This document describes the medical benefits provided under the Baker Hughes Incorporated Retiree Health & Welfare Benefits plans as of January 1, 2013 (collectively, the plan) and the Baker Hughes Incorporated Retiree Health Reimbursement Arrangement (the Retiree HRA). The plan and Retiree HRA are benefit programs offered under the Baker Hughes Incorporated Welfare Benefits plan.

Retirees of Baker Hughes Incorporated (Baker Hughes) and its subsidiaries who are eligible for retiree medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606) or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and Prior To January 1, 1990 (Division 607) are not eligible for the benefits described in this document (contact the Baker Hughes North America Total Rewards for Summary Plan Descriptions covering the benefits under those programs).

Please note that the information presented in this document is only a summary. It replaces all previously published Summary Plan Descriptions for the plan and the Retiree HRA. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern the plan and Retiree HRA are contained in their respective plan documents or, in the case of the plan, group insurance contracts for the plan. If, in our efforts to make the plan and Retiree HRA easy to understand, any of the plan’s or Retiree HRA’s provisions have been omitted or misstated, the official plan documents or insurance contracts for the plan must remain the final authority. The legal documents also govern the administration of the plan 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, write to:

Baker Hughes Incorporated
P.O. Box 4740
Houston, TX 77210-4740
Attn: North America Total Rewards
(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 plan indefinitely. However, Baker Hughes reserves the right to amend, cancel, change the carrier for, or discontinue all or any part of the plan 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 the Benefits Center en 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 Retiree Health & Welfare Benefits plans and the Baker Hughes Incorporated Retiree Health Reimbursement Arrangement. If you have difficulty understanding any part of this document, contact the 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.

About Your Baker Hughes Summary Plan Description

This document, called a Summary Plan Description (SPD), provides information about the Retiree Medical benefits offered at Baker Hughes effective January 1, 2013. 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 five main sections:

- General Information — details about eligibility, enrollment procedures, and when coverage starts and ends for the plan
- Retiree Medical — information about your Medical and Prescription Drug plans, as well as continuation of Dental, Vision, and the Health Care Flexible Spending Account under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Benefits Rights — information about your rights under the law and continuation of coverage when you retire from Baker Hughes
- Important plan Information — reference details, such as plan number and administrator
- Glossary of Terms — definition of terms found throughout these sections with a cross-reference to the applicable section in 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 Retiree Medical plans as clearly as possible and have included definitions, examples, reminders, tips, and tools to highlight key information. Please keep this SPD for your future reference.
## Benefits Resources At-A-Glance

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Plan</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
</table>
| **The Benefits Center** | • Eligibility  
• Enrollment  
• COBRA Administrator | 1-866-244-3539 (toll-free)  
1-847-883-0945 (worldwide) | go.bakerhughes.com/myrewards |
| **UnitedHealthcare (UHC)** | • Basic PPO  
• Catastrophic PPO | 1-866-743-6549 (toll-free)  
1-866-802-8572 (worldwide) | www.myuhc.com |
| **Extend Health** | • Supplemental Medicare coverage | 1-855-663-4227 | www.extendhealth.com/bakerhughes |
| **Express Scripts** | Prescription Drug  
Specialty Pharmacy | 1-877-432-8979  
1-800-899-2114 (TTY)  
1-866-848-9870 | www.express-scripts.com |

### Advocacy

Advocacy is a team of claim specialists available to assist you with any unresolved health plan access or claim issue you may be experiencing under a Baker Hughes plan. The service is available to Retirees and their family members enrolled in any of the following Baker Hughes plans:

- Retiree Medical
- Prescription Drug
- Dental (COBRA)
- Vision (COBRA)
- Health Care Flexible Spending Account (COBRA)

Although most issues are resolved after a phone call to your health care service provider, there are situations when you need additional help to resolve an issue. If you have made at least one attempt to resolve the issue and still need assistance, contact the Benefits Center at 1-866-244-3539.

A Benefits Center representative will review the issue to determine next steps. If the issue requires Advocacy assistance, the representative will forward your issue to an Advocate, who will begin research. The Advocate will then contact you within two business days to provide an update.
The following section describes general information about coverage including:

- Eligibility
- How to Enroll
- Default Coverage
- Identification Cards
- Making Changes After Enrollment
- Cost of Benefits
Am I Eligible?

Retiree Eligibility

You are eligible for Retiree Medical benefits under the plan if you are at least 55 years of age, have not yet attained age 65, and have at least 10 years of service with Baker Hughes or a subsidiary of Baker Hughes on the date of your retirement from Baker Hughes or a subsidiary of Baker Hughes. In addition, you must be covered under a Baker Hughes active employee Medical plan at the time of your retirement to be eligible for Retiree Medical benefits under the plan.

Employees who are inpatriates to the U.S. or Non-U.S. Assignees/Rotators are not eligible for benefits under the plan. Retirees of Baker Hughes and its subsidiaries who are eligible for Retiree Medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606) or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and prior to January 1, 1990 (Division 607) are not eligible for benefits under the plan.

If you are enrolled in a Baker Hughes plan providing Dental or Vision coverage or you participate in the Baker Hughes Incorporated Health Care Flexible Spending Account plan at the time of your retirement from Baker Hughes or a subsidiary, you may be eligible to continue that coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the COBRA section in the Baker Hughes Retiree Incorporated Health & Welfare plan Summary Plan Description for active employees for additional information.

Retiree Dependent Eligibility

If you’re an eligible retiree as described above, you may cover your eligible dependents under the plan. The eligible dependents you may cover are:

- Your spouse of opposite gender, including common law in states recognizing common law marriage, or a legally separated spouse in states recognizing legal separation.
- 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 an eligible dependent under the plan or under a Baker Hughes active employee Medical plan (up to age 26).

The retiree must reimburse the plan for any benefits that the plan pays for a spouse or dependent at a time when the spouse or child did not satisfy these conditions.
Eligible Dependents Do Not Include:

- Those who are in full-time military service
- Parents, siblings, grandparents, nephews, nieces, etc.
- Domestic partners

Definition: Children include:

- Your biological children
- Your adopted children and children placed for adoption
- Your stepchildren
- Any children for whom you have legal custody
- Foster children in your care
- A child for whom there is a qualified medical child support order (QMCSO)

Call the Benefits Center at 1-866-244-3539 or 1-847-883-0945 (worldwide) with questions about eligibility for coverage.

If You Retire but Your Spouse Continues to Work at Baker Hughes

In general, every eligible retiree and employee may enroll eligible dependents. However, if you retire but your spouse continues to work at Baker Hughes, you may:

- Choose to enroll yourself in Retiree Medical coverage, while your spouse enrolls in You Only active employee coverage
- Choose to enroll yourself as a dependent of your spouse under the active employee coverage. However, if you decline retiree coverage when you first become eligible, you will not be able to elect retiree coverage at a later date (for example, if your spouse leaves Baker Hughes). If you choose to decline coverage, you must actively make this election. If you do not actively choose to decline coverage, you will receive default coverage (as described on page 6).

Eligible children may be enrolled as dependents of either you or your spouse, but not both.
How Do I Enroll?

New Retirees

If you’re a new retiree, you may enroll and choose Retiree Medical coverage within 31 days of your date of retirement. The information you’ll need to enroll can be found in your Retiree Benefits Guide for new retirees and employees considering retirement. To request a copy, contact the Benefits Center at 1-866-244-3539 or 1-847-883-0945 (worldwide).

If you do not enroll in your Retiree Medical coverage within 31 days from the date of your retirement, you’ll be provided the default coverage shown below. If you do not want the default coverage, you must enroll and select the No Coverage option. However, if you do not elect Retiree Medical coverage when you first become eligible, you will not be able to elect retiree coverage at a later date.

If you default or elect coverage, you will only be able to make changes to these elections during the Annual Enrollment period typically held in October or November of each year or if you have a qualified change in status, such as marriage or divorce. For more information, refer to the Can I Make Changes After I Enroll section. If you have a change in status, you will need to make any election changes within 31 days of the date the status change occurred.

Your Default Coverage

If you do not actively enroll in or waive Retiree Medical coverage, you will be provided the default coverage shown below. You will need to pay for the default medical and prescription drug coverage, unless your Retiree Medical Account (RMA) balance covers the cost. For more information on the RMA, see page 9. The first invoice for the premium will be mailed to you within 45 days of receiving your Retirement Confirmation of Enrollment statement. If you do not have an RMA or if your RMA balance doesn’t cover the full cost of the premium, you will need to pay the balance on your initial invoice or your coverage will be dropped back to your retirement date. You must pay each subsequent bill to keep your coverage. Once coverage ends, you will not be able to re-enter the plan at a later date.

<table>
<thead>
<tr>
<th>If you are</th>
<th>Your default retiree coverage is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 65 years of age</td>
<td>Medical — Basic plan at the same coverage level you had before you retired</td>
</tr>
<tr>
<td>65 years of age or older</td>
<td>No coverage unless you enroll in Medicare supplemental coverage, as described on page 58</td>
</tr>
<tr>
<td>Any age</td>
<td>COBRA Dental, Vision, or Health Care FSA — No continuation of coverage</td>
</tr>
</tbody>
</table>

Note: If you do not want to participate in a Baker Hughes Retiree Medical plan you must elect No Coverage or you’ll be automatically enrolled in the default benefit coverage (see Your Default Coverage chart above). If you elect No Coverage, you will not be able to enroll in a Baker Hughes Retiree Medical plan in the future.
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.

If you do not make any changes during Annual Enrollment and you remain eligible for the plans, you will receive the benefit options and coverage levels you had the previous year with the exception of FSA, which cannot be elected for any year after the year in which you retire.

There Are Two Ways to Enroll in Your Retirement Benefits:

<table>
<thead>
<tr>
<th>Online — myRewards</th>
<th>By phone — Benefits Center representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>myRewards at go.bakerhughes.com/myrewards</td>
<td>1-847-883-0945 (worldwide)</td>
</tr>
<tr>
<td>Access is available 24 hours a day,</td>
<td>1-866-244-3539 (within the U.S.)</td>
</tr>
<tr>
<td>Monday through Saturday, and after 12 p.m.</td>
<td>Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time.</td>
</tr>
<tr>
<td>Central Time on Sundays</td>
<td></td>
</tr>
</tbody>
</table>

If you can’t remember your User ID or Password and cannot answer the security questions online, call the Benefits Center to speak with a Representative. You may say Representative at any time during the main menu to be connected to a Benefits Center Representative. If you need assistance enrolling online, a Representative can walk you through the process while you’re logged in.

Dental, Vision and Health Care Flexible Spending Account Enrollment

If you were enrolled in Dental, Vision or the Health Care Flexible Spending Account before you retired, you and your covered dependents may be eligible to continue your coverage through COBRA. To enroll in COBRA coverage, contact the Benefits Center by the enrollment deadline listed on your COBRA enrollment worksheet. Once enrolled, you have 45 days to make your first premium payment. Refer to the COBRA section of the Baker Hughes Retiree Incorporated Health & Welfare Summary Plan Description for active employees for additional information.

Identification Cards

Once you enroll, your medical and/or prescription drug administrator will send identification card(s) to your address on file at the Benefits Center. 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, find errors on the card or would like additional cards, contact the provider (refer to the Benefits Resources At-A-Glance section for contact information).
Can I Make Changes After I Enroll?

Normally, the choices you make during the Annual Enrollment period or at retirement stay in effect for the entire plan year (January 1 through December 31). However, during the year you may change your elections if you have a qualified change in status. Such changes are defined by the Internal Revenue Service (IRS) and include changes such as marriage, divorce, or adoption of a child. Any election changes must be consistent with the status change.

The limited benefit changes that are permitted must be made within 31 days of the change in status or the coverage you had before the change will remain in effect for the full calendar year.

Approved IRS Changes in Status Include:

- If you marry
- If you divorce
- If you have a birth, adoption, or placement for adoption or court-ordered guardianship
- If you or your dependent gains or loses Medicare coverage
- If you or your dependent loses eligibility or becomes eligible for assistance under Medicaid or a State child health plan*

*The approved changes must be made within 60 days of the date eligibility is lost; or, within 60 days from the date the retiree 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 timeframe specified above. To make the approved changes, access Life Events on the myRewards website (go.bakerhughes.com/myrewards) or contact the 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).
Who Pays the Cost of My Benefits?

Retiree Medical Account

For eligible employees who are age 45 or older, on January 1, 2013 Baker Hughes has established a Retiree Medical Account (RMA) on your behalf to offset the cost of your Retiree Medical benefits. The balance of your account is based on a calculation determined by your age at retirement and years of service beginning in the year in which you turned 45 years of age (or prior to 1/1/2002, at 55 years of age). Effective January 1, 2013, Baker Hughes will no longer offer RMAs to those employees turning 45 and older. For existing RMA account holders, your RMA account was frozen effective January 1, 2013, and the company will not make future annual contributions to your RMA.

If you are under the age of 65 and participate in the Retiree Medical plan, the balance in your RMA will automatically be used to pay Retiree Medical premiums for you and your eligible dependents. Once the balance in your RMA has been depleted, you will need to pay the full cost of your Retiree Medical premiums for as long as you wish to continue coverage. The length of time your RMA will last depends on the amount in your RMA when you retire and both the medical option and level of coverage you choose. If you are a new retiree and you choose to waive coverage under the plan, or if you are an active retiree and you discontinue coverage under the plan, the balance of your RMA will be forfeited, and you will not be able to re-enroll in the plan at a later date.

If you are age 65 or older, refer to the section titled Health Reimbursement Arrangement for Retirees and Spouses over 65 on page 69 for information regarding your RMA. Your RMA may only be used toward the cost of a Baker Hughes Retiree Medical plan. RMA balances cannot be used toward COBRA coverage.

**Note:** If you were an employee on January 1, 1994 and your age plus years of service on this date totaled 65 or more (the “rule of 65”), you will not have an RMA. Instead, you will be eligible to receive a Retiree HRA. **This rule of 65 does not apply to retirees from Bird Machine, Western Atlas, or any other company acquired after January 1, 1994. Retirees from Bird Machine, Western Atlas, or other companies acquired after January 1, 1994, are eligible for the RMA only.**

**Rule of 65:** Your Age + Years of Service equaled 65 or more on January 1, 1994
(except for Bird Machine, Western Atlas, or any Company acquired after January 1, 1994)

If you are eligible for an RMA, you may see your RMA balance on myRewards at go.bakerhughes.com/myrewards. Baker Hughes reserves the right to change how coverage is paid regardless of either the RMA or Rule of 65 groups.

When Does My Coverage Begin?

New Retiree Effective Date

You have 31 days from your retirement date to complete the Retiree Medical benefits enrollment process. Once enrolled, your Retiree Medical coverage is effective as of your first date of retirement for you and any enrolled dependents. If you do not actively enroll within 31 days of becoming eligible, you’ll automatically be enrolled in the default coverage listed on page 6.
Retiree Effective Date
If you’re an existing retiree, any new coverage you elect during Annual Enrollment will generally take effect the following January 1. If you have a 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 marriage, divorce, etc., the change will take effect retroactively to the date of the marriage or divorce as long as the change is made within the required timeframe, as detailed in Can I Make Changes After I Enroll.

Dependent Effective Date
If you enroll family members in the plan, their coverage will start on the later of the following dates:

- Date your coverage becomes effective
- Date you enroll your dependent(s) 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)

When Does My Coverage End?
If coverage ends for any reason other than death (for example, you obtain insurance from another source), coverage for you and/or your dependent(s) will end on the day:

- You stop paying premiums to the plan or are late in paying your premiums
- You’re no longer eligible (refer to the Am I Eligible section)
- Your dependent(s) is no longer eligible (refer to the Am I Eligible section)
- Baker Hughes changes or terminates the plan

Benefit coverage for your eligible dependent(s) 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.

If you drop coverage at any time or do not pay the required premiums, you will not be allowed to re-enter the plan in the future.

In certain situations, you or your dependent(s) may be able to continue group health plan coverage through COBRA. Refer to the COBRA section for additional information.

If You Die
If you die while receiving Retiree Medical coverage from Baker Hughes, and have coverage other than You Only, your eligible dependent(s) may be eligible to elect to continue their medical coverage through COBRA for up to 36 months. For the first three months of COBRA coverage, the cost will be equal to 100% of the applicable retiree premium. For the remaining months, the cost will be equal to 100% of the applicable COBRA premium, plus an administrative fee.

The RMA balance (if applicable) will be forfeited and cannot be used toward COBRA coverage. Cost sharing under the Rule of 65 provision will no longer apply and dependent(s) will be required to pay 100% of the applicable COBRA premiums plus an administrative fee.

COBRA coverage will end if your covered dependent(s):

- Becomes covered under another group health plan or Medicare
- Is no longer eligible
- Stops paying premiums to the plan or is late in paying these premiums
- COBRA coverage expires
The Baker Hughes Retiree Medical Plans are designed to help you manage your care needs, whether you have a specific health concern or primarily use preventive health care services. The choices for Retiree Medical coverage depend on your age and the age of your eligible dependent(s).

<table>
<thead>
<tr>
<th>Medical Benefits</th>
<th>If you’re under age 65</th>
<th>If you’re age 65 or older</th>
<th>If your dependent(s) are under 65</th>
<th>If your dependent(s) are age 65 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare (UHC) Basic PPO</td>
<td>✓</td>
<td></td>
<td>Extend Health</td>
<td>Extend Health</td>
</tr>
<tr>
<td>UnitedHealthcare (UHC) Catastrophic PPO</td>
<td>✓</td>
<td></td>
<td>Extend Health</td>
<td>Extend Health</td>
</tr>
</tbody>
</table>
Pre-65 Retiree Medical Plans

If you and/or your dependent(s) are under 65 years of age, your choices for medical coverage are:

<table>
<thead>
<tr>
<th>Retiree Medical Plans</th>
<th>UHC Provider Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• UHC Basic PPO</td>
<td>UHC Choice Network</td>
</tr>
<tr>
<td>• UHC Catastrophic PPO</td>
<td></td>
</tr>
<tr>
<td>• UHC Basic Out-of-Area PPO*</td>
<td>UHC Options PPO Network</td>
</tr>
<tr>
<td>• UHC Catastrophic Out-of-Area PPO*</td>
<td></td>
</tr>
</tbody>
</table>

*If your home zip code is out of the UHC Choice Network service area, you and/or your dependent(s) will be offered the out-of-area options.

If you enroll in Retiree Medical coverage, you automatically receive prescription drug coverage. See the Prescription Drug section for details.

The choices for Retiree Medical coverage depend on your age or the age of your dependents. If your age is different from your dependent, you and your dependent may be offered different medical coverage options.

The Medical plans offered to retirees less than 65 years of age are Preferred Provider Organization (PPO) Medical plans. A Preferred Provider Organization (PPO) is a type of Medical plan that provides you with access to a network of physicians and providers. Each time you need medical care, you decide whether or not to use a provider within the network.

The Out-of-Area plans utilize the UHC Options 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 expenses are subject to the plan deductible, coinsurance, and Reasonable and Customary (R&C) amounts, as well as any amounts above R&C. R&C charges are the standard costs for treatment/services in a geographical area.

To find out if you reside within the UHC Choice network service area, go online to the myRewards website or call a Benefits Center Representative.
Understanding UHC Networks

If you use a network provider, the amount you pay will be lower because UHC has negotiated lower fees with their network providers.

If you use a non-network provider, you may have to pay for care at the time of service and submit a claim form to UHC for reimbursement. When paying or reimbursing a non-network claim, UHC considers R&C allowable amounts. R&C charges are the standard costs for services in a geographical area.

What Happens if My Local Physicians Are Not in the UHC Network?

If you do not have a physician or health care provider near where you live, you may:

- Drive to a physician or health care provider in the PPO network to receive network coverage or
- Talk to your physician about joining the UHC choice network

What if I Need a Specialist Who isn’t in the UHC Choice Network?

If you are enrolled in a UHC Choice Network plan (UHC Basic PPO or UHC Catastrophic PPO) and need highly specialized care, but that specialty is not represented in your network area (within 30 miles from your home), you may request authorization to receive benefits at the network level. To request authorization, contact Personal Health Support before your appointment at 1-866-743-6549.

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.
How Do the Medical Plans Work?

With the UHC plans, you don’t need to select a primary care physician. You simply make an appointment to see any provider whenever you need care.

For an office visit, with a provider in the UHC network, just provide your UHC plan ID card at the time of service and pay a copay. Your physician files a claim with UHC, who will pay the provider for eligible services.

If you choose a provider who is not in the UHC network (non-network) or you participate in an Out-of-Area plan, you may be required to pay for care at the time of service and submit a claim form to UHC for reimbursement. Once you meet your annual deductible, UHC will reimburse you less any coinsurance, fees above the R&C allowable amount, or expenses not covered. UHC will provide you with an Explanation of Benefits explaining how benefits were paid.

**Definition:** Reasonable and Customary (R&C) Allowable Amounts. If you use a non-network provider and they charge more than the R&C allowable amounts in your area, you may have to pay the difference between what is charged and the R&C allowable amount. In determining what the R&C allowable amounts are, UHC looks at what providers charge for services in your geographical area.

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**Additional Resources**

UHC Customer Service: 1-866-743-6549

Via Internet: www.myuhc.com

WellWorks NurseLine™: 1-866-635-9530

When you enroll in either the Basic or Catastrophic Medical plans or their respective Out-of-Area plans, you’ll be able to register at myuhc.com. This is a self-service health and well-being website. It is secure and easy to use. Through myuhc.com, you will be able to:

- Make real-time inquiries into the status and history of your health claims
- Order new or replacement ID cards for the entire family or print a temporary ID card
- Search for doctors available in your plan through the online directory
- View, modify, or print your Personal Health Record
- Access health and well-being information
- View your eligibility information

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**WellWorks NurseLine™ — 24 hours a day**

You can speak with a registered nurse by calling the WellWorks NurseLine™ at 1-866-635-9530 or chat online at myuhc.com (look for the live nurse chat link and follow the onscreen instructions) 24 hours a day. NurseLine™ can help you learn more about:

- Self-care for minor illnesses and injuries
- Specific medications
- Diagnosed conditions
- Preparing questions for doctor visits
- Possible benefits and risks of various treatment options
- How to develop healthy living habits
- How to choose the right care at the right time
The Pre-65 Retiree Medical Plans differ by:

- The amount of annual deductible
- The amount of annual out-of-pocket maximum
- The premium you pay to cover the cost of the plan

Plan Features

When you receive medical care, you and the plan share the cost. This means that you’ll pay deductibles, copays, and coinsurance according to the type of service you receive and whether you use a provider in the Retiree Medical plan network.

Copay

A copay is a flat dollar amount you pay for certain in-network services, such as physician office visits. Copays are required for each service visit and do not apply to the deductible or out-of-pocket maximum.

Deductible

A deductible is the amount you pay each year before the plan begins to share in the cost of covered expenses. The individual deductible applies separately to you and each of your covered family members. When one person meets his or her individual deductible, the plan begins to share in the cost of covered expenses for that person.

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. Once you reach your family deductible, the plan shares in the cost of covered expenses for all enrolled family members for the remainder of the plan year. Deductibles do not apply toward the out-of-pocket maximum.

Coinsurance

Coinsurance is a form of cost-sharing between you and the plan. After you’ve satisfied your annual deductible, you pay a certain percentage of the eligible covered expenses and the plan will pay the rest for eligible health care expenses up to plan limits. The coinsurance amounts you pay for in-network services apply to the out-of-pocket maximum.
Out-of-Pocket Maximum*

The out-of-pocket maximum limits the total amount of network coinsurance you pay each year for medical care. The **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 up to annual maximums.

The **family** out-of-pocket maximum can be satisfied by two or more covered family members, even if each does not satisfy the individual 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 up to annual maximums.

*Non-network expenses, deductibles, non-covered expenses, and amounts above R&C charges do not apply to the out-of-pocket maximum. If you are enrolled in the UHC Basic Out-of-Area PPO or UHC Catastrophic Out-of-Area PPO plan, your eligible in-network and non-network coinsurance applies.

The **Pre-65 Retiree Medical Schedule of Benefits** in this SPD lists your copay, deductible, coinsurance, and out-of-pocket maximum amounts under each plan.

Annual Maximums

An annual maximum is the most the plan pays in benefits per person per year, depending on the type of treatment or service. Annual maximum benefits are:

<table>
<thead>
<tr>
<th>Service</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>20 visits per calendar year</td>
</tr>
<tr>
<td>Chiropractic, Speech, Physical, or Occupational Therapy</td>
<td>40 visits per calendar year</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90 visits per calendar year</td>
</tr>
<tr>
<td>Nutrition</td>
<td>10 visits annually (non-preventive)</td>
</tr>
<tr>
<td>Skilled Nursing or Extended Care Facilities</td>
<td>60-day limit per calendar year</td>
</tr>
<tr>
<td>Temporomandibular Joint Disorder</td>
<td>$500 per covered person</td>
</tr>
</tbody>
</table>

*Note: All maximums are combined whether Network, Non-network, or Out-of-Area.*

**IMPORTANT**

For information on covered expenses, refer to the **Covered Expenses and Exclusions and Limitations** sections on pages 27 and 37 respectively. Also, to confirm that the services you plan to receive are covered, request a pre-determination from UHC Personal Health Support.
Pre-65 Retiree Medical Schedule of Benefits

The following tables provide a summary of your benefits. Depending on where you live, you will be eligible for either the Basic or Catastrophic coverage OR Out-of-Area coverage. Check your enrollment worksheet to confirm the plan(s) for which you are eligible.

**UHC Basic**

<table>
<thead>
<tr>
<th>Plan feature</th>
<th>Network</th>
<th>Non-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td>$2,500 Individual/$5,000 Family</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>UHC Basic Deductible</strong></td>
<td>$750 Individual/$1,500 Family</td>
<td></td>
</tr>
</tbody>
</table>

### Plan feature

**Acupuncture** (up to 20 visits per year)
- 80% after deductible
- 80% after deductible

**Allergy care**
- Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay
- 60% after deductible

**Injection only**
- 100%
- 60% after deductible

**Ambulance**
- Non-emergency: 80% after deductible
- True emergency: 100%

**Birthing Center**
- (pre-notification required; minimum stay for vaginal delivery = 48 hours, C-section = 96 hours)
- 80% after deductible
- 60% after deductible

**Chiropractic, speech, physical or occupational therapy**
- (up to 40 visits per calendar year)
- Certain exclusions apply; contact Personal Health Support for a pre-determination
- Specialist – 100% after $35 copay
- 60% after deductible

**Colonoscopy (diagnostic)**
- Outpatient surgery
- (diagnostic office visits subject to copay)
- 100%
- 60% after deductible

**Congenital Heart Disease**
- (See Covered Expenses section on page 27 for additional details)
- 80% after deductible
- 60% of R&C after deductible

**Durable Medical Equipment (DME)**
- 80% after deductible
- 60% after deductible

**Emergency room**
- Non-emergency
- 80% after deductible
- 60% after deductible
- True emergency
- 100% after $100 copay
- 100% after $100 copay

**Home health care**
- (pre-notification required; 90 visits per calendar year)
- 80% after deductible
- 60% after deductible

### IMPORTANT

For information on covered expenses, refer to the **Covered Expenses and Exclusions and Limitations** sections on pages 27 and 37 respectively. Also, to confirm that the services you plan to receive are covered, request a pre-determination from UHC Personal Health Support.
<table>
<thead>
<tr>
<th>Plan feature</th>
<th>Network</th>
<th>Non-network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice care</strong></td>
<td>100%; no deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(pre-notification required for inpatient)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital care</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Outpatient and inpatient services (pre-notification required for inpatient)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(routine child and adult immunizations)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Injections</strong></td>
<td>100%; no deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><em>(professionally assisted)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory services</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>80% after deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><em>(you or a covered dependent)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Inpatient (pre-notification required)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient professional fees and office setting</strong></td>
<td>100% after $20 copay</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition counseling</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(up to 10 visits annually; non-preventive)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Office setting</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Outpatient and inpatient services</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Includes annual physical; Well Woman, Well Man and Well Child visits; Colonoscopy</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiologist, Anesthesiologist, and Pathologist services</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Second/third surgical opinions</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(voluntary)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Office setting</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing/inpatient rehabilitation</strong> <em>(pre-notification required; up to 60 days per calendar year)</em></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Substance abuse</strong></td>
<td>100% after $20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Outpatient, office setting</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Professional fees</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>– Facility fees</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient (pre-notification required for inpatient)</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>TMJ (5$00 lifetime maximum for non-surgical treatment; excludes prescription drugs)</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>Office setting</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient facility</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Plan feature</td>
<td>Network</td>
<td>Non-network¹</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td>100% U.R.N. only</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td>United Resource Network (U.R.N.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel/Lodging ($10,000 lifetime maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodging Allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child - $200 maximum applies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Search and Procurement (except bone marrow, limited to $25,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>100% after $50 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>X-ray major services</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Office setting or Outpatient facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(MRIs, scans, PET scans, nuclear scans, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>X-ray services</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Office setting or Outpatient facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(outpatient facility; excludes major x-ray services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>All Other Eligible Coverage</strong></td>
<td>80% after deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><strong>Maximum benefit</strong></td>
<td></td>
<td>unlimited</td>
</tr>
<tr>
<td>(aggregate lifetime maximum for all benefits covered under the plan)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹Up to Reasonable & Customary (R&C) allowable amount. R&C is the standard cost for services in a geographic area. Members are responsible for amounts above R&C charges. Applies to eligible expenses reimbursed by the plan.

²If the facility is not part of the U.R.N., your coverage will be subject to the deductible and coinsurance (Network — 80% after deductible; Non-network — 60% of R&C after deductible).

**Note:** The deductible, non-network services, copays, ineligible expenses, and amounts above R&C charges do not apply to the out-of-pocket maximum.

**UHC Catastrophic**

**Deductible**

<table>
<thead>
<tr>
<th>Out-of-pocket maximum</th>
<th>Network</th>
<th>Non-network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000 Individual/$6,000 Family</td>
<td>$4,000 Individual/$8,000 Family</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Plan feature**

<table>
<thead>
<tr>
<th>Plan feature (up to 20 visits per year)</th>
<th>Network</th>
<th>Non-network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Allergy care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection only</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>True emergency</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Up to Reasonable & Customary (R&C) allowable amount. R&C is the standard cost for services in a geographic area. Members are responsible for amounts above R&C charges. Applies to eligible expenses reimbursed by the plan.
<table>
<thead>
<tr>
<th>Plan feature</th>
<th>Network</th>
<th>Non-network¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birthing Center</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(pre-notification required; minimum stay for vaginal delivery = 48 hours, C-section = 96 hours)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic, speech, physical or occupational therapy</strong></td>
<td>Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(up to 40 visits per calendar year)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain exclusions apply; contact Personal Health Support for a pre-determination</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Colonoscopy (diagnostic)</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(diagnostic office visits subject to copay)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Congenital Heart Disease</strong></td>
<td>80% after deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><em>(See Covered Expenses section on page 27 for additional details)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency room</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Non-emergency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>True emergency</strong></td>
<td>100% after $100 copay</td>
<td>100% after $100 copay</td>
</tr>
<tr>
<td><strong>Home health care</strong> (pre-notification required; 90 visits per calendar year)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td>100%; no deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(pre-certification notification required)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital care</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient and inpatient services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(pre-notification required for inpatient)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(routine child and adult immunizations)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Injections (professionally assisted)</strong></td>
<td>100%; no deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><strong>Laboratory services</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Maternity Care</strong> (you or a covered dependent)**</td>
<td>80% after deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient</strong> (pre-notification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient professional fees and office setting)</strong></td>
<td>100% after $20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Nutrition counseling</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(up to 10 visits annually; non-preventive)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office setting</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient hospital</strong></td>
<td>80% after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Physician office visit</strong></td>
<td>Primary care physician – 100% after $20 copay; Specialist – 100% after $35 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><em>(outpatient and inpatient services)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan feature</td>
<td>Network</td>
<td>Non-network&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Includes annual physical; Well Woman, Well Man</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Well Child visits; Colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiologist, Anesthesiologist, and Pathologist services</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td><strong>Second/third surgical opinions</strong> (voluntary)</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing/inpatient rehabilitation</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>(pre-notification required; up to 60 days per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance abuse</strong></td>
<td>100% after $20 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient, office setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Professional fees</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>– Facility fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (pre-notification required for inpatient)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>TMJ</strong> ($500 lifetime maximum for non-surgical treatment; excludes prescription drugs)</td>
<td>60% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant Services</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>100% U.R.N. only</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td>United Resource Network (U.R.N.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel/Lodging ($10,000 lifetime maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodging Allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child - $200 maximum applies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ Search and Procurement (except bone marrow, limited to $25,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>100% after $50 copay</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>X-ray major services</strong></td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Office setting or Outpatient facility (MRIs, scans, PET scans, nuclear scans, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>X-ray services</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Office setting or Outpatient facility (excludes major x-ray services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>All Other Eligible Coverage</strong></td>
<td>80% after deductible</td>
<td>60% of R&amp;C after deductible</td>
</tr>
<tr>
<td><strong>Maximum Benefit</strong> (aggregate lifetime maximum for all benefits covered under the plan)</td>
<td>unlimited</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Up to Reasonable & Customary (R&C) allowable amount. R&C is the standard cost for services in a geographic area. Members are responsible for amounts above R&C charges. Applies to eligible expenses reimbursed by the plan.

<sup>2</sup>If the facility is not part of the U.R.N., your coverage will be subject to the deductible and coinsurance (Network — 80% after deductible; Non-network — 60% of R&C after deductible).

**Note:** The deductible, non-network services, copays, ineligible expenses, and amounts above R&C charges do not apply to the out-of-pocket maximum.
Network PPO Coverage Example (UHC Basic or Catastrophic PPO):

Example:
Take a look at what options you have and how the PPO process works. Assume you’re enrolled in the Basic PPO plan and have **not yet met your deductible**.

You want to make an appointment to see Dr. Smith, your family doctor, for a regular office visit.

- **If Dr. Smith is in-network**
  - You make an appointment to see Dr. Smith
  - You pay a $20 copay during your visit
  - As part of the network agreement, Dr. Smith bills UHC directly for any additional balance
  - The network doctor visit costs you $20

- **If Dr. Smith is a non-network physician**
  - You make an appointment to see Dr. Smith, knowing that non-network charges will apply
  - You pay the total fee for service during your visit — $80
  - You complete a claim form (available from www.myuhc.com or by calling UHC at 1-866-743-6549) and submit the form and receipts directly to UHC for processing. (Keeping a copy for your records.)
  - UHC applies the R&C charges toward your individual deductible. You are responsible for any amounts above R&C.
  - The non-network doctor visit costs you $80

**Note:** Dollar amounts are examples only and do not reflect actual costs.
Tip!
To find out if your physician is in the UHC network:

- Ask your physician if he or she participates in the UHC Choice Network (or Options PPO Network if Out-of-Area)
- Go to www.myuhc.com, select Find Physician/Hospital and follow the instructions on screen
- Call UHC Customer Service at 1-866-743-6549
- Go to myRewards, select Find a Doctor in your current Medical plan and follow the instructions on screen

Out-of-Area PPO Coverage Example (UHC Basic Out-of-Area or Catastrophic Out-of-Area PPO):

Example:
If you have Out-of-Area coverage and you need to see a physician, review your options and how the Out-of-Area PPO process works. When you have Out-of-Area PPO coverage, you may choose any physician. In this example, let's assume you have Basic coverage and have already met your $750 deductible.

You decide to see Dr. Brown, a general practitioner and non-network provider.

You make an appointment to see Dr. Brown (You have already met your Basic plan $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 (available online at www.myuhc.com or by calling 1-866-743-6549) and submit the form and receipts directly to UHC for processing. (Keeping a copy for your records.)

UHC assesses the R&C charge

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 (R&C allowed amount). UHC reimburses you for $54.

The doctor visit costs you the balance or $21

The R&C allowable amount is $67.50. The plan benefit is $67.50 x 80% = $54. You will pay $7.50 (difference between R&C and billed charges) + $13.50 (20% coinsurance after UHC payment) = $21.00.
What if I have a Medical Emergency?

For each emergency room visit, you must pay a $100 emergency room copay whether you use a network or non-network facility. If you have a true medical emergency and are admitted to the hospital within 24 hours, the copay is waived.

For an emergency room visit that is not considered to be a true emergency (non-emergency), any covered expenses incurred are paid based upon whether the facility is network or non-network. The applicable network or non-network plan level coinsurance applies, once the deductible is met. Refer to the Pre-65 Retiree Medical Schedule of Benefits for plan benefit levels.

**Definition:** A true emergency means a serious medical condition or symptom resulting from injury, sickness, or mental illness which 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.

What if I am admitted to a Hospital?

If you’re admitted to the hospital through the emergency room within 24 hours, the $100 emergency room copay will be waived. If you’re admitted to a non-network hospital, contact UHC to notify Personal Health Support. You will need to 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.

Wellness and Preventive Care

The plan is designed to encourage you, your spouse, and your eligible dependents to have routine checkups by providing an annual wellness benefit. Covered expenses are payable at 100% when services are received from a network provider;* no calendar year deductible or copay applies. The benefit for non-network providers is 60% after you meet the calendar-year deductible.

Examples of preventive care include:

- Well-woman, well-man, or well-child exam
- Prostate exam
- Cholesterol check
- Immunizations, including flu shots
- Blood pressure screening
- Colonoscopy (refer to the Pre-65 Retiree Medical Schedule of Benefits for additional coverage details)

*Out-of-Area plan participants may use network or non-network providers.

**Note:** This is a screening and prevention benefit — it does not apply to diagnostic services or ongoing care related to a diagnosed condition.

**What is a Preventive Service?** Preventive services are services that contribute to the prevention of a condition or disease. Examples include annual well-woman, well-man, and well-child exams; mammograms and colonoscopies.

**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.
Nutrition Counseling

The plan also provides a nutrition counseling benefit. Participants may receive up to 10 nutrition counseling sessions annually covered at 100% when received from a network provider. Refer to the Pre-65 Retiree Medical Schedule of Benefits for additional coverage details.

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 emergency injury means a serious medical condition or symptom resulting from injury, illness, or mental illness that both:

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

If it is determined by UHC that the emergency care was necessary, the regular plan benefits will be paid. If a dispute should arise, UHC reserves the right to make the final decision.
UHC’s Personal Health Support Program for Pre-65 Retiree Medical Plan Participants

Coordination of Your Care

The Personal Health Support program is designed to make sure the health care services you receive are covered by the Medical plan. Personal Health Support does not replace your physician’s recommendations and the final decision about care is up to you and your physician.

Notification Requirements

Prior notification is required before you receive certain covered health services. In general, network providers are responsible for notifying Personal Health Support before they provide these services to you. There are some network benefits, however, for which you are responsible for notifying Personal Health Support.

For Mental Health/Substance Abuse services, you are responsible for notifying the Mental Health/Substance Abuse designee.

When you choose to receive certain covered health services from non-network providers, you are responsible for notifying Personal Health Support before you receive these covered health services. Some of the services requiring notification include:

- Accident-related dental services
- Congenital Heart Disease services
- Durable Medical Equipment over $1,000
- Home Health Care
- Hospice Care
- Hospital confinements
- Maternity care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth
- Mental Health and Substance Abuse services (Inpatient only)
- Reconstructive procedures
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement
- Transplant services
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

*For planned or scheduled admissions, call five days before admission; for non-planned or non-scheduled admissions, call within one day of admission; for emergency admissions, call within two business days or as soon as reasonably possible.

Note: If the Personal Health Support program is not used, a $300 non-notification penalty will apply.

To notify Personal Health Support or the Mental Health/Substance Abuse Designee, call the telephone number on your ID card for Claims Administration.

When you choose to receive services from non-network providers, we urge you to confirm with Personal Health Support that the services you plan to receive are covered health services, even if not indicated in the Notification Requirements section. That’s because in some instances, certain procedures may not meet the definition of a covered health service and therefore are excluded. In other instances, the same procedure may meet the definition of covered health services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after cancer surgery, when it is always considered a covered health service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven services exclusion.
- Any other limitation or exclusion of the plan.
Covered Expenses

Pre-65 UHC Retiree Medical Plans

Covered expenses are charges for services covered by the plan and are reimbursed up to the Reasonable and Customary charge or the rate that has been negotiated with network providers. 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 Schedule of Benefits and:

**Ambulance**
- Emergency transport by professional ambulance to the nearest medical facility where emergency services can be provided
- Local professional ambulance service to and from the nearest hospital or convalescent facility where care and treatment can be given

**Durable Medical Equipment and Prosthesis**
- Purchase of artificial limb(s) or eye(s), 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 durable medical equipment, 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
- Requirements:
  - Notification required on any expense over $1,000 for participants enrolled in a Pre-65 Retiree Medical plan
  - 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 a disease or disability
    - If more than one piece of equipment can meet the patient’s functional needs, durable medical equipment benefits are available only for the most cost-effective piece of equipment. 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 & connectors), or braces (including adjustments to shoes to accommodate braces that stabilize any injured body part).
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 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.

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. A copy of this plan of care must be provided to UnitedHealthcare (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; and
  - Any other services and supplies provided in lieu of the services which would have been covered if the patient had been confined in a hospital or convalescent facility.

- 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

- Limited to 90 visits per calendar year
Hospice

• Charges for services and supplies for hospice care incurred by you or your dependent if such charges are made or ordered by the attending physician for a covered person diagnosed by a physician as having six months or less to live. Services include physical and psychosocial care for the terminally ill person and short-term grief counseling for immediate family members covered under the plan. Hospice services must be received from a licensed hospice agency.

Licensed Medical Providers

• Charges by licensed medical personnel operating within the scope of their license, for:
  — Speech therapy to restore or correct impaired function due to: accidental injury, surgical operation, cerebrovascular accident (stroke), or 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 Exclusions and Limitations section on page 37 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 after the start of treatment. Limited to 40 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
  — Cost of hearing aids and fittings for children prior to age 19
  — 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 Baker Hughes Express Scripts 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)
  — 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.
Mental Health and Substance Abuse Services

- Treatment of mental health and substance abuse diagnoses listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), unless those services are specifically excluded under the plan
- Services necessary for short-term evaluation, diagnosis, treatment, or crisis intervention

Outpatient Services
Mental health and substance abuse services received on an inpatient or intermediate care basis in a hospital or an alternate facility.

- Mental health, substance abuse, and chemical dependency evaluations and assessment
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Short-term individual, family, and group therapeutic services (including intensive outpatient therapy)
- Crisis intervention
- Psychological testing

For outpatient services, notification to the Mental Health/Substance Abuse Designee is not required. However, for assistance in locating a network provider, contact the Mental Health/Substance Abuse Designee.

Inpatient and Intermediate Care Services

- Mental health and substance abuse services received on an inpatient or intermediate care basis in a hospital or an alternate facility
- Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being
- The Mental Health/Substance Abuse Designee will determine the appropriate setting for the treatment; if an inpatient stay is required, it is covered on a semi-private room basis
- For inpatient or intermediate care services, notification to the Mental Health/Substance Abuse Designee is required before services are received
Organ and/or Tissue Transplant

- Charges for organ and/or tissue transplant expenses. Covered expenses include all inpatient and outpatient hospital, surgical, and medical expenses for the organ and/or tissue transplant and any related expenses.

- Related expenses include, but are not limited to, donor organ and/or tissue procurement, organ/tissue storage charges, pre-operative/post-operative care, and immunosuppressive drug therapy

- If you or your dependent chooses to use a United Resource Network (URN) facility, covered expenses will also include up to $10,000 in charges for:
  - Transportation to and from the transplant site
  - Lodging and necessary living expenses while at the transplant site

  **Note:** Necessary living expenses do not include child care, house-sitting charges, kennel boarding, or reimbursement of lost wages.

- Transportation, lodging, and necessary living expenses for one companion will also be considered as part of the patient’s covered expenses and will be subject to the same $10,000 maximum. A companion must be a spouse, family member, or guardian of the patient. The transportation, lodging, and living expenses benefit will not be paid if you or your dependent does not have the transplant performed at a URN facility.

- Charges for covered expenses related to receiving or donating an organ and/or tissue for the donor and recipient when the recipient is covered under this plan. The following provisions are also applicable to the organ and/or tissue transplant benefit under the URN program. Expenses of a recipient and/or donor are covered only if:
  - The recipient of the transplant is a covered person under the plan;
  - Prior notification is received from UnitedHealthcare (UHC); and
  - In the case of a bone marrow or stem cell transplant, there is a human leukocyte antigen which is an identical five out of six allogenic match between the donor and the recipient.

  If the covered person donates an organ and the recipient is not a covered person under the plan, the cost will not be a covered expense under the plan and benefits will not be paid.

- Charges for organ donor expenses. If a covered person must have an organ transplant, up to $25,000 of the cost of acquiring and preserving an organ, from a living human or cadaver, is included as part of the patient’s covered expenses. For the purposes of this provision:
  - Organ transplant includes human organs and tissue
  - Acquiring and preserving the organ means:
    - Pre-diagnostic testing expenses, hospital, and surgical expenses for removal of the donor organ
    - The storage and preservation of the donated organ
    - The transportation of the donated organ

- Charges for bone marrow or stem cell donation expenses. The cost of acquiring and preserving the bone marrow or stem cells from a living human will be included as part of the patient’s covered expenses. For the purposes of this bone marrow or stem cell donor provision, the term acquiring and preserving the bone marrow stem cells means:
  - Pre-diagnostic testing expenses, hospital, and surgical expenses for removal of the donor tissue/organ
  - Storage and preservation of the donated tissue/organ

- Transportation of the donated tissue/organ

- However, if the bone marrow or stem cells were obtained from the National Marrow Donor Program registry, an additional $15,000 in connection with the bone marrow or stem cell donation will be allowed as part of the patient’s covered expenses
Physician Fees

• Physicians’ fees for:
  — Surgical operations and assisting at surgery, when required for medical reasons
  — Non-surgical medical care rendered in hospital, home, or office visits
  — 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
  — Hyper-alimentation or total parenteral nutrition for persons recovering from or preparing for surgery, or as sole source of nutrition

Sterilization

• Charges for services and supplies for sterilization (not reversal) and contraceptives administered by a provider (example: Depo-Provera™)
Exclusions and Limitations

Pre-65 Retiree Medical Plans

This 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
- 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 Retiree Medical section of this SPD 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
- Services received by a naturopath or a naturalist
- 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 work or treatment which 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
  - 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

- Treatment of congenitally missing, malpositioned, or super numerary 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 tumors; or

- Treatment of an accidental injury to sound natural teeth other than eating or chewing (including their replacement) immediately after an accident.

- TMJ and related care, except as provided under Covered Expenses

Durable Medical Equipment and Prosthetics

- Duplicate prosthetics, cost for 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, cost for the replacement of stolen durable medical equipment, and durable medical equipment that is less than three years old are not covered, except as stated in Covered Expenses
Drugs

- Prescription drug products for outpatient use that are filled by a prescription order or refill

Note: Some of these expenses may be covered under your prescription drug plan. Refer to the Prescription Drug section for more information.

- Self-injectable medications
- Non-injectable medications given in a Physician’s office except as required in an Emergency
- Over-the-counter drugs and treatments

Experimental, Investigational, or Unproven Services

Experimental, Investigational, and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming, cutting, or debriding
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - 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
- Toenails (other than the removal of nail matrix or root or services furnished in connection with treatment of metabolic or peripheral vascular disease or a neurological condition)
- Treatment of subluxation of the foot
- Shoe orthotics except for custom molded shoe inserts prescribed to treat a disease or illness of the foot

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
  - Gauze and dressings
- Tubings, nasal cannulas, connectors, and masks are not covered except when used with Durable Medical Equipment
Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for Mental Health and Substance Abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias, and other Mental Illnesses that will not substantially improve beyond the current level of functioning or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methanol), Cyclazocine, or their equivalents
- Treatment provided in connection with or to comply with involuntary commitments, police detentions, and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee
- Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism, or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
  — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions
  — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome
  — Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective
  — Not consistent with the Mental Health/Substance Abuse Designee’s guidelines or best practices as modified from time to time. The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
- Pastoral counselors
- Treatment provided in connection with autism
- Treatment provided in connection with tobacco dependency
- Routine use of psychological testing without specific authorization

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 plan’s nutrition provisions
- 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 Covered Expenses
Orthotics

- Orthotics Excluded:
  - Cranial orthotics (helmets) unless there is documentation of severe nonsynostotic positional plagiocephaly and when there is likelihood of ocular and oral complications as consequence of the persistent plagiocephaly deformity
  - Braces or orthotics solely for the purpose to reshape a body part for cosmetic reasons
  - Braces, orthotics, or equipment used specifically as safety items or to affect performance primarily in sport-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercises, fitness, flexibility, and diversion or general motivation

Physical Appearance

- Cosmetic or reconstructive procedures and any related services or supplies, which alter appearance but do not restore or improve impaired physical function, except when performed to:
  - Repair defects from an accident
  - Replace diseased tissue which has been surgically removed
  - Reconstruct a breast following mastectomy, including reconstruction of the other breast to produce symmetry
  - Correct birth defects
- Excluded Cosmetic Procedures. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures)
  - 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
- Physical 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 plan’s nutrition provisions
- Wigs regardless of the reason for the hair loss
- 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 freestanding 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.
Reproduction
- Health services and associated expenses for infertility treatments
- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and/or storage of frozen embryos
- Over-the-counter birth control measures

Services Provided Under Another Plan
- An injury or illness arising from any employment or occupation
- 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

Therapy Services
- Speech therapy, to treat learning disabilities, developmental delay, stuttering, stammering, or other articulation disorders
- Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly
- Outpatient rehabilitation services, spinal treatment, or supplies including, but not limited to, spinal manipulations by a chiropractor or other doctor, 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
Transplants

- Health services for organ and tissue transplants, except those described in Covered Expenses
- 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 plan.)
- Health services for transplants involving mechanical or animal organs
- Artificial or non-human transplants
- Any multiple organ transplant not listed as a Covered Health Service under the heading Organ and/or Tissue Transplant in the section Covered Expenses on page 27 unless determined by Personal Health Support to be a proven procedure for the involved diagnoses and determined to be appropriate according to UnitedHealthcare’s transplant guidelines
- Transportation, lodging, and necessary living expenses if a United Resource Network is not used
- 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
- The costs for and associated with organ, bone marrow, or stem cell donations except as described in Covered Expenses

Travel

- Travel or transportation expenses, even though prescribed by a Physician

Vision and Hearing

- Purchase cost or fitting charge for eye glasses or contact lenses
- Routine eye or hearing exams, eye refractions, hearing aids, or any type of external appliances used to improve visual or hearing acuity and their fittings, except as specifically provided under Covered Expenses
- 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 do not meet the definition of a Covered Expense (see the definition in Glossary Terms for you)
- Charges that exceed Reasonable and Customary limits
- Education or training, except as provided under Covered Expenses
- Food supplements, except as provided under Covered Expenses
- 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 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
  — 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 plan ends, including health services for medical conditions arising before the date your coverage under the 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 plan
- In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- 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)
- Sex transformation operations
- Custodial care
- Domiciliary care
- Private duty nursing received on an inpatient basis
- Respite care
- Rest cures
- Psychosurgery
Other Exclusions Continued

- 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 outpatient facility charge in excess of payable amounts under Medicare
- 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
- Overall treatment that is intended to maintain a current state and is not effective at treating an existing medical condition
- Additional charges submitted after payment has been made and the self-funded corporate account balance is zero
How Do I File a Medical Claim?

If you use a network physician, specialist, or health care provider, he or she will submit claims on your behalf. You’re only responsible for copays, 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 for reimbursement to UHC for any services you receive.

Claim forms are available from:

- [www.myuhc.com](http://www.myuhc.com)
- UHC Customer Service 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 from 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 of 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.

If you provide UHC with a written authorization to allow direct payment to a provider (on the claim form), all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of you. UHC will not reimburse third parties who have purchased or been assigned benefits by physicians and other providers. Unless you authorize payment to be sent to a health care provider or your provider notifies UHC that your signature is on file assigning benefits directly to that provider, payment will be forwarded to you once your claim is processed.

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
  - Date(s) of service
  - Procedure code(s) and descriptions of service(s) rendered
  - Place of service (e.g., office, outpatient hospital, inpatient hospital, independent lab, birthing center, home, or other)
  - Charge for each service rendered
  - Service provider’s name, address, and tax identification number
- 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 for other coverage you must include the name of the other carrier(s).

Send your completed claim forms and supporting documentation 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 the UHC website at www.myuhc.com.

Notification of claims decision

Urgent care claims

Your claim may require immediate action if you or your physician judge that a delay in treatment covered by the claim 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 24 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.

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 timeframes 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 timeframes, 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 plan is an urgent care claim, your request will be decided under the Urgent Care Claim procedures described above.

If your request 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, with respect to which the terms of the Medical plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (i.e., preauthorization).

The claims administrator will notify you of the Medical plan’s decision within a reasonable time period, 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 to have at least 45 days from the date you receive the notice to provide the specified information.

Post-Service Claims. “Post-service claims” are any Medical plan claims that are 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 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 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:

- 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, Utah 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:
    - A delay in treatment that could seriously jeopardize 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 urgent care requests for benefits.*

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

*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 of receipt of the Level One decision. Because your appeal will be reviewed by an appropriate individual(s) 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.

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.

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.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination made by the claims administrator or if the claims administrator fails to respond to your appeal within the time period set out above, you may request an External Review of the claims administrator’s decision regarding your appeal. An External Review is a review of a final internal adverse benefit determination conducted pursuant to the External Review program set out in this section. You or your authorized representative may request an External Review of an adverse claims decision or a final internal adverse benefit determination only if the claim involves (1) medical judgment or (2) a rescission of coverage. You may not request an External Review regarding any other claim, including one that relates to Baker Hughes’ determination regarding whether you are eligible to participate in and receive benefits under the Medical plan or any option offered under the Medical plan.

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure or a rescission of coverage. The process is available at no charge to you if after exhausting the appeals process identified above you receive a decision that is unfavorable, or if UHC fails to respond to your appeal in accordance with applicable regulations.

How Does the External Review Program Work?

If your claim qualifies for review under the External Review Program, you may request an independent review of the adverse benefit determination. Neither you nor UHC will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision. All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination.

Who Can Request an External Review?

You, your treating physician, other medical provider or an authorized designated representative may request an External Review by calling the toll-free number on your Medical plan ID card or by sending a written request to the address on your ID card.
What is the External Review Process?

The External Review will be performed by an independent review organization (Independent Review Organization) that employs individuals such as a physician who is qualified to decide whether the requested service, procedure, or product is a Covered Health Service under the Medical plan. The Independent Review Organization (IRO) has been contracted by UHC and has no material affiliation or interest with UHC. To ensure External Reviews under the Medical plan are unbiased and independent, the Medical plan has obtained rights from UHC under those contracts to have the IRO make External Reviews requested by Medical plan participants. UHC will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

There are two types of External Reviews available under the Medical plan: a Standard External Review and an Expedited External Review, which are described further below.

Standard External Review

A Standard External Review comprises:

- A preliminary review by UHC of the External Review request;
- A referral of the External Review request by UHC to the IRO; and
- A decision from the IRO.

Each of these steps is described further below.

Preliminary Review by UHC of External Review Request

Within five business days following the date of receipt of the External Review request, UHC must complete a preliminary review of the request to determine whether the individual for whom the Standard External Review request was submitted (the External Review Claimant):

- Is or was covered under a medical program option offered under the Medical plan at the time the health care service, procedure or product that is at issue in the External Review request was provided;
- Has exhausted the applicable internal appeals process for the Medical plan (unless the External Review Claimant is not required to exhaust the internal appeals process under the deemed exhaustion rules of the applicable Treasury Regulations); and
- Has provided all the information and forms required so that UHC may process the External Review request.

UHC will also review the request to ensure that the request does not relate to a determination made by Baker Hughes or its delegate regarding whether the External Review Claimant is eligible to participate in and receive benefits under the Medical plan.
Within one business day after UHC completes the preliminary review, UHC will issue a notification in writing to the External Review Claimant. If the External Review request is complete but not eligible for External Review, the notification issued by UHC must include the reasons the request is not eligible for External Review and contact information for the Employee Benefits Security Administration; the toll-free number is 1-866-444-EBSA (3272).

If the request is not complete, the notification issued by UHC must describe the information or materials needed to make the request complete and UHC must allow the External Review Claimant additional time to complete the request for External Review. The External Review Claimant will have at least 48 hours following his or her receipt of the notification from UHC to submit the additional information needed to complete the request. However, if that 48 hour period ends before the end of the four-month period for filing that External Review request, the External Review Claimant will have until the end of the four-month period for filing that External Review request to submit the additional information needed to complete the request.

Referral of Standard External Review Request by UHC to Independent Review Organization

An IRO is not eligible for any financial incentives from the Medical plan or UHC based on the likelihood that the IRO will support the denial of benefits. The IRO will utilize legal experts where appropriate to make applicable determinations.

The IRO will notify in a timely manner the External Review Claimant in writing of the request’s eligibility and acceptance for External Review. The notice from the IRO will include a statement that the External Review Claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

What Information is Submitted to the Independent Review Organization (IRO)?

Within five business days after the date of assignment of the IRO, UHG will forward to the IRO the document and information UHC considered in making its decision regarding a claim or appeal, including:

- All relevant medical records;
- All other documents relied upon by UHC in making a decision on the case; and
- All other information or evidence that you or your physician have already submitted to UHC.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UHC will include it with the documents forwarded to the IRO.

A failure by UHC to provide in a timely manner the documents and information will not delay the conduct of the External Review. If UHC fails to provide in a timely manner the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse UHC’s determination.

Upon receipt of any information submitted by the External Review Claimant, the IRO must within one business day forward the information to UHC. Upon receipt of any such information, UHC may reconsider its determination that is the subject of the External Review. Reconsideration by UHC will not delay the External Review. The External Review may be terminated as a result of the reconsideration only if UHC determines, upon completion of UHC’s reconsideration, to reverse UHC’s prior determination and provide coverage or payment. Within one business day after making such a decision, UHC will provide written notice of UHC’s decision to the External Review Claimant and the IRO. The IRO must terminate the External Review upon receipt of such a notice from UHC.
The IRO will review all of the information and documents received in a timely manner by the IRO. In reaching a decision, the IRO will review the claim anew and without being bound by any decisions or conclusions reached by UHC during the internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The External Review Claimant’s medical records;
- The attending health care professional’s recommendation;
- Reports from appropriate health care professionals and other documents submitted by UHC, the External Review Claimant, or the External Review Claimant’s treating provider;
- The terms of the Medical plan and the medical program option offered under the Medical plan in which the External Review Claimant was enrolled to ensure that the IRO’s decision is not contrary to the terms of the plan and program, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Medical plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the IRO’s clinical reviewer or reviewers after considering the information described above to the extent the information or documents are available and the clinical reviewer or reviewers considers appropriate.

Notice of Final External Review Decision

The IRO must provide written notice of the determination made by the IRO at the conclusion of the External Review (the Final External Review Decision) within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of Final External Review Decision to the External Review Claimant and UHC.

The Final External Review Decision must include the clinical basis for the determination. The IRO will provide you and UHC with the reviewer’s decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

The assigned IRO’s decision notice will contain:

- 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 decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching the decision;
- A discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to either the Medical plan or to the External Review Claimant;
- A statement that judicial review may be available to the External Review Claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793.

The IRO must maintain records of all claims and notices associated with the External Review process for six years after a Final External Review Decision is issued. An IRO must make such records available for examination by the External Review Claimant, the Medical plan, or state or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.
Reversal of UHC’s Decision

Upon receipt of a Final External Review Decision reversing UHC’s determination, the Medical plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the benefit claim at issue in the External Review, regardless of whether the Medical plan or UHC intends to seek judicial review of the External Review decision unless or until there is a judicial decision otherwise.

If the Final External Review Decision is to approve payment, the Medical plan will accept the decision and provide the benefits for such health care service, procedure or product in accordance with the terms and conditions of the plan. If the Final External Review Decision is that payment or referral will not be made, the Medical plan will not be obligated to provide benefits for the health care service, procedure or product at issue.

Expedited External Review

An Expedited External Review is similar to a Standard External Review in that the review comprises:

- A Preliminary Review by UHC of the External Review request;
- A referral of the External Review request by UHC to the IRO; and
- A decision from the IRO.

The most significant difference between a standard and an Expedited External Review is the time periods for completing certain portions of the Expedited External Review process are much shorter than those for a Standard External Review, and in some instances you may file an Expedited External Review before completing the internal appeals process.

The Medical plan must allow a participant to make a request for an Expedited External Review with the plan (the Expedited External Review Claimant) at the time the individual receives:

- An adverse decision regarding a claim or appeal if the adverse decision involves a medical condition of the Expedited External Review Claimant for which the timeframe for completion of an expedited internal appeal under the Medical plan would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and the Expedited External Review Claimant has filed a request for an expedited internal appeal, or
- A final Level Two appeal decision, if the Expedited External Review Claimant has a medical condition where the timeframe 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 Level Two appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the Expedited External Review Claimant received emergency services, but has not been discharged from a facility.

Each of the steps for an Expedited External Review is described further below.

Preliminary Review by UHC of Expedited External Review Request

Immediately upon receipt of the request for an Expedited External Review, UHC will determine whether the Expedited External Review Claimant:

- Is or was covered under a medical program option offered under the Medical plan at the time the health care service, procedure or product that is at issue in the Expedited External Review request was provided, and
- Has provided all the information and forms required so that UHC may process the Expedited External Review request.
UHC will also review the request to ensure that the request does not relate to a determination made by Baker Hughes or its delegate regarding whether the Expedited External Review Claimant is eligible to participate in and receive benefits under the Medical plan.

After UHC completes the preliminary review, UHC will immediately send a notice in writing to the Expedited External Review Claimant. If the Expedited External Review request is complete but not eligible for Expedited External Review, the notification issued by UHC must include the reasons the request is not eligible for Expedited External Review and contact information for the Employee Benefits Security Administration; the toll-free number is 1-866-444-EBSA (3272).

If the request is not complete, the notification issued by UHC must describe the information or materials needed to make the request complete and UHC must allow the Expedited External Review Claimant additional time to complete the request for External Review. The Expedited External Review Claimant will have at least 48 hours following his or her receipt of the notification from UHC to submit the additional information needed to complete the request.

Referral of Expedited External Review Request by UHC to IRO

Upon determination that a request is eligible for Expedited External Review following the preliminary review, UHC will assign an IRO in the same manner UHC utilizes to assign Standard External Reviews to IROs. UHC will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final Level Two appeal decision 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 described above that are considered in a Standard External Review (see the What Information is Submitted to the Independent Review Organization (IRO) section). In reaching a decision, the IRO will review the claim anew and without being bound by any decisions or conclusions reached by UHC during the internal claims and appeals process.

Notice of Final External Review Decision

The IRO must 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 for an Expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and UHC.

Communications in Foreign Languages

In connection with the External Review program 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 an External Review request 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’ External Review requests 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 External Review requests 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.
Coordinating Your UHC Plans with Other Benefits

Coordination of benefits applies when you or your covered dependent(s) have coverage under a Baker Hughes 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 plan is primary, it will pay benefits first. Benefits under Baker Hughes plan will not be reduced due to benefits payable under the other plan.

If the Baker Hughes plan is secondary, the other plan pays first and benefits under Baker Hughes plan will be reduced by benefits payable under other plan(s). 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 claim.

Example:

If you and your spouse retire from different companies and you both enroll in each other’s medical plans:

<table>
<thead>
<tr>
<th></th>
<th>Your Coverage</th>
<th>Your Spouse’s Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baker Hughes Medical Plan</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Your Spouse’s Company Plan</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
</tbody>
</table>

Raul’s wife, Jane, retires from a different company. She has retiree medical coverage through her company and is also enrolled as a dependent under Raul’s Baker Hughes Retiree Medical plan.

Jane’s retiree medical coverage is her primary plan coverage and the Baker Hughes plan is secondary. Let’s assume that Jane has met the deductible of her company plan and the Baker Hughes plan. If Jane’s total 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 paid by her primary plan. If her company’s plan pays 75% ($75), the Baker Hughes Medical plan will pay 5% ($5) to reach the maximum benefit available through the Baker Hughes plan.

If Raul or Jane are 65 years of age or older, Medicare will be their primary coverage.
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 and the child is covered on each plan:
  — A qualified medical child support order (QMCSO) 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
  — The plan of continuation coverage will pay second
- When the rules above do not apply, the plan which has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.
Coordinating with Medicare

Effective January 1, 2013, Baker Hughes has partnered with Extend Health, a Medicare exchange coordinator that will help you transition to an individual plan that supplements Medicare. Your Extend Health benefit advisor will help you understand all of your options for selecting an individual Medicare supplement plan from the Medicare marketplace. While you will have a choice of different plan designs, all of the supplement plans that are available fall into the categories shown below.

Medical and prescription drug options

Your individual coverage through Extend Health will consist of:

**Medicare Supplement Insurance Plan** *(often called a Medigap plan)*, which helps pay some or all of the medical costs not covered by Medicare Parts A and B, such as coinsurance, deductibles, and copayments

With this type of plan, you can use the doctors and hospitals of your choice.

**Medicare Advantage Plan** *(also known as Medicare Part C)*, which generally replaces and covers the same services as Medicare Parts A and B and often includes coverage for prescription drugs. Note: Medicare Advantage plan options vary depending on where you live.

With this type of plan, you may need to choose doctors and hospitals in the plan’s network.

You must enroll in Medicare Part B before you can elect any supplemental insurance coverage, and you should do it well in advance of your retirement date. Medicare allows you to enroll up to 90 days prior to retirement.

### Coordinating with Medicare

The following table shows how the Baker Hughes Retiree Medical plans coordinate with Medicare:

<table>
<thead>
<tr>
<th>Age/Disability</th>
<th>BHI Plan</th>
<th>Medicare</th>
<th>Extend Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired &lt; 65</td>
<td>Primary</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Retired &lt; 65 with disability</td>
<td>Secondary</td>
<td>Primary</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Retired 65+</td>
<td>Not Eligible</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
</tbody>
</table>
Prescription Drug Plan

This Prescription Drug plan only applies to retirees enrolled in the UHC Basic and Catastrophic Medical plans, including Out-of-Area.

Your Prescription Drug Plan Choices

If you enroll in any of the UHC Retiree Medical plans, you’ll automatically receive prescription drug coverage through Express Scripts. This program allows you to receive prescription drugs by paying a fixed copay or coinsurance amount. For all plans, costs are based on whether you purchase your prescription drugs through Express Scripts network of retail pharmacies, Express Scripts Home Delivery or a non-network pharmacy.

UHC Basic and UHC Catastrophic PPO Plans (including Out-of-Area) for Pre-65 Retirees

If you enroll in the UHC Basic or Catastrophic Plan, you will pay copays for generic medications. Formulary and non-formulary medications are subject to coinsurance with minimums and maximums. Coinsurance is a percentage of eligible covered expenses shared between you and the plan. The amount of network coinsurance you pay applies to the out-of-pocket maximum. After you reach the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. The cost for each drug category is listed below:

Pre-65 Coverage – Express Scripts

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Retail Pharmacy up to a 30-day Supply</th>
<th>Home Delivery up to a 90-day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$15</td>
<td>$30</td>
</tr>
<tr>
<td>Formulary Brand</td>
<td>25% coinsurance ($40 minimum/$60 maximum)</td>
<td>25% coinsurance ($100 minimum/$150 maximum)</td>
</tr>
<tr>
<td>Non-formulary Brand*</td>
<td>30% coinsurance ($60 minimum/$80 maximum)</td>
<td>30% coinsurance ($150 minimum/$200 maximum)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum**</td>
<td></td>
<td>$2,000 individual/$4,000 family</td>
</tr>
</tbody>
</table>

*Non-formulary drugs do not apply toward the out-of-pocket maximum.

**Coinsurance and copays apply.

If you use a non-network pharmacy, you will need to pay the full cost of the prescription up front and submit a claim form to Express Scripts for reimbursement. You will be reimbursed up to the discounted retail pharmacy price minus the applicable copay/coinsurance amount.

If you have questions about your Baker Hughes Retiree Medical or Prescription Drug coverage, contact the Benefits Center at 1-866-244-3539 or 1-847-883-0945 (worldwide).

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 formulary drug is a brand name drug that is on the Express Scripts preferred drug list, while a non-formulary drug is one that is not. Generally, each non-formulary drug has at least one formulary alternative available at a lower cost on the list. Non-formulary drugs are covered by the plan, but at higher costs.
Clinical Guidelines

In an ongoing effort to effectively manage your prescription drug benefits, clinical guidelines are included as part of your prescription benefit plan design. These clinical guidelines are known as Prior Authorization (PA) and Quantity Level Limits (QLL).

Why Are Clinical Guidelines Necessary?

Clinical guidelines are necessary because there are certain medications that require closer review to support their benefit(s) to the patient. Express Scripts provides recommendations concerning coverage of these medications by verifying their appropriateness before payment of a prescription can be authorized.

The medications that have been selected for PA or QLL typically have off-label (not approved by the FDA) uses, have the potential to be used inappropriately or tend to be high 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 in a timely manner.

What is Prior Authorization?

Express Scripts will conduct reviews of certain medications before allowing coverage under the Prescription Drug plan. Some reviews are as simple as verifying age and/or gender, while others may require a proof of Medical Necessity from your physician. Typically, this review consists of two steps:

1. Step 1: A medical diagnosis is obtained from the prescribing doctor (some medications may require additional information, such as proof of Medical Necessity). Your doctor (or sometimes a pharmacist) can call or fax the appropriate medical documentation directly to Express Scripts.

2. Step 2: Clinical personnel at Express Scripts 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 the medication will be covered by your prescription plan.

If the medication does not meet the Prior Authorization requirements, your plan will not cover the medication. Therefore, you can speak to your doctor about an alternative or you can pay the full amount for the non-authorized drug.

What Are Quantity Level Limits?

Your prescription drug plan 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 Food and Drug Administration (FDA) has determined to be safe in only limited amounts. QLLs are in place for a limited number of medications; however, this clinical guideline may be added to newly approved medications.

Understanding Your Drug Formulary

As a plan member, it is important that you understand your drug formulary. But what exactly is a drug formulary, why does your prescription benefit plan have one, and how does it work?

What is a Formulary?

A formulary is a list of prescription drugs that are preferred based on clinical and cost effectiveness. Drugs are included on a formulary only after a team of pharmacists and physicians evaluate their effectiveness and cost relative to available alternatives.
A formulary is a convenient reference guide that helps doctors select medication that will achieve the best results for patients while controlling health care costs for the plan.

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

**Who Decides if a Drug is Formulary or Non-Formulary?**

Baker Hughes has selected Express Scripts to administer your prescription drug benefit plan. Formulary decisions for Express Scripts 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 available in various therapeutic classes of drugs. (Examples of therapeutic classes are Cholesterol-Reducing Agents, Antibiotics, etc.).

**Will I Receive a Listing of Non-Formulary Drugs and Their Formulary Alternatives?**

The Express Scripts Formulary Drug List can be found on their website at www.express-scripts.com or by calling Express Scripts Member Services at 1-877-432-8979. You should take it with you when you visit your doctor so that he/she can prescribe a Formulary Drug whenever possible.

**Why has Baker Hughes Selected a Formulary?**

Introducing a formulary is one of the ways that health plans can enhance the quality of patient care while controlling health plan costs.

**Can My Pharmacist Substitute a Formulary Drug for a Non-Formulary Drug for Me?**

No, only your doctor can substitute a Formulary drug for a Non-Formulary drug. The pharmacist would need to contact the doctor to obtain a new prescription for the formulary drug. That is why you should take the Express Scripts Formulary Drug list with you when you visit your doctor. Your doctor will appreciate having a copy of the formulary to refer to when prescribing medications for you or your eligible dependents.

Generic drugs can save a great deal of money — both for you and the Company. The Baker Hughes Prescription Drug plan contains a generic substitution provision. This means that your prescription will be filled with the generic equivalent, when available and permissible by law, unless you or your doctor requests 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 direct otherwise. If your physician requests that your prescription not be substituted, his or her signature must appear on the original prescription in the Dispense as Written (DAW) designated area. If you request that Express Scripts not substitute with a generic, you must indicate this on the prescription order form that accompanies your prescription. By requesting no substitution, you will pay the difference between the cost of the brand name drug and its generic equivalent.

If you do not indicate no substitution, your prescription will be automatically converted to the generic, which is identical to the brand at the molecular level and has the same active ingredients, and you will benefit with the lower generic copay.

**Remember…**

If you fill a brand name drug when a generic alternative is available, you are required to pay the applicable cost, plus the difference in cost between the brand name drug and the generic alternative. If your doctor requires the brand name drug when a generic alternative is available (and indicates on the prescription), you are required to pay the brand or non-formulary brand cost, however, you will not be subject to the penalty described above.
If My Drug is Listed as a Non-Formulary Drug, Does That Mean it is Not Covered?

No, Non-Formulary drugs are covered. (The exception, however, would be an instance where the plan has elected not to cover a drug.) Non-Formulary simply means that the drug will be subject to the higher, non-formulary cost.

Retail Network Pharmacy

To locate an Express Scripts network pharmacy:

- Ask your local pharmacist if he or she participates in the Express Scripts network
- Log on to Express Scripts website via the Internet at www.express-scripts.com and use the pharmacy locator
- Call Express Scripts Member Services at 1-877-432-8979

Show your Express Scripts ID card at an Express Scripts network pharmacy, and pay the appropriate cost based on the drug category of your prescription.

Additional Resources

Express Scripts Member Services: 1-877-432-8979
Via Internet: www.express-scripts.com

- Order prescription refills
- Obtain a list of formulary brand name drugs
- Verify order status
- Order new or replacement ID cards for the entire family or print a temporary ID card
- Check benefit coverage
- Research drug information
- View prescription drug history
- Locate Express Scripts network pharmacies and run cost comparisons between pharmacies
- Access health information

Note: If you choose to have your prescriptions filled at a pharmacy that is not part of the Express Scripts network, you’ll need to pay the full amount of the prescription price. You will then need to submit a claim form to Express Scripts for reimbursement. Your reimbursement of covered expenses will be at the discounted cost of the medication minus the coinsurance or copay amount.
Home Delivery Feature

Home Delivery is ideal for people who use maintenance medications (medications used on an ongoing basis for treatment of high blood pressure, high cholesterol, diabetes, and other chronic medical conditions). In addition, Home Delivery can save you time and money for any prescription that needs to be taken for longer than 30 days. The cost is lower for a larger supply of medication not obtained through a retail pharmacy and after your prescription has been entered into the Express Scripts system, you can use the online service for your refills at www.express-scripts.com.

**Note:** You can obtain three prescription fills (initial prescription plus two refills) for maintenance medication from an Express Scripts network pharmacy. After that, you must use home delivery. If you continue to get your maintenance medication from a retail pharmacy, no benefits will be paid and you will be required to pay the full cost for the medication.

To order online or by mail, ask your physician to write two prescriptions — one 30-day supply to fill at an Express Scripts network pharmacy and one 90-day supply with three refills to submit to Express Scripts Home Delivery pharmacy.

Maintenance medications are prescription drugs that need to be taken for over 90 days, and must be filled through Express Scripts Home Delivery after obtaining three 30-day prescription fills through a retail pharmacy (original prescription plus two refills). After the third retail fill, you will no longer have retail coverage for that prescription and would be required to pay the full cost of the medication if you do not fill your prescription through home delivery.

**Tip!** Use generic prescription drugs when possible. Instead of purchasing a formulary brand or non-formulary brand name medication, ask your physician if a generic equivalent is available. The brand name is the product name under which a drug is advertised and sold. In fact, brand name drugs of today are the generic drugs of tomorrow. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength, and purity as their brand name counterparts. Generic drugs cost less than their brand name equivalents, offering you a way to reduce your out-of-pocket cost.
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 is a new approach to getting you 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 approving and writing your prescriptions.

- **Step 1**: The program usually starts with generic drugs as the first step. Rigorously tested and approved by the U.S. Food & Drug Administration (FDA), the generics covered by the plan have been 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 copayment 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 been proven to be effective in treating many medical conditions).

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

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

If you have any questions, Express Scripts Patient Advocates can assist you at 1-877-432-8979.

Specialty Pharmacy

If your physician has prescribed medication addressing a condition such as:

- Cancer
- Crohn’s Disease
- HIV/AIDS
- Hemophilia
- Hepatitis
- Growth Deficiency
- Multiple Sclerosis
- Organ Transplant
- Rheumatoid Arthritis
- Respiratory Syncytial Virus (RSV)

You’ll need to have the prescription filled through CuraScript, Express Scripts Specialty Pharmacy. CuraScript provides you or a covered family member with:

- Direct delivery of temperature-controlled, time-sensitive pharmaceutical and ancillary supplies
- An assigned care team to work with your physician and offer you expert, proactive support including compliance coaching for better medical outcomes
- Access to care team members with experience in your prescribed medication to answer your questions
- Links to support groups, foundations, or information sources

Please note that 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 CuraScript, Express Scripts’ Specialty Pharmacy. You may access CuraScript through [www.express-scripts.com](http://www.express-scripts.com) or by calling 1-866-848-9870.
Covered Drugs

The following are covered unless listed as an exclusion below:

- Drugs and medicines for which a physician’s prescription is required (also called legend drugs)
- 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) written prescription

Exclusions — What the Express Scripts Prescription Drug Plan Will Not Cover

The following are excluded from coverage, unless specifically included above:

- Drugs and medicines that can be obtained without a physician’s prescription
- Non-legend drugs other than insulin

**Definition:** Legend describes medications that require a prescription from a licensed health care professional.

- Hair growth agent
- Biological serum, 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 which dispenses drugs or medicines (these drugs may be covered under your medical plan)
- Any refill of a prescription that exceeds the number of refills ordered by a physician
- Any refill dispensed more than one year after the date of the prescription
- Prescription drugs which 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
- Legend products with Over-the-Counter (OTC) Equivalents
- Non-sedating antihistamines and oral tetracyclines
• Legend Homeopathic products
• Legend Medical foods
• Drugs or medicines for:
  — Any cosmetic procedure or treatment (i.e. Photo-aged skin products and skin depigmentation 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
• Drugs prescribed for infertility purposes
• Contraceptive implants, diaphragms, and IUDs
• Allergens
• Diagnostic, testing, and imaging supplies

**Filing Prescription Drug Claims**

**You do not need to file a claim form when you use an Express Scripts network pharmacy.**

**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 Express Scripts for reimbursement for such prescription drug purchases. Express Scripts will reimburse covered expenses at the discounted cost minus the copay or coinsurance amount and is subject to the same plan rules as clinical guidelines, mandatory home delivery, etc.

The claim form includes instructions on 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 claim form, attach all evidence to support your claim, including receipts, and file your claim directly with Express Scripts 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:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

If your claim is denied, you can call or write to Express Scripts Member Services as listed on your claim form. If you are not satisfied with the results of a coverage decision, you may begin the appeals process.

**Tip!** Prescription Drug Claim Forms are available through myRewards or directly from Express Scripts at www.express-scripts.com.
Appealing a Denied Claim

Following the appeal procedures below, you or your authorized representative can appeal a denied claim.

- **Level One Appeal:** Members can appeal a denial of a benefit by sending Express Scripts a written letter of appeal, a copy of their initial denial, and any additional information they or their physician believes to be relevant to the appeal. The first level appeal should be sent to Express Scripts at:

  Express Scripts  
  Clinical Appeals — BHU  
  6625 W. 78th Street  
  Mail Route BLO390  
  Bloomington, MN 55439

If the additional information supports the approval of the appeal, based on Prescription Drug plan provisions, Express Scripts will approve the appeal and respond to the member.

If the additional information does not support approval of the appeal based on Prescription Drug plan provisions, the first level appeal will be forwarded, on behalf of the member, for review and determination to MCMC, the independent third party conducting the appeals process for the Prescription Drug plan.

MCMC will receive documentation from Express Scripts regarding any previous denial/appeal, specific plan language, and specific criteria that was used to make the initial coverage determination.

MCMC will notify the member in writing within one business day of receipt of the case; inform him/her of their rights to submit additional records for review; and provide the name and telephone number of a contact person to answer questions related to the appeal process. The member has five business days from the date of receipt of their claim to respond with any additional information. The case determination is made on the 5th day if MCMC has not heard from the member.

The independent specialist(s) selected by MCMC to conduct the review will review documentation within five business days from when MCMC received the case. In cases where a medical determination is required, the independent specialist will be a board certified physician in the same specialty as the prescribing physician. In the case of a benefit or coverage determination, the independent specialist will be a Pharmacist or a doctor of Pharmacy. Should additional information be needed, MCMC may contact the member’s provider to request the additional information where MCMC considers such information necessary or potentially useful in MCMC’s review.

A letter will be sent by MCMC to the member with a copy to Express Scripts within five business days of having received all information from Express Scripts, the patient, and/or the attending physician.

The five business day timeframe may be extended in circumstances where MCMC is awaiting additional information from the Prescription Drug plan, provider, or member. All decisions are rendered within the ERISA timeframes.

In the case of a first level appeal, the letter will include:

1. The decision of the independent specialist and the reasoning behind the decision;
2. References to the Prescription Drug plan provisions on which the decision is based, such as the definition of medical necessity or the prior authorization criteria that was or was not met; and
3. A statement indicating that this is the first level of appeal and the member has one additional level of appeal if they so choose.
• **Level Two Appeal:** The Member can appeal the first level appeal decision by sending MCMC a written letter of appeal, a copy of their initial denial, a copy of the denial for the first level appeal, as well as any other information they or their physician believes to be relevant to the appeal. The second level appeal should be sent directly to MCMC at:

Express Scripts  
Clinical Appeals — BHU  
6625 W. 78th Street  
Mail Route BLO390  
Bloomington, MN 55439

MCMC will follow the same processes as defined on the previous page in the first level of appeal. Upon completion of the review, a letter is sent that details the final and binding decision.

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

— The final decision;
— The reasons for the final decision;
— References to the specific plan provisions on which the decision is based; and
— 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
— A statement describing any voluntary appeal procedures offered by the plan and your right to bring civil action in court.

In addition to the letter, Express Scripts will receive a copy of the actual case review done by the independent specialist(s).

All documentation received with the case will be kept on file at MCMC.

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate a legal action for benefits until you have completed the Level One and Level Two Appeal processes.
Health Reimbursement Arrangement for Retirees and Spouses Over 65

Beginning January 1, 2013, if you or your spouse are at least age 65, you or your spouse may be eligible to participate in the Baker Hughes Health Reimbursement Arrangement (Retiree HRA). For participants in the Retiree HRA, Baker Hughes will establish an account (HRA Account) to which it will credit amounts that can be used by the participant to reimburse his or her eligible health care expenses (as defined in Section 213 of the Internal Revenue Code) and the eligible health care expenses of the participant’s eligible dependents.

The Retiree HRA is funded from the general assets of Baker Hughes, meaning that amounts credited to a participant’s HRA Account are not held in a separate trust or other funding vehicle. Amounts credited to or debited from a participant’s HRA Account are not taxable to the participant.

Eligibility and Enrollment

Am I Eligible to Participate in the Retiree HRA?

Eligibility to participate in the Retiree HRA is provided as follows:

<table>
<thead>
<tr>
<th>Baker Hughes retirees</th>
<th>Eligible Spouse</th>
<th>Eligible Dependent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you were a Medicare-eligible retiree who was receiving supplemental Medicare coverage under the Baker Hughes Incorporated Retiree Welfare Benefits plan on December 31, 2012 (an Active Post-65 Retiree), you are eligible to participate in the Retiree HRA if:</td>
<td>If you are a Baker Hughes retiree who participates in the Retiree HRA, is eligible to participate in the Retiree HRA, or who would be eligible to participate in the Retiree HRA but for the fact that you are not Medicare-eligible, your spouse is eligible to participate in the Retiree HRA if:</td>
<td>If you participate in the Retiree HRA, amounts credited to your HRA Account may be used to reimburse qualified medical expenses incurred by your dependent(s) if:</td>
</tr>
<tr>
<td>• You were at least age 65 on December 31, 2012;</td>
<td>• Your spouse is at least age 65;</td>
<td>• Your dependent is at least age 65;</td>
</tr>
<tr>
<td>• You were enrolled in Medicare Parts A and B on December 31, 2013; and</td>
<td>• Your spouse was either covered under the Baker Hughes Incorporated Welfare Benefits plan or the Baker Hughes Incorporated Retiree Welfare Benefits plan immediately prior to his or her enrollment in the Retiree HRA;</td>
<td>• Your dependent was either covered under the Baker Hughes Incorporated Welfare Benefits plan or the Baker Hughes Incorporated Retiree Welfare Benefits plan immediately prior to your and/or your spouse’s enrollment in the Retiree HRA;</td>
</tr>
<tr>
<td>• You enrolled in Qualified Medicare Supplemental Coverage on or before December 31, 2012.</td>
<td>• You are enrolled in Medicare Parts A and B; and</td>
<td>• You are enrolled in Medicare Parts A and B; and</td>
</tr>
<tr>
<td>If you are a retiree who is not an Active Post-65 Retiree (a Future Post-65 Retiree), you are eligible to participate in the Retiree HRA if:</td>
<td>• You enroll your spouse in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which your spouse turns age 65.</td>
<td>• You enroll your dependent in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which your dependent turns age 65.</td>
</tr>
<tr>
<td>• Immediately prior to enrollment in the Retiree HRA you were (i) an active employee covered under the Baker Hughes Incorporated Welfare Benefits plan, or (ii) covered under the Baker Hughes Incorporated Retiree Welfare Benefits plan;</td>
<td>If your spouse does not enroll in a timely manner in Qualified Medicare Supplemental Coverage, your spouse will not be eligible to participate in the Retiree HRA.</td>
<td>If your dependent does not enroll in a timely manner in Qualified Medicare Supplemental Coverage, your dependent will not be eligible to participate in the Retiree HRA.</td>
</tr>
<tr>
<td>• You are at least age 65;</td>
<td>• You are enrolled in Medicare Part A and have applied for Medicare Part B (and are or will be expeditiously enrolled in Medicare Part B);</td>
<td>• You are enrolled in Medicare Part A and B; and</td>
</tr>
<tr>
<td>• You are enrolled in Medicare Part A and have applied for Medicare Part B (and are or will be expeditiously enrolled in Medicare Part B);</td>
<td>• You enroll in Qualified Medicare Supplemental Coverage within 63 days of the later of (a) your retirement, or (b) the first day of the month in which you turn age 65.</td>
<td>• You enroll your spouse in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which your spouse turns age 65.</td>
</tr>
<tr>
<td>• You enroll in Qualified Medicare Supplemental Coverage within 63 days of the later of (a) your retirement, or (b) the first day of the month in which you turn age 65.</td>
<td>If you do not enroll in a timely manner in Qualified Medicare Supplemental Coverage, you and your spouse will not be eligible to participate in the Retiree HRA.</td>
<td>If you participate in the Retiree HRA, amounts credited to your HRA Account may be used to reimburse qualified medical expenses incurred by your dependent(s) if:</td>
</tr>
<tr>
<td>If you do not enroll in a timely manner in Qualified Medicare Supplemental Coverage, you and your spouse will not be eligible to participate in the Retiree HRA.</td>
<td>If your spouse does not enroll in a timely manner in Qualified Medicare Supplemental Coverage, your spouse will not be eligible to participate in the Retiree HRA.</td>
<td>• Your dependent is at least age 65;</td>
</tr>
<tr>
<td>If your dependent does not enroll in a timely manner in Qualified Medicare Supplemental Coverage, your dependent will not be eligible to participate in the Retiree HRA.</td>
<td>If you participate in the Retiree HRA, amounts credited to your HRA Account may be used to reimburse qualified medical expenses incurred by your dependent(s) if:</td>
<td>• Your dependent was either covered under the Baker Hughes Incorporated Welfare Benefits plan or the Baker Hughes Incorporated Retiree Welfare Benefits plan immediately prior to your and/or your spouse’s enrollment in the Retiree HRA;</td>
</tr>
<tr>
<td>If you do not enroll in a timely manner in Qualified Medicare Supplemental Coverage, you and your spouse will not be eligible to participate in the Retiree HRA.</td>
<td>• You enroll your spouse in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which your spouse turns age 65.</td>
<td>• You enroll your dependent in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which your dependent turns age 65.</td>
</tr>
</tbody>
</table>
Special Rule for Eligible Surviving Spouses of Former Employees

If on December 31, 2012, you are a surviving spouse of a deceased former Baker Hughes employee who did not have an RMA Account, you are eligible to participate in the Retiree HRA if you are an “Eligible Surviving Spouse.” You are an Eligible Surviving Spouse if:

- Immediately prior to your enrollment in Qualified Medicare Supplemental Coverage you were covered under the Baker Hughes Incorporated Retiree Welfare Benefits plan as a spouse of a former Baker Hughes employee;
- You are receiving an annuity pension benefit under the Petrolite Corporation Retirement Plan component plan under the Baker Hughes Incorporated Pension plan;
- You are at least age 65;
- You are enrolled in Medicare Parts A and B; and
- You enroll in Qualified Medicare Supplemental Coverage within 63 days of the first day of the month in which you turn age 65.

How Do I Enroll?

Active Post-65 Retirees

If you were an Active Post-65 Retiree, you must have enrolled in Qualified Medicare Supplemental Coverage between October 3, 2012 and December 31, 2012 to participate in the Retiree HRA.

To enroll yourself in Qualified Medicare Supplemental Coverage, contact the Extend Health Call Center at 1-855-663-4227, or go online at www.extendhealth.com/bakerhughes to schedule an enrollment appointment with an Extend Health Benefit Advisor.

After you worked with Extend Health to select and enroll in Qualified Medicare Supplemental Coverage, Extend Health automatically set up your HRA Account, which was effective January 1, 2013.

Future Post-65 Retirees

If you are a Future Post-65 Retiree, you must enroll in Qualified Medicare Supplemental Coverage within 63 days of the later of (a) your retirement from Baker Hughes, or (b) the first day of the month in which you turn age 65.

To enroll yourself in Qualified Medicare Supplemental Coverage, contact the Extend Health Call Center at 1-855-663-4227, or go online at www.extendhealth.com/bakerhughes to schedule an enrollment appointment with an Extend Health Benefit Advisor.

Once you work with Extend Health to select and enroll in Qualified Medicare Supplemental Coverage, Extend Health will automatically set up your HRA Account effective as of the first day of the calendar month following your eligibility for Medicare.
Eligible Spouse

You must enroll your spouse in Qualified Medicare Supplemental Coverage in order for him or her to participate in the Retiree HRA.

To enroll your spouse in Qualified Medicare Supplemental Coverage, contact the Extend Health Call Center at 1-855-663-4227, or go online at www.extendhealth.com/bakerhughes to schedule an enrollment appointment with an Extend Health Benefit Advisor.

Once you work with Extend Health to select and enroll your spouse in Qualified Medicare Supplemental Coverage, Extend Health will automatically set up an HRA Account effective as of the first day of the calendar month following your spouse’s eligibility for Medicare.

Split Families

You are considered a “split family” if you or your spouse is Medicare-eligible and the other is not. In this situation, the Medicare-eligible individual may enroll in Qualified Medicare Supplemental Coverage through Extend Health and the non-Medicare-eligible individual will continue to receive his or her existing coverage under the Baker Hughes group health plan.

It is important to know that the decisions made by you will control the available options to your spouse and/or dependent(s).

Please review the chart and decision scenarios below.

<table>
<thead>
<tr>
<th>If you are…</th>
<th>then this is how your spouse/dependent is affected:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare-eligible and enroll in Qualified Medicare Supplemental Coverage</td>
<td>Your non-Medicare eligible spouse/dependent will continue with existing medical and prescription drug coverage through the Baker Hughes group health plan. Once your spouse/dependent becomes Medicare-eligible and is over age 65, he or she will be eligible to enroll in Qualified Medicare Supplemental Coverage and participate in the Retiree HRA.</td>
</tr>
<tr>
<td>Medicare-eligible and do not enroll in Qualified Medicare Supplemental Coverage</td>
<td>Your non-Medicare-eligible spouse/dependent will lose coverage through Baker Hughes. Your spouse/dependent will not be eligible to participate in the Retiree HRA when he or she becomes Medicare-eligible.</td>
</tr>
<tr>
<td>Non-Medicare-eligible and continue coverage through the Baker Hughes group health plan</td>
<td>Your Medicare-eligible spouse will participate in the Retiree HRA only if he or she enrolls in a timely manner in Qualified Medicare Supplemental Coverage.</td>
</tr>
<tr>
<td>Non-Medicare-eligible and drop coverage under the Baker Hughes group health plan</td>
<td>Your Medicare-eligible spouse/dependent is not eligible to participate in the Retiree HRA.</td>
</tr>
</tbody>
</table>

Your status will not be affected if your Medicare-eligible spouse/dependent does not enroll in Qualified Medicare Supplemental Coverage or if your non-Medicare-eligible spouse/dependent drops coverage under the Baker Hughes group health plan. However, if your Medicare-eligible spouse/dependent does not enroll in a timely manner in Qualified Medicare Supplemental Coverage, your spouse/dependent will not be eligible for the Retiree HRA.
When Does My Participation in the Retiree HRA End?

<table>
<thead>
<tr>
<th>If you are a(n)...</th>
<th>Your participation in the Retiree HRA ends...</th>
</tr>
</thead>
</table>
| Baker Hughes Retiree| • When you are no longer eligible for a Retiree HRA, for any reason;  
|                     | • On the date you are rehired by Baker Hughes as an active employee;  
|                     | • When you are no longer eligible for Medicare Parts A and B;  
|                     | • When you die;  
|                     | • On the effective date of any amendment terminating your eligibility to receive the Retiree HRA; or  
|                     | • On the date the Retiree HRA is terminated. |
| Eligible Spouse or Dependent| • When you are no longer eligible for a Retiree HRA, for any reason;  
|                     | • On the date you are hired by Baker Hughes as an active employee;  
|                     | • When you are no longer eligible for Medicare Parts A and B;  
|                     | • When you die;  
|                     | • When your Baker Hughes retiree dies, unless you are an Eligible Surviving Spouse;  
|                     | • On the date you are no longer considered an eligible spouse or eligible dependent, for any reason;  
|                     | • On the effective date of any amendment terminating your eligibility under the plan; or  
|                     | • On the date the Retiree HRA is terminated. |
| Eligible Surviving Spouse| • When you are no longer eligible for a Retiree HRA, for any reason;  
|                     | • On the date you are hired by Baker Hughes as an active employee;  
|                     | • When you are no longer eligible for Medicare Parts A and B;  
|                     | • When you die;  
|                     | • On the date you are no longer considered an eligible spouse or eligible dependent, for any reason;  
|                     | • When you are no longer receiving an annuity under the Petrolite Corporation Retirement plan component under the Baker Hughes Incorporated Pension plan, remarry, or your Petrolite Legacy Spouse Survivor Coverage Continuation Period ends;  
|                     | • On the effective date of any amendment terminating your eligibility under the plan; or  
|                     | • On the date the Retiree HRA is terminated. |

You must promptly notify the Administrator if there are any changes that affect your eligibility to participate in the Retiree HRA.

Amounts credited to your HRA Account may not be used to reimburse expenses incurred by you or your enrolled eligible dependents after the date on which your participation in the Retiree HRA ends. You will have until March 31 of the year following your termination of coverage to submit claims for reimbursement of eligible health care expenses incurred during your period of coverage. However, your spouse will forfeit all rights to amounts credited to your HRA Account immediately upon your death unless your spouse is an Eligible Surviving Spouse.
About the Contribution to your HRA Account

If you participate in the Retiree HRA, Baker Hughes will establish an HRA Account on your behalf. Baker Hughes will annually credit your HRA Account with that year’s annual contribution on the first day of each plan year. The annual contribution to your HRA Account for any year is determined at Baker Hughes’ sole discretion, and Baker Hughes reserves the right to change or discontinue funding the Retiree HRA in the future.

Amounts credited to your HRA Account are not taxable. The funds can be used to reimburse, up to the amount credited to your HRA Account, eligible health care expenses that you or your eligible dependents incur during your participation in the Retiree HRA. You may not make additional contributions to your HRA Account.

You will receive account statements in the first and third quarters of each year that show your HRA Account balance and reimbursement activity. This information is also available online at www.extendhealth.com/bakerhughes.

Individual vs. Joint HRA Account

The type of account that is set up depends on whether your spouse also participates in the Retiree HRA. If you alone participate in the Retiree HRA, your HRA Account will be established as an individual account. If both you and your spouse participate in the Retiree HRA, your HRA Account will be a joint account in your name. This means that eligible expenses of both you and your spouse may be reimbursed from the joint HRA Account.

2013 HRA Account Credit

Active Post-65 Retirees and Spouses

If you are an Active Post-65 Retiree who had an RMA Account on December 31, 2012, your HRA Account was credited on January 1, 2013, with an amount equal to the balance in your RMA Account on December 31, 2012. Such amount will be deemed credited with simple interest (currently an annual rate of 5 percent). If you do not enroll in a timely manner in the Retiree HRA, you will permanently forfeit your RMA Account.

If you are an Active Post-65 Retiree who did not have an RMA Account on December 31, 2012, your HRA Account was credited on January 1, 2013 with $1,600. If your spouse also participated in the Retiree HRA beginning January 1, 2013, your joint HRA Account will be credited on January 1, 2013 with $3,200. This amount will not be credited with interest.

Future Post-65 Retirees and Spouses

If you are a Future Post-65 Retiree who had an RMA Account on December 31, 2012, your HRA Account will be credited on the date you commence participation in the Retiree HRA with an amount equal to the balance in your RMA Account as of the date you enroll in Qualified Medicare Supplemental Coverage. Such amount will be deemed credited with simple interest (currently an annual rate of 5 percent). If you do not enroll in a timely manner in the Retiree HRA, you will permanently forfeit your RMA Account.

If you are a Future Post-65 Retiree who did not have an RMA Account on December 31, 2012, your HRA Account will be credited on the date you commence participation in the Retiree HRA with $1,600, prorated on a monthly basis for a period of your participation of less than 12 months during 2013. If your spouse also participates in the Retiree HRA, your joint HRA Account will be credited with an additional $1,600, prorated on a monthly basis for a period of your spouse’s participation of less than 12 months during 2013. This amount will not be credited with interest.
HRA Account Credits for Years after 2013
The amount, if any, to be credited to your HRA Account for any year after 2013 will be determined by Baker Hughes and announced to you. Baker Hughes reserves the right to discontinue credits to your HRA Account at any time.

Carryover of Amounts Credited to your HRA Account
If any balance remains in your HRA Account at the end of the calendar year after all reimbursements have been made for that calendar year, that balance will be carried over to be available for reimbursement of your eligible expenses incurred in the subsequent calendar year.

What Expenses Will My HRA Account Reimburse?
Eligible Expenses
To be eligible for reimbursement, an expense must be an eligible health care expense (as defined in Section 213 of the Internal Revenue Code) incurred by you, your participating spouse or an eligible dependent.

Your eligible health care expenses are any expenses incurred by you, your participating spouse or an eligible dependent for medical care (within the meaning of Section 213 of the Internal Revenue Code). This includes:

• Health insurance premiums for a group health plan sponsored by Baker Hughes or plans or policies identified by Extend Health;
• Out-of-pocket medical expenses like deductibles, copayments, and your share of coinsurance;
• Out-of-pocket prescription drug expenses; and
• Dental and vision out-of-pocket expenses.

However, the following expenses are ineligible and cannot be reimbursed under your HRA Account:

• Expenses that may be reimbursed by another medical, dental, vision, workers’ compensation, or accident or private insurance, or through Medicare or another Federal or state program;
• Unprescribed medicines or drugs (other than insulin), without regard to whether such medicine or drug could be obtained without a prescription;
• Expenses you already claimed or will claim as deductions or credits on a Federal or state income tax return;
• Expenses for qualified long-term care services;
• Expenses that are not eligible to be claimed as deductions on your Federal income tax return; and
• Expenses identified by Extend Health as ineligible for reimbursement.

How Do I Get Reimbursed from my HRA Account?
This section provides information about claim submission timeframes. Also included are descriptions about how to submit claims — either online, via a hard copy claim form or through automatic reimbursement of premium payments.

Claim Submission Timeframes
You may submit claims for eligible expenses incurred during the calendar year any time until March 31 of the following year if you remained an eligible participant for the entire calendar year.
If you were not eligible for the Retiree HRA for the entire calendar year (e.g., death, no longer considered eligible, etc.), only expenses incurred during your period of coverage may be reimbursed. (Note: You still have until March 31 of the following year to submit those expenses, but they must be for dates of service while you were a participant.)
In the case of a joint HRA Account where you or your spouse loses eligibility during the year, expenses for the remaining participants may be reimbursed from the joint HRA Account for the remainder of the calendar year as long as they remained eligible participants.

How Automatic Reimbursement Works
Some medical plans through Extend Health offer an automatic reimbursement of insurance premiums option. This feature allows you to be reimbursed automatically from your HRA Account (to the extent that HRA Account funds are available) for your insurance premium payments without having to submit claim forms.
Extend Health can assist you in determining whether the plans you are enrolled in offer this feature.

How Do I Submit Claims?
You must submit supporting documentation to be reimbursed for eligible expenses.

Documentation on the Retiree HRA claim form includes:

• Name of Retiree HRA participant whose expenses you are seeking reimbursement. (Note that the claim form provides for reimbursement for two participants.)
• Name of provider.
• Date of service (or coverage period if seeking premium payment reimbursement).
• Reimbursement request amount.

The completed claim form should be followed by copies of your receipts and other documentation — Explanation of Benefits (EOBs). If you are submitting a claim for your monthly insurance premiums, attach a copy of the premium invoice, a copy of your bank statement or cancelled check that verifies you made the payment.
Before submitting a claim, you may want to ensure that the expense will not be paid by another benefit plan (e.g., your Medicare plans, dental or prescription drug plan).
Submit a Retiree HRA Claim Form and supporting documentation and mail or fax the form to:
PayFlex Systems USA, Inc.
Extend Health HRA
P.O. Box 3039
Omaha, NE 68103-3039
Fax info: (402) 231-4310 — No Cover Page Required

Claims are processed in the order received. Reimbursements will either be:

• Mailed to the address you have on file with Extend Health.
• Deposited directly into your checking or savings account if you elect direct deposit. Direct deposit payments are issued approximately three business days after they are approved. Contact Extend Health for more information about the direct deposit option.
How Do I Get Reimbursed from my HRA Account?

This section provides information about claim submission timeframes. Also included are descriptions about how to submit claims — either online, via a hard copy claim form or through automatic reimbursement of premium payments.

**Claim Submission Timeframes**

You may submit claims for eligible expenses incurred during the calendar year any time until March 31 of the following year if you remained an eligible participant for the entire calendar year.

If you were not eligible for the Retiree HRA for the entire calendar year (e.g., death, no longer considered eligible, etc.), only expenses incurred during your period of coverage may be reimbursed. (Note: You still have until March 31 of the following year to submit those expenses, but they must be for dates of service while you were a participant.)

In the case of a joint HRA Account where you or your spouse loses eligibility during the year, expenses for the remaining participants may be reimbursed from the joint HRA Account for the remainder of the calendar year as long as they remained eligible participants.

**How Automatic Reimbursement Works**

Some medical plans through Extend Health offer an automatic reimbursement of insurance premiums option. This feature allows you to be reimbursed automatically from your HRA Account (to the extent that HRA Account funds are available) for your insurance premium payments without having to submit claim forms.

Extend Health can assist you in determining whether the plans you are enrolled in offer this feature.
How Do I Submit Claims?

You must submit supporting documentation to be reimbursed for eligible expenses.

Documentation on the Retiree HRA claim form includes:

- Name of Retiree HRA participant whose expenses you are seeking reimbursement. (Note that the claim form provides for reimbursement for two participants.)
- Name of provider.
- Date of service (or coverage period if seeking premium payment reimbursement).
- Reimbursement request amount.

The completed claim form should be followed by copies of your receipts and other documentation — Explanation of Benefits (EOBs). If you are submitting a claim for your monthly insurance premiums, attach a copy of the premium invoice, a copy of your bank statement or cancelled check that verifies you made the payment.

Before submitting a claim, you may want to ensure that the expense will not be paid by another benefit plan (e.g., your Medicare plans, Dental or Prescription Drug plan).

Submit a Retiree HRA Claim Form and supporting documentation and mail or fax the form to:

PayFlex Systems USA, Inc.
Extend Health HRA
P.O. Box 3039
Omaha, NE 68103-3039
Fax info: (402) 231-4310 — No Cover Page Required

Claims are processed in the order received. Reimbursements will either be:

- Mailed to the address you have on file with Extend Health.
- Deposited directly into your checking or savings account if you elect direct deposit. Direct deposit payments are issued approximately three business days after they are approved. Contact Extend Health for more information about the direct deposit option.
Benefits Rights
Important Benefits Rights

Please read this section carefully. It contains information concerning your Baker Hughes Incorporated Retiree Health & Welfare Benefits plans and it includes important facts and information about your rights as a plan participant.

This SPD is designed to inform you about retiree benefits that Baker Hughes provides and how you may receive them. You cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit under any plan.

Importance of a Current Address on File After You Retire

Because most benefit-related information is mailed to you, you must contact the Benefits Center and Stock plan administrators to inform them of any change to your current mailing address. Otherwise, you may not receive important information about your benefits.

Sending a USPS change of address card does not change your address on file — many of our administrators require the security of a User ID and/or Password to make changes to your account — that includes making changes to your mailing and/or email address. Baker Hughes has no obligation or duty to locate a plan participant, beneficiary, or dependent.

If you provided a personal email address on myRewards, you will also need to update your email address should it change.

Keeping Your Health Information Private

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your private health information.

The Baker Hughes Incorporated Retiree Health & Welfare Benefits plans and the Company (as plan sponsor, will not use or disclose health information protected by HIPAA, except when such use or disclosure is necessary for treatment, payment, health plan operations (collectively known as “TPO”), or as permitted or required by other state and federal law. All of the plan’s business associates (organizations who have a contract with the Company to provide certain services, such as legal, actuarial, accounting, consulting, and data aggregation of financial circumstances) must also observe HIPAA’s privacy rules. Furthermore, the plan 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 it has obtained your written authorization for such use and disclosure.

Protected Health Information (PHI) is “individually identifiable” health information related to your 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 that electronically transmits such information. Under HIPAA, you have rights with respect to your protected health information, including:
**Access:** You have the right to inspect and receive a copy of your Protected Health Information, with limited exception (e.g. psychotherapy notes).

**Disclosure Accounting:** You have the right to request an accounting of certain disclosures made by the group health plan (however, you are not entitled to an accounting of disclosures made for payment, treatment or health care operations, or disclosures you authorized in writing).

** Restriction:** You have the right to ask the group 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 group 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 group 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 you reasonably believe that other disclosure could pose a danger to you. 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).

**Right to a Paper Copy of the Notice:** If you agree to receive this notice electronically, you have the right to request and obtain a paper copy from the group health plan. If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the 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 Incorporated  
Privacy Officer – Corporate Benefits Department  
P.O. Box 4740  
Houston, TX 77210-4740  
Tel: 1-800-229-7447 or 1-713-439-8600 (worldwide)

The plan maintains a privacy notice (i.e., notice of privacy practices), which provides a complete description of your rights under HIPAA’s privacy rules. If you would like a copy, write to the Privacy Officer to obtain the privacy notice. If you have questions about the privacy of your health information, please contact the Company’s Privacy Officer.

The Baker Hughes Incorporated Retiree Health & Welfare Benefits plans and Baker Hughes are separate and independent entities, who 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 claim reports with a listing of diagnosis and treatment (no individual employee information is included in this kind of report) with Baker Hughes. PHI will only be shared with Baker Hughes if the Company 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 the Company provides PHI agrees to the same restrictions and conditions that apply to the Company
• 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 group 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 group health plan and destroy PHI copies when no longer needed for disclosure
• Ensure an adequate separation between the group health plan and the Company

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 Baker Hughes Retiree Medical benefits plans are in compliance with this law.

Under this Act, the medical plans and the claim administrators that offer mastectomy coverage under the plans, must, for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

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

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient and will be subject to the same annual deductibles and co-insurance provision consistent with those established for other benefits under the medical plans.
Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female retirees 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 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 cesarean delivery
- Requiring a provider to obtain authorization from the plan for prescribing any length of stay required above
- Denying mother or newborn eligibility or continued eligibility to enroll or re-enroll 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
- Restricting benefits for any portion of such hospital stay to be less than benefits for any stay prior to the birth

If the mother chooses, she and the newborn may be released earlier. Authorization is required for lengths of stay that exceed those listed above for participants enrolled in a Pre-65 Retiree Medical plan.

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 the 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 plan will be reimbursed. The reimbursement will be made to the plan or claims administrators 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 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 plan, a benefit recipient and their legal counsel and other affiliates have a duty to cooperate fully with the plan and claims administrators 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 administrators to fully protect the plan’s rights. Each benefit recipient agrees to provide all such necessary assistance as a condition of participation in the 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.
The plan and claims administrators will 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
- 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”)

**By electing coverage and accepting benefits under the plan, you and each other benefit recipient agree (for himself or herself and all affiliates):**

- That the 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 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 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 plan and claims administrators 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 plan or 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 plan
- That no doctrine, including the “make whole” doctrine or the “common fund” doctrine, will apply to qualify the 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 plan will have no liability with respect to such attorneys’ fees
- To assign to the plan or claims administrator 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 plan’s right or reimbursement or subrogation
- To notify the plan and claims administrators 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 plan and claims administrators 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 Incorporated
- To not dispose of any recovery proceeds before the 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 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 plan will be subject to liability under ERISA if he or she disposes of such recovery proceeds prior to the satisfaction of the plan’s reimbursement rights.
• That any person who holds recovery proceeds in a constructive trust for the 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 plan or claims administrator to subrogation and reimbursement

• That you will do nothing to prejudice the plan or claims administrator rights under the plan, either before or after the need for services or benefits under the plan

• That the 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 plan or claims administrator may reasonably request from you

• If a benefit recipient or their affiliate described above fails to comply with a benefit recipient’s duties and obligations with respect to the plan’s reimbursement and subrogation rights, the benefit recipient’s benefits under the plan may, in the discretion of the plan administrator, be forfeited. 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 the 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.

Refund of Overpayments

If the plan or claims administrator pays benefits for expenses incurred by you or your dependent, you or any other person or organization that was paid, must make a refund to the plan or claims administrator if either of the following apply:

• All or some of the expenses were not paid by you or did not legally have to be paid by you

• All or some of the payment the plan or claims administrator made exceeded the allowable benefits under the plan

The refund equals the amount the plan or claims administrator paid in excess of the amount they should have paid under the plan. If the refund is due from another person or organization, you agree to help the plan or claims administrator obtain the refund when requested.

If you or your dependents do not promptly refund the full amount, the plan or claims administrator may reduce the amount of any future benefits that are payable under the plan. The reductions will equal the amount of the required refund. The plan or claims administrator may have other rights in addition to the right to reduce future benefits.
Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a plan participant, you’re entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

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 retiree with a copy of this summary annual report.

Continue Group Health Care 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.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage, from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the enrollment date for your coverage.

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 benefit or exercising your rights under ERISA.
Enforcement of Your Rights

If your claim for a 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’re 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 Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Certificate of Creditable Coverage

HIPAA, among other things, protects workers who lose health coverage by providing better access to other group health plan coverage. Some employer group health plans do not cover pre-existing conditions and HIPAA limits the time period of these restrictions so that most plans must cover an individual’s pre-existing conditions after 12 months. Under HIPAA, if you change jobs a new employer’s plan will be required to give you credit for the length of time that you had continuous health coverage thereby reducing the 12-month exclusion period. If, at the time you change jobs, you have had 12 months of continuous health coverage (without a break in coverage of more than 63 days or more), you will not have to start over with a new 12-month exclusion for any pre-existing conditions.

A new plan generally receives information about an individual’s creditable coverage from a certificate furnished by a prior plan or issuer, referred to as a “Certificate of Creditable Coverage” (if you do not have a Certificate of Creditable Coverage, you may present other evidence of creditable coverage).

If you lose coverage under the plan or become entitled to elect COBRA continuation coverage or your COBRA continuation coverage ceases, the plan will automatically provide a Certificate of Creditable Coverage to you. If you make a request, the plan will furnish a Certificate of Creditable Coverage to you before your coverage ceases or within 24 months of your losing coverage.
“Creditable Coverage” means a person’s prior medical coverage as defined in HIPAA and includes the following:

(a) a group health plan;

(b) health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;

(c) Medicare (Part A or B of Title XVIII of the Social Security Act);

(d) Medicaid (Title XIX of the Social Security Act);

(e) CHAMPUS (Title 10 U. S. C. Chapter 55);

(f) the Indian Health Service or a tribal organization;

(g) a State health benefits risk pool;

(h) the Federal Employees Health Benefits Program;

(i) a public health plan maintained by a State, county, or other political subdivision of a State;

(j) Section 5(e) of the Peace Corps Act; and

(k) State Children’s Health Insurance Program.

HIPAA requires Baker Hughes to track and report your and your covered family members’ periods of Creditable Coverage under the plan.

A Certificate of Creditable Coverage issued by the plan will include the following information:

• The date the certificate is issued;

• The name of the plan;

• The name of the plan participant or dependent with respect to whom the certificate applies and any other information necessary for the plan to identify the individual, such as the individual’s identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

• The name, address, and telephone number of the plan administrator;

• A telephone number to call for further information;

• Either a statement that an individual covered by the certificate has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage or the date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

• The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

• An educational statement regarding HIPAA, which explains: (1) the restrictions on the ability of a plan or issuer to impose a pre-existing condition exclusion (including an individual’s ability to reduce a pre-existing condition exclusion by creditable coverage); (2) special enrollment rights; (3) the prohibitions against discrimination based on any health factor; (4) the right to individual health coverage; (5) the fact that state law may require issuers to provide additional protections to individuals in that state; and (6) where to get more information.

If you would like to request a Certificate of Creditable Coverage, contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).
What Is COBRA Coverage?

Under 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 coverage under the Baker Hughes group health plans (the group health plans) at group rates in certain instances where that coverage, including coverage under an HMO, 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 group health 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 your spouse or other dependent gains coverage under COBRA, 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 *FMLA information* in this section of the SPD) 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, Vision and the EAP, and 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 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 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 Benefits Center, the 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 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 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. The law also requires that you be allowed to enroll in an individual conversion health plan, if otherwise generally available under the group health plans, if coverage ends because of the expiration of the 18-month or 36-month, as applicable, continuation period.

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 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 Benefits Center within 31 days of the date you acquire the new family member. Any child(ren) 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):

<table>
<thead>
<tr>
<th>If You Experience One of these Qualifying Events</th>
<th>COBRA Coverage May be Elected for</th>
<th>Up to a Maximum of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your death</td>
<td>Your spouse and/or dependent child(ren)</td>
<td>36 months</td>
</tr>
<tr>
<td>Your divorce or legal separation</td>
<td>Your spouse and/or dependent child(ren)</td>
<td></td>
</tr>
<tr>
<td>Your child(ren) is no longer eligible for benefits under the group health plan</td>
<td>Your child</td>
<td></td>
</tr>
<tr>
<td>Your eligibility for Medicare benefits</td>
<td>Your spouse and/or dependent child(ren)</td>
<td></td>
</tr>
<tr>
<td>Your termination of employment (unless terminated for gross misconduct) or a reduction of work hours</td>
<td>You, your spouse, and/or dependent child(ren)</td>
<td>18 months generally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36 months for a spouse and child(ren), 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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36 months for the spouse and child(ren), if you were entitled to receive Medicare within 18 months before your termination of employment or reduction of work hours</td>
</tr>
</tbody>
</table>

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 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 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 timely pay the premium for your coverage;
- You become entitled to Medicare after making your COBRA coverage election;
- You become covered under another group health plan, unless there is a pre-existing condition exclusion as explained below; 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, even if the COBRA coverage is primarily only for coverage of conditions that are excluded under another group health plan’s pre-existing condition(s) exclusion. 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 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 Benefits Center. If a payment is received after the due date and any applicable grace period, COBRA coverage ends and cannot be reinstated.
Special COBRA Rules for the Health Care Flexible Spending Account

Under COBRA, you may elect to continue making contributions to your Health Care Flexible Spending Account 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.
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 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 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 hereunder.

Participants and beneficiaries under the plan can obtain, without charge, a copy of the plan’s QMCSO procedures from the Benefits Center by calling the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide) between 7 a.m. and 7 p.m. (Central), Monday through Friday.

The plan administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.
Important Plan Information
Plan Administration and Funding

The Baker Hughes Incorporated Retiree Heath & Welfare Benefit plans and the Retiree HRA are funded wholly by participant and/or company contributions.

Plan Administrator

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 plan administration. By participating in any such plan, 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 Incorporated
P.O. Box 4740
Houston, TX 77210-4740
Attn: North America Total Rewards
1-713-439-8600 or 1-800-229-7447 (worldwide)

Claim Administrator

For some of the plans, Baker Hughes has delegated authority to third party administrators to administer benefit claims under the plan. The claim administrator for each benefit plan is listed in the Claim Administrators section beginning on the next page. Subject to Baker Hughes’ overall authority as plan administrator, the claim administrator has discretionary authority to interpret plan provisions and determine benefit claims.

Cost of Administering the Plans

Baker Hughes intends to pay certain expenses of administering the plans except for COBRA and other plan costs described therein, which are paid by retirees.

Contributions to the Plans

Baker Hughes offers some welfare plans 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 Retiree H&W Benefit plans are individually identified by name and number as shown in the following table. The records of each plan are kept on a calendar-year basis.
## Claim Administrators

| **Employer or Plan Administrator/Sponsor** | **Baker Hughes Incorporated**  
Attn: North America Total Rewards  
P.O. Box 4740 Houston, TX 77210-4740  
OR  
2929 Allen Parkway, Suite 2100 Houston, TX 77019-2118  
For information call 1-713-439-8600 or 1-800-229-7447 worldwide |
| **Plan Sponsor’s Employer Identification Number (EIN)** | 76-0207995 |
| **Plan Number for the Baker Hughes Incorporated Welfare Benefits Plan** | 501 |
| **Plan Year** | The plan year begins January 1 and ends December 31 |
| **Agent For Service of Legal Process** | Baker Hughes Incorporated  
General Counsel  
P.O. Box 4740  
Houston, TX 77210-4740  
OR  
2929 Allen Parkway, Suite 2100  
Houston, TX 77019-2118 |

### Plan Name: Medical Plan (UHC Basic and Catastrophic Plans)

- **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 Name: Baker Hughes Incorporated Retiree Health Reimbursement Arrangement

- **Plan Type**: Welfare plan providing comprehensive medical benefits
- **Type of Administration**: This plan is a welfare plan funded by Baker Hughes Incorporated.
- **Benefit Administrator**: Extend Health  
P.O. Box 4740  
Houston, TX 77210-4740

### Plan Name: Prescription Drug Plan

- **Plan Type**: Welfare plan providing prescription medication benefits
- **Type of Administration**: Self insured
- **Plan Number**: BHUA
- **Benefit Administrator**: Express Scripts, Inc.  
One Express Way  
St. Louis, MO 63121

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**Important Plan Information**
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.

Benefit Administrators, Claims Payors, and Trustees

Baker Hughes has contracts with benefit administrators, claims payors, and trustees. 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 intends to continue the plan and Retiree HRA, Baker Hughes reserves the right to terminate or amend the plan and/or the Retiree HRA in whole or in part at any time and for any reason. The Company’s right to amend or terminate the plan and/or Retiree HRA 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(s) and/or Retiree HRA. If the benefit under the plan and/or Retiree HRA is 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 benefit under the plan and/or Retiree HRA other than payment of any covered expenses you incurred prior to the amendment or termination.

Collective Bargaining Agreement

This plan is administered in consideration of a collective bargaining agreement. A copy of this agreement may be obtained upon written request to the plan administrator and is available for examination by participants and their beneficiaries.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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; or  
• 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). |
| Amendment                           | Any attached written description of additional or revised provisions or benefits to the plan. Amendments are subject to all conditions, limitations, and exclusions of the plan, except for those that are specifically amended.                                                                                                                                                                                                                                                                                                                       |
| Annual Enrollment Period            | The period each year during the fall when eligible covered retirees are eligible to change benefit coverage elections.                                                                                                                                                                                                                                                                                                                                                                                   |
| Benefits                            | Your right to payment for and/or services that are available under the plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the plan, including this SPD and any applicable amendments.                                                                                                                                                                                                                                                                                                                             |
| Birthing or Birthing Center         | A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which 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  
• 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 which is part of a Hospital, as defined herein, will be considered a birthing center for the purposes of this plan. |
<p>| Brand-Name Drug                     | Drugs manufactured under a registered trade name or trademark.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Chemical Dependency                 | A physiological or psychological dependency or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered by his or her social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Administrator</td>
<td>The person designated by Baker Hughes Incorporated to administer claims under a plan described in this SPD.</td>
</tr>
<tr>
<td>COBRA</td>
<td>The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. This act allows employees and qualifying dependents to continue their health coverage for a specified length of time on the occurrence of certain events.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The percentage of eligible expenses shared between the participant and the plan. The coinsurance is applied to eligible expenses after the deductible(s) has been met, if applicable.</td>
</tr>
<tr>
<td>Company</td>
<td>Baker Hughes Incorporated and its affiliated companies that have adopted this plan on behalf of their employees.</td>
</tr>
<tr>
<td>Confinement</td>
<td>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.</td>
</tr>
<tr>
<td>Contribution</td>
<td>The amount that the retiree pays toward the cost of coverage to participate in a plan.</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>You and your dependents may have medical coverage under another group plan. In such cases, any incurred services may be subject to COB applicable industry rules to determine which plan will pay as primary and to what extent.</td>
</tr>
<tr>
<td>Copay</td>
<td>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.</td>
</tr>
<tr>
<td>Covered Expenses</td>
<td>Health services or supplies determined to be:</td>
</tr>
<tr>
<td></td>
<td>• Provided for the purpose of preventing, diagnosing, or treating sickness, injury, mental illness, substance abuse, or their symptoms;</td>
</tr>
<tr>
<td></td>
<td>• Consistent with nationally recognized scientific evidence as available and prevailing medical standards and clinical guidelines as described below;</td>
</tr>
<tr>
<td></td>
<td>• Not provided for the convenience of the covered person, physician, facility, or any other person;</td>
</tr>
<tr>
<td></td>
<td>• Identified as a covered expense;</td>
</tr>
<tr>
<td></td>
<td>• Provided to a covered person who meets the plan’s eligibility requirements; and</td>
</tr>
<tr>
<td></td>
<td>• Not identified as being excluded under the plan.</td>
</tr>
<tr>
<td>Covered Person</td>
<td>A person who is eligible for and enrolled in coverage under a plan described in this SPD upon satisfying the eligibility and participation requirements.</td>
</tr>
<tr>
<td>Custodial Care</td>
<td>Services that:</td>
</tr>
<tr>
<td></td>
<td>• Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or</td>
</tr>
<tr>
<td></td>
<td>• Are health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient who requires the services is not changing; or</td>
</tr>
<tr>
<td></td>
<td>• Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.</td>
</tr>
<tr>
<td>Deductible</td>
<td>The amount you must pay for covered expenses in a plan year before the plan begins to share in the cost of covered expenses.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Durable Medical Equipment   | Medical equipment that is all of the following:  
|                             | • Used to serve a medical purpose with respect to a sickness, injury, or their symptoms;  
|                             | • Can withstand repeated use;  
|                             | • Not disposable;  
|                             | • Used to serve a medical purpose;  
|                             | • Generally not useful to a person in the absence of a sickness, injury or their symptoms;  
|                             | • Appropriate for use in the home; and  
|                             | • Not implantable within the body.                                                                                                                                                                                                                                                                                                 |
| Eligible Expenses           | The amount paid for covered expenses, incurred while the plan is in effect, are determined as stated below. Eligible Expenses are based on either of the following:  
|                             | • When covered expenses are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider  
|                             | • When covered expenses are received from non-Network providers, the claims administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged through the claims administrator. In this case, Eligible Expenses are the fee(s) that are negotiated with the Non-Network provider.  
|                             | Eligible Expenses are determined solely in accordance with the Claim Administrator’s reimbursement policy guidelines. The reimbursement policy guidelines are developed, at the Claim Administrator’s discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:  
|                             | • As indicated in the most recent edition of the Current Procedural Terminology, a publication of the American Medical Association  
|                             | • As reported by generally recognized professionals or publications  
|                             | • As used for Medicare  
|                             | • As determined by medical staff and outside medical consultants pursuant to another appropriate source or determination that the claims administrator accepts.                                                                                                                                                     |
| Eligible Retiree            | You are eligible for Retiree Medical benefits under the plan if you are at least 55 years of age and have at least 10 years of service with Baker Hughes or a subsidiary of Baker Hughes on the date of your retirement from Baker Hughes or a subsidiary of Baker Hughes. In addition, you must be covered under a Baker Hughes active employee medical plan at the time of your retirement to be eligible for Retiree Medical benefits under the plan.  
|                             | Employees who are inpatriates to the U.S. or Non-U.S. Assignees/Rotators are not eligible for benefits under the plan. Retirees of Baker Hughes and its subsidiaries who are eligible for Retiree Medical benefits under the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired Prior to September 15, 1968 (Division 605), the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After September 15, 1968 and Prior to January 1, 1984 (Division 606) or the Hughes Tool Company Employee Retirement Health & Welfare Program for Retirees Who Retired On or After January 1, 1984 and Prior To January 1, 1990 (Division 607) are not eligible for benefits under the plan.  
|                             | If you are enrolled in a Baker Hughes plan providing Dental or Vision coverage or you participate in the Baker Hughes Incorporated Health Care Flexible Spending Account Plan at the time of your retirement from Baker Hughes or a subsidiary, you may be eligible to continue that coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refer to the COBRA section in the Baker Hughes Incorporated Health & Welfare program Summary Plan Description for active employees for additional information. |
| Emergency or True Emergency  | A serious medical condition or symptom resulting from injury, sickness, or mental illness which is both:  
|                             | • Arises suddenly, and  
<p>|                             | • In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health.                                                                                                                                                    |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Experimental and/or Investigational Services | Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatment, procedures, drug therapies, or devices that, at the time a determination is made 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; or  
  - The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.  
If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment), the plan may determine that an experimental or investigational service meets the definition of a covered expense for that sickness or condition. Prior to such a consideration, the plan must determine that the procedure or treatment is promising, but unproven, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health. |
| Explanation of Benefits (EOB)            | A statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:  
  - The Benefits provided (if any);  
  - The allowable reimbursement amounts;  
  - Deductibles;  
  - Coinsurance;  
  - Any other reductions taken;  
  - The net amount paid by the plan; and  
  - The reason(s) why the service or supply was not covered by the plan. |
<p>| Generic Drug                             | A drug identified by its official chemical name rather than an advertised brand name. These drugs are made with the same active ingredients and are available in the same strength and dosage as the equivalent brand name drugs. Generic drugs meet the same FDA standards for safety, strength, and effectiveness as brand name drugs. |
| Health Care Provider                     | A physician, practitioner, nurse, hospital, or specialized facility. |
| Home Health Care Agency                  | A program or organization authorized by law to provide health care services in the home. |
| Hospice                                  | Hospice care is an integrated program recommended by a physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical and psychological care for the terminally ill person, and short-term grief counseling for immediate family members covered under the plan while the member is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Facility</td>
<td>A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six months or less. The facility must have an interdisciplinary medical team consisting of at least one Physician, one registered Nurse, one social worker, one volunteer, and a volunteer plan. A Hospice Facility is not a facility or part thereof that is primarily a place for rest, custodial care of the aged, drug addicts or alcoholics, a hotel, or similar institution.</td>
</tr>
</tbody>
</table>
| 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. |
| 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.                                                                                                                           |
| Injury                        | Bodily damage other than sickness, including all related conditions and recurrent symptoms.                                                                                                                                                                                                                                               |
| Inpatient                     | An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility, or inpatient rehabilitation facility.                                                                                                                                                                                                     |
| 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.                                                                                             |
| Intensive Care                | A service that is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance prescribed by the attending physician.                                                                                                                                                                       |
| Intermediate Care             | Mental Health/Substance Abuse treatment that encompasses the following:  
  - Care at a residential treatment center which provides a program of effective Mental Health Services and Substance Abuse Services and:  
    - Is established and operated in accordance with any applicable state law;  
    - Provides a program of treatment approved by a physician and the Mental Health/Substance Abuse Administrator;  
    - Has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;  
    - Provides at least the following basic services:  
      - Room and board;  
      - Evaluation and diagnosis;  
      - Counseling;  
      - Referral and orientation to specialized community resources;  
    - Care at a partial Hospital/day treatment program, which is a freestanding or hospital-based program that provides services for at least 20 hours per week; and  
    - Care through an intensive outpatient program, which is a freestanding or hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.                                                                                     |
<p>| 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).                                                                                                                                                                         |
| 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.                                                                                                                                                  |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Medicaid</td>
<td>A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the programs’ costs.</td>
</tr>
<tr>
<td>Medicare</td>
<td>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.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Covered services for the diagnosis and treatment of mental illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a covered service.</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, unless those services are specifically excluded under the plan.</td>
</tr>
<tr>
<td>Military Service</td>
<td>Service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service pertaining to the military.</td>
</tr>
<tr>
<td>Network</td>
<td>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 provide covered expenses to covered persons. 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.</td>
</tr>
<tr>
<td>Network Provider</td>
<td>A physician, hospital, pharmacy, or other health care provider who has agreed to provide services to plan participants pursuant to a negotiated arrangement.</td>
</tr>
<tr>
<td>Non-Network Provider</td>
<td>A physician, hospital, pharmacy, or other health care provider that does not have a network Provider agreement in effect with the plan administrator at the time services are rendered.</td>
</tr>
<tr>
<td>Nurse</td>
<td>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.</td>
</tr>
<tr>
<td>Nursery Care</td>
<td>Care for the initial confinement of a newborn if the child is enrolled in a hospital-sponsored medical option.</td>
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<tr>
<td>Oral Surgery</td>
<td>Necessary procedures for surgery in the oral cavity, including pre-operative and post-operative care.</td>
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<tr>
<td>Organ and/or Tissue</td>
<td>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.</td>
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<tr>
<td>Procurement</td>
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<tr>
<td>Orthotics</td>
<td>Devices that straighten or change the shape of a body part, including but not limited to cranial banding and some types of braces.</td>
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| 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.                                                                                                                                                                                                 |
| Out-of-Area                 | Refers to a geographic area where the plan does not offer sufficient network access to contracted providers. Eligibility for Out-of-Area plans is determined by the Retiree’s home zip/postal code on file with the Benefits Center.                                                                                                                                                                                                                           |
| Out-of-Pocket Maximum       | The maximum amount of network coinsurance you pay each plan year for covered expenses. 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 plans; non-network coinsurance applies)  
• Deductibles  
• Any charges for non-covered expenses  
• Charges that exceed eligible expenses  
• Amounts above reasonable and customary limits  
• Copays                                                                                                                                                                                                 |
| 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  
• An ambulatory surgical facility and the stay is less than 24 consecutive hours                                                                                                                                                                                                                                                                       |
<p>| Partial Hospitalization/Day Treatment | A structured ambulatory program that may be a freestanding or hospital-based program and that provides services for at least 20 hours per week.                                                                                                                                                                                                                                                                                       |
| Personal Health Support     | A program provided by the claims administrator designed to encourage an efficient system of care for covered persons by identifying and addressing possible unmet covered health care needs.                                                                                                                                                                                                                          |
| Physician                   | Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed and qualified by law. Please 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. |
| Placed for Adoption          | The date the participant assumes legal obligation for the total or partial financial support of a child during the adoption process.                                                                                                                                                                                                                                                                                      |
| Plan Administrator          | Baker Hughes Incorporated or its designee.                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Plan Sponsor                | Baker Hughes Incorporated.                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Plan Year                   | January 1 through December 31, the 12-month period of time on which the plan’s records are maintained.                                                                                                                                                                                                                                                                                                                                                                           |</p>
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<tr>
<td>Preferred Provider Organization (PPO)</td>
<td>UHC selects and contracts with certain hospitals, physicians and other health care providers to provide services, supplies and treatment at a discounted rate.</td>
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<td>Pregnancy</td>
<td>Includes all of the following:</td>
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<tr>
<td></td>
<td>• Prenatal care</td>
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<td>• Postnatal care</td>
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<td></td>
<td>• Childbirth</td>
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<td>• Any complications associated with pregnancy</td>
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<tr>
<td>Prescription Drug</td>
<td>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.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Defined as services that contribute to the prevention of a condition or disease, such as: annual well-woman, well-man, and well-child exams, and preventive lab and x-ray services.</td>
</tr>
<tr>
<td>Qualified Beneficiary</td>
<td>A qualified beneficiary is an individual who, on the day before a qualifying event, has Baker Hughes Medical, Dental, Vision, and/or Health Care Spending Account coverage. A qualified beneficiary can be:</td>
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<tr>
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<td>• The covered employee or retiree;</td>
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<td>• The covered spouse of a covered employee or retiree;</td>
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<td></td>
<td>• The covered dependent child of a covered employee or retiree;</td>
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<tr>
<td></td>
<td>• A newborn or newly adopted child or a child placed for adoption who is added to a former employee’s or retiree’s COBRA coverage within 31 days of birth, adoption, or placement for adoption; and/or</td>
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<td></td>
<td>• 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).</td>
</tr>
<tr>
<td>Reasonable and Customary</td>
<td>Reasonable and Customary (R&amp;C) is the standard cost for a service in a geographic area. When a member utilizes a non-network provider for services, R&amp;C costs are the basis for determining the amount considered. The member may be responsible for any amounts above R&amp;C, in addition to any other plan responsibility, such as deductible and/or coinsurance.</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>A facility that provides a program of effective Mental Health/Substance Abuse treatment and that meets all of the following requirements:</td>
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<td>• It is established and operated in accordance with applicable state law for residential treatment programs;</td>
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<td>• It provides a program of treatment under the active participation and direction of a physician and approved by the Mental Health/Substance Abuse administrator;</td>
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<td>• It has or maintains a written specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and</td>
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<td></td>
<td>• 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.</td>
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<tr>
<td></td>
<td>A residential treatment facility that qualifies as a hospital is considered a hospital.</td>
</tr>
<tr>
<td>Retail Network Pharmacy</td>
<td>A pharmacy which contracts with the pharmacy benefit manager to fill or refill your prescription when you present a valid prescription drug plan ID card.</td>
</tr>
<tr>
<td>Retiree</td>
<td>An eligible person who is properly enrolled under the plan. The Retiree is the person (who is not a dependent) on whose behalf the plan is established.</td>
</tr>
<tr>
<td>Term</td>
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<tr>
<td>Semi-Private Room</td>
<td>A room with two or more beds. When an inpatient stay in a semi-private room is a covered health service, 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.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>A hospital or nursing facility that is licensed and operated as required by law.</td>
</tr>
<tr>
<td>SPD</td>
<td>Summary Plan Description. This document, which describes the Baker Hughes Incorporated Retiree Health &amp; Welfare Benefits plans.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>A physiological or psychological dependency or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>Covered expenses for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, unless those services are specifically excluded. 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.</td>
</tr>
<tr>
<td>Surgery</td>
<td>Any operative procedure performed in the treatment of an injury, disease, or illness by an instrument or cutting procedure through any natural body opening or incision.</td>
</tr>
<tr>
<td>Unproven Services</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Urgent Care                 | Treatment of an unexpected sickness or injury that is not life threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection. The sickness/injury must meet one or both of the following criteria:  
  • A delay in treatment could seriously jeopardize life or ability to regain functionality, and/or  
  • In the opinion of a physician with knowledge of the medical condition, could cause severe pain. |