursing received on an inpatient basis
- Respite care
- Rest cures
- Psychosurgery
- Treatment of benign gynecomastia (abnormal breast enlargement in males), except as needed to treat a medical condition
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms, or record processing
- Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment
- Any charge for services, supplies, or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Any additional charges submitted after payment has been made and your account balance is zero
- Any outpatient facility charge in excess of payable amounts under Medicare
- Any charges related to Christian Science
- Chelation therapy, except to treat heavy metal poisoning
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- Additional charges submitted after payment has been made and the corporate account balance is zero
- The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

How do I File a Medical Claim?

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

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

Claim forms are available from:

- Your Baker Hughes benefits account
- **www.myuhc.com**, or by calling UHC at **1-866-743-6549**

Read your claim form carefully and make sure you answer all questions and include all required information and documentation.

Once you complete the form, attach all evidence to support your claim, including receipts, and file your claim directly with UHC as soon as possible after your treatment. You have 12 months after the date of service to file a claim for expenses incurred. If a non-network provider submits a claim on your behalf, you'll be responsible for the timeliness of the submission. If you do not provide this information to UHC within 12 months after the date of service, benefits for that service will be denied. This time limit does not apply if you're legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

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

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

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

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

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

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

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

Required information for claims includes:

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

Send your claim forms to:
UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555

What is a Health Statement or an EOB?

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

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

Notification of Claims Decision

Urgent Care Claims

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

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

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

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

Remember...

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with Medical plan access or claims issues that you have not been able to resolve. Call the Baker Hughes Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide) for more information. Advocates are available Monday through Friday from 7:00 a.m. to 6:00 p.m. Central Time.

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

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

Non-Urgent Care Claims

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

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

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

Pre-Service Claims. A "pre-service claim" is any request for approval of a benefit in advance of obtaining the related medical care (i.e., preauthorization).

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

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

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

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

Manner and Content of Notification of Claims Decision

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

- The specific reasons for the adverse decision;
- Reference to the specific Medical plan provisions on which the decision is based;
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the Medical plan's claims denial appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse claims decision;
- If an internal rule, guideline, protocol, or other criteria was relied on in the decision-making, either (1) a copy of such rule, guideline, protocol, or other criteria, or (2) a statement that such rule, guideline, protocol, or other criteria was relied upon and that a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request;
- If the adverse claims decision was based on a medical necessity or experimental treatment, or similar exclusion or limit either (1) an explanation of the scientific or clinical judgment for the determination applying the terms of the Medical plan to your medical circumstances or (2) a statement that such explanation will be provided free of charge to you upon request;
- For an adverse claims decision involving an urgent care claim, a description of the expedited claims denial appeal process applicable to such claims;
- Information sufficient to identify the benefit claim involved, including (1) the date of service, (2) the health care provider, and (3) the benefit claim amount (if applicable);
- An explanation of the reason or reasons for the adverse claims decision, including the denial code and its corresponding meaning, as well as a description of the Medical plan's standard, if any, that was used in denying the benefit claim;
- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (and if you request such information, the request will not be treated as a request for an appeal of the adverse claims decision or a request for an External Review of that decision);
- A description of the Medical plan's available claims denial appeal and External Review processes and procedures applicable to the Medical plan, including information regarding how to initiate an appeal and the time limits applicable to such processes and procedures; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act (PHSA) to assist individuals with the internal claims and appeals and External Review processes.

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

What if my Medical Claim is Denied?

If Your Claim is Denied

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

How to Appeal a Denied Claim

- **Level One:** If you wish to appeal a denied claim, including a denied pre-service request for benefits, post-service claim or a rescission of coverage, you must submit your appeal in writing within 180 days after receiving the denial. Your written appeal must include, as applicable:
  - The patient's name and ID number on the ID card;
  - The provider's name;
  - The date of medical service;
  - The reason you think your claim should be paid; and
  - Any documentation or other written information to support your request.

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

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

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

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

You or your authorized representative will be provided, upon request to the Medical plan and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your benefit claim at issue in the appeal.

The appeal process will not afford deference to the initial decision regarding your claim and will be conducted by an appropriate named fiduciary of the Medical plan who is neither the individual who made the adverse claims decision regarding your claim nor the subordinate of such individual.

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

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

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

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

You or your authorized representative will be allowed to present evidence and testimony to the appropriate named fiduciary of the Medical plan who will conduct the appeal.

Before the Claims Administrator can issue a final internal adverse benefit determination based on a new or additional rationale, you or your authorized representative will be provided, free of charge, with the rationale and the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under the Medical plan to give you a reasonable opportunity to respond prior to that date.

The Medical plan will ensure that all benefit determination appeals are adjudicated in a manner designed to ensure the independence and impartiality of the person involved in making the decision.

To the extent required under regulations of the Department of Labor, the Department of Treasury and the Department of Health and Human Services, the Medical plan will provide continued coverage for a claimant who files a benefit determination appeal pending the outcome of the benefit determination appeal. For this purpose, the Medical plan must comply with the requirements of Department of Labor Regulation §2560.503 1(f)(2)(ii), which generally requires that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

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

- Urgent care*
  - The claimant must be notified of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account medical emergencies, but not later than 72 hours after the receipt of the claim.
  - Urgent appeals must meet one or both of the following criteria:
    - Application of the time periods for making a non-urgent care determination could seriously jeopardize the patient's life or health or ability to regain maximum functionality, and/or
    - In the opinion of a physician with knowledge of the medical condition, could cause severe pain.
- Pre-service claim, within 15 days
- Post-service claim, within 30 days

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

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

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

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

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

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

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

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

Important

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

Manner and Content of Notification of Appeals Decision

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

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

Communications in Foreign Languages

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

Federal External Review Program

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

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

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

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

An External Review request should include all of the following:

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

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

- A standard External Review, and
- An expedited External Review.

Standard External Review

A standard External Review comprises all of the following:

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

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

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

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

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

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

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

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

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

Expedited External Review

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

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

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

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

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

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

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

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

Coordinating Your Medical Plan with Other Benefits

Coordination of benefits applies when you or your covered dependents have coverage under the Baker Hughes Medical plan and one or more other plans. In this case, one of the plans will pay the benefits first, making that plan primary. Other plans will pay benefits next, making those secondary or even tertiary. The rules below help determine which plan pays first.

How Coordination Works

If the Baker Hughes Medical plan is **primary**, it will pay benefits first. Benefits under the Baker Hughes Medical plan will not be reduced due to benefits payable under the other plan.

If the Baker Hughes Medical plan is **secondary**, benefits under the Baker Hughes Medical plan will be reduced by benefits payable under other plans. The secondary plan will not pay more than the maximum benefit (see example below).

Your bills and receipts must first be filed with the primary plan before being filed with the secondary plan. A copy of the primary plan's Explanation of Benefits (EOB) should be included with the secondary plan claim (for more information about your EOB, go to **www.myuhc.com**).

Example:

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

	Your Coverage	Your Spouse's Coverage
Baker Hughes Medical Plan	Primary	Secondary
Your spouse's Company Plan	Secondary	Primary

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

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

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

Which Plan Pays First?

When two or more plans provide benefits for the same covered person, the benefit payment will follow the following rules in this order:

- A plan that does not provide for coordination of benefits will pay its benefits first.
- A plan that covers a person as an employee will pay its benefits before the plan that covers the person as a dependent, and a plan that covers a person as an active employee is primary over a plan that covers a person who is laid off or a retiree.
- When a child is covered by the plans of both parents, unless they're divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year, regardless of the year of birth, will pay first. However, if the other plan's coordination of benefits provisions do not use this "birthday rule," the other plan's provisions will make the determination as to which pays first.
- If a child's parents are divorced or legally separated:
  - A qualified medical child support court order determines who pays first, otherwise:
    - The custodial parent's plan pays first;
    - The step-parent's plan pays second; and
    - The non-custodial parent's plan pays third.
- If a person whose coverage is provided under a right of continuation pursuant to a federal or state law (e.g. COBRA) is also covered under another plan, the effect on benefits is as follows:
  - The plan covering the person as an employee (or as the employee's dependent) will pay first, and
  - The plan of continuation coverage will pay second.
- When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. For example, if you are a new employee as the result of an acquisition of a business by Baker Hughesand your group health plan coverage continues with your former employer for a period of time after the acquisition, your former employer's plan will pay first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

Coordination with Medicare Secondary Payer Rules

The Medical plan includes provisions to comply with the Medicare Secondary Payer rules.

Coverage for Active Employees and Spouses Who are Age 65 or Older and Eligible for Medicare

The Medicare Secondary Payer rules provide generally that if an employee or the employee's spouse covered by the Medical plan qualifies for Medicare because the employee and/or his or her spouse is age 65 or older, the employee and his or her spouse are entitled to the same benefits under the Medical plan as any individual or spouse under age 65. Consequently, if you are an active employee, the Medical plan will provide your primary coverage regardless of whether you or your spouse is eligible for Medicare coverage because one of you is age 65 or older. There is an exception to the above rules for an individual with end stage renal disease (see *Coverage for End Stage of Renal Disease* below).

Coverage for Disabled Persons Who are Eligible for Medicare

The Medicare Secondary Payer rules also provide generally that if an employee or the employee's family member covered by the Medical plan qualifies for Medicare because he or she is disabled, the employee and his or her family members are entitled to the same benefits under the Medical plan as any individual who is not disabled. Consequently, if you are an active employee, the Medical plan will provide you and your qualifying family members primary coverage regardless of whether you or a family member is eligible for Medicare coverage due to a qualifying disability. There is an exception to the above rules for an individual with end stage renal disease (see *Coverage for End Stage of Renal Disease* below).

If you cease to be an active employee but receive disability benefits under the Baker Hughes Long-Term Disability plan and continue coverage under the Medical plan, Medicare will provide your primary medical coverage once you are eligible to enroll for medical benefits under Medicare. Consequently, if you continue coverage under the Medical plan, you must enroll in both Parts A and B of Medicare as soon as you are eligible to enroll. If (1) you are eligible to enroll for medical benefits under Medicare, (2) you are not actively working for Baker Hughes, and (3) you have been receiving disability benefits from Baker Hughes plans for more than six months, the benefits you are eligible to receive under the Medical plan will be determined as if Medicare was providing your primary medical coverage, regardless of whether you enroll in Medicare Parts A and B. In that case, your Medical plan coverage will only pay benefits to the extent the plan provides a higher level of benefit than Medicare. The Medical plan Claims Administrator will process your medical claims only after receiving the Medicare Explanation of Benefits. If you do not enroll in Medicare Parts A and B, the administrator will process your claims by estimating the amount Medicare would have paid and will pay only the amount that is payable under the Medical plan that exceeds the amount that would have been paid by Medicare. Refer to the *Long-Term Disability* section for additional information.

Coverage for End Stage of Renal Disease

The Medicare Secondary Payer rules provide an exception to the general rules stated in the two sections above for an individual with end stage renal disease (ESRD). If you are an active employee and you or one of your covered family members becomes eligible for Medicare due to ESRD, the Medical plan will continue to be primary to Medicare with respect to the individual with ESRD for the first 30 months of Medicare coverage. After the first 30 months, Medicare will provide the primary coverage for the individual with ESRD and the Medical plan will provide secondary coverage only.

Under the Medical plan, Medicare will provide primary coverage to employees and dependents eligible for Medicare to the extent permitted by applicable law.

Care Management Programs

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

Programs and Services	Is Program Voluntary or by Invitation?	Offered to Employees	Offered to Spouses	Offered to Dependents	Must be in Medical plan to Participate
Health Surveys	Voluntary	✓		✗	✓
Chronic Health Management Programs **UHC: 1-866-743-6549**	Voluntary, and participants invited based on: • Medical and Prescription Drug claims data • Health Survey feedback			✓	
Personal Health Support (UHC Nurse Case Management) **UHC: 1-866-743-6549**	Voluntary, and participants invited based on: • Medical and Prescription Drug claims data • Health Survey feedback • Hospital stay			✓	
Maternity Support Program **UHC: 1-866-743-6549**	Voluntary, and participants invited based on: • Medical claims data			✓	
Fertility Solutions **UHC: 1-866-743-6549**	Voluntary			✓	
Kidney Resources Program **UHC: 1-866-561-7518**	Voluntary			✓	
Bariatric Resource Services **UHC: 1-888-936-7246**	Voluntary			✓	
Rally Missions® **1-866-743-6549**	Voluntary	✓		✗	✓

Care Management Programs are Voluntary and Confidential

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

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

Health Surveys

All medical plan participants and their spouses are encouraged to complete a confidential, voluntary Health Survey. This assessment will calculate your current health status and provide you with results that are easy to understand. It only takes 15 minutes and can be completed online or via paper.

You'll walk away from the Health Survey with the knowledge of what you're doing right and what you need to work on for better health in the future. Armed with your results, you'll be able to create a personalized action plan that will allow you to focus on your top priority health behaviors and improve your health. Based on your feedback, you may be invited to join other programs.

After completing a confidential Health Survey, if your results show you have a health risk that could be improved, you may be invited to participate in one or more of these programs.

Tip!

To access Rally, you must make an election to join or decline coverage under the Baker Hughes medical plan.

Chronic Health Management Programs

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

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

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

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

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

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

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

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

Personal Health Support

For participants in a UHC Medical plan, a team of personal nurses will work with you and your family to:

- Provide hospital pre-admission counseling to help you prepare for planned inpatient surgery;
- Help answer your questions and/or plan for any needs you may have after hospital discharge;
- Provide inpatient care advocacy to assist you in receiving the care your physician orders, when you need it, while in the hospital;
- Provide health information when released from a hospital stay of three or more days, or when released with certain chronic conditions, to help you understand and follow discharge instructions and have the support you need;
- Communicate regarding the necessary medication, equipment, and follow-up medical services needed upon your discharge from a hospital stay; and
- Refer members to other care management programs.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. Members enrolled in the program prior to their 34th week of pregnancy will receive 550 Energize reward points to the employee's Energize account compliments of Baker Hughes and the Care Management Program. To enroll, call the number on the back of your ID card. As a program participant, you can always call your nurse with any questions or concerns you might have.

Fertility Solutions

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Infertility Solutions program provides:

- Specialized clinical consulting services to employees and enrolled dependents to educate on infertility treatment options.
- Access to specialized network facilities and physicians for infertility services.
- The plan pays benefits for the infertility services described above when provided by designated providers participating in the Fertility Solutions program. The Fertility Solutions provides education, counseling, infertility management, and access to a national network of premier infertility treatment clinics.

Covered persons who do not live within a 60 mile radius of a fertility solutions designated provider will need to contact a Fertility Solutions case manager to determine a network provider prior to starting treatment. For infertility services and supplies to be considered covered health services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at **1-866-774-4626**.

To take part in the Fertility Solutions program, call a nurse at **1-866-774-4626**. The plan will only pay benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the designated provider performing the services (even if you self-refer to a provider in that network).

Bariatric Resource Services

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

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

HealtheNote Care Reminders

Based on medical and prescription drug data, opportunities to improve health will be identified based on evidence-based medicine guidelines. HealtheNote and HealtheNote reminders are generated and mailed monthly to your home by UHC. Opportunities available in the HealtheNote mailings will include:

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

HealtheNote reminders will include reminders for the following screenings:

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

Wellness Programs and Services

Rally offers a variety of innovative and informative programs to make it easier for you to get healthier. Healthy Activities through Rally are designed to help you learn more about your current health status and take steps toward improving and maintaining your overall health and well-being.

Some steps toward improving your health include: taking the Health Survey, completing your annual Health Screening, working with a Rally personal coach via telephone or chat, participating in Rally Health Missions, and tracking your physical activity by participating in Rally Challenges.

If you are ready to make a change to improve your health, these programs provide the guidance, educational materials, and encouragement you need to ensure success. Rather than simply telling you what to change, these programs will help you develop a personalized action plan for making changes.

Rally Missions

Missions are self-directed health education modules on Rally that are recommended to individuals as a result of their responses to the Health Survey, as well as health risk factors identified through other sources and the individual's readiness to change. Individuals select their paths based on their motivational preferences and the health-related areas they would like to improve. Missions are paced to the individual, encouraging tiny habit changes to improve health and wellness. By supporting incremental behavior change, the Missions help the participant to develop new habits through repetition. As the journey unfolds, each person receives in-the-moment behavior change messaging on the Web portal or Rally app, to help them reach their goals.

Personal Coaching

Rally's personal coaching will help you eat better, get fit, reduce stress, or find the personal support and motivation to reach health goals. Personal coaching is available in ten categories to help you in all areas of life.

1. Weight & Wellness
2. Quit Tobacco
3. Stress Less
4. Eat Smart
5. Fit for Life
6. Diabetes Lifestyle (no online course)
7. Healthy Heart
8. Sleep Well
9. General Wellness
10. Family Wellness

Weight & Wellness

Rally's weight management program focuses on increasing your awareness of the benefits of proper nutrition and exercise while helping you learn to manage your weight through behavioral modifications.

Quit Tobacco Program

Rally's tobacco cessation program focuses on specific measurable and attainable goals, such as establishing a quit date and avoiding cues that lead to smoking. The tobacco cessation program combines telephonic coaching with print and online education.

Stress Less Program

The telephonic wellness stress management program will provide you with information to help you manage stress through positive behavioral changes. Members are eligible for the program if they feel tense, anxious, or depressed often and/or if stress has had a noticeable impact on their health over the past year.

Eat Smart Program

Rally's nutrition management program will provide you with information designed to increase your awareness of the importance of proper nutrition, setting dietary goals, and making lifestyle changes. Members reporting greater than three servings of fatty food servings per day are eligible to participate in the program.

Fit for Life Program
The exercise management program will provide you with information to assist you in developing an appropriate exercise regime, giving consideration to factors such as age, weight, and other health-related conditions. You will also receive exercise educational materials.

Diabetes Lifestyle Management Program
The diabetes lifestyle management program is designed to educate you on proper diet, weight loss/management, and exercise. You receive educational materials and guidance focused on prevention through diet, weight loss management, exercise and, when applicable, compliance with prescribed medication.

Healthy Heart Program
The healthy heart lifestyle management program provides you with an overall understanding of the factors that affect heart health, such as blood pressure and cholesterol. You receive assistance in making lifestyle changes to reduce risks, in addition to guidance on factors that increase risks, such as lack of proper nutrition and exercise.

Sleep Well

With the Sleep Well Program, you will learn how to get the rest you need – because good sleep can be key to good health. As part of the program, you will learn how stages of sleep and sleep cycles work, what it does for you, and the effects of poor sleep, fatigue, and sleep deprivation. In addition, the program covers the power of strategic naps, fitting them into your life, practicing ways to help you fall asleep consistently, night after night. And you will track your sleep to design a sleep program that's right for you.

General Wellness
Set yourself up for a healthier life with ways to help you stay active, eat healthily, reduce stress, and more. Understand the basics of nutrition, healthy eating and weight loss, and how exercise fits into the equation. Learn about stress, how it may impact your health, and get help managing it. And learn about tobacco addiction and the benefits of quitting.

Family Wellness

Explore exercise, nutrition, and more to make healthy and happy a family activity. Learn the benefits and basics of healthy family-meal planning, and how to overcome barriers to healthy eating. In addition, learn how to sit less, skip the screen time, and put the fun back in family exercise and activity. Finally, you'll get tips on how to enjoy family time more – how to think healthy thoughts, relieve stress, sleep better, and get help from your pediatrician.

Rally Health Challenges
Rally Health Challenges encourage participants to make physical activity part of daily life. By tracking your physical activities you'll see firsthand just how easy it is to maintain an active lifestyle. In a Challenge, the member uses the Rally Health digital platform to walk or run in the real world and apply that mileage to a virtual course in a scenic city. Challenges are easily integrated with fitness tracking devices which can populate members' progress.

Communities
Communities leverage social media and connectivity, connecting members with similar health interests. Community recommendations are based on survey results and may include fitness and exercise, heart health, sleeping better, and more. These social networking groups are anonymous and drive motivation and compassion.

Coins
Rally members receive Rally coins as rewards for a wide range of activities, including taking actions on the Rally site (such as logging on to the site, completing the health survey, or completing a Mission). Members can use Rally coins to enter drawings to win prizes and compete in auctions, among other fun activities.

Prescription Drug Plan

Prescription Drug Plan Benefits At-a-Glance

Type of Plan	Prescription Drug plan for members enrolled in a Medical plan option (including out-of-area options)		
Who Pays the Cost	You share the cost of medical coverage with Baker Hughes.		
Employee Eligibility	Employees and eligible dependents enrolled in one of the following Medical plan options: • Standard option • Premium HSA option • Basic HSA option • Standard Out-of-Area option • Premium HSA Out-of-Area option • Basic HSA Out-of-Area option		
When Coverage Begins	Coverage begins on your date of hire or date of transfer.		
Enrollment Period	Eligible employees are automatically enrolled in the Prescription Drug plan upon enrolling in the Medical plan.		
Cost	**Standard and Standard Out-of-Area Options**		
	Deductible	N/A	
	Retail – Generic	$7	
30-day	Retail – Preferred Brand	25% ($30 minimum/$60 maximum)	
30-day	Retail – Non-Preferred Brand	25% ($60 minimum/$100 maximum)	
30-day	Retail or Mail – Specialty	30% ($250 maximum)	
30-day	Mail – Generic	$15	
90-day	Mail – Preferred Brand	25% ($75 minimum/$150 maximum)	
90-day	Mail – Non-Preferred Brand	30% ($150 minimum/$250 maximum)	
	Out-of-Pocket Maximum	$2,000 Individual/$4,000 Family*	
	Premium HSA, Basic HSA, Premium HSA Out-of-Area, and Basic HSA Out-of-Area Options		
	Deductible	Premium HSA and Premium HSA Out-of-Area Options: Combined with Medical** ($1,500 Individual/$3,000 Family)	
	Deductible	Basic HSA and Basic HSA Out-of-Area Options: Combined with Medical** ($3,250 Individual/$6,500 Family)	
	Retail – Generic	$7 after deductible	
30-day	Retail – Preferred Brand	30% after deductible	
30-day	Retail – Non-Preferred Brand	30% after deductible	
30-day	Retail or Mail – Specialty	30% after deductible	
30-day	Mail – Generic	$15 after deductible	
90-day	Mail – Preferred Brand	30% after deductible	
90-day	Mail – Non-Preferred Brand	30% after deductible	
	Out-of-Pocket Maximum (includes deductible)	Premium HSA and Premium HSA Out-of-Area Options: Combined with Medical ($5,000 Individual/$10,000 Family)	
	Out-of-Pocket Maximum (includes deductible)	Basic HSA and Basic HSA Out-of-Area Options: Combined with Medical ($6,500 Individual/$13,000 Family)	
Contact	CVS/caremark: **www.caremark.com** | **1-877-252-3485**		

*Prescription drugs apply to the out-of-pocket maxmium.

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

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

Standard and Standard Out-of-Area Medical Plan Options

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

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

Prescription Drug Coverage		Standard and Standard Out-of-Area Options
Deductible		N/A
30-day	**Retail – Generic**	$7
	Retail – Preferred Brand	25% ($30 minimum/$60 maximum)
	Retail – Non-Preferred Brand	25% ($60 minimum/$100 maximum)
	Retail or Mail – Specialty	30% ($250 maximum)
90-day	**Mail – Generic**	$15
	Mail – Preferred Brand	25% ($75 minimum/$150 maximum)
	Mail – Non-Preferred Brand	30% ($150 minimum/$250 maximum)
Out-of-Pocket Maximum		$2,000 Individual/$4,000 Family

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

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

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

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

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

Prescription Drug Coverage		Premium HSA and Premium HSA Out-of-Area Options	Basic HSA and Basic HSA Out-of-Area Options
Deductible (does not apply to certain preventive drugs)*		Combined with Medical ($1,500 Individual/$3,000 Family**)	Combined with Medical ($3,250 Individual/$6,500 Family**)
30-day	**Retail – Generic**	$7	$7 after deductible
	Retail – Preferred Brand	30% after deductible	30% after deductible
	Retail – Non-Preferred Brand	30% after deductible	30% after deductible
	Retail or Mail – Specialty	30% after deductible	30% after deductible
90-day	**Mail – Generic**	$15	$15 after deductible
	Mail – Preferred Brand	30% after deductible	30% after deductible
	Mail – Non-Preferred Brand	30% after deductible	30% after deductible
Out-of-Pocket Maximum		Combined with Medical ($5,000 Individual/$10,000 Family)	Combined with Medical ($6,500 Individual/$13,00 Family)

*For a list of preventive drugs, please visit **www.caremark.com** or call **1-877-252-3485**.
**You must meet the combined Medical and Prescription Drug Family deductible if coverage level is other than *You Only*.

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

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

CVS/caremark National Network of Retail Pharmacies

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

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

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

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

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

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

Additional Resources

BakerHughesBenefits.com

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

You can register online at **www.caremark.com** after you have enrolled in the Medical plan. Allow approximately two weeks for your enrollment to be updated with CVS/caremark.

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

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

Maintenance Choice®

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

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

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

To participate in Maintenance Choice®, you have TWO options. First, you have an option to use any CVS Pharmacy; please ask your physician for a 90-day prescription. Your other option is to use the CVS Caremark Mail Service. Ask your physician for two separate prescriptions. The first prescription will be for the 30-day supply with two refills that you can fill at a retail pharmacy. Your second prescription should be for a 90-day supply (with appropriate refills) that you will fill through Maintenance Choice®. You may pay for your prescription by check, electronic check, money order or via a debit or credit card (Visa, MasterCard, American Express, Discover). If you use mail service, CVS/caremark will deliver your order directly to the destination of your choice via First Class U.S. mail within 7 to 10 days of receipt of the order.

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

- Call FastStart® toll-free at **1-800-875-0867** from 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday.
- Log on to **www.caremark.com** and select "Order Prescription" and request a prescription.

Additional Resources

For questions regarding Maintenance Choice® or to enroll in mail service:

Call: **1-877-252-3485** | Internet: **www.caremark.com**

Refills

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

Understanding the CVS/caremark Performance Drug List

A CVS/caremark Performance Drug List is a list of prescription drugs that are preferred based on clinical effectiveness and cost. Drugs are included on the CVS/caremark Performance Drug List only after a team of pharmacists and physicians evaluate their efficacy and cost relative to available alternatives. Final decisions for CVS/caremark are made by an independent group of clinical pharmacists and physicians known as the Pharmacy and Therapeutics (P&T) committee. Baker Hughes is not involved in this process. The P&T Committee evaluates the safety and effectiveness of available prescription drugs. They apply their expertise to evaluate the options in various therapeutic classes of drugs. (Examples of therapeutic classes are cholesterol-reducing agents, antibiotics, etc.)

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

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

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

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

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

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

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

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

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

Explanation of Terms

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

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

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

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

Clinical Guidelines

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

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

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

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

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

Prior Authorization

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

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

Quantity Level Limits

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

Step Therapy Program

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

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

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

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

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

CVS/caremark Specialty Pharmacy

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

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

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

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

Note: If you live in West Virginia, Oklahoma and Arkansas, you must use the CVS/caremark Specialty Pharmacy after your first two fills.

If you choose to take a prescription for a specialty medication to a CVS/pharmacy store, the prescription can be filled and processed, unless the medication in question is considered Limited Distribution or if it is subject to a Prior Authorization. If the prescription is Limited Distribution or if a Prior Authorization is required, the pharmacist will provide you with the appropriate action that you should take to obtain the medication.

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

- A CVS/caremark representative will call you and your doctor to fill the prescription, or you can call the CVS/caremark Specialty Pharmacy at 1-800-237-2767. Hours are 6:30 a.m to 8:00 p.m. Central Time Monday through Friday.
- CVS/caremark Specialty Pharmacy will work with you to fill the prescription and have it delivered to your home, to a local CVS/pharmacy store, the physician's office or another location you choose.

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

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

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

Covered Drugs

The following are covered:

- Drugs and medications for which a physician's prescription is required (also called federal legend drugs);
- Legend drugs, which are medications that require a prescription from a licensed health care professional;
- An extemporaneously prepared combination of two or more drug products containing at least one federal legend drug in a therapeutic amount;
- Insulin, needles, and syringes;
- Ostomy supplies;
- Any other drug which, under applicable state law, may only be dispensed by a physician's (or other authorized person's) written prescription;
- Drugs prescribed for infertility purposes are covered up to a $10,000 lifetime maximum; and
- Tobacco cessation medications for up to a 90-day supply (retail pharmacy only; no mail service).

Exclusions and Limitations

The following are excluded from coverage:

- Drugs and medications that can be obtained without a physician's prescription
- Non-legend drugs other than insulin
- Hair growth agents
- Immunization agents (excluding preventive vaccinations), biological serums, blood products, or blood plasma
- Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs. Experimental or investigational drugs; or drugs prescribed for experimental indications
- Drugs or medicines dispensed or administered to you or your covered dependents while in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, physician's office, or any other institution that dispenses drugs or medicines (these drugs may be covered under the plan)
- Any refill of a prescription that exceeds the number of refills ordered by a physician
- Any refill dispensed more than one year after the date of the prescription
- Prescription drugs that may be obtained without charge under local, state, or federal programs (such as Workers' Compensation)
- Drugs purchased outside the United States that are not legal inside the United States
- Therapy devices or appliances, including support garments and other non-medical substances, regardless of their intended use
- Certain legend products with over-the-counter (OTC) equivalents
- Legend homeopathic products

- Legend medical foods
- Drugs or medicines for:
  - Any cosmetic procedure or treatment (i.e., photo-aged skin products and skin de-pigmentation products)
  - Experimental treatment
- Extemporaneously prepared combinations of raw bulk chemical ingredients or combinations of federal legend drugs in a non-FDA approved dosage form
- Drugs prescribed for consumption or use during a period when no coverage is in force
- Contraceptive implants, diaphragms, and IUDs
- Allergens
- Diagnostic, testing, and imaging supplies
- Non-sedating antihistamines and brand name oral tetracyclines

Filing Prescription Drug Claims

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

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

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

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

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

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

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

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

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

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

If your claim is denied, you can call or write to CVS/caremark as listed on your claim form. If you are not satisfied with the results of the coverage decision, you may begin the appeals process. Except for appeals involving urgent claims, you must submit all appeals in writing.

Tip!

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

Appealing a Denied Claim

1st Level Appeal and Decision

You must file an appeal within 180 days after the date you receive the adverse benefit determination with the notice that your claim is denied.

How to File an Appeal. If you want to appeal a denied claim under the Prescription Drug program, contact CVS/caremark Customer Care at **1-877-252-3485**. The Customer Care representative will send you an appeal form and instruct you on how to submit your appeal to:

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

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

You should include the reasons you disagree with the denial of your claims and any information, documents or arguments you want considered in the 1st level appeal. You may submit written comments, documents, records, and other information relating to your claim. Upon request, you are entitled to receive, free of charge, reasonable access to and copies of the relevant documents, records, and information used in the claims process.

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

2nd Level Appeal and Decision

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

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

2nd Level Appeal Decision. Once CVS/caremark receives all of your information, the IRO has 15 days (or in the case of an urgent care claim, as soon as possible but no later than 72 hours) to make a decision and notify you of that decision. If your appeal is denied, you will receive a final adverse benefit determination notice, which includes the reason for the denial, reference to the relevant plan provisions and other information as required by federal law or regulations (see "*Manner and Content of Notification of Appeals Decision*" section of this SPD for a further general explanation of the information that must be included).

External Review

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

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

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

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

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

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

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

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

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

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

Dental Plan

Dental Benefits At-a-Glance

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

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

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

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

Dental Coverage Options

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

- You Only
- You + Children
- You + Spouse
- You + Family

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

What is the Cost of these Coverage Options?

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

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

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

Did you know?

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

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

CIGNA Dental PPO Program

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

Schedule of Benefits

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

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

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

Covered Expenses

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

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

Preventive and Diagnostic Services

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

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

Basic Dental Care Services

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

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

Major Dental Care Services

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

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

Orthodontic Care

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

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

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

Pre-Treatment Review

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

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

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

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

Dental Expense Timing

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

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

Extended Dental Benefits

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

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

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

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

PPO Exclusions and Limitations

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

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

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

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

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

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

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

How Do I File a Dental Claim?

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

The CIGNA claim form includes instructions on where and how to file a claim. Read your claim form carefully and make sure you answer all questions and include all required information and documentation.

Once you complete the form, attach all evidence to support your claim, including receipts, and file your claim directly with CIGNA as soon as possible after your treatment. You have 12 months from the date of service or treatment to file a claim for expenses incurred.

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

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

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

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

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

What is an EOB?

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

What if My Dental Claim is Denied?

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

Denial - Appeal

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

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

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

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

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

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

Notice of Benefit Determination on Appeal

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

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

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

Additional Resources — CIGNA

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

- Download a claim form
- Find claim status and detail

Customer Service: 1-800-542-4293

Remember...

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

Vision Plan

Vision Benefits At-a-Glance

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

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

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

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

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

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

How Does the Vision Plan Work?

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

For Questions Contact:

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

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

Remember...

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

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

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

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

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

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

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

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

Vision Network

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

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

Tip!

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

How the Process Works Using a VSP Preferred Provider

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

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

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

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

Using your Benefits Outside the VSP Network

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

Example 1 - the High Plan*:

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

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

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

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

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

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

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

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

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

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

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

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

VSP mails your allowance of $170 to your home address ($45 eye exam allowance and $125 contact lens allowance).

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

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

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

Example 2 - the Low Plan*:

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

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

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

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

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

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

- You make an appointment to see Dr. Green, knowing that non-network charges will apply.
- You must pay the total fee for service during your visit with Dr. Green – $352 ($152 eye exam; $200 contact lenses).
- You send your claim directly to VSP for processing (remember to make a copy for your records).
- VSP mails your allowance of $170 to your home address ($45 eye exam allowance and $105 contact lens allowance).

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

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

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

Vision Schedule of Benefits

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

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

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

You pay additional costs for the following:

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

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

Visually Necessary

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

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

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

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

Exclusions

No benefits are paid for services or materials connected with:

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

How Do I File a Vision Plan Claim?

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

If you use a provider outside the network, you must submit a claim to VSP for reimbursement. To file a claim, send VSP the following information:

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

Send your claim to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

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

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

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

What if My Vision Plan Claim is Denied?

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

Appealing a Denied Claim

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

Initial Appeal

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

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

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

Second Level Appeal

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

Remember...

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with Vision plan access or claim issues that you have not been able to resolve on your own. Call the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) for more information.

Other Remedies

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

Additional Resources

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

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

Coordination of Benefits for the Vision Plan

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

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

How Coordination Works

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

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

How to Determine if Your Baker Hughes Vision Plan is Primary

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

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

Flexible Spending Accounts

Flexible Spending Accounts At-a-Glance

Type of Plan	Voluntary H&W benefit (Flexible Spending Accounts)	
Who Pays the Cost	You pay the full cost of coverage. You can elect to have Baker Hughes set aside pre-tax money into Health Care or Dependent Care Flexible Spending Accounts based on your expected health care and dependent care costs.	
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees or • Benefits-eligible part-time employees	
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.	
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if they have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you participate in an FSA, you must actively change your contribution during Annual Enrollment or your contribution amount will default to $0.	
Contact	UnitedHealthcare: • **www.myuhc.com** • 1-866-743-6549	
	Health Care Flexible Spending Account	**Dependent Care Flexible Spending Account**
Eligible Dependents	See the Eligible Dependents chart in the *HCFSA* section	See the Eligible Dependents chart in the *DCFSA* section
Eligible Expenses	See the chart in the *Eligible Health Care Expenses* section	Qualifying expenses that allow you and your spouse, if any, to work, look for work, or attend school full time. For examples, see the *DCFSA* section and IRS Publication 503 at **www.irs.gov**.
Minimum Contribution	$60	$300
Maximum Contribution	$2,700	• $5,000 for single taxpayers and for married taxpayers filing a joint tax return* • $2,500 for married taxpayers filing separate returns*

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

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

Flexible Spending Accounts

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

There are two separate accounts:

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

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

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

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

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

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

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

Tax Savings with the Flexible Spending Accounts

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

Health Care Flexible Spending Account

What Can the Health Care FSA Do For You?

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

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

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

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

Eligible Dependents*

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

- Your Spouse
- Eligible dependents

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

Eligible Dependents	Qualifying Child	Qualifying Relative
Relationship to Employee	Examples include your: • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece The individual cannot be the qualifying child of any other person.	Examples include your: • Son/daughter • Grandchild • Stepchild • Nephew/niece • Brother/sister • Parent • Stepbrother/stepsister • Grandparent • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Residency Requirements	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico	Is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico
Age Requirement	• Younger than you, under age 27 at the end of the tax year, regardless of full-time student status OR • Any age if permanently and totally disabled	No requirement applicable
Support Requirement	Will not provide over half of his or her own support for the year	You will provide over half of the individual's support for the year.
Income Limitations	No limitation applicable for individual being claimed. If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	Will have gross income for the year less than $4,150
Joint Return Limitation	If married, will not file a joint federal income tax return with his or her spouse	If married, will not file a joint federal income tax return with his or her spouse

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

How the Health Care FSA Can Save You Money

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

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

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

Consider This...

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

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

How Much Should You Contribute?

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

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

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

Did you know…

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

Eligible Health Care Expenses

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

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

Medical

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

Vision

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

Hearing

- Hearing exams
- Hearing aids and repair
- Special equipment, training, and dogs for the deaf

Examples of Over-the-Counter (OTC) items that require a prescription to qualify for FSA purchase or reimbursement:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrheal medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine anti-fungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointment for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

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

If you buy the medicine off the shelf you will need to submit an FSA claim form, a copy of your receipt and your provider's prescription, for the medicine you purchased. The prescription must include:

- Your name
- Name of medicine
- Dosage and form
  - Quantity prescribed
  - Instructions
- Signature of the provider who wrote the prescription

If you ask a pharmacist to fill the prescription, you will need to submit an FSA claim form with your receipt. Ask for a receipt that includes:

- Prescription number
- Your name
- Date of purchase
- Dollar amount

For more information visit **www.healthcare.gov**, the federal government's health care reform website designed to help you understand the Health Care Reform law and how it will affect you. Or visit **www.irs.gov/publications/p502** for more detailed information about eligible expenses for reimbursement.

Ineligible Health Care Expenses

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

Health Care Flexible Spending Account	
• Bottled water • Cosmetic surgery (except for the correction of birth defects, accidental disfigurement, or reconstruction following mastectomy) • Cosmetics, toiletries, toothpaste • Custodial care in an institution, such as a nursing home • Electrolysis • Funeral, cremation, or burial expenses • Health club dues or exercise equipment • Household and domestic help • Items that are not medically necessary	• Licensed practical nurse (LPN) for the care of a healthy newborn • Marriage or family counseling • Maternity clothes and diaper services • Premiums for health, automobile, life, disability, or accident insurance • Social activities, such as dance lessons or classes • Special school tuition for a child with discipline or emotional problems • Uniforms • Vacation or travel taken for general health purposes • Weight loss and fitness programs for general health purposes (except in cases of morbid obesity)
Over-the-Counter	
• Bath products, cleansers, soap • Creams, lip balm, lipstick, lotions, moisturizers • Deodorants/antiperspirants • Feminine hygiene • Foot care products • Hair care products • Hair removal products	• Medicine dispensers • Powders • Shaving and grooming products • Snoring aids • Stimulants (to stay awake) • Sunscreen, sunless tanning, after-sun products

Uniformed Services Employment and Reemployment Rights Act

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

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Health Care FSA by notifying the Plan Administrator in advance and providing payment of any required contribution (i.e., contributions to the account) for the Health Care FSA. If an employee's Military Service is for a period of time of fewer than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the Health Care FSA.

An employee may continue Health Care FSA coverage under the USERRA for up to the lesser of:

- The 24 month period beginning on the date of the employee's absence from work, or
- The day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the Health Care FSA, if the employee returns to a position of employment, the employee's Health Care FSA will be reinstated.

You should call the Plan Administrator if you have questions about your rights to continue the Health Care FSA under the USERRA.

Dependent Care Flexible Spending Account

What Can the Dependent Care FSA Do For You?

The Dependent Care FSA allows you to pay for eligible expenses with pre-tax dollars so that you and your spouse (if any) can work or attend school full time. This account allows you to:

- Reduce the cost of eligible dependent care expenses (not health care expenses). The amount you save is determined by the amount of income tax and Social Security tax you do not have to pay.
- Help manage your dependent care expenses. Money must be in your account before you can be reimbursed. For example: If you have made contributions to your account totaling $300, you can be reimbursed only for up to $300 worth of eligible expenses.

Eligible Dependents*

Eligible Dependents	Spouse	Qualifying Child	Other Qualifying Person
Relationship to Employee	Your spouse	**Examples include your:** • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild 1 • Nephew/niece The individual cannot be the qualifying child of any other person.	**Examples include your:** • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece • Parent • Grandparent • Uncle/aunt • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Disability Criteria	Is physically or mentally not able to care for himself or herself	No disability criteria required	Is physically or mentally not able to care for himself or herself
Residency Requirement	Will live with you for more than half of the year	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico
Age Requirement	No requirement applicable	Is under the age of 13 when the care is provided	No requirement applicable
Support Requirement	No requirement applicable	If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	You will provide over half of the individual's support for the year.

*The information provided in the table above does not include all the requirements for a "qualifying individual" for federal income tax purposes. For more information on those requirements, see Sections 21 and 152 of the Internal Revenue Code and IRS Publications 503 and 501, which are available on the IRS website at **www.irs.gov**.

Eligible Dependent Care Expenses

The IRS provides information that can help you determine which dependent care expenses are eligible for reimbursement. For detailed information, see IRS Publication 503, which is available on the IRS website at **www.irs.gov**.

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

Dependent Care Flexible Spending Account

- A qualified day care center, nursery school, or summer day camp
- A housekeeper whose duties include day care
- Someone who cares for an elderly or incapacitated dependent
- A babysitter inside or outside your home
- A relative who cares for your dependents, as long as that relative is not one of your dependents for whom you can claim an exemption or one of your children under age 19

Remember, you'll need to provide a tax ID number or the Social Security Number of the care provider when you fill out your reimbursement request.

Ineligible Dependent Care Expenses

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

Dependent Care Flexible Spending Account

- Care provided by your children who are under the age of 19, or by anyone you claim as a dependent for federal income tax purposes
- Charges for the services of a care provider who has no Social Security or taxpayer identification number
- Child support payments
- Care for days not worked — including time off or holidays — or days when eligibility requirements are not met
- Education and food from first grade on
- Expenses for care received before you were covered by the Dependent Care FSA
- Food, clothing, education, transportation, or entertainment (food and education will be covered if provided by the nursery school or day care center as part of its preschool care services)
- Residential care, such as a nursing home
- Tuition or overnight camp

Important: If you do not use all of the money in your Dependent Care FSA by the end of the year, what is left in your account will be forfeited.

How Much Should You Contribute?

Estimate Your Dependent Care Expenses

If you have never used a Dependent Care FSA, estimate conservatively until you are comfortable with how it works. If you are newly eligible for benefits, or if you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).

Dependent Care FSA vs. Income Tax Credit

The payment method that is best for you depends on your individual situation. In some cases, using the Dependent Care FSA can save you more. In other cases, you may save more by taking a credit on your federal income tax return. To help you determine whether the Dependent Care FSA or the tax credit is better for your particular situation, you may want to consult a tax specialist, contact the IRS at **www.irs.gov**, or call **1-800-TAX-FORMS** and ask for Publication No. 503.

How Flexible Spending Accounts Work

Although the accounts cover different types of expenses, they generally operate in the same way:

1. When you're first hired or become eligible, and during each Annual Enrollment period, estimate your expected eligible expenses for health care and/or dependent care for the year for which you are enrolling in coverage. **You can enroll in one account or both, depending on your needs and your family's needs.**
2. Designate the amount you want to contribute.
3. The amount you choose to contribute is automatically deducted, in equal amounts, from your paychecks on a pre-tax basis throughout the year. Your contributions are then deposited into the FSAs that you select.
4. When you incur an eligible expense during the year, you file a claim form for reimbursement (eligible Baker Hughes medical and prescription drug expenses are automatically filed for you). A claim form is available online at **http://go/mybenefits** or **www.myuhc.com**. Refer to *Filing a Reimbursement Request* below for more information.
5. Reimbursement from your Flexible Spending Accounts is based on when the eligible expense was incurred rather than when the eligible expense was paid. Expenses must be incurred by December 31 of a calendar year to be reimbursed from the FSA for such year. Claims must be filed no later than March 31 of the following year.

Important: If you do not change the contribution amount during the next Annual Enrollment period, your contribution will automatically default $0.

Filing a Reimbursement Request

When you have eligible expenses of $25 or more, submit your claim using a UnitedHealthcare (UHC) FSA claim form and include supporting documentation (the provider's Explanation of Benefits [EOB] or detailed receipts) as proof of services rendered. Please ensure that the supporting documentation clearly indicates the applicable date or period for which the service was provided. Submit the claim form by fax or mail as instructed on the claim form or submit a claim using the online claim form. Claim forms are available at **www.myuhc.com** or the Baker Hughes Intranet at **http://go/mybenefits** or submit a claim using the online claim form. If you do not have access to the Internet, call UHC at **1-866-743-6549** to request a copy of the claim form.

You may file claims for reimbursement of covered expenses at any time during the year in which they are incurred and no later than March 31 of the following year. The expenses must have been incurred during the calendar year covered by the FSA.

Reimbursements are typically processed and paid via check within two to three weeks. If you prefer to receive reimbursements directly into your bank account, log on to **www.myuhc.com** and set up direct deposit.

Claim activity and account balance information will be provided in a monthly Health Statement, as well as in quarterly statements. You can access these statements, as well as Explanations of Benefits (EOB) for each processed claim at **www.myuhc.com**.

Changing Your Contribution Amounts

IRS regulations do not permit you to stop or change the amount you contribute to a Flexible Spending Account during the calendar year unless you meet one of the following conditions:

A. With regard to both a Health Care FSA and a Dependent Care FSA, one of the following changes in status events occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse, or dependent, including termination or commencement of employment, a strike or lockout, and the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the Health Care FSA or Dependent Care FSA.

B. For individuals who participate in the Health Care FSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your Health Care FSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
- If the Health Care FSA receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child, then the Health Care FSA Plan Administrator may change your election. The new election will provide coverage for that child if the order requires you to provide coverage for the child under the HCFSA, or permit you to cancel your child's coverage under the HCFSA, if the order requires your former spouse to provide coverage and that coverage is provided.

C. For individuals who participate in a Dependent Care FSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider, or
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Baker Hughes within 31 days of the above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code and, to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event and that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting.

Changes in contribution amounts made during the plan year are effective on the date that you notify Baker Hughes of the change in status.

Notification of Claims Decision

Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Plan Administrator will notify you of the plan's benefit determination within a reasonable time period, but not later than:

- Baker Hughes Company, LLC Health Care Flexible Spending Account Plan (the HCFSA plan): 30 days after receipt of the claim by the plan. The Plan Administrator may extend this period for up to 15 days, as long as the extension is necessary due to matters beyond the control of the HCFSA plan and the Plan Administrator notifies you in writing or electronically before the initial 30-day period expires.
- Baker Hughes Company, LLC Dependent Day Care Flexible Spending Account Plan: 90 days after receipt of the claim by the Dependent Care Flexible Spending Account plan. The Plan Administrator may extend this period for up to 90 days, as long as the extension is necessary due to matters beyond the control of the Dependent Care Flexible Spending Account plan and the Plan Administrator notifies you in writing or electronically before the initial 90-day period expires.

The notice to you will state the reason for the extension and the date by which the plan expects to provide a decision. If the extension is necessary because you failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. You then have 45 days from the date you receive the notice to provide the specified information.

UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final. The table below describes the time frames in an easy-to-read format that you and UnitedHealthcare are required to follow for the HCFSA plan.

Claim Denial and Appeals	
	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal the claim denial no later than:	180 days after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Manner and Content of Notification of Claims Decision

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

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the decision is based;
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse claims decision;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either: (1) a copy of such rule, guideline, protocol, or other criteria, or (2) a statement that a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request; and
- If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either: (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you upon request.

Remember...

If you enroll in a Baker Hughes Medical plan and contribute to a Health Care FSA, eligible medical and prescription drug claims processed by UnitedHealthcare and prescription drug claims processed by CVS/caremark will automatically be processed through the Health Care FSA. This saves you the time and paperwork associated with submitting a claim manually. If you prefer to process these types of claims manually, you can turn off the automatic claim initiation feature online at **www.myuhc.com** or by calling UHC at **1-866-743-6549**.

What if My Flexible Spending Account Claim is Denied?

If Your Claim is Denied

If you have a question or concern about a claim reimbursement determination, you may call a UnitedHealthcare customer service representative at 1-866-743-6549 to discuss, on an informal basis, your questions regarding the determination. You may also call the number on the back of your medical ID card. If the Flexible Spending Account customer service representative cannot resolve the issue to your satisfaction, you may request an appeal as described below. This procedure is voluntary. You are not required to call UnitedHealthcare customer service before filing a formal appeal.

- **Level One:** You, your eligible dependent, or authorized representative can appeal a denied FSA claim within 180 days after you receive notification of the claim denial. If you wish to request an appeal of a denied claim for reimbursement, you, your eligible dependent, or authorized representative must submit your appeal in writing to UnitedHealthcare at the following address:

  UnitedHealthcare
  FSA Appeals
  P. O. Box 981512
  El Paso, TX 79998-1178

  — Your appeal must include:
    - The patient's name and identification number (or Social Security Number);
    - A description of the claim determination that you are appealing;
    - The reason you believe your claim should be reimbursed; and
    - Any documentation or other written information to support your appeal.

A qualified individual who was not involved in the initial benefit decision being appealed will be designated to review the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

The Level One appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim.

- **Level Two:** If you are not satisfied with the Level One appeal decision, you have the right to request a second level of appeal from Baker Hughes. Your Level Two appeal request must be submitted in writing within 60 days from receipt of the Level One appeal decision to Baker Hughes at the following address:

  Baker Hughes Company, LLC
  Attn: Total Rewards H&W Department — Appeals
  17021 Aldine Westfield Road
  Houston, TX 77073

The Level Two appeal will be conducted, and you will be notified by Baker Hughes of the decision in writing within 30 days from receipt of a request for a Level Two appeal.

Baker Hughes has the exclusive right to interpret and the discretionary authority to administer the FSA plans, and these decisions are conclusive and binding.

Notice of Benefit Decision on Appeal

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

1. Specific reasons for denial;
2. Reference to the specific plan provisions on which the decision is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information, including any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment, or other similar exclusion or limit; and
4. A statement describing your right to bring civil action in court under Section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate legal action for benefits until you have completed the Level One and Level Two appeal processes.

Any other questions about the process for requesting a review should be addressed to UnitedHealthcare at **1-866-743-6549**.

IRS Rules and Other Limitations

Federal tax law restricts your Flexible Spending Account in several important ways:

- **No transfers.** Once you designate amounts for your Health Care and Dependent Care FSAs, you may not move money between those accounts. For example, suppose you designate $400 to each account for the year (total of $800) and you actually spend $200 for health care and $600 for dependent care. The $200 of health care expenses would be reimbursed from your Health Care FSA. You could receive reimbursement for only $400 of the dependent care expenses from your Dependent Care FSA. The other $200 of dependent care expenses would not be reimbursed, and the remaining $200 in your Health Care FSA would be forfeited after the end of the calendar year.
- **Forfeitures.** If you do not incur eligible expenses during the calendar year for all of the money in your account (and file reimbursement claims for all of the money in your account by March 31 of the following year), you'll lose any money left over in your account. This means that careful planning is important in determining the amount you want to put into each account.
- **Changes.** You cannot stop, increase, or decrease your Flexible Spending Account contributions until the next Annual Enrollment period, except in certain situations involving a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).

Dependent Care Flexible Spending Account

If you're single, you can use your Dependent Care FSA to care for a dependent while you work. If you're married, you can use the account if the expenses are to care for a dependent while you work and:

- To enable your spouse to work, or look for work;
- To enable your spouse to study as a full-time student for at least five calendar months during the year; or
- To provide care for your dependents if your spouse is incapable of self-care.

Note: If you're a highly compensated employee, your contributions to the accounts may be reduced or suspended.

What if I Go On a Leave of Absence?

Refer to the *Leave of Absence* section in this SPD for details.

When Coverage Ends

Your coverage ends on the date your employment with Baker Hughes terminates. If you leave Baker Hughes, you'll have until March 31 of the following year to submit claims for reimbursement. Your claims must be for qualifying expenses incurred through your date of termination of employment.

If you terminate employment and would like to continue participating in the HCFSA plan, you and your covered dependents may be eligible to continue participating as authorized by COBRA. This coverage can continue for the remainder of the year in which you terminate if the amounts you must pay to continue coverage are less than the remaining benefits you can receive under the HCFSA plan. However, contributions for continuation of coverage will be on an after-tax basis and include a 2% administrator fee. Participation in a Health Care FSA cannot continue past the end of the year in which your employment terminates.

If you do not elect to continue participation under COBRA coverage, only claims incurred through your date of termination of employment can be submitted for reimbursement.

Note: You cannot continue participation in the plan Dependent Care FSA under COBRA.

Remember...

In order to give Flexible Spending Accounts their tax-free status, the IRS provides guidance to help you determine which health care and dependent care expenses are eligible. Eligible expenses for a calendar year must be incurred by December 31 of that year and claims must be filed no later than March 31 of the following year.

Things To Consider

Health Care Flexible Spending Account	Dependent Care Flexible Spending Account
• If you contributed to a Health Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount. In addition, please remember that contributions in 2020 will be limited to $2,700. • It might be helpful to review your health care expenses in recent years. Do you have recurring, predictable expenses? Also consider any anticipated changes that might affect your out-of-pocket expenses next year, such as a new baby. • If you're changing your medical and/or dental coverage, consider how this will affect your out-of-pocket expenses such as the deductibles, coinsurance, and out-of-pocket maximums — all of which are eligible for reimbursement under the account. • If you're enrolled in a Health Savings Account (HSA), you are not eligible to participate in a Health Care FSA.	• If you contributed to a Dependent Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount. • What dependent care expenses do you expect to have during the next calendar year? • Do you have any dependents becoming ineligible this year (for example, turning age 13)? • Will your dependent care expenses change during the summer months and holidays?

Note:

- If you claim health care expenses for reimbursement under your Health Care Flexible Spending Account, you cannot claim them as itemized deductions on your federal tax return.
- Because you pay no Social Security taxes on the amounts set aside in your account, participating in the account may slightly reduce future Social Security benefits. In most cases, the tax savings from participating should be greater than any loss of Social Security benefits.

Important: Because of the tax advantages provided by these accounts, they're subject to certain Internal Revenue Code and regulation limitations. It is important to plan carefully. If you do not use all of the FSA money during the year, the Internal Revenue Code and regulation requires you to forfeit the balance in your account. You cannot carry over a credit to the next year for money left in your account at the end of the year, you cannot transfer balances between the two accounts, nor can that money be refunded to you. Focus on predictable amounts of expenses when determining if this will work for you.

Additional Resources

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

- Track a claim online or access your claims history
- Locate a list of eligible expenses
- Estimate annual expenses using the FSA calculator
- Download a claim form
- Sign up for Electronic Funds Transfer/Direct Deposit
- Find more information about how FSA plans work

Customer Service: 1-866-743-6549

Health Savings Account

Health Savings Account At-a-Glance

Type of Plan	Voluntary H&W benefit (Health Savings Account)
Who Pays the Cost	You contribute to this account on a pre-tax basis, and then you can use the HSA to pay for qualified medical expenses incurred by you and your covered tax dependents. You control your HSA funds and decide whether to use them for current medical expenses or to save your HSA funds for the future. **Note: An employee does not have to provide coverage for a dependent under a Baker Hughes Medical plan to use the HSA dollars for a dependent's qualifying medical expenses. The dependent only needs to be a qualifying tax dependent.**
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees or benefits-eligible part-time employees, and • Enrolled in the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option Individuals are eligible to contribute to an HSA if: • They are covered by the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option • They or their spouse are not contributing to or covered by a Health Care Flexible Spending Account (FSA), even if the spouse is covered under his or her own plan • They are not covered by another health plan including a Health Care Flexible Spending Account • They are not enrolled in Medicare or TRICARE and have not received Department of Veteran Affairs benefits in the preceding three months • They cannot be claimed as a dependent on another taxpayer's tax return
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits and electing the applicable Medical plan within 31 days. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). You will need to re-elect your HSA contribution amount at each Annual Enrollment period or your contribution amount will default to $0.
Minimum Contribution	N/A
Maximum Contribution*	• $3,550 for You Only • $7,100 for You + Spouse • $7,100 for You + Children • $7,100 for You + Family If you are age 55 or older, special catch-up contributions will allow you to contribute an extra $1,000 in 2020.
Contact	• UnitedHealthcare via **www.myuhc.com** or at **1-866-743-6549** • Optum Bank via **www.optumbank.com** or at **1-800-791-9361**

*The maximum contribution amounts listed here include the Baker Hughes contribution, if applicable (see below).

Employer contribution

When you elect to enroll in one of the Baker Hughes high deductible health plans (Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area Plan), Baker Hughes will automatically deposit an employer contribution into your HSA ($500 if you elect Individual coverage, $750 if you elect You + Spouse or You + Children, or $1,000 if you elect Family coverage). This contribution is subject to review and change in future years.

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

Benefits of an HSA

An HSA works with your high deductible health plan to help you plan, save and pay for medical care.

HSAs offer triple tax savings:*

- The money you put in is not included in your taxable income for federal income tax purposes up to the limit allowed by the Internal Revenue Code.
- Your savings grow tax-free.
- Any money you take out to pay for qualified medical expenses is not included in your taxable income for federal income tax purposes.
- An HSA is like no other savings account. With an HSA, **you are in charge**. You decide:
- How much you will contribute to your account (subject to certain limits imposed by the Internal Revenue Code);
- When you want to use your savings to pay for or reimburse yourself for qualified medical expenses;
- What bank will administer your account (if it is a new account, through your employment with Baker Hughes, the HSA will be set up with Optum Bank); and
- Whether or not to invest some of your savings in mutual funds for greater potential long-term growth.

The money in your HSA is always yours — there is no "use it or lose it" rule. All amounts in your HSA belong to you, and the unspent balance remains in your account until spent. Your account is portable and will not be forfeited even if you:

- Change jobs
- Change medical coverage
- Become unemployed
- Move to another state
- Get married or divorced

*State tax treatment of HSAs varies. Go to www.myuhc.com or consult your state's department of revenue to find out more.

Will a Health Savings Account Work For You?

You are eligible to participate in the HSA if:

- You are enrolled in the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option;
- You and your spouse are **NOT** contributing to a Health Care Flexible Spending Account (FSA);
- You are **NOT** covered by another health plan including a Health Care Flexible Spending Account;
- You are **NOT** enrolled in Medicare or TRICARE. Veterans with a service-related disability are now permitted to enroll in the HDHP (with no other disqualifying coverage) and make or receive HSA contributions regardless of when they received Veterans Affairs benefits; and
- You can **NOT** be claimed as a dependent on another taxpayer's tax return.

Similar to the FSA, each year at Annual Enrollment you elect the amount you want to contribute to the HSA. If you do not change your election during Annual Enrollment, your contribution will default to $0. Once you elect the amount to contribute, deductions will be taken from your paycheck on a pre-tax basis.

See the following chart for a comparison of Flexible Spending Accounts versus Health Savings Accounts.

	Health Care Flexible Spending Accounts	Health Savings Accounts
Pre-Tax	Yes	
Tax-Free Interest	No	Yes
Expense Types	Most qualified medical care expenses	
Availability of funds in the account	Available on day one	Funds must accumulate before available for use
Forfeit at the end of the year	Yes	No, accumulated amounts roll over from year to year
Portable	No	Yes

You can use your HSA funds to pay for qualified medical expenses, even if an expense is not covered by your health plan. For example, few health plans cover the cost of acupuncture, but HSAs can. Your HSA dollars also apply not only to you, but also to your spouse and dependents, even if they are not covered by your high deductible health plan.

A list of qualified medical expenses is provided by the IRS, and it includes a wide range of dental, vision and medical expenses. You should become familiar with the list and consult it as needed to determine if an expense can be paid for with your HSA. Some covered eligible expenses include:

- Deductibles and coinsurance under the Medical, Prescription Drug, and Dental Plans;
- Vision care expenses, such as eye exams, glasses, contacts, and laser eye surgery;
- Hearing care expenses, including exams and necessary hearing aids; and
- Certain over-the-counter medication and drugs that have been prescribed by your physician or other provider that are purchased for medical care, including those used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Visit **www.irs.gov/publications/p502** for more detailed information about eligible expenses for reimbursement.

Generally, you cannot use your HSA to pay for health insurance premiums, but there are exceptions. You may use your HSA to pay for:

- Individual Long-Term Care insurance policies;
- COBRA coverage;
- Health plan coverage while receiving unemployment benefits; and
- If age 65 or older, any health insurance except a Medicare supplement policy (A-J), such as Medigap coverage.

Visit **www.irs.gov/publications/p969** for detailed IRS information about HSAs.

If You Participate in a Health Care FSA

You have the option to participate in the HSA or the Health Care Flexible Spending Account (FSA), but you cannot participate in both accounts due to limitations imposed by the Internal Revenue Code. If you elected to participate in the Health Care FSA at the beginning of the year, you cannot contribute to the HSA at any point during that plan year.

The Dependent Care FSA is provided under a separate plan from the Health Care FSA. You may be eligible to make contributions to the Dependent Care FSA whether or not you choose to participate in the HSA or Health Care Flexible Spending Account.

Fees

Baker Hughes pays the HSA set-up fee and monthly service fees for each participating employee for HSAs administered by Optum Bank. If you are not enrolled in the Medical plan but still maintain a balance in your HSA, you will be responsible for the $3 monthly service fee associated with the Optum Bank account. This fee will be automatically deducted from your account each month. These fees cover a debit card and a monthly statement at no additional cost. The debit card can be used at merchant locations, with no transaction charge, for eligible purchases up to your available account balance. ATM cash withdrawals using your card, to reimburse yourself for eligible expenses, are subject to a fee of $1.50 per transaction (plus any fees that may be imposed by the owner of the ATM). For more information on the other fees associated with the account, contact Optum Bank, the administrator of the HSA.

Note: In order to contribute pre-tax dollars through Baker Hughes to your Health Savings Account, you must be enrolled in one of the Baker Hughes high deductible health plans (Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option), however, you can make contributions to any other HSA you have up to the allowable maximum contribution.

Additional Resources

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

Online banking through Optum Bank is accessible 24/7 and includes:

- Account balances and transaction history
- Interest rate and payment information
- Beneficiary information
- Contribution maximum
- Account statements
- Download the Optum Bank mobile app

Customer Service: 1-866-743-6549

Using the HSA

Although the accounts cover different types of expenses, they generally operate in the same way:

1. Once your account is open and deposits have been made to your account, you can start using your HSA. You are 100% vested and have total control over the funds in your account as soon as they are deposited. You decide whether to spend your HSA funds for current medical expenses or to pay the cost of those expenses out-of-pocket so you can save your HSA money for the future.

2. Your funds will earn tax-free interest. The interest rates are set by Optum Bank and are subject to change by Optum Bank without notice. Once your account balance reaches $2,000, you will have the option to invest your HSA funds into different investment fund choices. Further information on these funds is available from Optum Bank.

3. When you incur an eligible medical expense, (reference the *Medical* section for information on how the Premium HSA, Premium HSA Out-of-Area, Basic HSA, and Basic HSA Out-of-Area options work), you can, depending on your balance, use:
   - Your Health Savings Account MasterCard Debit CardSM at a doctor's office, pharmacy, or health care facility that accepts MasterCard debit cards to pay for care at the time of service. **However, you cannot spend the funds before they are deposited into the account**. If you do not have the full amount to cover your expense in the account, you can pay for the expense out-of-pocket and reimburse yourself at a later date.
   - Your Health Savings Account MasterCard Debit CardSM at any ATM displaying the MasterCard logo. There are fees imposed by Optum Bank on reimbursements made by using an ATM withdrawal.
   - Online bill payment at **www.myuhc.com**.
   - Payments can also be made using HSA dollars from the UHC mobile app and the Optum Bank mobile app.
4. You have access to online monthly statements at **www.myuhc.com** to track your account balance and activity. If you prefer to have statements mailed to your home, notify Optum Bank. You can opt out of electronic statements at **www.myuhc.com** or by calling Customer Service at **1-866-743-6549**.

5. At the end of every year, any unused amounts in the HSA will automatically roll over for use in the next year. In the event you terminate employment with Baker Hughes, you may take your HSA with you from employer to employer or roll into another individual HSA.

6. Keep in mind that you must be able to substantiate your medical expenses if asked by the IRS. UHC and Optum do not require any substantiation (claims or receipts) to use your HSA dollars. If you are using your HSA funds, keep your receipts in case you need to substantiate the expense later. If you withdraw funds from your HSA for reasons other than eligible medical expenses, you will have to include that amount as taxable income and pay a 20% additional tax on that amount.

Contribution Limits

	Health Savings Accounts (HSAs)	
Minimum Contribution	N/A	
Maximum Contribution (includes Baker Hughes contribution)	• $3,550 for You Only • $7,100 for You + Spouse	• $7,100 for You + Children • $7,100 for You + Family

- Your annual HSA contribution cannot exceed the maximum contribution listed above unless you are age 55 or older and making "catch-up" contributions. However, individuals who enroll during the year (after January) and remain eligible to make contributions on December 1 of that same year may contribute the full annual contribution limit allowed for that year. Individuals who make contributions under this provision must remain eligible for the 12 months following the end of the year. Otherwise, your contributions will be included as income and subject to a 10% penalty.
- Individuals 55 and older can make additional catch-up contributions until they enroll in Medicare. Catch-up contributions will allow you to contribute an extra $1,000 in 2020. You will be entitled to take an above-the-line tax deduction for the year on these payments. **You cannot contribute to an HSA if you are enrolled in Medicare (including Part A)**.
- If you have contributed an amount into your HSA that exceeds your maximum allowable contribution for the year, you may withdraw the excess amount and any earnings on the excess amount prior to the due date, including extensions, of your tax return for the year the contribution was made (which is generally the following year). There is no additional tax or other penalty on withdrawals of excess contributions that are made in a timely manner. However, you must pay income tax on your excess contributions and income tax on any earnings on the excess contribution.
- If you do not withdraw the excess contribution to your HSA in a timely manner, you must pay a 6% excise tax on the excess contribution and on any earnings on the excess contribution. If in the next year you decreased your maximum contribution by the amount of your excess contribution made the year before, you do not have to pay the 6% excise tax again. If, however, you leave the excess contribution in, and do not decrease your maximum contribution by the amount of your excess contribution made the year before, you will have to pay the 6% excise tax each year the excess contributions and earnings remain in the HSA.

Health Savings Account Funding Rules

When considering your annual contribution amount, keep in mind the Employer contribution is included in the annual plan maximum. If you are enrolled in the Premium HSA or Premium HSA Out-of-Area Plan and elect to participate in the Health Savings Account, Baker Hughes will provide an annual lump sum contribution to your Health Savings Account ($500 if you elect Individual coverage, $750 if you elect You + Spouse or You + Children, or $1,000 if you elect Family coverage). If you enroll in the Basic HSA or Basic HSA Out-of-Area option, you will not receive a Baker Hughes contribution.

- The employer-funded contribution will be applied as soon as administratively possible at the start of a new plan year. Employees must be Active when the employer-funded contribution is processed in order to be eligible to receive a contribution. If the Company does not receive an account number from Optum Bank before the final paycheck of the year, the employee will not be eligible to receive the employer contribution.*
- If your employment terminates, the funds in your HSA, including the employer contribution, will continue to be owned and controlled by you. If you are rehired during the same plan year, you will not be eligible for additional employer funding upon reinstatement of your employment.
- If you are hired after January 1 of the current plan year, the annual employer-funded contribution will be prorated based on your date of hire.

*The company reserves the right to discontinue employer-funded contributions to the Health Savings Account or change the funding rules at any time.

Eligible Expenses

In order to allow HSAs to retain their tax-free status, the IRS determines which medical care expenses are eligible. It is very important that you save all of your medical care receipts and records of withdrawals from your HSA for tax reporting to the IRS. Please refer to the charts in the *Flexible Spending Account* section for some examples of eligible, reimbursable medical care expenses. Consider using the Receipt Vault on **www.OptumBank.com** or on the Optum Bank Mobile App.

Ineligible Expenses

Any funds you withdraw from your HSA that are not used for qualified medical expenses will be subject to federal income tax at your income tax rate plus an additional tax of 20%. You should save all of your receipts and records of withdrawals for tax reporting to the IRS. If you use your funds for non-qualifying expenses, you must report those withdrawals accordingly. You are responsible for maintaining all records associated with your HSA — neither Baker Hughes nor Optum Bank are responsible for documenting how you use the amounts that are distributed from your HSA.

Withdrawals that were made for what you reasonably thought were qualified medical expenses, but turned out not to be, may be eligible to be returned to the HSA on or before April 15th following the year in which you mistakenly withdrew the funds. Contact Optum Bank for more information.

Please refer to the chart in the *Flexible Spending Account* section for some examples of expenses the IRS considers ineligible for reimbursement.

Important: Be sure to keep your receipts and medical records. You are responsible for saving receipts and keeping track of all expenses paid from your HSA funds, in case you need to prove to the IRS that distributions from the HSA were for qualified medical expenses.

If these records verify that you paid qualified medical expenses using your HSA, you are not required to include the amounts withdrawn to pay such expenses in your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified medical expenses, you may need to report the distribution as taxable income on your tax return. Baker Hughes and UnitedHealthcare will not verify that distributions from your HSA are for qualified medical expenses.

The IRS will likely request receipts during a tax audit. Baker Hughes, Optum Bank, UnitedHealthcare, and the Claims Administrator are not responsible or liable for the misuse of HSA funds or for the use of HSA funds for non-qualified medical expenses.

You can download an expense tracking worksheet through **www.myuhc.com** to help you maintain your records or you may use your own money management software. Consider using the Receipt Vault on **www.OptumBank.com** or on the Optum Bank Mobile App. If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and possibly an additional 20% tax. Consult your tax advisor to determine how your HSA is impacted by your unique tax situation.

What if I Go on a Leave of Absence?

If you go on an unpaid leave of absence, HSA deductions will cease. However, if you continue to be covered under the Premium HSA, Premium HSA Out-of-Area, Basic HSA, or Basic HSA Out-of-Area option, you can continue to make contributions to your HSA by sending in contributions directly to Optum Bank. Contact Optum Bank directly by calling **1-866-743-6549**. Upon return from an unpaid leave, contact the Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) to arrange for your contributions to resume.

Note: If you are on an unpaid leave in January when the employer seed amount is applied, your account will not receive the employer seed. Upon your return to an actively at work status, the employer seed will be applied and prorated based on your date of return.

When Coverage Ends

If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the high deductible health plan in which you were enrolled. You can use HSA funds on a tax-free basis for qualifying medical expenses incurred AFTER the establishment of your HSA, as long as these expenses are not paid or reimbursed through another health plan.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are received by you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the Medical plan and COBRA premiums while COBRA coverage is in effect.

Special Section for Legacy GE Oil & Gas Employees

Limited Purpose HRA

For certain Legacy GE Oil & Gas Employees, a Limited Purpose HRA is funded by your employer. The limited purpose HRA only covers out-of-pocket costs for certain eligible vision and dental services in accordance with the requirement of Section 213(d) for the Internal Revenue Code.

The Limited Purpose HRA will be offered to GE Oil & Gas (GEOG) employees who have an HRA balance greater than or equal to $10 with GE as of June 30, 2019. In order to access these funds, the employee must have enrolled in the Baker Hughes Dental or Vision plan during the Annual Enrollment period for the 2019 plan year or he or she will forfeit the funds. All funds will be made available to GEOG employees who meet the criteria in August 2019. The funds in your Limited Purpose HRA will be available through December 31, 2020, to pay for eligible Dental and/or Vision plan expenses, if you remain enrolled in a Baker Hughes Dental or Vision Plan.

Filing a Reimbursement Request

You will submit your dental and/or vision claims on **myuhc.com** for reimbursement from your Limited Purpose HRA. You can receive your reimbursement either by check or by setting up direct deposit into your personal bank account. Direct deposit reimbursements take about 2 to 3 days to receive after your claim has been processed. Check reimbursements take about 7 to 10 days to receive after your claim has been processed. Please note that check and EFT reimbursement must be a minimum of $25 threshold is not met within 30 days, the funds will release according to the method the member that requested set up when submitting the claim. Go to **myuhc.com** for more information about setting up direct deposit. If you do not have access to the Internet, call UHC at **1-866-743-6549** to request a copy of the claim form. You may submit a request for reimbursement for any dental or vision claims incurred from January 1, 2019, through December 31, 2020, as long as you remain enrolled in a Baker Hughes Dental and/or Vision plan.

Employee Assistance Program

EAP At-a-Glance

Type of Plan	Voluntary Health & Welfare program
Who Pays the Cost	EAP benefits are paid by Baker Hughes and are free to all eligible employees
Employee Eligibility	All eligible employees, their dependents, and household members*
When Coverage Begins	Coverage begins on your date of hire or date of transfer
Enrollment Period	No enrollment necessary
Plan Information	Confidential counseling, legal, and financial consultation, and referrals to help you respond to personal issues or concerns
Benefits	• In person (face-to-face) counseling with a provider in your area (up to five sessions per issue or concern, per year) • 24-hour, seven days a week crisis counseling, consultation, and referral services • Nationwide community resource referral • Legal and financial consultation services
Contact	• Online at **www.liveandworkwell.com** and enter the access code "Baker Hughes" • Speak to experts at **1-855-409-7074** (24 hours a day, seven days a week) • Baker Hughes Benefits website: **BakerHughesBenefits.com** • The Baker Hughes Benefits Center at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

*Household member is defined as an individual who physically resides in the household of an employee on a permanent basis, or an eligible dependent of an employee, whether or not residing with the employee.

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

How the EAP Works

The Baker Hughes Employee Assistance Program will provide you or your household member with a maximum of five in-person or phone counseling sessions per problem, per year, per member, for assessment and referral or short-term problem-solving. The EAP may refer you for outside counseling or treatment services if you need longer-term counseling, a higher level of care or a specialist. Should this occur, and you are covered under the Medical plan, you may have additional mental health and substance abuse benefits available to you through the Medical plan.

Additional Resources

Via Internet: **www.liveandworkwell.com** and enter the access code "BakerHughes"

- Learn about available services and programs
- Find information and tools to help with life's challenges
- Get a referral to see a counselor

Customer Service: 1-855-409-7074

How to Use the EAP

1. Log on to Optum's website at **www.liveandworkwell.com** and enter the access code "BakerHughes".

2. Call Optum's dedicated, confidential, toll-free line at **1-855-409-7074**, 24 hours a day, seven days a week.

3. Download the App "myLiveandworkwell" available in the Apple Store and Android Play.

If you are referred for outside counseling or treatment services and you are not a participant in the Medical Program, then there is no further benefit available. This is significant because outside counseling is not included in the EAP. Subsequent mental health benefits not covered by the EAP may be available if you are enrolled in a Medical plan option.

The EAP can assist you and your household members with stress, depression, parenting issues, relationship problems, and substance abuse. You may contact the EAP for a recurring or new situation at any time, as long as the eligibility criteria are met.

Services provided to help you or your household member are:

- Face-to-face counseling;
- Online self-assessment and personal plan programs, such as resource locators, financial calculators, private online consultations, or articles on topics such as self-improvement and approaches to personal problems;
- Telephone counseling; and
- Unique online service site (www.liveandworkwell.com); through this website, you will access convenience services such as personalized research and referrals for:
  - — Cleaning and domestic help;
  - — Home improvement and repair;
  - — Car maintenance and repair; and
  - — Fitness and recreation opportunities near you.

Examples of some personal problems addressed are:

- Adult/elder care services;
- Alcohol or drug abuse;
- Cautions on prescriptions;
- Child care and elder care resource referrals including Solutions for Caregivers;
- Education and schooling;
- Emotional problems;
- Family difficulties;
- Financial issues;
- Financial pressures;
- Grief, depression, and stress issues;
- Health and medical information;
- Information about self-care and illness/disease prevention;
- Legal problems;
- Marital difficulties;
- Minor medical emergencies;
- Parental difficulties;
- Personal legal;
- Personal safety and violence issues; and
- Separation or divorce.

You don't have to pay any fees for the phone counseling services, and these services are unlimited. A team of EAP professionals including masters-level counselors is available to speak with you 24 hours a day, 365 days a year. These professionals will answer your questions, listen to your concerns, and help you identify and work toward resolving the problem. In addition to helping you over the phone, the counselor may refer you to other resources in your community, such as professional, legal and/or financial consultation in addition to resources specific to elder/child care needs, when appropriate. The counselor may follow up with you to make sure you received the help you needed.

Employee Assistance Program Additional Services

Whether you or an eligible family member is facing a difficult personal problem, a stressful work environment, or a serious concern such as depression, the EAP is there to offer assistance. In addition to the five free counseling sessions described under How the Program Works, you can receive resources and referrals for a variety of other services. Additional EAP services include:

- Consultation and qualified resource referrals for child care, elderly parent care, disabled dependent care;
- Telephonic financial consultation; up to 60-minutes per separate issue
- Family mediation service providers for a free 30-minute telephonic or face to face consultation and referrals to local mediators whose services are available at a 25% discount;
- Self-help support groups for issues such as depression and alcohol, drug, or food abuse;
- Community financial assistance with debt management and budget planning; and
- Legal services, including a referral to a lawyer for either a 30-minute telephonic or face-to-face consultation. Additional legal services are available at a 25% discount.

Program Costs

The EAP is currently provided at no cost to employees. However, Baker Hughes reserves the right to institute an arrangement by which employees will share in or pay a portion of the cost of this benefit. All costs of administering the EAP will be paid out of general assets of the Baker Hughes and shall be entirely unfunded.

When Coverage Ends

You and your eligible family members may use the EAP while you are employed by Baker Hughes. Coverage under this Program continues while you are on a family, medical, military, or personal leave. Coverage under the EAP ends on the last day of the month in which your employment with Baker Hughes terminates, but may be continued under COBRA. In the event that your position at Baker Hughes is eliminated, coverage will continue in accordance with Baker Hughes' severance policy in effect at the time of job elimination.

Protection

Protection benefits provide financial protection for you and your family in the event of an accident, disability, or death.

These benefit plans include:

- Short-Term Disability
- Long-Term Disability
- Basic Life Insurance
- Supplemental Life Insurance
- Basic Accidental Death & Dismemberment Insurance
- Voluntary Accidental Death & Dismemberment Insurance
- Business Travel Accident Insurance Plan
- Legal Plan
- Critical Illness Plan
- Accident Protection Plan

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

Designate a Beneficiary for your Protection Benefits.

You need to designate one or more beneficiaries for the following benefits:

- Basic Life Insurance
- Basic AD&D Insurance
- Supplemental Life Insurance
- Voluntary AD&D Insurance

Make sure you have the birth date and Social Security Numbers of your beneficiaries. If you don't designate a beneficiary, the benefit will be paid according to the terms and conditions of the plan.

You can designate a beneficiary online or via the telephone.

Via Internet: go to **BakerHughesBenefits.com**

Via Telephone: **1-866-244-3539**

It's a good idea to review your beneficiary information from time to time. If you have a qualified change in status, you may want to re-evaluate or update your beneficiary information.

Baker Hughes

Short-Term Disability

Short-Term Disability At-a-Glance

Type of Plan	Payroll practice that provides income replacement if an employee becomes disabled because of outpatient surgery, hospitalization, or is unable to work due to illness, pregnancy, the birth of a child (based on type of birth), or injury
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Short-Term Disability coverage
Employee Eligibility	Active Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary.
Coverage	100% of benefits base pay weeks 1 up to 8 weeks and 75% weeks 9 up to 26 weeks, or terms of a union agreement, if applicable. Pay is based on a 5 day, 40-hour week and clinical determination made by Sedgwick.
Elimination Period	Benefits begin on the first day of disability due to outpatient surgery, the birth of a child or hospitalization, or after seven consecutive calendar days for illness, pregnancy complications, or injury. **Note: The elimination period can be satisfied with partial and/or total days of disability.**
Contact	• To initiate a claim: Call Sedgwick at **1-877-423-8677** or go online at **www.claimlookup.com** (enter **Client Number** 8504) • Baker Hughes Benefits Website: **BakerHughesbenefits.com** • For medical or financial benefit questions, contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

What is Short-Term Disability?

Baker Hughes Short-Term Disability (STD), administered by Sedgwick, allows you to continue to receive a percentage of your benefits base pay when you're unable to work as a result of an illness or injury that occurs either on or off the job. Short-Term Disability also pays benefits when you're unable to work as a result of pregnancy or illness. If you're eligible, Baker Hughes will automatically enroll you for coverage, and your coverage will begin on your first day actively at work. This benefit does not cost you anything; Baker Hughes pays the full cost of the STD premium.

Definition: For STD, Disabled or Disability means for STD that either:

- You're prevented from performing the material and substantial duties of your regular occupation and you aren't working in any occupation that you are qualified to do based on your level of education, training, or experience,

OR

- You're working, but due to injury or sickness, you are unable to earn more than 80% of your regular pay in any occupation for which you are qualified based on your level of education, training, or experience.

To be eligible for STD under the Baker Hughes plan, you must be under the regular care of a physician. Your physician must be someone other than you or a family member, and his or her specialty or expertise must be appropriate to treat your disability.

If you remain approved for disability benefits for more than 26 weeks (the 26-week elimination period equals 180 days total), Sedgwick may assist you in transitioning to Long-Term Disability coverage with Prudential, if eligible. See the *Long-Term Disability Plan* section for more information.

What is the Employee's Cost of Short-Term Disability?

You do not contribute anything to receive STD coverage. Baker Hughes pays 100% of the cost of the benefit.

When Does Coverage Start?

Baker Hughes provides you with STD coverage on the first day you report to work. No enrollment is necessary.

The elimination period begins on the day you become disabled. The elimination period is a period of continuous disability which must be satisfied before you begin receiving STD benefit payments. The elimination period can be satisfied with both partial and/or total days of disability. By request, you may use Personal Illness/Personal Business (PIPB) or vacation time during this period. Exempt employees will be paid during the elimination period under the permissive approach to paid time off once the STD claim has been approved.

If your disability is a result of a hospitalization, the birth of a child, or outpatient surgery, payment of the STD benefit begins on the day that you are admitted into the hospital or outpatient facility. If your disability is a result of illness, pregnancy complications, or injury, STD benefit payments will begin after seven consecutive calendar days.

Definition: Elimination Period means a period of continuous disability that must be satisfied before you will begin to receive disability benefit payments. Your elimination period begins the day you become disabled. You will not be paid STD during the Elimination Period. However, PIPB for up to 26 weeks, and/or vacation days may be requested and used concurrently during the Elimination Period. If your inactive status continues beyond 26 weeks of STD, you will be direct billed for benefit continuation. If your inactive status continues beyond 26 weeks of STD, you will be direct billed for benefit continuation.

Although coverage begins on the first day you report to work, in order to receive STD, you must initiate a claim with Sedgwick and your physician must complete the required paperwork necessary to determine approval. The paperwork must be submitted to Sedgwick on or before the medical due date provided to you on the date you initiated your claim.

STD Schedule of Benefits

Minimum benefit payment:	None
Amount of benefit:	100% of benefits base pay for weeks 1 up to 8 75% of benefits base pay for weeks 9 up to 26 (Based on clinical review by Sedgwick)
Elimination period:	None for hospitalization, the birth of a child, or outpatient surgery 7 days for illness, pregnancy, complications, or injury
Maximum period of coverage:	Based on the clinical determination made by Sedgwick up to 26 weeks (the 26-week elimination period equals 180 days total), or the date you are no longer disabled, whichever is earlier

Note: Your Short-Term Disability benefits may be reduced by other disability income benefits. See below for an explanation of other disability income benefits. Additionally, the duration of your Short-Term Disability benefits is determined by Sedgwick's clinical review. See below for an explanation of other disability income benefits.

All STD benefit payments are taxed as ordinary income. Deductions normally taken from your paycheck will continue to be deducted from your STD benefit payments. If your STD benefit payment is not enough to cover the entire cost of your benefit deductions, you will be direct-billed by the Baker Hughes Benefits Center.

Other Disability Income Benefits

Your STD benefit payments will be reduced (offset) by other disability income benefits you're eligible to receive, such as:

- State disability benefits;
- Social Security disability benefits for either you or your dependents;
- State-mandated paid family leave regulations;
- Workers' Compensation benefits; and
- Damages for loss of income that you recover from a third party as a result of your disability, such as no-fault auto insurance.

If you receive other disability income benefits in addition to STD benefits from Baker Hughes, an overpayment may result. **As a condition of receiving STD benefits, you agree to return or pay back any overpayments to Baker Hughes.**

If you are receiving Workers' Compensation benefits due to an occupational disability and the amount of your Workers' Compensation award is less than your regular pay, you may also be eligible to receive STD benefit payments.

If the amount of your other disability income benefits is greater than your regular pay, you will not receive STD benefit payments. In this situation, you will be direct billed for benefit continuation or arrears will accumulate and repayment will be due upon return to work.

Note: After 26 weeks, you may be eligible to receive LTD benefit payments. Contact Prudential as soon as possible to ensure you understand the qualifications for being considered disabled under the LTD plan and to ensure prompt payment of LTD benefits. In order to maintain medical coverage, you will be direct-billed from the Baker Hughes Benefits Center.

STD and FMLA

If you have a qualified Family and Medical Leave Act (FMLA) or state-specific Family and Medical Leave absence from work that is due to your illness, you may also qualify for STD benefits. For more information on how STD and FMLA coordinate, please contact Sedgwick at **1-877-423-8677**.

Note: STD leave will run concurrently with FMLA and/or state-specific leave, if eligible. FMLA is calculated on a "rolling back" basis. The "rolling back" period applies to determine how much of the 12-week leave entitlement has not been used during the immediately preceding 12 months.

How to Calculate Your STD Payment

Short-Term Disability pay is based on a 5 day, 40 hour work week regardless of an employee's standard work schedule. Benefits base pay for disability is your pre-disability regular base earnings excluding any bonuses, any premium pay (such as overtime, lead pay, shift differentials, and allowances) fringe benefits, and employee benefits.

1. Calculate the regular STD benefit payment, and
2. Subtract any other disability income benefits for which you're eligible.

Example:

Paul is an STD-eligible employee. He wakes one day, not feeling well and running a temperature. After notifying his boss, he doesn't report to work. Two days later, after not feeling any better, Paul visits his physician and is told that he has bacterial pneumonia and can't return to work for another three weeks. After speaking with his boss, Paul contacts Sedgwick to apply for Short-Term Disability. Sedgwick confirms the disability, approving benefits for a three-week disability duration. Paul is away from work for a total of three weeks.

Paul's regular biweekly pay when he becomes disabled is $1,800. Because his disability results from an illness, his STD benefits start after he is unable to work for seven calendar days. Paul receives $1,800 total in STD benefits.

First 7 Days	STD waiting period (If Paul is an hourly employee, he can use PIPB, no pay, or vacation during this time)
Next 7 Days	$900 weekly benefit
Final 7 Days	$900 weekly benefit
Total STD benefit payment to Paul	**$1,800**

Recurrent Disability

A recurrent disability is one that is related to an earlier disability for which you received the STD benefit. A recurrent disability is considered part of your earlier disability claim if, after receiving STD benefits, you:

- Return to your regular job on a full-time basis for less than 15 calendar days, and
- Perform all the regular and essential duties of your job.

If you return to your regular job on a full-time basis for 15 calendar days or more and then become disabled again, this will be treated by Sedgwick as a new period of disability. If your disability is a result of an illness, injury, or pregnancy, you must complete another seven-day elimination period.

Light Duty and Workplace Modification

During your disability, you may be able to return to work through participation in light duty or workplace modification. During this time, you will continue to receive 100% of regular pay for time worked and up to 100% of benefits base pay for time off (STD benefits) from weeks 1 through 8. From weeks 9 through 26, you will continue to receive 100% of regular pay for time worked and up to 75% of benefits base pay for time off (STD benefits).

Note: Short-Term Disability does not pay benefits if you refuse to participate in light duty or workplace modification.

How Long Will STD Benefit Payments Continue?

STD benefit payments continue up to recovery (the 26-week elimination period equals 180 calendar days total) or whichever is earlier, or until the date we are notified by Sedgwick of the first of the following:

- You fail to furnish proof that you're continuously "approved" by Sedgwick as disabled;
- You're no longer under the regular care of a physician;
- You refuse to be examined, if an examination is required;
- You fraudulently misrepresent your need for disability;
- You return to any work other than work approved by Baker Hughes;
- You refuse to participate in light duty or workplace modification;
- You die;
- You cease to be disabled; or
- You cease to be covered under STD coverage.

Note: If you separate from service from the Company and are on an approved disability claim at the time of separation from service, your STD benefits may continue with proper medical documentation to support your continued need for disability benefits.

Continuation of Health & Welfare Benefits While on STD

Your H&W benefits will continue while you are receiving STD benefit payments except in the event of termination of employment. Deductions will be taken as usual. If your employment with Baker Hughes is terminated while you are receiving STD benefit payments, your H&W benefits will also terminate. You may be eligible to continue your group health plan coverage through COBRA if you had coverage before your disability began. Refer to the *Benefits Rights* section for more information.

If you have questions regarding your benefits or benefit deductions while you are receiving STD benefit payments, please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide).

Short-Term Disability Process

Disability results from illness, pregnancy complications, or injury

Will you be off work for more than seven days?

Yes

Call Sedgwick on day 4 to initiate a STD claim.

No

Start PIPB leave and let your manager know when you'll return to work.
Absences for three or more consecutive days require a call to Sedgwick for FMLA or State Leave Purposes.

Disability results from hospitalization or outpatient surgery

Note: for FMLA and/or state disability, we require that EEs call Sedgwick on day 4 (after 3 days of time away for illness or injury).

Step 1 Call Sedgwick at **1-877-423-8677** or go online at **www.claimlookup.com** (Enter **Client Number** 8504).

You will need to provide Sedgwick authorization to access your medical information by completing a Medical Authorization for Release of Information form and providing a copy to both Sedgwick and your physician.

Step 2 Sedgwick will ask you for the following information:

- Employee name, Social Security Number, date of birth, date last worked, date of hire
- Employer's name, address and telephone number
- Manager's name and telephone number
- Physician's name and telephone number
- HR representative's name and telephone number Description of illness or injury
- Description of job or occupation
- Last day worked
- Estimated return to work day

Step 3 Once your claim is approved by Sedgwick, Short-Term Disability payments will be coordinated with Payroll. Short-term disability payments will continue as long as you meet the definition of disability, up to 26 weeks, whichever is earlier.

STD Exclusions

What Is Not Covered

Short-Term Disability does not pay benefits if your disability is caused by, contributed to, or resulting from:

- Committing or attempting to commit a felony;
- Elective plastic surgery (complications related to plastic surgery may be a covered benefit);
- Attempted suicide or self-inflicted injury.
- In addition, benefits are not payable for any period during which:
- You are confined to a penal or correctional facility;
- You are not under the care of a physician; or
- You are not eligible for coverage under Short-Term Disability.

Termination of Coverage

- Your STD coverage will end when:
- You do not provide requested medical information to Sedgwick;
- Baker Hughes stops providing Short-Term Disability;
- You no longer satisfy the requirements for being considered disabled for STD purposes;
- You retire;
- You cease to be eligible for coverage. You will cease to be eligible for coverage on the date you are no longer actively at work, if you are not disabled on that date; or
- You die.

How Do I File a Short-Term Disability Claim?

Call Sedgwick at **1-877-423-8677** or go online at **www.claimlookup.com** (enter **Client Number** 8504) as soon as possible to file an STD claim.

When you call to file your claim, Sedgwick will ask you for the following information:

- Name, Social Security Number and/or Employee ID, date of birth, date last worked, estimated return to work date, and date of hire
- Employer's name, address, and phone number
- Manager's name and phone number
- Physician's name and phone number
- HR representative's name and phone number
- Description of illness or injury
- Description of job or occupation

Note: If you are unable to call, a family member, close friend, or your manager or HR can make the call for you.

Sedgwick will review the requested information and determine whether your claim is approved or denied. If your claim is approved, bi-weekly STD benefit payments will be made directly to you through the Baker Hughes payroll.

Periodically, Sedgwick may request additional information about your disability. Remember, it is ultimately your responsibility to ensure all requested information is provided to Sedgwick. Your physician's failure to provide necessary medical documentation may result in a delay or suspension of your STD benefit payments.

You will not receive STD payments or pay during the elimination period until your claim is approved by Sedgwick. STD pay is paid on a biweekly basis on Baker Hughes regular pay cycles.

Medical Authorization

When filing a claim for STD benefits, you must provide Sedgwick authorization to access your medical information by completing a Medical Authorization for Release of Information form and providing a copy to your physician.

You can obtain the Medical Authorization for Release of Information form by calling Sedgwick at **1-877-423-8677**.

Disability Claims Denial Notice

You will receive written notice of Sedgwick's claim decision. If your claim is denied, the notification will include:

- Specific reasons for the denial;
- Specific provisions on which the decision is based;
- A description of any additional material or information necessary for the claim to be completed, as well as an explanation of why such material or information is necessary;
- A description of the review procedures and their applicable time limits;
- A description of any internal rules, guidelines, protocols, or other similar criteria instrumental in the decision-making, or a statement that the decision was based on the applicable items mentioned above. In this case, Sedgwick provides you with copies of the applicable material upon request (free of charge); and
- An explanation of the scientific or clinical judgment used in the decision regarding medical necessity, experimental treatment, or similar exclusion or limit. The decision applies the terms of the benefit to your medical circumstances, or you will receive a statement that an explanation will be provided upon request (free of charge).

Appealing a Denied Disability Claim

Appeals must be in writing and should be submitted to the Appeals Unit address below:

Sedgwick
Appeals Unit
P.O. BOX 14446
Lexington, KY 40512-4446

Complete the Baker Hughes STD Appeal Form and include the following information:

- Claim Number
- Employee name
- Address
- Telephone Information
- Physician Information
- Reasons for requesting the appeal
- Additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim.

The appeal decision will be communicated directly to you and/or your duly authorized representative.

You, or your authorized representative, will have 180 days after receiving notice that your disability claim is denied to appeal the decision in writing to Sedgwick, as well as submitting any information relevant to the claim (e.g., written comments, documents, records).

In addition, Sedgwick provides you with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

At the first level of appeal, the claimant submits additional proof of disability to the original claims adjuster. If this additional information changes the decision of the denial, then the claim resumes payments. If not, then the claim would go to the second step of appeals as outlined below.

A plan fiduciary, who had no role in the initial claim denial, reviews your appeal. The review is independent and will not give the original denial any special consideration.

If a medical judgment is involved, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved and who had no role in the initial claim denial.

Sedgwick notifies you of the appeal decision within 45 days after Sedgwick receives your request for review. If there are special circumstances requiring a delay, you will be notified of the final decision no later than 90 days after your request for review is received.

Special Circumstances Requiring Delay of Appeal Decision

Under normal circumstances, you will be notified in writing of the final decision within 45 days of the date your request for review is received. If there are special circumstances requiring a delay, the period can be extended (before the end of the original 45-day period) as the result of matters beyond the control of Sedgwick. Any notice for extension before the end of the original 45-day period will further explain:

- The reason for the extension and when Sedgwick expects to rule on your claim;
- Standards on which the right to a benefit is based;
- Unresolved issues that prevent a decision on the claim; and
- Additional information needed to resolve those issues.

Please note that you will be notified of the final decision no later than 90 days after your request for review is received.

How Short and Long-Term Disability Benefits Work Together

Short-Term and Long-Term Disability benefits work together, when applicable. Short-Term Disability benefits are payable for the first 26 weeks of disability, and then, if you continue to be disabled, Long-Term Disability benefits may take over. STD and LTD have different provisions, but both are offered to protect you and your family from loss of income in the event of an injury or illness that does not allow you to work. If you are receiving STD benefit payments and continue to be eligible for disability coverage, Sedgwick automatically transitions your claim to Prudential for LTD consideration.

Long-Term Disability

Long-Term Disability At-a-Glance

Type of Plan	Welfare benefit plan that provides income replacement if an employee continues to be disabled for more than 26 weeks (the 26-week elimination period equals 180 days)
Who Pays the Cost	Baker Hughes pays 100% of the cost of Core LTD coverage. However, you pay the additional cost if you elect LTD Buy-up coverage.
Employee Eligibility	Active employees on U.S.-based payroll who are: • Regular full-time employees • Union employees, if applicable • Benefits-eligible part-time employees
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Coverage Options	• Core coverage • Buy-up coverage
Enrollment Period	**Core coverage:** No enrollment necessary **Buy-up coverage:** • New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you'll default to Core coverage. • Employees can make changes during Annual Enrollment or if you have a qualfying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year or you will default to core coverage only.
Coverage*	**Core coverage:** • If disabled, the Core coverage will pay you 50% of your pre-disability base pay earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the *LTD Schedule of Benefits* section for the maximum period payable if you're 62 or older when your disability occurs. • Maximum monthly benefit is $15,000 per month. • Mental illness is covered for up to 24 months within your lifetime. • Medical coverage is continued for a maximum of 24 months if you had coverage in place and premiums are maintained while on LTD. **Buy-up coverage:** • If disabled, Buy-up coverage will pay you 60% of your pre-disability base pay earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the *LTD Schedule of Benefits* section for the maximum period payable if you're 62 or older when your disability occurs. • Maximum monthly benefit is $15,000 per month. • Mental illness is covered for up to 24 months within your lifetime. • You must be actively at work to be eligible for the LTD buy up plan. If you elect buy-up coverage while on a Leave of Absence, your new coverage will not begin until you return to an active work status. • Medical coverage is continued for a maximum of 24 months if you had coverage in place and premiums are maintained while on LTD.
Elimination Period	26-week elimination period (which equals 180 days total). (During this time, you may be eligible for Short-Term Disability benefits. See the *Short-Term Disability* section for details.) The LTD elimination period is the greater of the Short-Term Disability maximum benefit period or 180 days.
Contact	• For questions regarding LTD benefit payments: Call Prudential at **1-800-842-1718** • For questions regarding the plan or about your benefits while on LTD: Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) • Baker Hughes Benefits Website: **BakerHughesBenefits.com**

Note: Pre-disability earnings means your gross monthly income, including field pay and 401(k) deferred compensation in effect just prior to your date of disability. It does not include income received from commissions; awards and bonuses; overtime pay; car allowance; housing allowance; lead pay; cell pay; machine pay; shift differentials; the grant, award, sale, conversion and/or exercise of shares of stock or stock options; the contributions on your behalf to any deferred compensation arrangement or pension plan; or any other compensation from the Baker Hughes.

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage. This section of the SPD summarizes certain provisions of the LTD plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits**, prepared by Prudential, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

What is Long-Term Disability?

Becoming permanently disabled or having an extended disability can have devastating financial implications by taking away your ability to make a living. While some people can get by without working for a few months, few people can afford to stop working altogether for an extended period of time. That's where the Baker Hughes Company, LLC Long-Term Disability Plan (the LTD plan) can help you. The LTD plan benefit picks up generally where your Short-Term Disability (STD) benefit leaves off and offers coverage for you if you are disabled because of a qualifying illness or injury. You will receive Core LTD coverage at no cost. However, you may purchase additional LTD coverage. The LTD plan is funded by an insurance policy issued by Prudential.

Definition: Disability or Disabled means that due to illness or as a direct result of accidental injury:

- You are unable to perform the material and essential duties of your regular occupation due to your sickness or injury; and
- You are receiving regular care from a doctor, and
- You have 20% or more loss in your monthly earnings due to that sickness or injury.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury:

- You are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- You are under the regular care of a doctor.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Note: On each July 1, Prudential will adjust your pre-disability earnings by the lesser of the current annual percentage increase in Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) or 10%.

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

LTD Core coverage is available at no cost to you. If you elect additional LTD coverage under Buy-up coverage, you pay the cost of the additional benefit. Your contribution is automatically deducted from your paycheck on a before-tax basis.

When Does Coverage Start?

Coverage starts on the first day you are actively at work if you enroll within 31 days from your date of hire. If you're either a newly hired regular full-time employee or a benefits-eligible part-time employee (scheduled to work at least 20 hours per week), you're eligible to enroll for Buy-up coverage under the LTD plan. You will automatically receive Core LTD coverage, which is effective on your first day of active work. However, you must elect additional Buy-up coverage within 31 days from your date of hire.

If you do not enroll within 31 days from your date of hire, you'll lose your right to elect Buy-up coverage until the following Annual Enrollment period or you experience a qualified change in status as defined in the *General Information* section.

When do LTD Benefit Payments Start?

Your LTD benefit payments will begin after a qualifying illness or injury has forced you to be away from work for 180 days and Prudential has made a determination about your claim. The Long-Term Disability elimination period is stated as the greater of the Short-Term Disability (STD) maximum benefit period or 180 days, and the elimination period can be satisfied with both partial and total days of disability. Your LTD payment will be paid by Prudential.

Disability coverage generally will be continuous from Short-Term Disability to Long-Term Disability.

Definition: Elimination Period means a period of continuous disability that must be satisfied before you be eligible to receive disability benefit. Your elimination period begins the day you become disabled. Your elimination period for LTD benefits is the greater of 180 days or the date your STD benefits end. The LTD elimination period is stated as the greater of the STD maximum benefit period or 180 days.

LTD Schedule of Benefits

Minimum benefit payment:	$25 per month*
Maximum benefit payment:	$15,000 per month
Amount of benefit:	Core coverage: 50% of your pre-disability earnings**
Maximum period of coverage:	Up to age 65***, or until you're no longer disabled, whichever is earlier. Mental and substance abuse disabilities are covered for up to 24 months in your lifetime.
Medical benefit continuation:	Maximum of 24 months if you had coverage in place and premiums are maintained while on LTD.

*Subject to overpayment and rehabilitation incentives.
**Pre-disability earnings means your gross monthly income, including field pay and 401(k) deferred compensation in effect just prior to your date of disability. It does not include income received from commissions; awards and bonuses; overtime pay; car allowance; housing allowance; lead pay; cell pay; machine pay; shift differentials; the grant, award, sale,conversion and/or exercise of shares of stock or stock options; the contributions on your behalf to any deferred compensation arrangement, or pension plan; or any other compensation from the Baker Hughes.
***May continue past age 65, depending on the age of onset (see chart below).

At the onset of a disability, if you are age 62 or older, the following table will apply if you are deemed eligible for LTD due to accidental illness or injury (excluding disability due to substance abuse or mental health issues). All LTD benefit payments are made by Prudential and are taxable for federal income tax purposes. You will receive LTD payments and a W-2 from Prudential for any LTD payments.

Age at LTD Onset*	Maximum Benefit Period Core Coverage or Buy-up Coverage
Prior to age 62	Up to age 65
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*This is your age at the onset of your disability, which may be the date STD began.

Note: Your LTD benefit payments may be reduced by other disability income benefits and sources of income. See below for an explanation of other sources of income.

Evidence of Insurability (EOI)

You will not be required to provide Evidence of Insurability (EOI) to receive LTD coverage, however, pre-existing condition exclusions will apply (see the *LTD Exclusions* section).

A pre-existing condition is a medical condition for which medical treatment or advice was rendered, prescribed, or recommended within 12 months prior to your effective date of coverage. A condition will not be considered pre-existing if it causes a disability that begins after you've been covered under the LTD plan for a period of 12 months. LTD benefits may not be payable if a pre-existing condition exists.

Other Disability Income Benefits and Sources of Income

Your LTD benefit payments may be reduced (offset) by other disability income benefits paid, payable, or for which there is a right under:

- The Social Security Act (including amounts for which your dependents may qualify because of your disability);
- Any Workers' Compensation or occupational disease act or law, or any other law which provides compensation for an occupational injury or sickness;
- Occupational accident coverage provided by or through Baker Hughes;
- Any statutory disability benefit law;
- Any pension or disability plan of any other nation or political subdivision thereof (**note**: this does not include the Baker Hughes Pension Plan);
- The Railroad Retirement Act;
- The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
- The Canada Old Age Security Act; or
- Any Public Employee Retirement System plan, or any State Teachers' Retirement System plan, or any plan provided as an alternative to any of the above acts or plans.

In addition, your LTD benefit payments may be reduced (offset) by the following sources of income:

- Retirement benefits paid under the Social Security Act;
- Any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described in Rehabilitation Incentives. This includes but is not limited to salary, commissions, overtime pay, bonus, or other extra pay arrangements from any source;
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement, or otherwise including future earnings;
- Any income received for disability under a group insurance policy to which Baker Hughes has made a contribution, such as benefits for loss of time from work due to any disability;
- Installment payments for permanent total disability;
- A government compulsory benefit plan or program;
- A self-funded plan, or other arrangement if Baker Hughes contributes toward it or makes payroll deductions for it;
- Any sick pay, vacation pay or other salary continuation that Baker Hughes pays to you;
- Occupational disease laws;
- Laws providing for maritime maintenance and cure; or
- Unemployment insurance law or program.

If you receive any of the benefits described above in addition to LTD benefit payments from Prudential, an overpayment may result. As a condition of receiving LTD benefit payments, you agree to return or pay back any overpayments, including lump-sum awards.

Important: After you have been disabled for five full months, you may be eligible for Social Security benefits. If Social Security assistance is appropriate for you, Prudential will arrange the services of an advocate — at no charge to you — to help you apply for and secure Social Security benefits.

Important: Please note that your LTD benefit payment will be offset by other disability income benefits to which you are entitled even if you do not apply for the other disability income benefits.

Family Social Security Integration

Any disability or retirement benefits paid to your dependents because of your disability or retirement will be deducted from your monthly benefit payment.

Example:

Joe earns $4,000 pre-disability earnings each month. He elected Buy-up coverage. After exhausting his STD benefits, Joe's disability is approved for LTD benefits by Prudential.

Joe's maximum LTD benefit would be $2,400 per month (60% X $4,000), less taxes.

Joe receives a Social Security award for himself of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by Prudential of $1,900 per month ($2,400 – $500).

Joe also receives a Social Security benefit for his dependents of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by Prudential of $1,400 per month ($1,900 – $500).

1. Calculate the LTD plan's regular LTD benefit payment.
2. Subtract any other income benefits for which you or your eligible dependents are eligible.

Mental Illness or Substance Abuse Limitation

If you're disabled due to a mental illness of any type, benefits will not be payable beyond 24 months in your lifetime. If you are confined to a hospital or institution at the end of the 24-month period, you may be eligible to have your benefits extended.

Definition: Mental illness includes but is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance-related disorders and/or adjustment disorders, or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine. Mental illness means a psychiatric or psychological condition regardless of cause.

The only exclusions from the limit are dementia as a result of stroke, trauma, viral infection, Alzheimer's disease, or other conditions not listed which are not usually treated by a mental health provider. Dementia as a result of stroke, trauma, viral infection, Alzheimer's disease, or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

Recurrent Disability

A recurrent disability is a disability that is related to a prior disability for which you received a monthly LTD benefit. It's considered part of your prior disability if, after receiving LTD benefits, you return to your regular job on a full-time basis for less than 180 days and then are disabled again due to the same or a related condition. If your disability is recurrent, you will not need to satisfy a new elimination period.

If you return to your regular job for more than 181 days and become disabled again, you'll start a new disability claim and will be subject to:

- A new 26-week elimination period (which may be covered by Short-Term Disability benefits); the Long-Term Disability elimination period is stated as the greater of the Short-Term Disability period or 180 days;
- A new maximum period payable; and
- Any other provisions of the LTD plan that are in effect on the date your disability recurs.

Rehabilitation Incentive

If you participate in a rehabilitation program, your monthly benefit will increase by an amount equal to 10% of the monthly benefit. The increase will occur before your monthly benefit is reduced by any other income.

Work Incentive

If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any, and
- Reduced by other income as defined in the section titled *Other Disability Income Benefits and Sources of Income*.

Your monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100% of your pre-disability earnings as calculated in the definition of disability.

Limit on Work Incentive

After the first 24 months following your elimination period, we will reduce your monthly benefit based on the amount you earn from working while disabled.

Family Care Incentive

If you work or participate in a rehabilitation program while you are disabled, we will reimburse you for up to $400 for monthly expenses you incur for each family member to provide:

- Care for your or your spouse's child, legally adopted child, or child for whom you or your spouse are alegal guardian and who is:
  - Living with you as part of your household;
  - Dependent on you for support; and
  - Under age 13.

The child care must be provided by a licensed child care provider who may not be a member of your immediate family or living in your residence.

- Care to your family member who is:
  - Living with you as part of your household;
  - Chiefly dependent on you for support; and
  - Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.
- Care to your family member may not be provided by a member of your immediate family.

We will make reimbursement payments to you on a monthly basis starting with the first monthly benefit payment until you have received 24 monthly benefit payments. Payments will not be made beyond the maximum benefit period. We will not reimburse you for any expenses for which you are eligible for payment from any other source. You must send proof that you have incurred such expenses.

Survivor Benefit

When Prudential receives proof that you have died, we will pay your eligible survivor a survivor benefit equal to 3 months of your gross disability payment.

The survivor benefit will be paid if, on the date of your death:

- Your disability had continued for 180 or more consecutive days; and
- You were receiving or were entitled to receive payments under the plan.

Rules apply based on the eligibility of the beneficiary. Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

How Long Will LTD Benefit Payments Continue?

LTD benefit payments continue up to age 65 for Core coverage and Buy-up coverage or until the date of the following:

- You're no longer disabled;
- You fail to furnish proof that you continue to be disabled;
- You're no longer under the regular care of a physician;
- You refuse to be examined, participate in any rehabilitative employment, or receive recommended treatment that is generally acknowledged by physicians to cure, correct, or limit the disabling condition;
- Your monthly earnings exceed 80% of your pre-disability earnings;
- The date benefits end as specified in the mental and nervous and drug and alcohol provisions;
- You reach the maximum period of coverage;
- You die;
- You become covered under any other group long term disability plan, you will not be eligible for payments under the Prudential plan; or
- You are incarcerated as a result of a conviction.

Note: If your disability or illness occurs on or after age 62, see the *LTD Schedule of Benefits* section for more details. If you become covered under any other group long term disability plan, you will not be eligible for payments under the Prudential plan.

Date Benefit Payments End

Your disability benefit payments will end on the earliest of:

- The end of the maximum benefit period;
- The date benefits end as specified in the mental and nervous and drug and alcohol provisions;
- The date you are no longer disabled;
- The date you die;
- The date you cease or refuse to participate in a rehabilitation program that we require and that is approved by your physician;
- The date you fail to have a medical exam requested by Prudential; or
- The date you fail to provide required proof of continuing disability.

While you are disabled, the benefits described in this section will not be affected if:

- Your insurance ends, or
- The group policy is amended to change the plan of benefits for your class.

Medical Benefit Continuation

If you are under the age of 65 when your LTD claim was approved, you may continue certain Baker Hughes Medical plan options and Basic Life insurance coverage for a maximum of 24 months from the date your LTD claim is approved. If you are approved for LTD at age 65 or after, and before you terminated employment with the Company, you may continue Medical plan option and Basic Life insurance coverage until you are no longer receiving disability benefits under the LTD plan. You'll have the option to convert your Life Insurance coverage to an individual policy at termination of employment. You will be required to pay your share of the cost for your Medical plan coverage, which will be billed to you monthly by the Baker Hughes Benefits Center. Failure to pay your premiums will result in termination of coverage.

If you are enrolled in the Supplemental Life insurance plan, your coverage will end when you are on LTD. You may be eligible to continue your coverage by converting it to an individual policy. For more information, contact Prudential at **1-800-524-0542**.

If your employment with Baker Hughes terminated before you transitioned to LTD benefits, you are not eligible for continuation of Medical or Basic Life insurance benefits. In this event, you may be eligible to continue Medical coverage through COBRA and convert your Basic Life insurance coverage to an individual policy. For more information on converting your Basic Life insurance coverage, contact Prudential at **1-800-524-0542**.

You will continue Voluntary AD&D coverage under premium waiver if you had coverage before your disability began and if you remain disabled.

You may elect to continue Dental, Vision, and your Health Care Flexible Spending Account through COBRA if you had such coverages before your disability began. Refer to the *Benefits Rights* section for more information on COBRA.

Medicare Eligibility and LTD

If you continue coverage under a Baker Hughes Medical plan while you are receiving disability benefits under the LTD plan and you are, or later become, eligible to enroll for medical benefits under Medicare, you must enroll in both Parts A and B of Medicare as soon as you are eligible to enroll. Although you may be eligible for certain medical benefits for up to 24 months, when/if you become eligible for Medicare, if it is before the 24 month period, you will need to enroll in Medicare, and at that time, Medicare will become your primary medical coverage. If (1) you are eligible to enroll for medical benefits under Medicare, (2) you are not actively working for Baker Hughes, and (3) you have been receiving disability benefits from Baker Hughes plans for more than six months, the benefits you are eligible to receive under the Baker Hughes Medical plan will be determined as if Medicare was providing your primary medical coverage, regardless of whether you enroll in Medicare Parts A and B. In that case, your Baker Hughes Medical plan coverage will only pay benefits to the extent the plan provides a higher level of benefit than Medicare. The Baker Hughes Medical Plan Administrator will process your medical claims only after receiving the Medicare Explanation of Benefits. If you do not enroll in Medicare Parts A and B, the administrator will process your claims by estimating the amount Medicare would have paid and will pay only the amount that is payable under the Baker Hughes Medical plan that exceeds the amount that would have been paid by Medicare.

If you have questions regarding your benefits while you are receiving LTD benefit payments, please contact the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide).

LTD Exclusions

What is Not Covered

The LTD plan does not pay benefits if your disability is caused by, contributed to, or results from:

- A pre-existing condition. A condition for which medical treatment or advice was rendered, prescribed, or recommended within 12 months prior to your effective date of coverage by the LTD plan. A condition shall no longer be considered pre-existing if it causes disability that begins after you have been covered under the LTD vplan for a period of 12 months;
- War, whether declared or not, or any act of war;
- Active participation in a riot;
- Committing or attempting to commit a felony; or
- Attempted suicide or self-inflicted injury or illness.

In addition, benefits are not payable for any period during which:

- You are confined to a penal or correctional facility;
- You are not under the care of a physician; or
- You are not eligible for coverage under the LTD plan.

Termination of Coverage

Your LTD plan coverage will end when:

- You do not provide requested medical information to Prudential;
- You cease to be eligible for coverage;
- You qualify for retirement benefits from Baker Hughes; or
- Baker Hughes terminates the LTD plan.

Date Your Insurance Ends

Your insurance coverage from Prudential under the LTD plan will end on the earliest of:

For All Coverages:

- The date the group policy coverage from Prudential under the LTD plan ends; or
- The date insurance ends for your class; or
- The end of the period for which the last premium has been paid for you.

For Disability Income Insurance: Long-Term Benefits:

- The date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease active work in an eligible class if you are not disabled on that date; or
- The date you retire in accordance with the date your employment ends; or
- The date your employment ends; or
- The last day of the period for which you made any contributions

How do I File a Long-Term Disability Claim?

If You Were Receiving STD Benefit Payments…

If you are already receiving STD benefit payments and continue to be eligible for disability coverage, Sedgwick automatically transitions your claim to Prudential for LTD consideration.

If You Were Not Receiving STD Benefit Payments…

If you are disabled for the duration of the 26-week LTD plan elimination period and were not receiving STD benefit payments, you must call Prudential at **1-800-842-1718** to initiate a claim for LTD benefits. The LTD elimination period is stated as the greater of the end of the STD maximum benefit period or 180 days.

Note: You are encouraged to call Prudential at the beginning of your disability to ensure you understand the qualifications for being considered disabled under the LTD plan and also to ensure prompt payment of LTD payments, should you be eligible.

Prudential may ask you for the following information:

- Name, Social Security Number
- HR Manager's name and phone number
- Employee ID (SAP ID), date of birth
- Description of illness or injury, date last worked, and date of hire
- Description of job or occupation
- Employer's name, address, and phone number
- Manager's name and phone number
- Physician's name and phone number

You may need to provide Prudential with written authorization to access your medical information by completing an authorization form and providing a copy to both Prudential and your physician.

You can obtain an authorization form by calling Prudential at **1-800-842-1718**.

Note: If you are unable to call, a family member, close friend, Human Resources representative, or your manager can make the call for you.

Note: It is ultimately your responsibility to ensure all requested information is provided to Prudential. Failure of your physician to provide necessary medical documentation may result in a delay or suspension of your LTD benefit payments.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in this section. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of this SPD and your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656**.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at **1-866-439-9026**.

Responding to Your Disability Claim

Prudential will notify you in writing about whether your claim has been approved or denied within a reasonable period of time, but not later than 45 days of receiving your claim. This period can be extended for up to another 30 days if you are notified (before the end of the original 45-day period) that the extension is necessary due to matters beyond the control of the LTD plan.

The 30-day extension period can be extended for up to an additional 30 days if you are notified (before the end of the first 30-day extension period) that the extension is necessary due to matters beyond the control of the LTD plan. Any notice for an extension will explain:

- The reason for the extension and when Prudential expects to rule on your claim, and
- Additional information needed to resolve those issues.

If an extension is required because you need to provide the information necessary to resolve claim issues, you will have 45 days from the time you receive the extension notice to provide the additional information. If you do not provide the requested information on or before the end of such 45-day period, your benefit claim will be denied by Prudential.

Disability Claims Denial Notice

You will receive written notice of Prudential's claim decision under the LTD plan. If your claim is denied, the notification will include:

- the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the LTD plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,
- references to the specific plan provisions on which the benefit determination was based,
- a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,
- a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,
- a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and
- copies of any internal rules or guidelines relied upon in making this determination, if applicable.

Appealing a Denied Disability Claim

Appeals must be in writing and must be submitted to the claim department address below.

Note: employment may not be protected during the LTD appeal process.

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480
Philadelphia, PA 19176
Phone: **800-842-1718**
Fax: **877-889-4885**

You should include the following information in writing:

- Employee name;
- Name of the LTD plan;
- Reference to the initial decision;
- Reasons for requesting the appeal; and
- Additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim.

The appeal decision will be communicated directly to you and/or your duly authorized representative.

You, or your authorized representative, will have 180 days after receiving notice that your disability claim is denied to appeal the decision in writing to Prudential. You can submit any information relating to the claim (e.g., written comments, documents, records). All comments, documents, records, and other information submitted by you or your authorized representative relating to your benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

In addition, Prudential provides you with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Prudential provides this information upon request and free of charge.

If the claimant submits additional proof of disability, the additional information will be reviewed first by the original claims adjuster. If this additional information changes the decision of the denial, then the claim decision will be revised. If any portion of the original claim denial remains, then the appeal of the claim denial would go to the second step of appeals as outlined below.

A plan fiduciary, who had no role in the initial claim denial and is not subordinate of the original claims adjuster who made the decision on the claim, reviews your appeal. The review is independent and will not give the original denial any special consideration.

If a medical judgment is involved, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial. The LTD plan will identify the medical or vocational experts whose advice was obtained. The health care professional consulted for the appeal will be an individual who was not consulted in connection with the initial claim denial and is not the subordinate of any health care professional who was consulted in connection with the initial claim denial.

Prudential notifies you of the appeal decision within a reasonable period of time, but not later than 45 days after Prudential receives your request for review. You will be notified in writing of any extension before the end of the original 45-day period if special circumstances require an extension of time for processing.

Such notice will state the special circumstances and the date by which the benefit decision on appeal will be made. If an extension is required, Prudential will notify you of its decision within 90 days after Prudential's receipt of your request for review.

Disability Appeal Denial Notice

Prudential will send you a written notice of Prudential's decision under the LTD plan regarding your appeal of a denied disability claim. If your appeal is denied in whole or in part, the notification will include:

- the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the LTD plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,
- references to the specific plan provisions on which the determination was based,
- a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,
- Prudential's review procedures and applicable time limits,
- a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,
- copies of internal rules or guidelines relied upon in making this determination, if applicable and
- a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitation period expires for the claim at issue.

You and Prudential can also seek other voluntary alternative dispute resolution options, such as mediation. Contact your local U.S. Department of Labor office and your State insurance regulatory agency to find out what resources are available.

If Prudential fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in court.

Note: All benefits and coverages described are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this SPD and the insurance policies, the insurance policies will always govern.

Basic Life Insurance

Basic Life At-a-Glance

Type of Plan	Welfare plan that provides Basic Life insurance
Premium Contributions	Baker Hughes pays 100% of the cost of your coverage. No premium contributions are required from you for this coverage.
Employee Eligibility	Employees on U.S.-based payroll who work not less than 20 hours per week
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary. However, if you wish to limit your coverage to $50,000 to avoid imputed income, you may do so within 31 days of your date of hire or transfer to a position with U.S. benefits. You can also make changes during Annual Enrollment or if you have a qualified status change (see the *Can I Make Changes After I Enroll?* information in the *General Information* section).
Coverage Options	• Coverage equal to 2x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000) • Coverage is reduced by 50% the first of the year following your 70th birthday. • You may limit your coverage to $50,000 to avoid imputed income. If you limit your coverage to $50,000 to avoid imputed income then decide to revert to 2X your annual benefits base pay, you will have to submit evidence of insurability.
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Basic Life plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits**, prepared by Prudential, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

Your Basic Life Insurance Coverage

Employee life insurance provides valuable financial protection for your family. If you die, your life insurance benefit can replace your income for a period of time and also help your family pay for expenses incurred as a result of your death. Because life insurance is such an important benefit, Baker Hughes provides Basic Life insurance coverage under the Baker Hughes Life insurance program (the Basic Life plan) at no cost to you, and no enrollment is necessary. Basic Life insurance coverage provides peace of mind for you and basic financial security to you or your beneficiaries in the event you die.

What is the Employee's Cost of the Basic Life Plan?

No premium contributions are required from you for this coverage.

When Does Coverage Begin?

The Basic Life plan provides you with Basic Life insurance coverage on the first day you are actively at work. No enrollment is necessary.

Definition: Actively at Work means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business or at other places Baker Hughes business requires you to travel.

How Does the Basic Life Plan Work?

Basic Life insurance is provided to all eligible employees at no cost to you. Your benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefit programs. This **does not** include overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later. Coverage increases due to changes in your benefits base pay are effective the following January 1. All increases are subject to the actively-at-work requirements.

If you die while covered by the Basic Life plan, your beneficiaries will receive a benefit based on your annual benefits base pay and age, as follows:

Your Age When You Die	Benefit Amount
Under Age 70	2x benefits base pay or $50,000 if coverage is capped to avoid imputed income, • Rounded to the next higher $1,000 (if not already a multiple thereof), and • Minimum $50,000; maximum $500,000.
Age 70 or Over	Coverage is reduced by 50% the first of the year following your 70th birthday.

Imputed Income

If your Basic Life insurance coverage is greater than $50,000, the value of this employer-paid coverage in excess of $50,000 is considered "imputed income" and subject to income tax. To avoid imputed income, you can elect to reduce your benefit by capping your Basic Life insurance coverage at $50,000 during an election period. The imputed income is added to your total annual compensation reported to the Internal Revenue Service (IRS). It appears on your W-2 statement and is taxable at your regular income tax rate.

Example:

Jose is 30 years of age and receives Basic Life insurance coverage of 2x his annual benefits base pay, which is $60,000. Imputed income is calculated on the value of $10,000 (or the difference between his coverage and $50,000) and equals approximately 40 cents per month. This amount will be included on his W-2 statement as taxable income.

Tip!

If you have previously capped your coverage to avoid imputed income, you may remove the cap from the benefit during any Annual Enrollment period or during certain qualified changes in status, so long as you provide satisfactory Evidence of Insurability.

Naming a Beneficiary

You must name a beneficiary for your Basic Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A beneficiary is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary, you may:

- Name one or more beneficiaries
  Note: If you select more than one beneficiary, you must choose the percentage of benefits that are to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (This is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Prudential at 1-800-524-0542.

If You Become Terminally Ill

If you become terminally ill while covered under the Basic Life plan, you may apply for an accelerated benefit. Subject to approval by the Basic Life insurance provider, Prudential, this allows you to receive the full or a partial amount of your Basic Life insurance benefit before you die.

Definition: Terminally Ill means that due to accident or sickness, you are expected to have less than 24 months to live.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Prudential that your life expectancy, because of sickness or accident, is 24 months or less. That evidence must include certification by a physician. Prudential reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Prudential's physician will prevail. Prudential retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

Conditions

Your right to be paid under this option is subject to these terms:

- To elect this option, you must use the claim form provided by Prudential and follow the instructions on the claim form. If you do not have a claim form, contact your employer.
- You must furnish a certification by a doctor that your life expectancy is 24 months or less. You should furnish the *Attending Physician's Certification* part of your claim form to your doctor and have your doctor complete the form.
- Your life insurance must not be assigned.

Terminal illness proceeds will be made available to you on a voluntary basis only. You are not eligible for this benefit if you elect the benefit involuntarily solely because:

- You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise.
- You are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement.

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The maximum is the amount equal to your Basic Life insurance coverage (which cannot exceed $500,000 when combined with Supplemental Life). If you die before all payments have been made, Prudential will pay the remainder to your named beneficiaries.

In no event will the amount of the accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Basic Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Basic Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force.

If you elect to receive accelerated benefits, Prudential will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit.

Accelerated Benefit Amount Calculation and Payment

Prudential will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender, and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy.

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you unless you validly assign them otherwise. If you die before all payments have been made, Prudential will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Prudential.

Filing a Basic Life Claim

To claim benefits, your beneficiary who is entitled to benefits in the case of your death (or you, in the case of an accelerated benefit), the claimant, must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**. Prudential will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but no later than 365 days from the date of the covered person's death, to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic Life plan are fully-insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Claims Denial Procedure

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

  (i) the views of your treating providers and vocational professionals who evaluated you,

  (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

  (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules or guidelines relied upon in making this determination, if applicable.

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you,

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

(iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of internal rules or guidelines relied upon in making this determination, if applicable and

(g) a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitation period expires for the claim at issue.

If a decision on an appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied, although you are not required to do so. You may submit with your voluntary appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request.

Legal Action Following Appeals

If your claim for benefits and any required appeal are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this SPD, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the amount payable under the Basic Life plan is paid to your beneficiaries by Prudential. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse; otherwise
- Your naturally born or legally adopted children in equal shares; otherwise
- Your surviving parents in equal shares; otherwise
- Your siblings in equal shares; otherwise
- Your estate.

The benefit will be paid in a single sum or by any other method agreeable to Prudential and your beneficiaries. Prudential will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Prudential based on current short-term market rates, or the minimum required by state law, whichever is greater.

When Does Coverage End?

Conversion of Basic Life Insurance

Your Basic Life insurance coverage will end if you retire or otherwise terminate employment with Baker Hughes or are no longer eligible for the coverage.

If your Basic Life insurance coverage ends because you move out of an existing eligible class or you are no longer in an eligible class, but the group policy continues, you must apply for the individual contract and pay the first premium by the latter of:

1. The 31st day after you cease to be eligible for the Basic Life insurance; and

2. The 15th day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the 92nd day after you cease to be covered for the Basic Life Insurance coverage.

If you die during the 31-day period allowed for conversion, Prudential will pay a death benefit regardless of whether or not an application for coverage under the individual policy has been submitted.

Porting Your Basic Life Insurance

If you leave Baker Hughes or retire, you may be able to take your Basic Life insurance with you and continue to pay group term rates directly to Prudential. Rates may be higher than you paid as an active employee.

You cannot continue your coverage if:

- You have attained the age of 80;
- You have converted your insurance to an individual policy; or
- Due to a sickness or injury, you were not actively at work on the date prior to your termination of employment or retirement.

There are maximums on the amount of coverage that can be ported. To learn more about your portability options, please call Prudential at **1-800-524-0542**.

If the Basic Life Plan is Terminated

If the Basic Life plan ends, you may convert to an individual policy as stated above. However, the converted policy will be limited to the lesser of:

- The amount of Basic Life insurance coverage you had under the Basic Life plan (less any life insurance amount you become eligible for under another group policy within 31 days after the Basic Life plan ends), and
- $10,000.

The converted policy will be effective 31 days after the group insurance provided under the policy terminates. If you should die during the conversion period, the amount of Basic Life insurance you could have converted under the policy will be paid to your beneficiary.

Converting or Porting Your Coverage

For more information, or to convert or port your coverage, contact Prudential at **1-800-524-0542**.

Supplemental Life Insurance

Supplemental Life At-a-Glance

Type of Plan	Voluntary Supplemental Life insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who work not less than 20 hours per week.
Eligible Dependents	• Lawful spouse • Qualified dependent child
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer (must be actively at work). If changes are made during Annual Enrollment, coverage goes into effect the following January 1.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year. Note: You may need to provide Evidence of Insurability (EOI) for yourself and your spouse (if spouse coverage is elected).
Coverage Options	• Employee: Coverage equal to 1x to 8x annual benefits base pay up to a maximum of $6 million multiplied and then rounded to the next higher $1,000, if not already a multiple thereof. Coverage is reduced by 50% the first of the year following your 70th birthday. There is a $250,000 coverage option for employees making less than $31,250. • Spouse: You can choose from the following options: — $25,000 — $50,000 — $75,000 — $100,000 — $150,000 — $200,000 — $250,000 • Children: $10,000 for each eligible dependent
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Supplemental Life plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Prudential and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits** prepared by Prudential and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Prudential, the certificate of coverage/insurance will prevail in all instances.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52656.**

Your Supplemental Life Insurance Coverage

You may purchase additional life insurance coverage for yourself and coverage for your spouse and your eligible dependents. The Baker Hughes Supplemental Life insurance program (the Supplemental Life plan) provides you with an additional benefit if you, your spouse, or your dependents were to die.

What is the Employee's Cost of the Supplemental Life Plan?

You pay for the full cost of this coverage through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within 31 days of becoming eligible for coverage, your coverage begins on your first day of active work if you are a new hire or existing employee transferring to a position with U.S. benefits; or the following January 1 if you enroll during the Annual Enrollment period and are actively at work. If you elect coverage that requires Evidence of Insurability (EOI), you will be covered at the highest level of coverage possible without EOI pending a decision by the provider, Prudential.

You and Your Spouse Both Work at Baker Hughes

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

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

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

The chart below outlines acceptable and unacceptable Supplemental Life coverage elections for married couples who both work at Baker Hughes. For assistance completing spouses who both work at Baker Hughes coverages, please call the Baker Hughes Benefits Center at 866-244-3539. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Supplemental Life Coverage Options	Employee A	Employee B	Employee A	Employee B	Employee A	Employee B
Supplemental Life	elected	elected	elected	elected	waived	elected
Supplemental Spouse Life	elected	elected	waived	waived	waived	elected
Supplemental Child Life	elected	elected	waived	waived	waived	elected
Baker Hughes Policy	Unacceptable[1]		Acceptable[2]		Acceptable[3]	

Note 1: ***The Baker Hughes Health and Protection Plan does not allow Dual Coverage.*** Spouses cannot each elect Supplemental Life, Supplemental Spouse Life and Supplemental Child Life coverage.

Note 2: Married employees who both work at Baker Hughes cannot elect Supplemental Spouse Life coverage on the other.

Note 3: Either spouse can elect Supplemental Life, Supplemental Spouse and Child Life coverage. ***However, both spouses cannot cover a dependent under child life.***

Definition: Actively at Work means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business or at other places Baker Hughes business requires you to travel.

How Does the Supplemental Life Benefits Base Pay Plan Work?

Supplemental Life insurance is available to all eligible employees. However, you must enroll and pay the full cost of this benefit. Just like Basic Life insurance, your Supplemental Life insurance benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefits programs. Benefits base pay does not include overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay and age are used as part of the premium calculation.

Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

If you die while covered by the Supplemental Life plan, your beneficiaries will receive a benefit based on your elected amount or approved EOI coverage amount. If a spouse or a dependent dies while covered by the Supplemental Life plan, you will receive a benefit based on the amount of coverage elected during enrollment or approved EOI coverage amount.

Coverage Level	Benefit Options You May Elect
Employee Under Age 70	Coverage equal to 1x to 8x annual benefits base pay multiplied and then rounded to the next higher $1,000 if not already a multiple thereof up to a maximum of $6 million. There is a $250,000 coverage option for employees making less than $31,250.
Employee Age 70 or Over	Coverage is reduced by 50% the first of the year following your 70th birthday.
Spouse	• $25,000 • $50,000 • $75,000 • $100,000 • $100,000 • $150,000 • $200,000 • $250,000 Note: The amount of spouse coverage cannot exceed 100% of your combined Basic and Supplemental Life insurance.
Dependent Children	$10,000 per covered child

Evidence of Insurability

If you enroll in Supplemental Life insurance coverage within 31 days of first becoming eligible, you may elect coverage up to the guarantee issue amounts without providing Evidence of Insurability (EOI). Guarantee issue is the maximum amount of insurance an employee or spouse can receive without EOI when first eligible under the Supplemental Life plan, provided enrollment is made in a timely manner within the initial enrollment period.

The guarantee issue amounts are as follows:

- **Employee Supplemental Life:** $250,000
- **Spouse Life:** $25,000
- **Child Life:** $10,000 (EOI does not apply regardless of when election is made)

Example:

Tom is a new hire whose annual benefits base pay is $100,000, and he elects three times salary. Tom is covered up to the guarantee issue amount of $250,000 until a decision is made on his EOI. If approved, he will receive the full benefit amount he elected of three times ($300,000) coverage. If the EOI is denied, coverage will remain at the guarantee issue amount of $250,000.

If you do not enroll in coverage when first eligible, you will be required to submit EOI for any future enrollment.

If you enroll in coverage when first eligible and then elect to increase your coverage during future enrollments, EOI will generally be required for amounts above the guarantee issue or when increasing coverage by more than one level. All coverage increases are subject to the actively-at-work requirements. Refer to the chart below for additional details.

Remember...

If you do not elect coverage as a new hire or when you first transfer to a position with U.S. benefits and decide to elect Supplemental Life insurance during a future enrollment period, you will be required to provide Evidence of Insurability for yourself and your spouse (if elected) for any amount of coverage elected.

Providing EOI Documentation

	Election Period	Election	EOI Required?
Employee	During the new hire enrollment period or newly eligible enrollment period	Any election less than or equal to the guarantee issue of $250,000	No
		Any election above the guarantee issue of $250,000	Yes
	After the new hire enrollment period or newly eligible enrollment period	Any election for one multiple that does not exceed the guarantee issue of $250,000	No
		Any election for more than one multiple	Yes
Spouse	During the new hire enrollment period or newly eligible enrollment period	Any election up to the guarantee issue of $25,000	No
		Any election above the guarantee issue of $25,000	Yes
	After the new hire enrollment period or newly eligible enrollment period	Any election amount, including new elections	Yes
		Any election from "No Coverage" to any elected amount	Yes
Dependent Children	No EOI required for coverage		No

Providing EOI Documentation

If you are required to provide Evidence of Insurability, you will be directed to EOI Connect to provide additional information. Until a decision has been made on your coverage, you or your spouse will be covered at the highest level of coverage possible without EOI. If EOI is approved, the Supplemental Life and/or Spouse Life insurance coverage at the higher coverage level will become effective on the day the EOI decision is made, or according to the Supplemental Life plan rules as long as you remain eligible and are actively at work. If the election requiring EOI was made during Annual Enrollment, the coverage will be effective the later of the date the EOI decision was made, or January 1 following Annual Enrollment. If an exam or tests are required to complete the EOI process, Prudential will arrange for the needed services at no cost to you.

Naming a Beneficiary

You must name a beneficiary for your Supplemental Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- Name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the percentage of benefits that are to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (this is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Prudential at **1-800-524-0542**.
- You're automatically the beneficiary for your dependent's (spouse and children) Supplemental Life insurance benefits.

If You Become Terminally Ill

If you become terminally ill while covered under the Supplemental Life plan, you may apply for an accelerated benefit. Subject to approval by the insurance provider, Prudential, this allows you to receive the full or a partial amount of your Supplemental Life insurance benefit before you die.

Definition: Terminally Ill means that due to sickness or accident, you are expected to have less than 24 months to live.

Remember...

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Prudential that your life expectancy, because of sickness or accident, is 24 months or less. That evidence must include certification by a physician. Prudential reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Prudential's physician will prevail. Prudential retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

Conditions

Your right to be paid under this option is subject to these terms:

- To elect this option, you must use the claim form provided by Prudential and follow the instructions on the claim form. If you do not have a claim form, contact your employer.
- You must furnish a certification by a doctor that your life expectancy is 24 months or less. You should furnish the *Attending Physician's Certification* part of your claim form to your doctor and have your doctor complete the form.
- Your life insurance coverage must not be assigned.
- Terminal Illness Proceeds will be made available to you on a voluntary basis only. You are not eligible for this benefit if you elect the benefit involuntarily solely because:
  - You are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise.
  - You are required by a government agency to use this option in order to apply for, get, or keep a government benefit or entitlement.

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The maximum is the amount equal to your Supplemental Life insurance coverage (which cannot exceed $500,000 when combined with Basic Life). If you die before all payments have been made, Prudential will pay the remainder to your named beneficiaries.

In no event will the amount of the Supplemental Life plan accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Supplemental Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Supplemental Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force and premiums will be reduced accordingly.

If you elect to receive accelerated benefits, Prudential will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit under the Supplemental Life plan.

Accelerated Benefit Amount Calculation and Payment

Prudential will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender, and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy.

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you, unless you validly assign them otherwise. If you die before all payments have been made, Prudential will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Prudential.

Filing a Supplemental Life Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**. Prudential will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but no later than 365 days from the date of the covered person's death, to the following address:

Group Life Claim Division
PO Box 8517
Philadelphia, PA 19176

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

After Prudential has processed the claim, the claimant will be notified by Prudential in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Supplemental Life plan are fully-insured and payable solely by Prudential. Therefore, to receive a benefit, the claimant must provide the information required by Prudential.

Claims Denial Procedure

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

  (i) the views of your treating providers and vocational professionals who evaluated you,

  (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

  (iii) an award of Social Security Administration disability benefits

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules or guidelines relied upon in making this determination, if applicable.

Appealing the Denial of a Claim

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following

  (i) the views of your treating providers and vocational professionals who evaluated you,

  (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

  (iii) an award of Social Security Administration disability benefits

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of internal rules or guidelines relied upon in making this determination, if applicable and

(g) a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitation period expires for the claim at issue.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied, although you are not required to do so. You may submit with your voluntary appeal any written comments, documents, records and any other information relating to your claim.

Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request.

Legal Action Following Appeals

If your claim for benefits and any required appeal are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this SPD, regardless of whether your claim is still pending in the claim or appeal process.

Payment of Benefits

After a claim is approved, the amount payable under the Supplemental Life plan is paid to your beneficiaries by Prudential. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse; otherwise
- Your naturally born or legally adopted children in equal shares; otherwise
- Your surviving parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

The benefit will be paid in a single sum or by any other method agreeable to Prudential and the beneficiaries. Prudential will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Prudential based on current short-term market rates, or the minimum required by state law, whichever is greater.

Note: Supplemental Life benefits for the employee and covered dependents will not be paid to the beneficiary if you or the covered dependent spouse commits suicide within 24 months of electing coverage.

Conversion of Supplemental Life Insurance

Your Supplemental Life insurance coverage will end if you retire or otherwise terminate employment with Baker Hughes or are no longer eligible for the coverage.

If your Supplemental Life insurance coverage ends because you move out of an eligible class, or you are no longer in an eligible class, but the group policy continues, you must apply for the individual contract and pay the first premium by the latter of:

1. The 31st day after you cease to be eligible for the Employee Term Life insurance; and
2. The 15th day after you have been given written notice of the conversion privilege. But, in no event may you convert the insurance to an individual contract if you do not apply for the contract and pay the first premium prior to the 92nd day after you cease to be covered for the Supplemental Life insurance coverage.

If you die during the 31-day period allowed for conversion, Prudential will pay a death benefit regardless of whether or not an application for coverage under the individual policy has been submitted.

If the Supplemental Life Plan is Terminated

If the Supplemental Life plan ends, you may convert your coverage to an individual policy as stated above. However, the converted policy will be limited to the lesser of:

- The amount of Supplemental Life insurance coverage you had under the Supplemental Life plan (less any life insurance amount you become eligible for under another group policy within 31 days after the Supplemental Life plan ends), and
- $10,000.

The converted policy will be effective 31 days after the group insurance provided under the policy terminates. If you should die during the conversion period, the amount of Supplemental Life insurance you could have converted under the policy will be paid to your beneficiary.

Portability Option of Supplemental Life Insurance

If you leave the Company or retire, you may be able to take your Employee Supplemental Life, Spouse Supplemental Life and/or Child Supplemental Life insurance with you and continue to pay group term life rates directly to Prudential. Rates may be higher than you paid as an active employee. If you elect to continue your own insurance, you can also continue insurance on your spouse and/or children.

Converting or Porting Your Coverage

For more information or to convert or port your coverage, contact Prudential at **1-800-524-0542**.

Basic AD&D Insurance

Basic AD&D At-a-Glance

Type of Plan	Welfare plan providing Accidental Death & Dismemberment insurance.
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Basic AD&D insurance.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	No enrollment necessary
Coverage Options	Coverage equal to 1x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000). This coverage amount is referred to as the principal sum by the insurance provider.
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Basic AD&D plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Chubb and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits** prepared by Chubb and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Chubb, the certificate of coverage/insurance will prevail in all instances.

Important: You may elect to cap your Basic Accidental Death & Dismemberment coverage at $50,000.

Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can provide you financial protection in addition to the protection you have through life insurance. Basic Accidental Death & Dismemberment coverage is provided under the Baker Hughes Accidental Death & Dismemberment program (the Basic AD&D plan).

Both Life and AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a death benefit; however, AD&D only pays if the cause of death was accidental.
- AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses.

You do not contribute anything to receive Basic AD&D insurance coverage. It is paid 100% by Baker Hughes.

The Basic AD&D plan provides you with Basic AD&D insurance coverage on the first active day of work. No enrollment is necessary.

Basic AD&D insurance coverage provides financial protection for your family if you die accidentally. The Basic AD&D plan also pays a benefit to you if you lose a limb, lose your sight or hearing, or become paralyzed as the result of an accident. Basic AD&D plan benefits are payable in addition to benefits from Basic Life insurance, Voluntary Accidental Death & Dismemberment insurance, and the Business Travel Accident insurance plan (if applicable).

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy which is in force and is the direct cause of loss.

The amount of your Basic AD&D plan benefit is based on the type of loss that you suffer, as shown in the following chart. No benefit will be payable for a loss which is not shown in this chart:

Basic AD&D

Your accidental death, dismemberment, paralysis, or other covered loss

You or your dependent contacts the **Benefit Center**

Once the Benefits Center has been contacted and the claim has been processed and approved by the insurance provider, a benefit will be paid to you or your beneficiaries

Naming a Beneficiary

You need to name a beneficiary for your Basic AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Remember...
It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

If you do not name a beneficiary under the Basic AD&D insurance plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that is to be paid to each beneficiary.
- You may assign your rights to a benefit under the Basic AD&D plan, called an absolute assignment, if you make the assignment in writing in a manner required by the insurance provider. You can make the assignment irrevocable. To make an absolute assignment, contact **Chubb** at **1-877-297-4225** for the required form. The assignment must be filed with the **Baker Hughes Benefits Center** and the insurance provider and provided at the time of the claim or at any other time required by the insurance provider.

How Does the AD&D Process Work?

What Losses are Covered by Basic AD&D Insurance?

The amount of your Basic AD&D plan benefit is based on the type of loss that you suffer, as shown in the following chart. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

Example:

Assuming that your maximum AD&D benefit is $50,000, the following benefit amounts would apply to the losses listed:

Type of Accidental Loss	Benefit
• Life • Both hands, both feet, the sight of both eyes, or any combination • One hand and one foot • One hand or one foot and the sight of one eye • Speech and hearing	$50,000
• One hand, one foot, or the sight of one eye • One arm or one leg • Speech or hearing (in both ears)	$25,000
• Thumb and index finger of the same hand	$12,500

If you suffer multiple losses as the result of one accident, only the single largest benefit will be payable. For example, if you lost an arm, your thumb, and index finger (on the other arm), you would receive a maximum benefit of $25,000.

If a covered loss occurs as a result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amount, which when totaled, exceeds the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Defining Loss

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by Chubb Group of Insurance Companies (Chubb).

Loss of foot means complete severance, through or above the ankle joint, even if the foot is later reattached.

Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least three fingers and the thumb on the same hand, even if the hand, fingers, and/or thumb are later reattached.

Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness can't be corrected by any aid or device, as determined by a physician.

Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.

Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.

Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints, of the thumb and index finger of the same hand as determined by a physician, even if one or both are later reattached.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than 365 days, as determined by a physician.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days, as determined by a physician.

Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than 365 days, as determined by a physician.

If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage at the time of the accident.

If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by the Plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

What Losses are not Covered by AD&D Insurance?

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft, or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide or intentionally self-inflicted injury.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.

The Basic AD&D plan and the insurance provided under the plan does not apply to an accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, as defined by the laws of the jurisdiction where the accident occurred, at the time of the accident.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of any narcotic at the time of an accident. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a physician.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.

The Basic AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss when:

- The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss, or
- There is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

Additional Basic AD&D Benefits

Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days of the accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within the first 30 days following the accident, the Basic AD&D plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% payment of the loss-of-life benefit, whichever is earlier. The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal sum amount is paid in full
- The date of recovery or death

If you die within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Psychological Therapy Expense

The Basic AD&D plan pays a benefit to you if a physician determines the need for you to have psychological therapy after you have suffered a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 1% of the principal sum to a maximum of $30,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Basic AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverage.

Rehabilitation Expense

The Basic AD&D plan pays a benefit to you if you suffer a loss covered under the plan which prevents you from performing all the duties of your regular occupation and requires you to obtain rehabilitation, as determined by a physician approved by Chubb.

The benefit pays for Reasonable and Customary rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 1% of the principal sum to a maximum of $30,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Basic AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverage.

Seat Belt

If you die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Basic AD&D plan will pay an additional benefit of 10% of your principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- You were an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer's instructions.

The seat belt benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverages.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental;
- The direct cause of a loss; and
- Occurs while a person is insured under the policy issued by Chubb under the Basic AD&D plan, which is in force.

Accidental bodily injury does **not** include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease;
- Bursitis;
- Chondromalacia;
- Shin splints;
- Stress fractures;
- Tendinitis; and
- Carpal tunnel syndrome.

Filing a Basic AD&D Claim

To claim benefits under the Basic AD&D plan, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Company, LLC
Attn: Total Rewards H&W Department
17021 Aldine Westfield Road
Houston, TX 77073

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Chubb. After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic AD&D plan are fully-insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of Baker Hughes receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to Chubb within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim denial, without regard to whether the advice was relied upon in making the claim denial, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,
- a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request to Chubb, and
- a statement that, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, that such rule, guideline, protocol or other similar criterion, a copy thereof will be provided free of charge upon written request to Chubb.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the Basic AD&D plan. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send the written appeal to the following address:

Chubb Group of Insurance Companies
Claims Service Center
600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700

Upon receipt of the claimant's the written appeal, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits;
- A statement of the right to sue in federal court under Section 502(a) of ERISA;
- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- Explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits; and
- A description of any applicable contractual limitations period that applies to your right to bring a civil action under section 502(a) of ERISA, including the calendar date on which the contractual limitation period expires for the claim at issue.

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to bring a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Basic AD&D plan after two years from the date the Basic AD&D plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Basic AD&D plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Basic AD&D policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- Your spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

When Does Coverage End?

Your coverage under the Basic AD&D plan will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Conversion of Coverage

If your coverage is terminated for any reason, other than termination of the policy, your insurance may be converted to an individual policy up to the amount for which you are insured, subject to a minimum of $50,000 and a maximum of $500,000, whichever is less. To take advantage of the conversion of coverage, you must make an application and submit the required premium within 90 days following the date your insurance terminates.

Coverage will not be in effect after the date your insurance terminates until your application for conversion is received. The cost of the converted policy will be based upon the commercial insurance company's individual policy rates in effect at the time of application. For more information about conversion of AD&D benefits call **1-877-297-4225**.

Voluntary AD&D Insurance

Voluntary AD&D At-a-Glance

Type of Plan	Voluntary Accidental Death & Dismemberment insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Level	• You Only • You + Family • No Coverage
Coverage Options	**Employee Coverage:** You can elect from 1x, 2x, 3x, 4x, or 5x your annual salary, up to a maximum of $4 million. **Employee + Family Coverage**: Based on the employee coverage levels above, if you elect family coverage, the spouse and children benefit is as follows: • Spouse only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse and children — 40% of employee coverage amount for your spouse and 10% of employee coverage amount, up to $20,000 per child
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Voluntary AD&D plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Chubb and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits** prepared by Chubb and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Chubb, the certificate of coverage/insurance will prevail in all instances.

Your Voluntary Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can give you financial protection in addition to the protection you have through life insurance. Voluntary Accidental Death & Dismemberment coverage is provided under the Baker Hughes Voluntary Accidental Death & Dismemberment program (the Voluntary AD&D plan).

What is the Difference Between Life and Voluntary Accidental Death & Dismemberment (AD&D) Insurance?

Both Life and AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a benefit if you or a covered family member dies. However, AD&D only pays if the cause of death was accidental.
- AD&D premiums are lower because the incidence of accidental death is much lower than that of death from natural causes.
- AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses.

Voluntary AD&D insurance should not be considered a substitute for life insurance; however, it can provide valuable additional protection, especially at younger ages when responsibilities are greatest and availability of funds is not.

Who Pays the Cost of the Voluntary AD&D Plan?

If you decide to enroll yourself, or yourself and your dependents, in the Voluntary AD&D plan, you'll pay the full cost through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within the specified time frame in Voluntary AD&D insurance coverage, your coverage begins on your first active day of work if you're a new hire or an existing employee transferring to a position with U.S. benefits, or the following January 1 if you enroll in the Plan during the Annual Enrollment period.

You and Your Spouse Both Work at Baker Hughes

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

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

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

The chart below outlines acceptable and unacceptable Voluntary AD&D coverage elections for married couples who both work at Baker Hughes. For assistance completing spouses who both work at Baker Hughes coverages, please call the Baker Hughes Benefits Center at 866-244-3539. Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST.

Voluntary AD&D Coverage Options	Employee A	Employee B	Employee A	Employee B	Employee A	Employee B
Voluntary AD&D	elected	elected	elected	elected	waived	elected
Voluntary AD&D Family (Spouse)	elected	elected	waived	waived	waived	elected
Voluntary AD&D Family (Child(ren))	elected	elected	waived	waived	waived	elected
Voluntary AD&D Family (SP and Child(ren))	elected	elected	waived	waived	waived	elected
Baker Hughes Policy	Unacceptable[1]		Acceptable[2]		Acceptable[3]	

Note 1: ***The Baker Hughes Health and Protection Plan does not allow Dual Coverage.*** Spouses cannot each elect Voluntary AD&D, Voluntary AD&D Family (Spouse), Voluntary AD&D Family (Child(ren)) and Voluntary AD&D Family (Spouse and Child(ren)).

Note 2: Married employees who both work at Baker Hughes cannot elect Voluntary AD&D Family (Spouse) coverage on the other.

Note 3: Either spouse can elect Voluntary AD&D, Voluntary AD&D Family (Spouse), Voluntary AD&D Family (Child(ren)) and Voluntary AD&D Family (Spouse & Child(ren)) coverage. ***However, both spouses cannot cover a dependent under Voluntary AD&D Child(ren).***

How Does Voluntary AD&D Insurance Work?

If you choose to participate in the Voluntary AD&D plan, the plan pays a benefit to you or your beneficiaries if you or a covered family member suffer accidental death, dismemberment, paralysis, or other covered losses.

Schedule of Benefits for Voluntary AD&D Insurance	
Employee Coverage	You can elect from 1x, 2x, 3x, 4x, or 5x your annual salary, up to a maximum of $4 million.
Employee + Family Coverage	Based on the employee coverage levels above, if you elect family coverage, the spouse and children benefit is as follows: • Spouse only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse and children — 40% of employee coverage amount for your spouse and 10% of employee coverage amount, up to $20,000 per child

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy which is in force and is the direct cause of loss.

How Does the Voluntary AD&D Process Work?

Basic AD&D

Enroll in coverage

↓

Name your beneficiaries

↓

You or your dependent's accidental death, dismemberment, paralysis, or other covered loss

↓

You or your dependent contacts the **Baker Hughes Benefits Center**

↓

Once the Baker Hughes Benefits Center has been contacted and the claim has been processed and approved by the insurance provider, a benefit will be paid to you or your beneficiaries

Note: You're automatically the beneficiary for your dependent's loss-of-life benefits.

Naming a Beneficiary

You need to name a beneficiary for your Voluntary AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

If you do not name a beneficiary under the Voluntary AD&D plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that is to be paid to each beneficiary.
- You may assign your rights to a benefit under the Basic AD&D plan, called an absolute assignment, if you make the assignment in writing in a manner required by the insurance provider. You can make the assignment irrevocable. To make an absolute assignment, contact **Chubb** at **1-877-297-4225** for the required form. The assignment must be filed with the **Baker Hughes Benefits Center** and the insurance provider and provided at the time of the claim or at any other time required by the insurance provider.

Remember...

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

What Losses are Covered by Voluntary AD&D Insurance?

The amount of your Voluntary AD&D plan benefit is based on the type of loss that you or your covered dependent suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, which when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Defining Loss

- Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by Chubb Group of Insurance Companies (Chubb).
- Loss of foot means complete severance, through or above the ankle joint, even if the foot is later reattached.
- Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least three fingers and the thumb on the same hand, even if the hand, fingers and/or thumb are later reattached.
- Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness can't be corrected by any aid or device, as determined by a physician.
- Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.
- Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.
- Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.
- Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.
- Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints, of the thumb and index finger of the same hand as determined by a physician, even if one or both are later reattached.
- Paraplegia means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than 365 days, as determined by a physician.
- Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days, as determined by a physician.
- Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than 365 days, as determined by a physician.
- If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage at the time of the accident.
- If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by the Plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

What Losses are not Covered by AD&D Insurance?

- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft, or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial o rviral infection, bodily malfunctions, or medical, or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide, or intentionally self-inflicted injury.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to an accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, as defined by the laws of the jurisdiction where the accident occurred, at the time of the accident.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of any narcotic at the time of an accident. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a physician.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.
- The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or when:
  - The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury, or loss, or
  - There is any other legal prohibition against providing insurance of any accident, accidental bodily injury, or loss.

Additional Basic AD&D Benefits

Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days of the accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within 30 days following the accident, the Voluntary AD&D plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% payment of the loss-of-life benefit amount, whichever is earlier.

The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal sum amount is paid in full
- The date of recovery or death

If you die within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Child Care Expense

If you enroll in Voluntary AD&D insurance coverage under the plan and elect to cover your eligible dependents, the plan will provide child care expense up to 5% of the principal sum up to $12,500 for each eligible dependent child up to the $200,000 maximum benefit amount if you die accidentally while you and your eligible dependents are covered under the plan, and:

- Your dependent child is under the age of thirteen years for whom child care expenses are incurred within 365 days of your death, and
- You elected insurance under the plan for such dependent child, and the insurance is in effect on the date of the accident.

Child care expense means the actual incurred costs for the care and supervision of your dependent child who is less than age thirteen.

The Voluntary AD&D plan will reimburse child care expenses for each eligible dependent child. However, the total payment for each dependent child and all dependent children will not exceed the maximum benefit amount of $200,000 for child care expense, regardless of the number of dependent children for whom payment is made.

If, on the date of your death, while covered under the Voluntary AD&D plan, you have coverage under this plan for a dependent child, but do not have any dependent children eligible for child care expense payments, then the plan will pay the alternate benefit amount of $2,500. If the alternate benefit amount is paid, then the plan will not make any further payments for child care expense.

Child care expenses shall be paid to the person who incurs such expenses for the dependent children. The alternate benefit amount of $2,500 in lieu of child care expense reimbursement shall be paid to the named beneficiary.

In the event of a common accident, only one benefit amount for child care expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for child care expense is payable in addition to any other applicable benefit amounts payable under your Voluntary AD&D insurance coverage.

Education Expense

To claim benefits under the Basic AD&D plan, if you or your beneficiary who is entitled to benefits enroll in Voluntary AD&D insurance coverage and elect to cover your eligible dependents, the plan will reimburse education expense up to $5,000 annually for each eligible dependent up to the $200,000 maximum benefit amount if you die accidentally while you and your eligible dependents are covered under the plan, and:

- Your dependent is enrolled as a full-time student at an institution of higher learning on the date of your death; an institution of higher learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth grade; or
- Subsequently enrolls as a full-time student at an institution of higher learning within 730 days following the date of your death; and
- Incurs education expense.

Education expense payments for each eligible dependent child will be available. However, the total annual payment for each dependent child will not exceed the $5,000 annual benefit amount for education expense.

The education expense payment is limited to four consecutive years for each eligible dependent child. In no event will the total payment exceed the maximum benefit amount of $200,000.

If, on the date of your death while covered under the Voluntary AD&D plan, you have coverage for a dependent child, but do not have any dependent children eligible for education expense payments, the plan will pay the alternate benefit amount of $2,500. If the alternate benefit amount is paid, then no further payments for education expense will be paid.

In the event of a common accident, only one benefit amount for education expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for education expense shall be paid to the person who incurs the expense. The alternate benefit amount in lieu of education expense reimbursement shall be paid to the named beneficiary.

The benefit amount for education expense is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Psychological Therapy Expense

The Voluntary AD&D plan pays a benefit if a physician determines the need for you or a covered family member to have psychological therapy after you have suffered a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 2% of the principal sum to a maximum of $5,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Voluntary AD&D plan coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Rehabilitation Expense

The Voluntary AD&D plan pays a benefit if you or your covered family member suffers a loss while covered under the plan if the loss prevents the insured person from performing all the duties of his or her regular occupation and requires rehabilitation, as determined by a physician approved by Chubb.

The benefit pays for Reasonable and Customary (R&C) rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 2% of the principal sum to a maximum of $5,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Voluntary AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Seat Belt Coverage

If you die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Basic AD&D plan will pay an additional benefit of 10% of your principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- You were an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

If it cannot be determined if the insured person was wearing a seat belt at the time of the accident, a limited alternate benefit of $3,000 will be paid in addition to the accidental loss-of-life benefit.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer's instructions.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental;
- The direct cause of a loss; and
- Occurs while a person is insured under the policy issued by Chubb under the Basic AD&D plan, which is in force.

Accidental bodily injury does **not** include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease;
- Bursitis;
- Chondromalacia;
- Shin splints;
- Stress fractures;
- Tendinitis; and
- Carpal tunnel syndrome.

Spouse Employment Training Expense

The Voluntary AD&D plan will reimburse your spouse up to $5,000 for spouse employment training expense if you die accidentally while you and your spouse are covered under the plan, and your surviving spouse incurs employment training expense within three years following the date of your death.

Spouse employment training expense means the actual costs incurred by a spouse for tuition, fees, room and board billed by an institution of higher learning. These costs must be incurred by your spouse to attend an institution of higher learning for the purpose of obtaining or refreshing skills needed for employment.

An institution of higher learning means any accredited public or private college, university, or professional trade or vocational school beyond the twelfth (12th) grade. Spouse employment training expense also means costs for required books or course supplies.

The benefit amount for spouse employment training expense will be paid to your spouse who incurs the expense. The benefit amount for spouse employment training expense is payable in addition to any other applicable benefit amounts under the Voluntary AD&D plan.

Filing a Voluntary AD&D Claim

To claim benefits under the Voluntary AD&D plan, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**. Baker Hughes will mail the appropriate forms to the claimant. The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Company, LLC
Attn: Total Rewards H&W Department
17021 Aldine Westfield Road
Houston, TX 77073

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Chubb. After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Voluntary AD&D plan are fully insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of Baker Hughes receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to Chubb within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim denial, without regard to whether the advice was relied upon in making the claim denial, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,
- a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request to Chubb, and
- a statement that, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, that such rule, guideline, protocol or other similar criterion, a copy thereof will be provided free of charge upon written request to Chubb.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the Voluntary AD&D plan. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send the written appeal to the following address:

Chubb Group of Insurance Companies
Claims Service Center
600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700

Upon receipt of the claimant's written appeal, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records, and other information relevant to the claimant's claim for benefits;
- A statement of the right to sue in federal court under Section 502(a) of ERISA;
- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- Explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits; and
- A description of any applicable contractual limitations period that applies to your right to bring a civil action under section 502(a) of ERISA, including the calendar date on which the contractual limitation period expires for the claim at issue.

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to bring a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Basic AD&D plan after two years from the date the Basic AD&D plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Voluntary AD&D plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Basic AD&D policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- Your spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

When Does Coverage End?

Your coverage under the Voluntary AD&D plan will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Conversion of Coverage

If your coverage is terminated for any reason, other than termination of the policy, your insurance and your dependent's insurance may be converted to individual policies up to the amount for which you are insured or $250,000, whichever is less. To take advantage of conversion of coverage, you must make an application and submit the required premium within 90 days following the date your insurance terminates.

Coverage will not be in effect after the date your insurance terminates until your application for conversion is received. The cost of the converted policy will be based upon the commercial insurance company's individual policy rates in effect at the time of application. For more information about conversion of Voluntary AD&D benefits call **1-877-297-4225**.

Business Travel Accident Insurance Plan

Business Travel Accident Insurance Plan At-a-Glance

Type of Plan	Welfare plan that provides Business Travel Accident insurance for employees traveling on Company business
Who Pays the Cost	Baker Hughes pays 100% of the cost of your business travel insurance.
Employee Eligibility	All employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	No enrollment necessary. You are automatically covered when traveling on business for Baker Hughes.
Coverage Options	• Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof subject to a minimum principal sum of $50,000; maximum $3 million. Your coverage amount is referred to as the principal sum by the insurance provider (and for purposes of this *Business Travel Accident* insurance section). • Maximum for spouse during relocation in connection with the relocation of the employee is $25,000, provided that all travel is authorized by, and at the expense of, Baker Hughes. • Maximum for eligible dependent children during relocation in connection with the employee is $10,000, provided that all travel is authorized by, and at the expense of, Baker Hughes.
Contact	• Baker Hughes Benefits website: **BakerHughesBenefits.com** • The **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Your benefits base pay is determined as of October of the prior year, or your date of hire, whichever is later.

Note: This section of the SPD summarizes certain provisions of the Business Travel Accident plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by Chubb and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits** prepared by Chubb and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by Chubb, the certificate of coverage/insurance will prevail in all instances.

Your Business Travel Accident Insurance

The Baker Hughes Business Travel Accident program (the Business Travel Accident plan) is designed to provide you accident insurance when traveling on authorized Baker Hughes business. "Baker Hughes business" means all circumstances arising from or occurring while you are traveling on assignment by or at the direction of Baker Hughes, including relocation. Relocation means assignment to a new regular place of employment that is more than 50 miles from the prior place of employment.

What is the Employee's Cost of the Business Travel Accident Plan?

You do not contribute anything to receive Business Travel Accident insurance coverage. It is paid 100% by Baker Hughes.

When Does Coverage Begin?

Baker Hughes provides you with Business Travel Accident insurance coverage on the first day of active work. No enrollment is necessary. You must be traveling on authorized Baker Hughes business to receive a benefit.

How Does the Business Travel Accident Insurance Plan Work?

With the Business Travel Accident insurance plan, you have the following coverage:

Schedule of Benefits for Business Travel Accident Insurance	
Employee	Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof subject to a minimum principal sum of $50,000; maximum $3 million.
Spouse	Maximum for spouse during relocation in connection with the relocation of the employee is $25,000.
Dependent Children	Maximum for dependent children during relocation in connection with the employee is $10,000.

The coverage amount is referred to as the principal sum by the insurance provider. If you suffer accidental death, dismemberment, paralysis, or other covered losses while traveling on authorized Baker Hughes business or during relocation for a Baker Hughes assignment, the plan will pay a benefit that is a percentage of the principal sum, depending on the type of covered loss. The plan will also pay a benefit if your spouse or dependent children suffer accidental death, dismemberment, paralysis, or other covered losses.

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy issued by Chubb under the Business Travel Accident plan which is in force and is the direct cause of loss, if it occurs while with the employee during a relocation due to a Baker Hughes assignment.

Note: The Business Travel Accident plan does not cover you while you're routinely commuting to/from work.

What Losses are Covered by Business Travel Accident Insurance?

The amount of your Business Travel Accident insurance benefit is based on the type of loss that you, your spouse, or dependent children suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $15 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Note: The maximum benefit payable for one accident cannot exceed 100% of five times your benefits base pay or $3 million, whichever is less.

In the event you incur more than one loss in any one accident, only the single largest benefit is payable for all injuries.

Example:

If you lose a thumb and index finger on the same hand and hearing (in both ears), you would receive 50% of your principal sum.

Defining Loss

- Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by the insurance provider.
- Loss of foot means complete severance through or above the ankle joint, even if the foot is later reattached.
- Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least 3 fingers and the thumb on the same hand, even if the fingers and/or thumb are later reattached.
- Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a physician.
- Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.
- Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.
- Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.
- Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.
- Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints of the thumb and index finger of the same hand, even if one or both are later reattached.
- Paraplegia means complete and irreversible loss of all motion and all practical use of both legs, that lasts longer than 365 days, as determined by a physician.
- Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs, that lasts longer than 365 days, as determined by a physician.
- Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg, that lasts longer than 365 days, as determined by a physician.
- If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage, at the time of the accident.
- If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by the Plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible but in no event later than 365 days from the date of loss.

Business Travel Accident Exclusions

What Is Not Covered

- The Business Travel Accident program and the coverage provided by the program does not apply to any: accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in, or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resultingfrom, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide, or intentionally self-inflicted injury.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, at the time of an accident. Intoxication is defined by the laws of the jurisdiction where such accident occurs.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of a narcotic at the time of an accident. This exclusion does not apply if any narcotic or controlled substance is taken and used as prescribed by a physician.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.
- The Business Travel Accident program and the coverage provided by the program does not apply to any accident, accidental bodily injury, or loss when:
  - The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury, or loss, or
  - There is any other legal prohibition against providing insurance of any accident, accidental bodily injury, or loss.

Additional Business Travel Accident Benefits Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days of the accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within the first 30 days following the accident, the Business Travel Accident insurance plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% of the loss-of-life benefit amount, whichever is earlier. The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal benefit amount is paid in full
- The date of recovery or death

If you or a covered family member dies within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Psychological Therapy Expense

The Business Travel Accident insurance plan pays a benefit if a physician determines the need for you or a covered family member to have psychological therapy after suffering a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Rehabilitation Expense

The Business Travel Accident insurance plan pays a benefit if you or a covered family member suffers a loss covered under the plan which prevents the insured person from performing all the duties of his or her regular occupation and requires rehabilitation, as determined by a physician approved by the insurance provider.

The benefit pays for Reasonable and Customary (R&C) rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Seat Belt and Occupant Protection Device Coverage

If you or a covered family member dies as the result of a private passenger automobile accident and the insured person was wearing a seat belt at the time, the Business Travel Accident insurance plan will pay an additional benefit of 10% for seat belt and 10% for occupant protection device. The overall maximum additional benefit for both is 20% of the principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- The insured person was an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

If it cannot be determined if the insured person was wearing a seat belt at the time of the accident, a limited alternate benefit of $2,000 will be paid in addition to the accidental loss-of-life benefit.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer's instructions.

The plan will also pay a benefit for an occupant protection device if you or a covered family member is positioned in a seat protected by a properly deployed occupant protection device. An occupant protection device means either an airbag, which inflates for added protection to the head and chest areas or any other personal safety restraint system other than a seat belt recognized by the U.S. National Highway Transportation Safety Board. The occupant protection device benefit will only be paid if a benefit is paid for seat belt coverage, other than the alternate benefit amount.

Verification of actual use of the seat belt and proper operation of the occupant protection device at the time of an accident must be part of an official report of such accident or be certified, in writing, by an investigating police officer.

Definition: Accidental Bodily Injury means bodily injury, which is:

- Accidental;
- The direct cause of a loss; and
- Occurs while a person is insured under this policy, which is in force.

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:

- Osgood-Schlatter's disease;
- Bursitis;
- Chondromalacia;
- Shin splints;
- Stress fractures;
- Tendinitis; and
- Carpal tunnel syndrome.

Filing a Business Travel Accident Claim

To claim benefits under the Business Travel Accident program, you or your beneficiary who is entitled to benefits (the claimant) must contact the **Baker Hughes Benefits Center** at **1-866-244-3539**. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Company, LLC
Attn: Total Rewards H&W Department
17021 Aldine Westfield Road
Houston, TX 77073

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Chubb Group of Insurance Companies (Chubb). After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Business Travel Accident insurance plan are fully insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of Baker Hughes receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to Chubb within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and an explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

In addition, if the claim involves a disability determination, Chubb must also include the following information:

- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your claim denial, without regard to whether the advice was relied upon in making the claim denial, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,
- A statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request to Chubb, and
- A statement that, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, that such rule, guideline, protocol or other similar criterion, a copy thereof will be provided free of charge upon written request to Chubb.

Appealing the Denial of a Claim

The claimant or an authorized representative may appeal any denial of a claim for benefits. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send the written appeal to the following address:

Chubb Group of Insurance Companies
Claims Service Center
600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700

Upon receipt of the claimant's written appeal, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits; and
- A statement of the right to sue in federal court under Section 502(a) of ERISA.

For disability claims only, it will also include:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision, and
- Explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, if applicable.
- A discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of your treating providers and vocational professionals who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) the disability determination you provide concerning an award to you of Social Security Administration disability benefits, and
- A description of any applicable contractual limitations period that applies to your right to bring a civil action under section 502(a)of ERISA, including the calendar date on which the contractual limitation period expires for the claim at issue.

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to bring a civil action under the Employee Retirement Income Security Act (ERISA).

No legal action may be brought to recover on this policy until sixty (60) days after Chubb has been given complete Proof of Loss. No such action may be brought after three (3) years from the time complete Proof of Loss is required to be given. No such action may be brought unless there has been full compliance with all of the terms of this policy.

In no case will Chubb be liable for benefits that are not payable under the terms of this policy or that exceed the applicable Benefit Amounts or limits of insurance of this policy.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Business Travel Accident policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for your loss-of-life, will be paid to you. Benefits for your loss-of-life will be paid to the Basic Life beneficiary designated by you. If no such designation has been established, then the benefits will be paid to the first surviving class in the following order:

- Your spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

When Does Coverage End?

Your coverage under the Business Travel Accident policy will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Legal Benefit

The Legal Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan providing legal advice and assistance.
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work)
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Family • No Coverage
Contact	LegalEASE: **1-888-416-4313** and reference Baker Hughes Company, LLC or your Member ID.

Note: This benefit summary is intended to highlight the Legal Plan's benefits and should not be relied on to determine coverage. Please refer to the certificate of coverage issued upon enrollment for a more complete explanation of your coverage. If this benefit summary conflicts with the certificate of coverage, the certificate of coverage will prevail.

Overview

The LegalEASE plan can ease the biggest stresses - finding and paying for legal expertise when you need it most. The LegalEASE plan provides benefits for both in-network and out-of-network assistance with your personal legal matters; from complex litigation, such as divorce and bankruptcy, to the more basic, such as drafting a lease agreement or updating a will.

What is the Employee's Cost of the Plan?

If you decide to enroll yourself or your family in the LegalEASE plan, you'll pay the cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your coverage level.

When Does Coverage Begin?

If you elect the LegalEASE plan, coverage begins on the first active day of work if you're a new hire or an existing employee transferring to a position with U.S. benefits, or on January 1 after you elect it during Annual Enrollment.

What is Covered by the Legal Plan?

The chart below summarizes a few of the popular services offered under the plan, and the maximum benefits when you seek coverage in-or out-of-network.

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Advice and Consultation			
Document Review (up to 6 pages)	Unlimited	Covered	$60
Financial Helpline			N/A
Initial Law Office Consultation	One hour per calendar quarter		$60/consultation
Legal Helpline; Online Legal Access	Unlimited		N/A
Consumer Matters			
Document Preparation (e.g., simple deed, promissory note, consumer dispute correspondence, installment sales agreement, simple affidavit, lease agreement [tenant only], timeshare agreement)	One use per year (One of each document)	Covered	$60/document
General Power of Attorney	One use per year		Employee – $40/document Family member – $60/document
Life Insurance Claims	Up to $2,000*		Up to $2,000*
Small Claims Court Representation	Up to 2 hours		$120
Consumer Dispute	One use per year		$60
Will, Codicil, Trust, and Probate			
Living Trust Document	One use per year	Covered	$240
Living Will, Health Care Power of Attorney			$40
Probate of Small Estate	Up to 2 hours		$120
Will or Codicil (includes member, spouse, family member)	One per year per person		$90/document
Will (complex)		25% discount	Not covered
Residential Matters			
Landlord/Tenant Dispute	Up to $2,000*	Covered	Up to $2,000*
Purchase of Primary Residence, including DocumentPreparation and Closing	One per year		$420
Refinancing Primary Residence			$150
Sale of Primary Residence			$240

*Subject to managed case rules.

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Financial Matters			
Bankruptcy Chapter 7 or 13	Up to defined in-network or out-of-network maximums	Up to $750*	Up to $660*
Debt Collection Defense	One use per year	Debt Collection Defense	
• Pre-litigation defense activities		Covered	$120
• Trial defense		Up to $700*	$480*
Identity Theft – Prevention/Recovery Assistance • Initial consultations with trained specialists (consultations can also be online) • Recovery document preparation/ review by a local attorney • Personal ID recovery package	Four per year	Covered	Not covered
Tax Audit Representation	Up to $2,000*		Up to $2,000*
Family Law			
Divorce/Separation – Uncontested	Up to 10 hours	Covered	Divorce – $500 Separation – $200 Consent/default divorce – $300
Divorce – Contested	Up to $2,000, or 28.5 hours*		Up to $2,000*
Guardianship/Conservatorship	One use per year	Contested: 25% discount	$400
Juvenile Court Proceedings		Covered	$375
Name Change			$200
Government Agency Adoptions		Covered	$300
Uncontested Stepparent Adoptions		Covered	$300
Civil/Criminal Defense			
Civil Litigation Defense	One use per year/up to $2,000*	Covered	Up to $2,000*
Criminal Defense	One use per year	Debt Collection Defense	
• Administrative proceeding (regarding suspension or revocation of license)		Covered	$200
• Misdemeanor defense		Up to $2,000*	Up to $2,000*
Miscellaneous Law Office Services			
Miscellaneous Law Office Services	Unlimited	25% discount from fee	Not covered

*Subject to managed case rules.

Note: Do not rely on this chart alone. It merely summarizes your benefits. Call the Baker Hughes Benefits Center at **1-866-244-3539** or LegalEASE at **1-888-416-4313** for a more complete explanation of your coverage.

Elder Parent Coverage

Parents of the plan member and the member's spouse are eligible for certain benefits under the Legal Plan if the member elected "Family" coverage. The benefits specified below extend not only to the member's parents and the member's spouse's biological parents, but to their step-parents and adoptive parents, as well.

Elder Parent Coverage includes:

- Legal Advisor Helpline – Advice and consultation with a plan attorney by toll-free telephone.
- Financial Helpline – Financial consultation by toll-free telephone.
- Simple Will preparation – One simple Will per eligible parent, per year
- Living Will preparation – One living Will per eligible parent, per year

Identity Theft Recovery Assistance Coverage

Coverage includes a basic Identity Theft HelpLine Service for covered members, their spouse and children, including stepchild, legally adopted child, child placed in the home for adoption and foster child, up to age 19, and from age 19 up to 26 years if they are primarily dependent upon the member for support, regardless of whether they are full-time students, married, or eligible for group health plan coverage.

Identity Theft Assistance Coverage includes:

- Advice and Consultation: ½ hour telephonic consultations (4 per year) with a Trained Identity Theft Recovery Specialist
- Personal Recovery Kit: designed to walk the member or family member step-by-step through the process of recovery
- Simple Recovery Letter preparation by plan attorney: a plan attorney will draft the simple affidavits to submit to specific agencies and organizations needed to establish the theft of the identity and prevent further loss of identity and credit rating
- Review of necessary recovery legal documents: up to 6 pages each

Exclusions

The following benefits are excluded:

- Appellate court proceedings, class actions, interventions, derivative action, and amicus curiae filings.
- The preparation and filing of individual, partnership or estate tax returns, appellate or administrative proceedings related to tax returns, litigation before the U.S. Tax Court, U.S. Court of Claims or any other federal, state or other courts with respect to tax matters.
- Matters relating to securities, trademark or patent matters; business or commercial interests, including, but not limited to, professional, partnership, and/or corporate matters; matters involving the law or laws of jurisdictions other than the United States and its territories; any matters involving a government (domestic or foreign) entity or agency; farm-related issues; matters involving commercial or rental property transactions, including the purchase, sale or lease of investment or income-producing property. A two-family house, whether or not used by the Member as his or her primary residence, is deemed an investment or income-producing property.
- Legal services which are fully paid for or provided at no cost by any governmental agency, organization or insurance company.
- Matters that the attorney deems frivolous, spurious, harassing, or unethical (collectively referred to as "frivolous") or otherwise prohibited by the Model Rules of Professional Conduct of the state in which the attorney is licensed.
- Costs associated with covered legal services, including but not limited to, all fines, court costs, penalties, sanctions, expert witness fees, bonds, bail bonds, attorney fees, exhibits, deposition costs, filing fees, transcripts, postage, telephone, photocopying, recording fees, messengers, judgements, jury fees, court reporter fees, investigative costs and all other incidental and out-of-pocket legal and litigation costs.
- Any services on behalf of a Family Member against the interests of the Member.
- Any employment-related matter. This includes, but is not limited to, any dispute involving the Member's Employer or its affiliates, their officers or directors, the Member's employee benefit plans, credit unions, programs or arrangements sponsored by an employer, or cases involving workers' compensation, unemployment compensation, sex harassment, age discrimination, etc.
- Any dispute or proceeding against the following persons or entities, their officers, directors, employees, or agents: any person or entity involved in the sale of the group policy; Administrator or its subsidiaries; Policyholder; Member's Employer; Virginia Surety Company, Inc. it's parents, subsidiaries or any affiliated or successor company, plan underwriter or reinsurer; Plan Sponsor; or any Participating and/or Non-Participating Attorney, if the dispute or proceeding pertains to services provided under the group policy / Certificate of Coverage.
- Except regarding LegalEASE Helpline and Financial Helpline services, benefits will not be provided in connection with pre-existing matters, which includes any matter where the Member and/or Family Member is on notice as to a pending legal dispute or has previously contacted an attorney.

Contacting a Legal Plan Representative

Prior to receiving any legal services, you must first contact the LegalEASE call center at **1-888-416-4313**. Reference Baker Hughes Company, LLC or your Member ID when calling. Member services is available from 7:30 a.m. to 7:30 p.m., CST. A Personal Access Specialist will match you to an available network attorney. You may choose to use a network attorney and receive the network benefits of the plan, or pay more when you go out-of-network. No matter your decision, you should contact the Legal Plan prior to incurring any legal expenses.

When Does Coverage End?

Coverage in the Legal Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The plan terminates
- You do not make the required contributions

If you are interested in continuing your coverage once your employment with Baker Hughes ends, or are currently involved in a legal matter before any of the above occur contact LegalEASE directly.

When Coverage Ends

If you become ineligible to participate in the Legal Plan through the Company, you will receive a letter to continue coverage after you leave the Company. You must contact LegalEASE within 31 days from the date your coverage ended to elect to continue coverage.

Critical Illness Plan

Critical Illness Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for critical illness
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee must be actively at work on the effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Spouse • You + Children • You + family
Maximum Benefit Amount	**Option 1** • Employee: $15,000 • Spouse: $15,000 • Child: $7,500 **Option 2** • Employee: $30,000 • Spouse: $30,000 • Child: $15,000
Wellness Benefit	$50 per plan year.
Contact	UnitedHealthcare: **1-800-444-5854**

Note: The information represented in this Summary Plan Description merely summarizes your benefits. Please read the full disclosure document posted on **http://go/mybenefits** or call UHC at **1-800-444-5854** for more details. If this benefit summary conflicts with the certificate of coverage issued upon enrollment, the certificate of coverage shall prevail.

Note: This section of the SPD summarizes certain provisions of the Business Travel Accident plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by UnitedHealthcare, and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits**, prepared by UnitedHealthcare, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by UnitedHealthcare, the certificate of coverage/insurance will prevail in all instances.

Overview

The UnitedHealthcare Critical Illness protection plan provides a lump sum payment if the covered person is diagnosed with certain specified diseases or has certain specified surgeries for the first time after insurance takes effect.

Critical Illness insurance coverage helps offset expenses not reimbursed by other types of insurance such as copays, deductibles, mortgage payments, child care, and other household expenses. This supplemental insurance option complements your existing medical and disability income insurance coverage by providing you with a lump-sum payment upon diagnosis of a covered illness.

Coverage is guaranteed provided the employee is actively at work on the coverage effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.

Employee and Spouse Benefits for Covered Conditions

Condition	Maximum Benefit
Benign Brain Tumor	100%
Cancer – Invasive Level 1	100%
Cancer - Non-Invasive Level 2	25%
Chronic Renal Failure	100%
Coma	100%
Coronary Artery Disease	100%
Heart Attack	100%
Heart Failure	100%
Major Organ Failure	100%
Permanent Paralysis	100%
Ruptured Aneurysm	100%
Stroke	100%

Child Critical Illness Benefits for Covered Conditions

Condition	Maximum Benefit
Cerebral Palsy	25% of employee's amount
Cleft Lip / Palate	25% of employee's amount
Cystic Fibrosis	25% of employee's amount
Down Syndrome	25% of employee's amount
Muscular Dystrophy	25% of employee's amount
Spina Bifida	25% of employee's amount

Reoccurrence Benefit:

Included
For each Category, not to exceed:

- 100% of Employee's Maximum Benefit Amount
- 100% of Spouse's Maximum Benefit Amount
- 100% of Child's Maximum Benefit Amount (whichever applies)

Portability

- Portability Policy Age Limit Included
- Coverage continued under Portability terminates at Age 75

Critical Illness Protection Plan Example

Say you enroll in the $15,000 coverage and you or a covered dependent has a heart attack. If you are enrolled in the Premium HSA option:

Critical Illness	Benefit Impact
Your estimated out-of-pocket costs (deductible, coinsurance) would be	$5,000
The Critical Illness plan would pay an Initial Benefit of	$15,000
If the same person had another heart attack, the Recurrence Benefit would be	$15,000

Wellness Benefit

If a covered person takes one of the screening/prevention measures listed below while insured under the Plan and after the insurance has been in effect for 30 days, UHC will pay a $50 health screening benefit upon submission of proof that such measure was taken. UHC will pay one health screening benefit per covered person per calendar year.

The screening/prevention measures for which a health screening benefit may be paid are:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the policy is in force and you and your dependents remain insured under this benefit. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments you and/or your dependents receive under the policy.

Interaction with Wellness Benefit: If you have purchased this Wellness Benefit under more than one policy issued by UnitedHealthcare, the Wellness Benefit for any Health Screening Test is payable only once per plan year for each person insured under this benefit, regardless of any other such benefit. Another Wellness Benefit is only payable if it is for a different Health Screening Test issued under a separate policy.

What is the Employee's Cost of the Plan?

If you decide to enroll in the Critical Illness plan, you'll pay the full cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your age and coverage level.

Premium Rate Change: Your premiums and the premiums for your covered dependents may change when your premium is due, if rates are changed under the policy.

When Does Coverage End?

Coverage in the Critical Illness plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The date you die
- The plan terminates
- You do not make the required premium payments

When Coverage Ends

If you become ineligible to participate in Critical Illness coverage through Baker Hughes, you will receive a letter from the **Baker Hughes Benefits Center** to continue coverage outside of the group plan at the same group premium rates. You must contact UHC Portability Department at **1-877-495-5743** within 31 days from the date your coverage ended to elect to continue coverage.

Exclusions

The Critical Illness plan will not cover a Critical Illness if it is due to:

- an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
- loss sustained while on active duty as a member of the armed forces of any nation except during any time period coverage is extended under the Continuation during Leave of Absence provision;
- any intentionally self-inflicted Injury;
- active participation in a riot;
- committing or attempting to commit a felony, or participating or attempting to participate in a felony;
- use of alcohol or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician;
- cosmetic or elective surgery; or
- attempted suicide, while sane or insane.

The Critical Illness plan also will not pay a benefit for a Critical Illness:

- for which the Employee's or Dependent's Date of Diagnosis for any type of Critical Illness, as defined in the Critical Illness policy, was prior to his Effective Date of coverage;
- that was diagnosed outside of the United States or Canada unless the diagnosis was confirmed by a Physician practicing within the United States or Canada; or
- with respect to a Dependent who is a Child, that is caused by or contributed to by a congenital defect.

Multiple Critical Illness Limitation

An Employee or Dependent can receive benefits for different Critical Illnesses described in this section if the Dates of Diagnosis for each Critical Illness is separated by at least 90 days.

Coverage for the Employee or the Dependent will cease when the employee is not eligible for any further benefits.

Accident Protection Plan

Accident Protection Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for accidents
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee must be actively at work on the effective date. If the employee is not actively at work, the coverage will be effective on the day the employee returns to active status.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a qualifying change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Spouse • You + Children • You + family
Wellness Benefit	$50 per plan year.
Contact	UnitedHealthcare: **1-800-444-5854**

Note: This section of the SPD summarizes certain provisions of the Accident Protection Plan and generally describes a plan participant's benefits and obligations under the plan. However, it cannot be relied on to determine a plan participant's rights and obligations under the plan. The plan is funded by an insurance policy issued by UnitedHealthcare, and the terms of the applicable insurance policy determine the benefits and obligations under the plan. Please refer to the certificate of coverage/insurance or other disclosure document for the plan posted on **http://go/mybenefits**, prepared by UnitedHealthcare, and issued upon enrollment in the plan for a complete explanation of your rights and obligations. If this section conflicts with the certificate of coverage/insurance provided by UnitedHealthcare, the certificate of coverage/insurance will prevail in all instances.

Overview

The United Healthcare Accident Protection Plan will pay money back to you if you have a covered injury and need covered care. The amount you receive is based on the covered expenses, which may include emergency room services, surgeries, recovery care and more. You can use the money to help pay your health plan deductible and other out-of-pocket costs. Or, use it to make up for lost wages, to help pay your mortgage or rent, and more.

After you submit a claim request and it is verified as a covered injury, your plan will send the benefit payment directly to you and you can use that money any way you see fit.

Here's a short list of the types of injuries that may qualify for a benefit payment but many other injuries may be covered.

- Fractures
- Dislocations
- Lacerations (cuts)
- Loss of fingers and toes

Base Benefits for covered expenses (per accident)

These are the base benefits for the Accident Protection Plan. The payment amount is what the plan will pay directly to you when your claim is submitted and approved.

Accidental Death & Dismemberment		
Life	Employee/Spouse Child*	$30,000 $15,000
Both hands or feet or combination	Employee/Spouse Child*	$30,000 $15,000
One hand or foot	Employee/Spouse Child*	$15,000 $7,500
Two or more fingers or toes or combination	Employee/Spouse Child*	$6,000 $3,000
One finger or toe	Employee/Spouse Child*	$3,000 $1,500
Accidental Death Common Carrier**	Employee/Spouse Child*	$120,000 $60,000

*Child benefit is 50% of employee/spouse.

**A common carrier is a company that provides some sort of public transportation. For the types of public transportation covered by United Healthcare's Accident Protection Plan, refer to the Certificate of Coverage. This information does not replace your Official plan documents. Please see your official plan documents for all coverage details, which includes limitations and exclusions.

Initial Care		Hospital Care	
Ground Ambulance	$300	**Hospital Admission**	$1,200
Air Ambulance	$1,800	**Hospital Inpatient Stay**	$240
ER Treatment	$150	**Hospital Intensive Care Unit (ICU) Admission**	$3,750
Physician Office/Urgent Care (per visit)	$60	**Hospital ICU Inpatient Stay** (per day up to 30 days)	$750

This information does not replace your official plan documents. Please see your official plan documents for all coverage details, which includes limitations and exclusions.

Wellness Benefit

The Plan will pay the amount the Maximum Benefit Amount shown for this Benefit in the Schedule per plan year for any one of the following health screening tests performed for the Covered Person.

The term Health Screening Test means any one of the following tests:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- Virtual Colonoscopy

This benefit will be paid as long as the Policy is in force and the Covered Person remains insured under this Benefit of the Policy. The benefit will be paid regardless of the results of the test. The Wellness Benefit is paid in addition to any other payments the Covered Person receives under the Policy.

Only one health screening test will be covered upon receipt by the Plan of adequate documentation to support the performance of any test for the Covered Person.

What is the Cost of the Plan?

If you decide to enroll in the Accident Protection Plan, you'll pay the full cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your age and coverage level.

Premium Rate Change: Your premiums and the premiums for your covered dependents may change when your premium is due, if rates are changed under the policy.

When Does Coverage End?

Coverage in the Accident Protection Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The date you die
- The plan terminates
- You do not make the required contributions

When Coverage Ends

If you become ineligible to participate in Accident Protection coverage through Baker Hughes, you will receive a letter from the **Baker Hughes Benefits Center** to continue coverage outside of the group plan at the same group premium rates. You must contact UHC Portability Department at **1-877-495-5743** within 31 days from the date your coverage ended to elect to continue coverage.

Exclusions

We will not cover any loss caused or contributed to by:

- Disease, bodily, or mental infirmity, or medical or surgical Treatment of these (except pyogenic infections through an accidental wound);
- Suicide or intentionally self-inflicted injury, while sane or insane;
- Participation in a riot or insurrection, or commission of a felony;
- War or any act of war, declared or undeclared;
- Voluntary use of drugs, hallucinogen, controlled substance, or narcotic unless prescribed by a physician;
- Participating in any event or activity, including the operation of a vehicle, while intoxicated or under the influence according to the applicable state law where the loss occurred;
- Engaging in the following hazardous activities: skydiving, hang gliding, sail gliding, parasailing, para kiting, motorized dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- Travel or flight in, or descent from any aircraft (excluding company aircraft), unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people;
- Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

Benefits Rights

Baker Hughes

Important Benefits Rights

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

This SPD is designed to inform you about benefits that Baker Hughes provides and how you may receive them. However, your participation in any of the benefit plans is not a guarantee of continued employment. The Company reserves the right to retain employees at its own discretion, regardless of benefits offered to them. Nothing in this SPD should be interpreted as a limitation of or restriction on that right. Also, in general, you cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit under any Baker Hughes Health & Welfare benefit program.

Importance of a Current Address

Because benefit-related information is mailed to you, you must notify your local human resources representative of any change to your current address. Otherwise, you may not receive important information about your benefits.

If you provided a personal email address on **http://go/mybenefits** you will also need to update your email address should it change.

Remember, if you terminate employment and are entitled to benefits under a Baker Hughes Health & Welfare benefit plan, you must keep the **Baker Hughes Benefits Center** informed of your current mailing address. If not, your benefits related information may not reach you.

Keeping Your Health Information Private

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Baker Hughes group health plans described in this SPD (the Health Plans) are required to protect the confidentiality of your private health information, and to provide individuals with notice of its legal duties and privacy practices with respect to that information. This notice covers the privacy practices of the Baker Hughes self-funded and fully insured Health Plans.

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

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

How the Health Plans May Use Your Protected Health Information

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

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

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

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

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

- Enrollment/dis-enrollment data – information on whether you participate in the Health Plan or whether you have enrolled or dis-enrolled from a Plan option (e.g., HMO), and
- Summary health information – summaries of claims from which names and other identifying information have been removed for purposes of obtaining premium bids from health plans or modifying, amending, or terminating a Health Plan.

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

Permitted Uses and Disclosures

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

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

In Special Situations…

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

The Health Plans are prohibited from using or disclosing your Protected Health Information when it is considered genetic information for underwriting purposes except to the extent that a Health Plan is an issuer of long-term care policies.

Uses of Protected Health Information Requiring Authorization

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

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

Your Rights Regarding Protected Health Information

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

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

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

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

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

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

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

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

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

Baker Hughes Company, LLC
HIPAA Privacy Officer
17021 Aldine Westfield Road
Houston, TX 77073
Tel: **1-800-229-7447** or **1-713-439-8600**

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

The Health Plans maintain a formal privacy notice (i.e., Notice of Privacy Practices), which provides a complete description of your rights under HIPAA's privacy rules. The most recent version of the privacy notice is located on the Baker Hughes Benefits website (**BakerHughesBenefits.com**). The Health Plans are required to abide by the terms of the notice currently in place. The effective date of the most current notice is September 1, 2019. The Health Plans reserve the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information that it maintains. The Health Plans will provide individuals with a revised notice on **BakerHughesBenefits.com**.

Contact your local human resources representative, the Corporate Benefits Department, or the HIPAA privacy officer to obtain a printed copy of the privacy notice. If you have questions about the privacy of your health information, please contact the Company's privacy officer.

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

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

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

Special Enrollment Rights

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

Special Enrollment Due to Loss of Other Medical Coverage

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

If your other coverage was group health plan continuation coverage mandated by COBRA, you will become eligible for special enrollment when your COBRA rights are exhausted. However, you will not become eligible if you lose COBRA coverage without exhausting your rights (for example, if you stop paying premiums). If your other group health plan coverage was non-COBRA coverage, you will become eligible for special enrollment if an employer that had been contributing to the cost of coverage stopped making those contributions or if your coverage terminated when you ceased to be eligible (for example, through legal separation, divorce or loss of dependent status). However, you must request special enrollment within 31 days after you or your qualifying dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Special Enrollment Due to Acquisition of a Dependent

If you are enrolled in one of the Health Plans described in this SPD and during the year you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, your dependent will be eligible for special enrollment in the plan, if the dependent meets the definition of an eligible dependent.

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

You must request special enrollment within 31 days after the applicable marriage, birth, adoption or placement for adoption. Enrollments following a marriage, birth, adoption or placement for adoption will be effective as of the date of the marriage, birth, adoption or placement for adoption.

Note: over aged dependents cannot be added to the plan during a QSC.

Special Enrollment for Certain Changes in Medicaid or CHIP Coverage

If you or your eligible dependent are eligible to enroll in one of the Health Plans described in this SPD but are not enrolled, you or your eligible dependent will be entitled to enroll for coverage under the plan if:

- You or your eligible dependent were covered under a Medicaid plan or under a state child health plan and that coverage was terminated because you or your eligible dependent lose eligibility for that coverage, or
- You or your eligible dependent become eligible under a Medicaid plan or under a state child health plan for assistance with your premium payments due under one of the Health Plans described in this SPD.

However, you must request enrollment in the plan not later than 60 days after the date of termination of the Medicaid plan or state child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

Some states have a Medicaid plan or a child health plan (CHIP) that can help pay for employer-provided group health plan coverage like that provided by the Health Plans described in this SPD. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health plan premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact that program to find out if premium assistance is available to you.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state's Medicaid or CHIP program to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for coverage under the plan.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical plan options described in this SPD are in compliance with this law.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Act. Under the Act, the Medical options and the Claim Administrators that offer mastectomy coverage under the options must for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

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

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

Coverage for Maternity Hospital Stay

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

Subrogation and Reimbursement

The Baker Hughes funded plan has a right to subrogation and reimbursement. For these purposes, a Baker Hughes funded plan means a Baker Hughes Health & Welfare benefit program that was not provided or funded through an insurance policy, a health maintenance organization (HMO) or dental maintenance organization (DMO). References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when a Baker Hughes funded plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly, may be, or is alleged to be, responsible. The right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the a Baker Hughes funded plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits. The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Baker Hughes funded plan 100% of any Benefits you receive for that Sickness or Injury from the plan. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example:

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the a Baker Hughes funded plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Sponsor An employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Baker Hughes funded plan and the Employer in protecting the plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the plan.
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.
- To promptly notify the Baker Hughes funded plan and Claims Administrator of the plan of any developments of which your or your legal counsel or other representative is aware that may impact the plan's reimbursement or subrogation rights.

Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan.

If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.

The Baker Hughes funded plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Baker Hughes funded plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent.
- No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Baker Hughes funded plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Benefits paid by the Baker Hughes funded plan may also be considered to be Benefits advanced.
- That the Baker Hughes funded plan will be reimbursed in full before any amounts (including attorney's fees incurred by you or affiliate) are deducted from the recovery proceeds for any reason, without regard to the sufficiency of the recovery;
- That any payment of Benefits under the Baker Hughes funded plan will only be made on the condition and with the understanding that the plan will be reimbursed.
- If you or your legal counsel receive any payment from any party as a result of Sickness or Injury, and the Baker Hughes funded plan alleges some or all of those funds are due and owed to the plan, you, your legal counsel and/or your other representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Baker Hughes funded plan, you agree that (i) any amounts recovered by you from any third party shall constitute plan assets to the extent of the amount of plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the plan (within the meaning of ERISA) with respect to such amounts and will comply with the fiduciary standards of ERISA with respect to such recovery proceeds until the plan's reimbursement rights relating to such recovery proceeds have been satisfied in full, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the plan to enforce its reimbursement rights.
- The Baker Hughes funded plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Baker Hughes funded plan, you agree to assign to the plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Baker Hughes funded plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the plan is governed by a six-year statute of limitations.
- That you and your legal counsel will not accept any settlement that does not fully reimburse the plan, without its written approval.
- The Baker Hughes funded plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Baker Hughes funded plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party., and to the parents, guardian, and other representatives of such Dependent child. If a parent or, guardian or other representative may bring a claim for damages arising out of a minor Dependent child's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third-party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this the Baker Hughes funded plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Baker Hughes funded plan pertaining to reimbursement, the Baker Hughes funded plan may terminate Benefits to you, your dependents or the participant employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to your failure to abide by the terms of the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.
- That no action will be taken that will frustrate or impede the Baker Hughes funded plan's right of reimbursement or subrogation.
- The Baker Hughes funded plan and all Administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Right of Recovery

- The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:
- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery. If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

If a Baker Hughes funded benefit plan described in this SPD pays with respect to benefits for expenses incurred on account of a covered person, that covered person, and any other person or organization that was paid, must make a refund to the plan if:

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

The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the Baker Hughes funded benefit plan. If the refund is due from another person or organization, the covered person agrees to assist the Baker Hughes funded benefit plan obtain the refund, when requested.

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

As a participant in certain of the Baker Hughes Health & Welfare benefit programs, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to the following rights:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or at **www.dol.gov/ebsa**, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA

Tip!

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

What is COBRA Coverage?

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

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

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

COBRA Qualifying Events

If you're an active employee covered by a group health plan, you may elect COBRA coverage if your coverage under the plan is lost because:

- Your hours of employment are reduced, or
- Your employment terminates (other than for gross misconduct).

If you're a covered spouse of a covered active or former employee, you may elect COBRA coverage for yourself if your coverage under the group health plan is lost for any of these reasons:

- Your spouse dies;
- Your spouse's hours of employment are reduced or employment terminates (other than for gross misconduct);
- You are divorced or legally separated from your spouse; or
- Your spouse becomes entitled to coverage under Medicare.

If you're a covered dependent child of a covered active or former employee, you may elect COBRA coverage for yourself if your coverage under the group health plan is lost for any of these reasons:

- The covered employee dies;
- The covered employee's hours of employment are reduced or employment terminates (other than for gross misconduct);
- Your parents divorce or legally separate;
- You cease to qualify as a dependent child of the covered employee under the group health plan; or
- The covered employee becomes entitled to coverage under Medicare.

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

Special Rules Apply if You Take a Leave Under FMLA

Taking a leave under the FMLA (see the *Leave of Absence* section) is not a qualifying event under COBRA. However, a COBRA qualifying event will occur on the last day of the FMLA leave if:

- You (or your dependent) are covered under the group health plan on the day before the FMLA leave begins;
- You do not return to employment with Baker Hughes at the end of the FMLA leave; and
- You (or your dependent) would otherwise qualify for COBRA coverage.

If the above requirements are met, COBRA coverage would continue for up to 18 months from the last day of your FMLA leave.

Type of Coverage Available Under COBRA

Continuation of coverage under the Medical, Dental, and Vision plans and the EAP, and limited continued participation in your Health Care Flexible Spending Account that is available under COBRA is the same coverage provided to covered active persons on the day before the COBRA qualifying event. If coverage under one of the group health plans is modified for covered active employees, the COBRA coverage will also be modified in the same manner. During the Annual Enrollment periods, as long as you are entitled to COBRA coverage, you have the same Annual Enrollment period rights that covered active employees have to add or eliminate coverage of family members or to switch to another applicable benefit option under the group health plans.

COBRA Eligibility

To receive continuation coverage under COBRA, you or a family member **must** notify the **Baker Hughes Benefits Center** when a covered employee and spouse divorce or legally separate, when a dependent child of the covered employee ceases to qualify as a dependent child under the group health plan, or when a covered employee or covered dependent becomes disabled. You, or your spouse or dependent, must contact the **Baker Hughes Benefits Center** at **1-866-244-3539** within 60 days after the event and provide the necessary information regarding the event. If you do not provide timely information to the **Baker Hughes Benefits Center**, the **Baker Hughes Benefits Center** cannot provide notice of COBRA continuation coverage rights resulting from that event and you and/or your spouse or dependents will not be entitled to receive COBRA continuation coverage. After the **Baker Hughes Benefits Center** is notified that a COBRA qualifying event has occurred, you and your qualifying dependents will be notified of your rights (via mail) to elect COBRA coverage and provided with application materials. You then have 60 days from the post-mark date of those materials to call the **Baker Hughes Benefits Center** to make COBRA elections. Covered employees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

You do not have to provide Evidence of Insurability to elect COBRA coverage. Once you or your dependents are receiving COBRA coverage, if you change your marital status or if you, your spouse, or your dependents change addresses, you should notify the **Baker Hughes Benefits Center** immediately.

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

Electing COBRA Coverage for New Dependents

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

COBRA Period

COBRA allows you to continue your coverage under a group health plan for up to the periods described below (other than the Health Care Flexible Spending Account to which special rules described in the section titled *Special COBRA Rules for the Health Care Flexible Spending Account* apply):

If You Experience One of these Qualifying Events	COBRA Coverage May be Elected for	Up to a Maximum of
Your death	Your spouse and/or dependent children	36 months
Your divorce or legal separation	Your spouse and/or dependent children	
Your children are no longer eligible for benefits under the group health plan	Your child	
Your eligibility for Medicare benefits	Your spouse and/or dependent children	
Your termination of employment (unless terminated for gross misconduct) or a reduction of work hours	You, your spouse, and/or dependent children	• 18 months generally • 29 months, if you, your spouse, or your child covered under the group health plan qualify for Social Security disability benefits due to a disability that existed the day of the qualifying event or began within the first 60 days of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage • 36 months for a spouse and children, if another qualifying event (other than bankruptcy of your employer) occurs during the initial 18-month or 29-month coverage period, as applicable, the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred and notice of the second qualifying event is properly given by the spouse or dependent child to the group health plan administrator • 36 months for the spouse and children, if you were entitled to receive Medicare within 18 months before your termination of employment or reduction of work hours

To be "disabled" for COBRA purposes, you or your spouse or dependent child must qualify for Social Security disability benefits and must have been disabled at the time of the qualifying event or become disabled within the first 60 days of COBRA coverage. To receive the up to 11-month extension of the COBRA continuation coverage period as a result of a qualifying disability, you or your spouse or dependent child must notify the **Baker Hughes Benefits Center** at **1-866-244-3539** of the disability before the end of the initial 18-month COBRA period. If you recover (are no longer disabled) you must notify the **Baker Hughes Benefits Center** 30 days after the date you are determined to no longer be disabled. If you recover within the initial 18-month COBRA period, and within 60 days after the date the Social Security Administration determination is made, you may keep your COBRA coverage for the remainder of the 18-month period. Should you recover in the 19th through the 28th month, your COBRA coverage will cease at the end of the month in which you're determined to no longer be disabled. If a person becomes eligible for COBRA coverage as a result of more than one COBRA qualifying event, the maximum COBRA coverage period for the individual will never be more than 36 months total for all events (other than in certain bankruptcy situations). Notwithstanding any of the provisions of this SPD or any other document provided to you, COBRA coverage is provided under the group health plans only to the extent required by COBRA except as permitted by the Plan Administrator.

Ending COBRA Coverage

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

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

If you become covered under another group health plan that excludes coverage for pre-existing medical conditions, you may keep your COBRA coverage until the earlier of:

- The date the pre-existing medical condition exclusion expires, or
- The date your COBRA coverage eligibility period ends.

Cost of COBRA Coverage

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

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

However, if you elect COBRA coverage due to termination of employment or reduction in work hours and then you qualify for Social Security disability benefits, your COBRA premium will be increased to 150% of the premium amount after 18 months of COBRA coverage. Please note that COBRA premiums are subject to change. However, COBRA participants will be notified of any rate change.

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

Special COBRA Rules for the Health Care Flexible Spending Account

Under COBRA, you may also be entitled to elect to continue making contributions to your Health Care Flexible Spending Account, but only if your contributions for the remainder of the plan year are less than the maximum amount of eligible health care expenses that can be reimbursed for the remainder of the plan year. For example, if you elected to set aside $1,200 in your Health Care Flexible Spending Account, you file a claim for $1,000 in March and then terminate April 1, the maximum benefit available for the rest of the year is only $200. However, the maximum amount the plan could require as payment would be approximately $900. Therefore, you would not be eligible under COBRA to continue participating in your Health Care Flexible Spending Account after your employment ended.

Under COBRA, your contributions to your Health Care Flexible Spending Account must be made on an after-tax basis and will be subject to an additional 2% administrative fee. You cannot continue making contributions to your Health Care Flexible Spending Account pursuant to COBRA for any plan year following the plan year in which your COBRA qualifying event occurs. If you choose not to continue making contributions to your account when you leave Baker Hughes, you can still be reimbursed for expenses incurred before you left, but you cannot be reimbursed for expenses incurred after you leave Baker Hughes.

If You Return to Work with Baker Hughes Before COBRA Coverage Ends

If you return to work as an employee while you're on COBRA coverage, you may elect to participate in the group health plan as an active employee. Upon your return to active coverage, you and all of your covered dependents will not be subject to any pre-existing medical condition limitations for medical conditions.

Coverage Options besides COBRA Coverage

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the health insurance marketplace, Medicaid, or other group health plan coverage options (such as a spouse's employer's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at **www.healthcare.gov**.

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) is issued with respect to your child, that child will be eligible for coverage as required by the order.

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

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

If the order is a properly completed national medical support notice, such notice meets the requirements above.

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

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

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

Participants and beneficiaries under the Baker Hughes group health plans can obtain, without charge, a copy of the plans' QMCSO procedures from the **Baker Hughes Benefits Center** by calling the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) between 7:00 a.m. and 7:00 p.m. Central Time, Monday through Friday.

The Plan Administrator is responsible for deciding whether a court order satisfies the conditions of a QMCSO.

Special Provisions Relating to the COVID-19 Pandemic

As a result of the COVID-19 pandemic, there are certain relief rules.

Extension of Certain Time Periods

The period of time between March 1, 2020 and 60 days after the end of the COVID-19 National Emergency as announced by the Internal Revenue Service and the Department of Labor will be disregarded for purposes of the following deadlines:

- the date by which you may file a benefit claim
- the date by which you may file an appeal for a benefit claim that is denied in whole or in part
- the date within which you may file a request for an external benefit review after receipt of a denial of your claim in whole or in part or after a final internal adverse benefit determination
- the date within which you may file information to perfect a request for external review upon a finding that your request for external review was incomplete
- the 30 and 60-day HIPAA special enrollment periods under section 9801(f) of the Internal Revenue Code (relating to newly acquired spouses and dependents, loss of COBRA coverage under another health plan and loss of coverage under the Medicaid or CHIPs)
- the 60 day election period for COBRA continuation coverage under group health programs
- the date for making initial COBRA premium payments
- the date for notifying the plan of a COBRA qualifying event or determination of disability for COBRA purposes

Increased Flexibility to Make Health Care Flexible Spending Account and Dependent Care Assistance Flexible Spending Account Changes for 2020

You may be able to make changes to your Health Care Flexible Spending Account and Dependent Care Assistance Flexible Spending Account elections for 2020 if you experienced changes due to COVID-19. The below reasons will be allowed to decrease your election amount:

- Reductions in hours
- Change in employment status impacting benefits eligibility
- FMLA leave
- Substantial change in employer benefits/cost
- Daycare and/or School Closures – Dependent Care FSAs only

To process a change to your Dependent Care FSA or Healthcare FSA, please contact the Baker Hughes Benefits Center. Representatives are available to assist you by phone Monday - Friday, 7:00 a.m. to 7:00 p.m. CST at 1-866-244-3539 (within the U.S.) or 1-847-883-0945 (worldwide).

Waiver of Cost-Sharing for COVID-19 Treatment, Testing, and Testing-Related Visits

There will be no cost-sharing for the inpatient treatment of COVID-19 through May 31, 2020, whether the providers are in network or out of network. There will be no cost-sharing for COVID-19 testing and testing-related visits.

Waiver of UHC Cost-Sharing for In-Network, Non-COVID-19 Telehealth

Starting March 31, 2020 until June 18, 2020, there will be a waiver of cost-sharing for **in-network, non-COVID-19 telehealth visits**. This includes all in-network telehealth visits for medical, outpatient behavioral and PT/OT/ST.

There will be a waiver of cost-sharing for telehealth visits related to COVID-19 testing, and a waiver of 24/7 Virtual Visits with preferred telehealth partners.

Important Plan Information

Baker Hughes

Plan Administration and Funding

The Baker Hughes Health & Welfare benefit programs described in this SPD are administered and funded in different ways. Some of the plans are funded through insurance with participant and/or Company contributions as described in the separate sections of this SPD. Others are funded wholly by participant and/or Company contributions.

Plan Administrator

Baker Hughes Company, LLC, the Plan Administrator, has discretionary authority to interpret plan provisions, construe unclear terms, determine eligibility for benefits, and otherwise make all decisions and determinations regarding administration of the Baker Hughes Health & Welfare benefit programs described in this SPD. By participating in one of the plans, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator as follows:

Baker Hughes Company, LLC
Attn: Total Rewards H&W Department
17021 Aldine Westfield Road
Houston, TX 77073
Phone: **1-713-439-8600** or **1-800-229-7447**

Note: The Short-Term Disability plan is not covered by ERISA.

Claims Administrator

For some of the Baker Hughes Health & Welfare benefit programs described in this SPD, Baker Hughes has delegated authority to third party administrators to administer benefit claims under the plan. The Claims Administrator for each benefit plan is listed on the following pages. Subject to Baker Hughes' overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret plan provisions and is the named fiduciary to determine benefit claims.

Cost of Administering the Plans

Baker Hughes intends to pay certain expenses of administering the Baker Hughes Health & Welfare benefit programs described in this SPD except for the Supplemental Life Plan, Voluntary AD&D Plan, Critical Illness insurance Plan, the Accident Plan, and the Legal Plan, which are paid wholly by the employee.

Contributions to the Plans

Baker Hughes offers some welfare benefit programs that are fully insured. For these plans, the insurance company designates the Benefits Administrator and provides the benefit and determines the premiums to be paid.

The Baker Hughes Health & Welfare benefit programs described in this SPD are individually identified by name and number as shown in the following table. Each of those plans, other than the STD Plan, are offered under the Plan. The records of each plan are kept on a calendar-year basis.

Claims Administrators

Plan	
Plan Administrator and Sponsor	Baker Hughes Company, LLC Attn: Total Rewards H&W Department 17021 Aldine Westfield Road Houston, Texas 77073 For information call **1-713-439-8600** or **1-800-229-7447**
Plan Sponsor's Employer Identification Number (EIN)	76-0207995
Plan Name	Baker Hughes Company, LLC Welfare Benefits Plan
Plan Number	501
Plan Year	The plan year begins January 1 and ends December 31.
Agent For Service of Legal Process	Baker Hughes Company, LLC Chief Legal Officer 17021 Aldine Westfield Road Houston, Texas 77073

Plan	Medical Plan
Plan Name	Baker Hughes Company, LLC Comprehensive Major Medical Plan
Plan Type	Welfare plan providing comprehensive medical benefits
Type of Administration	Self insured
Plan Number	701368
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Prescription Drug Plan
Plan Name	Baker Hughes Prescription Drug program
Plan Type	Welfare plan providing prescription medication benefits
Type of Administration	Self insured
Plan Number	1424
Benefit Administrator	CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Plan	Dental Plan
Plan Name	Baker Hughes Company, LLC Group Dental Care Plan
Plan Type	Welfare plan providing comprehensive dental benefits
Type of Administration	Self insured
Plan Number	3215512
Benefit Administrator	CIGNA 1111 Market Street Chattanooga, TN 37402

Plan	Vision Plan
Plan Name	Baker Hughes Company, LLC Vision Program
Plan Type	Welfare plan providing comprehensive vision benefits
Type of Administration	Fully insured
Plan Number	12210899
Benefit Administrator	Vision Service Plan 12222 Merit Drive, Suite 1410 Dallas, TX 75251

Plan	Flexible Spending Accounts
Plan Name	Baker Hughes Company, LLC Health Care Flexible Spending Account Plan and Baker Hughes Company, LLC Dependent Day Care Flexible Spending Account Plan
Plan Type	Welfare plan for the use of pre-tax money for health and dependent care costs
Type of Administration	Self insured
Plan Number	705742
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Health Savings Account
Plan Name	Health Savings Accounts
Plan Type	Welfare plan accumulating pre-tax money for medical expenses if you participate in an HDHP
Plan Number	701368
Benefit Administrator	Optum Bank P.O. Box 271629 Salt Lake City, UT 84127-1629

Plan	Employee Assistance Program
Plan Name	Baker Hughes Employee Assistance Program
Plan Type	Welfare service providing referral services
Type of Administration	Fully insured
Plan Number	BAHC
Benefit Administrator	Optum Headquarters 13625 Technology Drive Eden Prairie, MN 55344

Plan	Short-Term Disability
Plan Type	Payroll practice providing income replacement
Type of Administration	Self insured
Plan Number	88110
Benefit Administrator	Sedgwick P.O. Box 14030 Lexington, KY 40512-4030

Plan	Long-Term Disability
Plan Name	Baker Hughes Company, LLC
Plan Type	Welfare plan providing long-term disability benefits
Type of Administration	Fully insured
Plan Number	52656
Benefit Administrator	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176

Plan	Basic and Supplemental Life insurance
Plan Names	Baker Hughes Life Insurance Program Baker Hughes Supplemental Life Insurance Program
Plan Type	Welfare plan providing Basic and Supplemental Life insurance
Type of Administration	Fully insured
Plan Number	33800-G
Benefit Administrator	The Prudential Insurance Company of America P.O. Box 13480 Philadelphia, PA 19176

Plan	Basic and Voluntary Accidental Death & Dismemberment
Plan Names	Baker Hughes Accidental Death & Dismemberment Program Baker Hughes Voluntary Accidental Death & Dismemberment Program
Plan Type	Welfare plan providing Basic and Voluntary Accidental Death & Dismemberment insurance
Type of Administration	Fully insured
Plan Number	6477-93-96
Benefit Administrator	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700

Plan	Business Travel Accident Insurance
Plan Name	Baker Hughes Business Travel Accident Program
Plan Type	Welfare plan providing Business Travel Accident insurance
Type of Administration	Fully insured
Plan Number	6477-59-66
Benefit Administrator	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700

Plan	Legal Plan
Plan Type	Voluntary plan providing legal advice and assistance
Plan Number	602482
Benefit Administrator	Legal Access Plans, LLC 5850 San Felipe, Suite 600 Houston, TX 77057

Plan	Critical Illness
Plan Type	Voluntary Welfare benefit plan that provides benefits for critical illness
Plan Number	305735
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Accident Protection Plan
Plan Type	Voluntary Welfare benefit plan that provides benefits for accidents
Plan Number	305735
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Rights of the Plan Administrator

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

General Powers of the Plan Administrator

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

Determinations of the Plan Administrator Final and Binding

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

Benefit Claims Disputes

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

Exhaustion of Administrative Remedies/Arbitration

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

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

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

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

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

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

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

Venue

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

Controlling Law

Subject to the provisions of ERISA that may be applicable and provide to the contrary, the Plan and the benefit programs offered under the Plan will be construed, regulated and administered under the laws of the state of Texas and, to the extent applicable, by the laws of the United States.

Limitations on Legal Actions

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

Assignments of Benefits

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

Reimbursement and Subrogation

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

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

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

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

Each Baker Hughes funded plan and the Claims Administrator for the plan may seek reimbursement for the reasonable value of services and benefits provided to a benefit recipient from any or all of the following:

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

Remember...

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with access or claim issues that you have not been able to resolve after initial contact with the Claim Administrator's customer service. The participant Advocacy service is available for the following benefit plans:

- All Medical plans
- Prescription Drug plan
- Dental plan
- Vision plan
- Health Care Flexible Spending Account
- Health Savings Account
- Employee Assistance Program

Call the **Baker Hughes Benefits Center** at **1-866-244-3539** (toll-free in the U.S.) or **1-847-883-0945** (worldwide) for more information.

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

- That the Baker Hughes funded plan will be reimbursed in full before any amounts (including attorneys fees incurred by the benefit recipient or affiliate) are deducted from the recovery proceeds for any reason, without regard to the sufficiency of the recovery;
- That the amount of the Baker Hughes funded plan's reimbursement will not be reduced by virtue of any characterization of the recovery proceeds in any settlement agreement or other agreement. For example, the Baker Hughes funded plan's right of recovery will not be negatively affected by virtue of the fact that a settlement agreement allocates a portion of the recovery proceeds to attorneys' fees, future medical costs, pain and suffering, a special needs trust, or otherwise;
- That the Baker Hughes funded plan and Claims Administrator will have a first priority lien on any and all recovery proceeds recovered until the plan has been reimbursed in full for any benefits paid under the plan with respect to the injury or illness, whether or not the benefit recipient is fully compensated for his or her loss;
- That regardless of whether or not you have been fully compensated, the Baker Hughes funded Plan and Claims Administrator may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Baker Hughes funded plan;
- That no doctrine, including the "make whole" doctrine or the "common fund" doctrine, will apply to qualify the Baker Hughes funded plan's right of reimbursement;
- That the benefit recipient will be responsible for all attorneys' fees incurred by him or her in seeking a recovery against a third party or parties and the Baker Hughes funded plan will have no liability with respect to such attorneys' fees;
- To assign to the Baker Hughes funded plan or Claims Administrator of the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits provided, plus reasonable costs of collection;
- That no action will be taken that will frustrate or impede the Baker Hughes funded plan's right of reimbursement or subrogation;
- To notify the Baker Hughes funded plan and Claims Administrator of the plan as soon as administratively practicable, in writing, of the existence of any potential third party liability with respect to any injury or illness for which the plan may pay benefits;
- To promptly notify the Baker Hughes funded plan and Claims Administrator of the plan of any developments of which he or she is aware that may impact the plan's reimbursement or subrogation rights;
- To not enter into any settlement or compromise agreement concerning recovery proceeds without the prior express approval of Baker Hughes;
- To not dispose of any recovery proceeds before the Baker Hughes funded plan has been reimbursed in full;
- That any recovery proceeds held by the person will be deemed to be held in constructive trust for the benefit of the Baker Hughes funded plan until the plan's reimbursement rights with respect thereto have been satisfied in full. Any person who holds such recovery proceeds in a constructive trust for the benefit of the Baker Hughes Funded Plan will be subject to liability under ERISA if he or she disposes of such recovery proceeds prior to the satisfaction of the Baker Hughes funded plan's reimbursement rights;

- That any person who holds recovery proceeds in constructive trust for the Baker Hughes funded plan is a fiduciary with respect to the plan within the meaning of ERISA and will comply with the fiduciary standards of ERISA with respect to such recovery proceeds until the plan's reimbursement rights relating to such recovery proceeds have been satisfied in full;
- To cooperate in protecting the legal rights of the Baker Hughes funded plan or Claims Administrator of the plan to subrogation and reimbursement;
- That you will do nothing to prejudice the Baker Hughes funded plan or Claims Administrator rights under the plan, either before or after the need for services or benefits under the plan;
- That the Baker Hughes funded plan or Claims Administrator may take necessary and appropriate action to preserve their rights under the plan's subrogation provisions, including filing suit in your name;
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Baker Hughes funded plan or Claims Administrator may reasonably request from you; and
- If a benefit recipient or their affiliate described above fails to comply with a benefit recipient's duties and obligations with respect to the Baker Hughes funded plan's reimbursement and subrogation rights, the benefit recipient's benefits under the plan may, in the discretion of the Plan Administrator and as permitted by applicable law, be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to the benefit recipient (including his or her dependents or any persons claiming through them) until the plan has recovered an amount equal to the amount of recovery proceeds it would have been reimbursed had the plan's reimbursement rights been complied with in full or until the plan's subrogation provisions are complied with.

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

Payments to Minors and Incapacitated Persons

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

No Vested Right to Benefits

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

Name and Address Changes

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

Change in Marital Status

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

Modifications of the Plan

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

No Oral Modifications

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

Written Modifications

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

Benefit Administrators and Claims Payers

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

Plan Amendment or Termination

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

Baker Hughes reserves the right to modify, amend, or terminate a plan, in whole or in part, if changes in the law or other conditions make it necessary.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and Baker Hughes and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide covered health services to covered persons.

Baker Hughes and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Baker Hughes and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Baker Hughes's employees nor are they employees of UnitedHealthcare. Baker Hughes and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Baker Hughes is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare, the Claims Administrator, for each covered person who selects a network provider within the group to perform or coordinate certain health services. The network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment.
- Bundled payments: Certain network providers receive a bundled payment for a group of covered health services for a particular procedure or medical condition. Your copayment and/or coinsurance will be calculated based on the provider type that received the bundled payment. The network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional copayment and/or coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some covered health services that are not considered part of the inclusive bundled payment and those covered health services would be subject to the applicable copayment and/or coinsurance as described in your *Schedule of Benefits*.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Glossary of Terms

Baker Hughes

Glossary of Terms

Term	Definition	Section
Accident	An unforeseen and unavoidable event resulting in an injury that is not due to any fault of the covered person, excluding any work-related injuries.	All plans
Actively at Work or Active Work	Has the meaning set forth in the applicable insured program portion of this SPD.	Protection
Administrative Committee	The committee appointed by the Board of Directors of Baker Hughes to perform any administrative functions with respect to the Plan that an insurer, HMO, or DMO is not required to perform.	All plans
Alternate Facility	A health care facility that is not a hospital and that provides one or more of the following services on an outpatient basis, as permitted by law: • Surgical services • Emergency Health Services • Rehabilitative, laboratory, diagnostic, or therapeutic services. An Alternate Facility may also provide Mental Health or Substance Abuse Services on an outpatient basis or inpatient basis (for example a residential treatment facility).	Medical
Annual Enrollment Period	The period each year during the fall when a U.S.-payroll based full-time or benefits-eligible, part-time employee is eligible to change Plan benefit coverage elections.	All plans
Assisted Reproductive Technology	The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve pregnancy. Examples of such procedures are: • In Vitro Fertilization (IVF) • Gamete Intrafallopian Transfer (GIFT) • Pronuclear Stage Tubal Transfer (PROST) • Tubal Embryo Transfer (TET) • Zygote Intra Fallopian Transfer (ZIFT)	Medical
Autism Spectrum Disorder	A group of neurobiological disorders that includes autistic disorder, Rhett's syndrome, Asperger's disorder, childhood disintegrated disorder, and pervasive development disorders not otherwise specified.	Medical
Beneficiary	A person or estate named in writing by the participant to receive benefits provided by the Plan if the participant dies. The designation must be on file with Baker Hughes Company, LLC, at the time of death to be effective.	Protection
Benefits	Your right to payment for services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including those described in this SPD.	All plans
Benefits Base Pay	Base salary including any before-tax contributions made through the benefits program. It does not include any overtime, bonuses, commissions, premium pay, or any other additional compensation. Benefits base pay is determined as of October of the prior year, or the date of hire, whichever is later.	All plans
Birthing or Birthing Center	A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests: • It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located, or • It meets all of the following requirements: — It is operated and equipped in accordance with any applicable state law. — It is equipped to perform routine diagnostic and laboratory examinations, such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity. — It has the ability to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature, and ventilation, and blood expanders. — It is operated under the full-time supervision of a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Registered Graduate Nurse (R.N.). — It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications. — It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary. — It is expected to discharge or transfer patients within 24 hours following delivery. A birthing center that is part of a hospital, as defined herein, will be considered a birthing center for the purposes of the Plan.	Medical

Term	Definition	Section
Brand Name Drug	Drugs manufactured under a registered trade name or trademark.	Prescription Drug
Cellular Therapy	Administration of living whole cells into a patient for the treatment of disease.	Medical
Center of Excellence	A facility or provider that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan to provide covered health services for the treatment of specified diseases or conditions. A Center of Excellence facility or provider may or may not be located within your geographic area. To be considered a Center of Excellence, a facility or provider must meet certain standards of excellence and have a proven track record of treating specified conditions.	Medical
Claims Administrator	The person designated by Baker Hughes Company, LLC to administer claims under a benefit program described in this SPD.	All plans
COBRA	The provisions of ERISA and the Internal Revenue Code enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, that allows employees and qualifying dependents to continue their group health plan coverage for a specified length of time on the occurrence of certain events.	Group health plans
Coinsurance	The percentage of eligible expenses shared between the participant and a plan. The coinsurance is applied to eligible expenses after the deductible or deductibles have been met, if applicable.	Medical, Dental, Prescription Drug
Company	Baker Hughes Company, LLC and its affiliated companies that have adopted the Plan.	All plans
Confinement	A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center resulting from an illness or injury diagnosed by a physician. Later stays will be considered part of the original confinement unless there was either complete recovery during the interim from the illness or injury causing the initial stay or the latter stay results from a cause or causes unrelated to the illness or injury causing the initial stay.	Medical
Contribution	The amount that the employee or Employer pays toward the cost of coverage in a plan described in this SPD.	All plans
Coordination of Benefits	You and your dependents may have health coverage under a Baker Hughes provided plan and another plan. In such cases, subject to applicable law, coordination of benefit rules determine which plan is primary — meaning, which plan pays first and to what extent.	Health
Copay	A cost-sharing arrangement where you or your dependent pays a set amount to a provider for a specific service at the time the service is provided.	Medical, Prescription Drug, Vision
Covered Expenses	The items of expense for which benefits may be paid are called covered expenses.	Health
Covered Health Services	Those health services, including services, supplies or pharmaceutical products, which the Claims Administrator determines to be: • Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease, or its symptoms. • Medically necessary. • Described as a Covered Health Service in this SPD under *Plan Highlights* and *Additional Coverage Details* and *Outpatient Prescription Drugs*. • Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in *Introduction*. • Not otherwise excluded in this SPD under *Exclusions and Limitations or Outpatient Prescription Drugs*.	

Term	Definition	Section
Covered Person	A person who is eligible for and enrolled in coverage under a Baker Hughes Health & Welfare plan described in this SPD upon satisfying the eligibility and participation requirements.	All plans
Custodial Care	Services that: • Are non-health related, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or • Are health-related that do not seek to cure, or that are provided during periods when the medical condition of the patient who requires the services is not changing; or • Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.	Medical
Date of Disability	The date that it is determined your injury or sickness impairs your ability to perform your regular occupation.	STD, LTD
Deductible	The amount you must pay for covered expenses in a plan year before the plan begins to share in the cost of covered services.	Medical, Prescription Drug, Dental
Definitive Drug Test	Test to identify specific medications, illicit substances, and metabolites, and is qualitative or quantitative to identify possible use or non-use of a drug.	Medical
Dental Care Provider	A dentist, dental hygienist, physician, practitioner, or nurse whose profession is the care of teeth and surrounding tissue.	Dental
Dental Plan	Baker Hughes Company, LLC Group Dental Care Plan	Dental
Dentist	A person acting within the scope of his or her license, holding the degree of Physician of Medicine (M.D.), Physician of Dental Surgery (D.D.S.), or Physician of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state of jurisdiction where the services are rendered.	Dental
Designated Provider	A provider and/or facility that: • Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions, or • The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures. A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers. You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.	Medical
Designated Virtual Network Provider	A provider or facility that has entered into an agreement with UHC, or with an organization contracting on UHC's behalf, to deliver Covered Health Services via interactive audio and video modalities.	Medical
Disability Earnings	The benefit amount you earn after disability begins. It does not include Social Security, sick pay, salary continuance payments, or any other disability payment you receive as a result of your disability. Any lump-sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.	STD, LTD
Durable Medical Equipment	Medical equipment that is all of the following: • Can withstand repeated use • Is not disposable • Is used to serve a medical purpose • Is generally not useful to a person in the absence of sickness, injury, or their symptoms • Is appropriate for use in the home	Medical

Term	Definition	Section
EAP	The Employee Assistance Program (EAP). This is a confidential counseling, legal and financial consultation and referral service available to all employees and their household members. The program is accessed by a dedicated toll-free number or website and puts employees in touch with master's-degreed counselors (up to 8 sessions per issue or concern, per year) and legal services (telephone consultation and referral only) at no charge.	EAP
Eligible Expenses	For Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UHC under the plan in accordance with its reimbursement policy guidelines.	Medical
Elimination Period	A period of continuous disability that must be satisfied before you will begin to receive disability benefit payments.	STD, LTD
Emergency or True Emergency	A serious medical condition or symptom resulting from injury, sickness, or mental illness that both: • Arises suddenly, and • In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.	All plans
ERISA	Employee Retirement Income Security Act of 1974, as amended.	All plans, except STD
Excluded Drug	These are drugs that are not covered under the formulary due to more cost-effective and clinically appropriate products out in the market. If you choose to utilize these products, you would be responsible for 100% of the cost of the medication.	Prescription Drug
Experimental and/or Investigational Services	Medical, surgical, diagnostic, psychiatric, mental health, substance-related, and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the UHC makes a determination regarding coverage in a particular case, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or • The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II, or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. Exceptions: • Clinical Trials for which Benefits are available as described under Clinical Trials. • If you are not a participant in a qualifying Clinical Trial as described under Clinical Trials, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition.	Medical, Prescription Drug, Vision, Dental
External Review	A review of an adverse benefit determination by an IRO described in the Federal External Review Program section.	Medical
FMLA	Family and Medical Leave Act of 1993. The act generally requires employers with 50 or more employees to provide eligible employees with up to 12 weeks of unpaid, job-protected leave each year for births, adoptions, foster care placement, illness, and injury.	All plans

Term	Definition	Section
Full-time Student	A person who is enrolled in and attending, full time, a recognized course of study or training at one of the following: • An accredited high school; • An accredited college or university; or • A licensed vocational school, technical school, beautician school, automotive school, or similar training school. Full-time student status is determined in accordance with the standards set forth by the educational institution.	All plans
Gainful Employment or Gainfully Employed	The performance of any occupation for wages, remuneration, or profit, for which you are qualified by education, training, or experience on a full-time or part-time basis, for the Employer or another employer, and which Baker Hughes approves and for which Baker Hughes reserves the right to modify approval in the future.	STD, LTD
Gender Dysphoria	**Diagnostic criteria for adults and adolescents:** • A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following: — A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics). — A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics). — A strong desire for the primary and/or secondary sex characteristics of the other gender. — A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). — A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender). — A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender). The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning. **Diagnostic criteria for children:** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below): • A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender). • In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing. • A strong preference for cross-gender roles in make-believe play or fantasy play. • A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender. • A strong preference for playmates of the other gender. • In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities. • A strong dislike of ones' sexual anatomy. • A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.	Medical

Term	Definition	Section
Gene Therapy	Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.	Medical
Generic Drug	A drug that is no longer under patent protection and may be a lower-cost equivalent of a brand medication. The U.S. Food and Drug Administration (FDA) requires that all generic drugs have the same active ingredients, strength, and dosage form as the brand name equivalents.	Prescription Drug
Genetic Counseling	Counseling by a qualified clinician that includes: • Identifying your potential risks for suspected genetic disorders; • An individualized discussion about the benefits, risks and limitations of genetic testing to help you make informed decisions about genetic testing; and • Interpretation of the genetic testing results in order to guide health decisions. Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.	Medical
Genetic Testing	Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.	Medical
Gestational Carrier	A gestational carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.	All plans
Health & Welfare Benefit Programs	The Baker Hughes Health & Welfare benefit programs described in this SPD.	All plans
Health Care Provider	A physician, practitioner, nurse, hospital, or specialized facility.	Medical
Home Health Care Agency	A program or organization authorized by law to provide health care services in the home.	Medical
Hospice Care Team	A group of trained medical personnel, homemakers, and counselors.	Medical
Hospital or Health Care Facility	An institution, operated as required by law, that both: • Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of physicians. • Has 24-hour nursing services. A hospital is not primarily a place for rest, custodial care, or care of the aged, and is not a nursing home, convalescent home, or similar institution.	Medical, STD, LTD
Illness	Physical sickness, disease, or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.	Medical
Infertility	A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.	Medical, Prescription Drug

Term	Definition	Section
Injury	Bodily damage other than sickness, including all related conditions and recurrent symptoms.	Medical, STD, LTD, AD&D, BTA
Inpatient	An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility, or inpatient rehabilitation facility.	Medical
Inpatient Rehabilitation Facility	A hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides physical therapy, occupational therapy, and/or speech therapy on an inpatient basis, as authorized by law.	Medical
Intensive Care	A service that is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance prescribed by the attending physician.	Medical
Intensive Outpatient Treatment	A structured outpatient mental health or substance use disorder treatment program that may be free-standing or hospital-based and provides services for at least three hours per day, two or more days per week.	Medical
Intermediate Care	Mental health or substance use treatment that encompasses the following: • Care at a residential treatment facility; • Care at a partial hospitalization/day treatment program; or • Care through an intensive outpatient treatment program.	Medical
Leave of Absence	An authorized absence from an employee's normal work schedule.	All plans
Lifetime	The period of time during which covered participants may receive certain benefits of the plan (or any prior or successor plan of the plan sponsor).	All plans
Material and Substantial Duties	The necessary functions of your regular occupation that cannot be reasonably omitted or altered.	STD, LTD
Maximum Benefits	The maximum amount that Baker Hughes will pay for benefits during the entire period of time that you are enrolled under the plan, or any other plan of the plan sponsor.	All plans
Maximum Period Payable	As shown in the Schedule of Benefits, the longest period of time that Baker Hughes will make payments to you for any one period of disability.	STD, LTD

Term	Definition	Section
Medical Necessity	Health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease, or symptoms. • Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. • If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion. • The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UHCprovider.com**.	Medical
Medical plan	Baker Hughes Company, LLC Comprehensive Major Medical Plan	Medical
Medicare	Parts A, B, C, and D of the insurance program established by Title XVIII of the United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.	Health
Mental Health Services	Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a covered health service.	Medical
Mental Illness	Those mental health or psychiatric diagnostic categories listed in the current edition of *the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.	Medical

Term	Definition	Section
Military Service	Service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service pertaining to the military.	All plans
Monthly Benefit and Maximum Period Payable	That benefit and those periods shown in the **Schedule of Benefits** that apply to you.	LTD
Net LTD Monthly Benefit	Your gross Long-Term Disability monthly benefit less any deductible sources of income.	LTD
Network	When used to describe a provider of health care services, this means a provider has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to participate in the network. This does not include providers who have agreed to discount their services. A provider may enter into an agreement to provide only certain covered expenses, but not all covered expenses, or to be a network provider for only some of the plan's products. In this case, the provider will be a network provider for the health services and products included in the participation agreement, and a non-network provider for other health services and products. The participation status of providers is subject to change throughout the plan year.	Medical, Prescription Drug, Vision, Dental
Network Provider	A physician, hospital, pharmacy, or other health care provider who participates in the network and has agreed to provide services to plan participants pursuant to a negotiated arrangement. A list of the network providers is available through all Baker Hughes-sponsored plans.	Health
New Pharmaceutical Product	A pharmaceutical product or new dosage form of a previously approved pharmaceutical product. It applies to the period of time starting on the date the pharmaceutical product or new dosage form is approved by the *U.S. Food and Drug Administration* (FDA) and ends on the earlier of the following dates: • The date it is reviewed; or • December 31st of the following calendar year.	Prescription Drug
Non-Network Provider	A physician, hospital, or other health care provider that does not have a network agreement in effect with the Claims Administrator at the time services are rendered.	Health
Non-Preferred Drug	A brand drug that is not on the CVS/caremark Performance Drug List and processes at a tier 3 copay/coinsurance. Generally speaking, these are higher-cost medications that have recently come to the market. In most cases, an alternative preferred medication (brand or generic) is available.	Prescription Drug
Nurse	A person holding the License of Registered Nurse (R.N.), Licensed Vocational Nurse, or Licensed Practical Nurse who is practicing within the scope of the license.	Health
Oral Surgery	Necessary procedures for surgery in the oral cavity, including pre-operative and post-operative care.	Dental
Organ and/or Tissue Procurement	All professional, facility, ancillary, transportation, and other services necessary to acquire a transplantable human organ or to procure bone marrow or stem cells including but not limited to: expenses associated with listing on a UNOS-approved waiting list; the surgical removal of a donor organ from a living person or a human cadaver; the storage and preservation of a donor organ; transportation expenses associated with procuring a human organ; and the harvesting or apheresis, cryopreservation, and storage of bone marrow or stem cells from a covered person or a related or unrelated donor, including any fees associated with locating an unrelated donor through the National Marrow Donor Program.	Medical

Term	Definition	Section
Other Plans	Any of the following plan types that provide health benefits or services for medical care or treatment: • Group policies or plans, whether insured or self-insured (this does not include school accident-type coverage); • Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group; • Group insurance and group subscriber contracts; • Uninsured arrangements of group coverage; • The medical benefits coverage in a group or individual automobile "no fault" and traditional automobile "fault" type contract; or • Medicare and other government benefits, except a state plan under Medicaid and except as mandated by federal law.	All plans
Out-of-Area	Refers to a geographic area where the Medical plan does not offer sufficient network access to contracted providers. Eligibility for out-of-area plans is determined by the employee's home zip/postal code on file with the Company.	Medical
Out-of-Pocket Maximum	The maximum amount of network coinsurance you pay each plan year for covered services. Once you reach the out-of-pocket maximum, benefits are payable at 100% of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any of the following: • Non-network expenses (except for UHC Out-of-Area options; non-network coinsurance applies) • Deductibles • Any charges for non-covered expenses • Charges that exceed eligible expenses • Amounts above Reasonable and Customary limits • Copays	Medical, Prescription Drug
Outpatient	A covered person will be considered to be an outpatient if he or she is treated at: • A hospital as other than an inpatient; • A physician's office, laboratory, or X-ray facility; or • An ambulatory surgical facility and the stay is less than 24 consecutive hours.	Medical
Partial Hospitalization/Day Treatment	A structured ambulatory program that may be a free-standing or hospital-based program and that provides services for at least 20 hours per week.	All plans
Pharmaceutical Product(s)	U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a physician.	Prescription Drug
Physician	Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed and qualified by law. **Note:** Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that we describe a provider as a physician does not mean that benefits for services from that provider are available to you under the plan. A physician cannot be yourself or an immediate member of your family.	All plans

Term	Definition	Section
Placed for Adoption	The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.	General Information
Plan	Baker Hughes Welfare Benefits Plan	All plans
Plan Administrator	Baker Hughes Company, LLC or its designee	All plans
Plan Sponsor	Baker Hughes Company, LLC	All plans
Plan Year	January 1 through December 31, the 12-month period of time on which the plan's records are maintained.	All plans
Preferred Drug	A brand drug that is on the CVS/caremark Performance Drug List and/or processes at a tier 2 copay/coinsurance. These drugs have been determined to be either more effective than or just as effective as another product in the same therapeutic class.	Prescription Drug
Pregnancy	Includes all of the following: • Prenatal care • Postnatal care • Childbirth • Any complications associated with pregnancy	Medical
Presumptive Drug Test	Test to determine the presence or absence of drugs or a drug class in which the results are indicated as a negative or positive result.	Medical
Prescription Drug	Drugs and medicines which require a prescription by a physician to dispense and are approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury.	Prescription Drug
Preventive Care	Services that contribute to the prevention of a condition or disease, such as: annual well woman, well man, and well child exams.	Medical, Dental
Prior Authorization	The process of determining benefit coverage based on medical necessity criteria, for services, tests or procedures that are appropriate and cost-effective for the individual member. It is a member-centric review to evaluate the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration.	Medical
Qualified Beneficiary	A qualified beneficiary is an individual who, on the day before a qualifying event, has Baker Hughes Medical, Dental, Vision, EAP, and/or Health Care Spending Account coverage. A qualified beneficiary can be: • The covered employee; • The covered spouse of a covered employee; • The covered dependent child of a covered employee; • A newborn or newly adopted child or a child placed for adoption who is added to a former employee's COBRA coverage within 31 days of birth, adoption, or placement for adoption; and/or • A covered spouse or dependent dropped in anticipation of a divorce or legal separation (upon receiving notice of the divorce or legal separation, COBRA continuation coverage will be made available effective on the date of the divorce or legal separation).	COBRA

Term	Definition	Section
Reasonable and Customary	Reasonable and Customary (R&C) is the standard cost for a service in a geographic area. When a member utilizes a non-network provider for services, R&C costs are the basis for determining the amount considered by the plan. The member may be responsible for any amounts above R&C, in addition to any other plan responsibility, such as deductible and/or coinsurance.	Medical, Dental
Regular Occupation	The occupation that you are performing for income or wages on your date of disability. It is not limited to the specific position you held with the Company.	STD, LTD
Rehabilitative Employment	Any gainful employment undertaken by you while receiving monthly benefits under the plan. Any planned vocational rehabilitation training program operated or sponsored by a private, nonprofit organization which regularly provides vocational rehabilitation training for disabled persons and approved by the Claims Administrator prior to your participating in it.	LTD
Reproductive Resource Services	A program administered by UHC or its affiliates made available to you by Baker Hughes. The RRS program provides: • Specialized clinical consulting services for you and your enrolled dependents that provide education on infertility treatment options, and • Access to specialized network facilities and physicians for infertility services.	Medical
RRS	See Reproductive Resource Services (RRS).	Medical
Residential Treatment Facility	A facility which provides a program of effective mental health services or substance use services treatment and which meets all of the following requirements: • It is established and operated in accordance with applicable state law for residential treatment programs; • It provides a program of treatment under the active participation and direction of a physician and is approved by the Mental Health/Substance Use Administrator; • It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and • It provides at least the following basic services in a 24-hour per day, structured environment: room and board; evaluation and diagnosis; counseling; and referral and orientation to specialized community resources. A residential treatment facility that qualifies as a hospital is considered a hospital.	Medical
Retail Network Pharmacy	A pharmacy which contracts with the Claims Administrator for the Prescription Drug plan to fill or refill your prescription when you present a valid Prescription Drug program ID card.	Prescription Drug
Semi-Private Room	A room with two or more beds. When an inpatient stay in a semi-private room is a covered expense, the difference in cost between a semi-private room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a semi-private room is not available.	Medical
Shared Savings Program	A program in which UnitedHealthcare may obtain a discount to a non-network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the non-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens, you should call the number on your ID Card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare.	Medical

Term	Definition	Section
Sickness	Sickness-or disease-causing disability that begins while your coverage is in force.	STD, LTD
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law.	Medical
SPD	This Summary Plan Description, which describes the benefit programs offered under the Baker Hughes Company, LLC Welfare Benefits Plans.	All plans
Substance Abuse	Covered services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.	Medical
Substance-Related and Addictive Disorders Services	Covered services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current edition of the International Classification of Diseases section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a covered health service.	Medical
Surgery	Any operative procedure performed in the treatment of an injury, disease, or illness by instrument or cutting procedure through any natural body opening or incision.	All plans
Surrogate	A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.	
Therapeutic Donor Insemination (TDI)	Insemination with a donor sperm sample for the purpose of conceiving a child.	
Total Disability or Totally Disabled	An employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a dependent's, or retired person's, inability to perform the normal activities of a person of like age and sex.	LTD
Unproven Services	Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the plan may consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, the plan must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.	Medical, Prescription Drug, Dental, Vision
Urgent Care	Must meet one or both of the following criteria: • A delay in treatment that could seriously jeopardize life or ability to regain functionality, and/or, • Could cause severe pain.	Medical
War	The term war means declared or undeclared war or any armed conflict resisted by any country.	Protection

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