Baker Hughes

Health & Welfare

2015 Summary Plan Description

BAKER HUGHES

This document describes the Baker Hughes Incorporated Health & Welfare benefits plans effective January 1, 2015. Please note that the information presented is only a summary. It replaces all previously published Health & Welfare Summary Plan Descriptions. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern these plans are contained in the plan documents or group insurance contracts. If, in our efforts to make the plans easy to understand, any of the plan provisions have been omitted or misstated, the official plan documents or insurance contracts must remain the final authority. The legal documents also govern the administration of the plans and payment of benefits. In the case of any dispute, the information in the plan documents or contracts will prevail. To request a copy of the plan documents, write to:

Baker Hughes Incorporated
P.O. Box 4740
Houston, TX 77210-4740
Attn: Employee Benefits Department

(Please provide your name and mailing address.)

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

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

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

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

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

The Baker Hughes Vision, Purpose, Core Values and Keys to Success are the Basis for Establishing a Common Culture at Baker Hughes

Our vision: To be the service company that best anticipates, understands and exceeds our customers' expectations.

Our purpose: Enabling safe, affordable energy, improving people's lives.

Our core values are:

- Integrity
- Performance
- Courage
- Teamwork
- Learning

Our keys to success are four priorities that guide decision-making at Baker Hughes:

- People contributing at their full potential. Every employee has a role to play. Everyone can make a difference.
- Being cost efficient in everything we do
- Delivering unmatched value to our customers
- Employing our resources effectively

We apply these same principles in our approach to providing you with your Baker Hughes benefits program.

About Your Baker Hughes Summary Plan Description

This Health & Welfare (H&W) benefits document, called a Summary Plan Description (SPD), gives you information about benefits offered at Baker Hughes effective January 1, 2015. It describes important features of each benefit plan, services that are covered, and how your benefits are paid.

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

- General Information — details about eligibility, enrollment procedures, and when coverage starts and ends for all the plans;
- Health — information about your Medical, Wellness 360°, Prescription Drug, Dental, and Vision plans, as well as Flexible Spending Accounts, Health Savings Account, and the Employee Assistance Program;
- Protection — information on the various insurance plans available to protect you and your family from financial hardship due to illness, accident, or death;
- Benefits Rights — information about your rights under the law and continuation of coverage if you leave Baker Hughes;
- Important Plan Information — reference details, such as plan number, sponsor, and the administrator; and
- Glossary of Terms — definition of terms found throughout this SPD.

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

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

- Medical plan
- Wellness 360°
- Prescription Drug plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account*
- Employee Assistance Program
- Short-Term Disability
- Long-Term Disability
- Basic Life insurance
- Supplemental Life insurance
- Basic Accidental Death & Dismemberment insurance
- Voluntary Accidental Death & Dismemberment insurance
- Business Travel Accident insurance
- Legal Plan
- Critical Illness plan
- Long-Term Care**

*Only available if Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plan elected.
**Applies to those accepted prior to December 31, 2011.

Who Do I Call?

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

Contact the Benefits Center Regarding:

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

Contact Your Human Resources Department Regarding:

- Taking a leave of absence
- Filing a Workers' Compensation claim
- Transferring within Baker Hughes
- Leaving Baker Hughes
- Changing your address or phone numbers via Employee Self Service (ESS)

Contact the Administrator or Insurance Company Regarding:

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

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

Additional Resources

Via my**Rewards**

Via Internet: www.myuhc.com

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

Customer Service: 1-866-743-6549

myRewards

There are two ways to access your myRewards account online:

1. From the Baker Hughes Intranet, go to go/myrewards.

2. From a personal computer, go to go.bakerhughes.com/myrewards. You will need to have your user ID and password.

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

Benefits Center
1-866-244-3539 (within the U.S.)
1-847-883-0945 (worldwide)

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

Contacts

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

Benefit Plan	Provider	Phone Number	Website
Enrollment, Eligibility, Summary Plan Descriptions, and Advocacy	Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	myRewards go/myrewards (from the Baker Hughes Intranet) go.bakerhughes.com/myrewards (from a personal computer)
Medical	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Prescription Drug	CVS/caremark	1-877-252-3485	www.caremark.com
Dental	Cigna	1-800-542-4293	www.mycigna.com
Vision	VSP	1-800-877-7195 or 1-916-635-7373 (worldwide)	www.vsp.com
Flexible Spending Accounts	UnitedHealthcare (UHC)	1-866-743-6549 or 1-866-802-8572 (worldwide)	www.myuhc.com
Health Savings Account	UnitedHealthcare (UHC) Optum Bank	1-866-743-6549 or 1-866-802-8572 (worldwide) 1-800-791-9361	www.myuhc.com
Health Assessment/Health Screening	Redbrick Health	1-855-427-5213	www.RedBrickHealth.com/login
Employee Assistance Program	Magellan	1-800-424-5915 or 1-314-387-4700 (worldwide)	www.magellanhealth.com/member
Short-Term Disability	Sedgwick	1-877-423-8677	www.sedgwick.com; client number 8504
Long-Term Disability	MetLife	1-877-423-8677	N/A

Benefit Plan	Provider	Phone Number	Website
Life and Accidental Death & Dismemberment (AD&D)	Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	my**Rewards** go/myrewards (from the Baker Hughes Intranet) go.bakerhughes.com/myrewards (from a personal computer)
Long-Term Care	John Hancock	1-888-389-6300 or 1-617-572-0048 (worldwide)	N/A
Legal Plan	Legal Access Plans LLC	1-888-416-4313	http://bakerhughes.legalaccessplans.com
Critical Illness Plan	MetLife	1-800-438-6388	N/A
Thrift Plan and Pension Plan	Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	my**Rewards** go/myrewards (from the Baker Hughes Intranet) go.bakerhughes.com/myrewards (from a personal computer)
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Benefits Center	1-866-244-3539 or 1-847-883-0945 (worldwide)	my**Rewards** go/myrewards (from the Baker Hughes Intranet) go.bakerhughes.com/myrewards (from a personal computer)

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Am I Eligible?

Employee Eligibility

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

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

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

Eligible Employees **Do Not** Include:

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

Are My Dependents Eligible?

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

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

Eligible Children Include:

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

Eligible Dependents **Do Not** Include:

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

Special Note on Dependent Children

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

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

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

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

If Eligibility for Benefits Coverage is Denied — How to Appeal

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

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

  Baker Hughes Incorporated
  Attn: Employee Benefits Department — Appeals
  P.O. Box 4740
  Houston, TX 77210

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

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

If Both You and Your Spouse Work at Baker Hughes

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

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

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

Retroactive Cancellation of Coverage

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

How Do I Enroll?

New Hires

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

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

Your Default Coverage

	Benefit Plan	Default Coverage Level
Health	Medical and Prescription Drug*	You Only coverage under the Choice Plus plan or UHC Out-of-Area PPO plan and Prescription Drug coverage through CVS/caremark
	Dental	No coverage
	Vision	No coverage
	Flexible Spending Accounts	No participation
	Health Savings Account **	No participation
	Employee Assistance Program	Automatic coverage
Protection	Short-Term Disability	Automatic coverage
	Long-Term Disability (Core)	Automatic Core coverage
	Basic Life Insurance	Automatic coverage
	Supplemental Life Insurance	No coverage
	Basic AD&D Insurance	Automatic coverage
	Voluntary AD&D Insurance	No coverage
	Business Travel Accident Insurance	Automatic coverage
	Legal Plan	No participation
	Critical Illness Plan	No coverage

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

**Only available if Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plan elected.

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

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

Annual Enrollment

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

There Are Two Ways to Enroll in the **Health** and **Protection** benefits.

Both are described below:

Online — Two Ways to Enroll	By Phone — Benefits Center Representative
1. From the Baker Hughes Intranet, go to go/myrewards. 2. From a personal computer, go to go.bakerhughes.com/myrewards. You will need to create a user ID and password to access the website. Access is available 24 hours a day, Monday through Saturday, and after 12 p.m. Central Time on Sundays.	Call the Benefits Center 1-866-244-3539 (within the U.S.) 1-847-883-0945 (worldwide) Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time. If you're a new hire or an existing employee transferring to a position with U.S. benefits, you can enroll via the telephone after you receive your first paycheck.

Tip! Baker Hughes automatically provides my**Rewards** with your Baker Hughes email address. If you forget your password, a password reset can be sent to your Baker Hughes email address within 15 minutes of your request unless you prefer to set up a personal email address as your preferred email.

If You Do Not Enroll

If you do not enroll during Annual Enrollment and you remain eligible to participate in the plans, you will receive the benefit options and coverage levels you had the previous year, including any obligation to contribute to a Flexible Spending Account. **During Annual Enrollment, you'll need to select $0 if you no longer wish to participate in a Flexible Spending Account. However, if you are enrolled in the Health Savings Account, your election will default to $0 and you will need to re-enroll.**

Remember…

You must have a user ID and password to enroll. If you don't already have one, you may create one by accessing my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer), or by calling the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

Remember…

Members of the Personal Choice Plus and Personal Out-of-Area PPO Medical plans will receive a combined ID card for both Medical and Prescription Drug coverage.

Identification Cards

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

Plan	Administrator	Website	Telephone
Medical Plan	UnitedHealthcare	www.myuhc.com	1-866-743-6549
Prescription Drug Plan	CVS/caremark	www.caremark.com	1-877-252-3485
Dental Plan	CIGNA	www.mycigna.com	1-800-542-4293

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

Can I Make Changes After I Enroll?

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

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

Approved IRS Changes in Status Include:

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

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

How Do I Make Approved Changes After I Enroll?

The approved changes must be made within the time frame specified above. To make the approved changes, access my**Rewards** 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.

Tip! In most cases, changes to your benefits must be consistent with the change in your status. For example, if you get married, you may add your spouse. If you want to know what changes you're allowed to make, access my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer), or call the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

When Does My Coverage Begin?

Newly Hired or Transferred Employee

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

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

Rehired Employees

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

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

Current Employee

Remember…

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

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

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

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

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

When Does My Coverage End?

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

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

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

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

Rescission of Coverage

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

- Choice Plus plan
- Personal Choice Plus plan
- UHC Out-of-Area PPO plan
- UHC Personal Out-of-Area PPO plan

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

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

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

If You Retire

Baker Hughes offers Medical benefits to our retired employees. To be eligible, you must be considered a retiree of Baker Hughes on your date of retirement. You will need to be at least age 55, with at least 10 years of service, and enrolled in a Baker Hughes active Medical plan on the date of retirement. If you're an eligible retiree and would like more information, contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

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

If You Become Disabled

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

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

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

If You Die

If you die while you're an active employee of Baker Hughes, your eligible dependents may elect to continue to be covered under a group health plan through COBRA and pay the applicable COBRA premiums. The first three months of COBRA coverage will be at the active employee rate. Refer to the *COBRA* section for more information.

COBRA coverage will end if your eligible dependents:

- Notify the Benefits Center they have become covered under another group health plan or Medicare;
- Is/(are) no longer eligible;
- No longer makes the required contributions; or
- COBRA coverage expires.

When Coverage Ends for Any Other Reason

If coverage ends for any reason other than retirement, disability, or death (such as you leave Baker Hughes), coverage for you and your dependents will end on the earliest of the following dates:

- You stop working for Baker Hughes;
- You're no longer benefits-eligible;
- You or your dependents are no longer eligible as described in the *Eligibility* section; or
- The plan ends.

If your employment ends, you may be eligible to continue your health coverage by electing COBRA (see the *COBRA* section for more information).

Leave of Absence

Family and Medical Leave

The federal Family and Medical Leave Act of 1993 (FMLA) provides for continuation of coverage during an unpaid leave of absence, and reinstatement of coverage following a return to active status. The following is a brief summary of the FMLA provisions that apply under the Baker Hughes plans.

Paid Leave

Your H&W coverage will be continued during a paid personal or FMLA leave. You may use your paid leave time for FMLA leave for up to 12 weeks in the applicable 12-month period, if:

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

During a paid leave of absence, such as Short-Term Disability, your portion of the cost of your H&W coverage during the leave of absence will be deducted from your pay.

Unpaid Leave

Your H&W coverage, excluding the Dependent Day Care Flexible Spending Account and Health Savings Account (HSA), will be continued during an unpaid personal or FMLA leave. You may take an unpaid FMLA leave for up to 12 weeks in the applicable 12-month period, if:

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

During an unpaid leave, or the unpaid portion of leave, the Company will maintain any H&W benefits the employee had prior to taking the leave, excluding the Dependent Day Care Flexible Spending Account and Health Savings Account. In addition, the employee may discontinue certain other benefits while on unpaid leave by contacting the Benefits Center within 31 days of the leave.

If the employee is not receiving pay from Baker Hughes during the leave, the benefit deductions will go into arrears and will be deducted from the employee's regular pay when he or she returns to work, according to the following schedule:

Length of Unpaid Leave	Repayment Schedule
1-3 weeks	1 pay cycle
4-6 weeks	2 pay cycles
7-9 weeks	3 pay cycles
10-12 weeks	4 pay cycles

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

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

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

Changing or Revoking Coverage Due to Unpaid Leave

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

Reinstatement of Canceled Coverage Following Unpaid Leave

When you return to work after your unpaid personal or FMLA leave, you may reinstate the coverage you elected to stop, as well as the Dependent Day Care Flexible Spending Account and the HSA. You must contact the Benefits Center within 31 days of your return from unpaid FMLA leave to reinstate your coverage.

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

Military Leave Continuation and Your Rights Under USERRA

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

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

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

Health

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

- Medical plan
- Wellness 360°
- Prescription Drug plan
- Dental plan
- Vision plan
- Flexible Spending Accounts
- Health Savings Account
- Employee Assistance Program

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

Medical Plan

Medical Benefits At-a-Glance

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

Medical Plan Features At-a-Glance

Plan Feature	Choice Plus (Choice Plus Network)	Personal Choice Plus[1] (Choice Plus Network)
Deductible	$600 Individual $1,200 Family	$1,300 Individual[1] $2,600 Family[1]
Coinsurance	80% in-network; 60% of Eligible Expenses out-of-network	80% in-network; 60% of Eligible Expenses out-of-network
Physician Office Visit	Subject to deductible and coinsurance	
Emergency Room	Subject to $100 copay, deductible and coinsurance. Copay is waived if admitted.	
HSA Employer Contribution	N/A	$500 Individual[2] $1,000 Family[2]
Preventive Care	Plan pays 100% for in-network services	
Out-of-Pocket Maximum (only in-network coinsurance applies)	$3,500 Individual $7,000 Family (includes deductible)	$4,000 Individual[1] $8,000 Family (includes deductible)[1]
Plan Feature	**UHC Out-of-Area PPO (Options PPO Network)**	**UHC Personal Out-of-Area PPO (Options PPO Network)[1]**
Deductible	$600 Individual/$1,200 Family	$1,300 Individual/$2,600 Family
Coinsurance	80% in-network; 80% of Eligible Expenses out-of-network	80% in-network; 80% of Eligible Expenses out-of-network
Physician Office Visit Emergency Room	Subject to deductible and coinsurance (Emergency Room copay does not apply to out-of-area plan.)	
HSA Employer Contribution	N/A	$500 Individual[2] $1,000 Family[2]
Preventive Care	100%	
Out-of-Pocket Maximum (only in-network coinsurance applies)	$3,500 Individual $7,000 Family (includes deductible)	$4,000 Individual $8,000 Family (includes deductible)

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

[2]When you elect the Personal Choice Plus option, you may also elect to open a Health Savings Account (HSA). If you do, Baker Hughes will automatically deposit money in your HSA ($500 if you elect Individual coverage and $1,000 if you elect Family coverage). This contribution is subject to review and change in future years.

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

Medical Choices

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

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

- Choice Plus plan
- Personal Choice Plus plan

OR

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

- UHC Out-of-Area PPO plan
- UHC Personal Out-of-Area PPO plan

These plans utilize the UHC Options PPO network. If you are eligible for an out-of-area plan, that means there are too few UHC providers, facilities, and/or hospitals in your area. As a result, you can use any provider for your health care. Your medical expense reimbursements are subject to the plan deductible, coinsurance, and Eligible Expense cost limitations. Eligible Expenses are determined by UHC's reimbursement policy guidelines. You will be responsible for any costs in excess of what are considered Eligible Expenses. For a complete definition of Eligible Expenses, please see page 34.

To find out if you reside within the UHC Choice Plus network service area, go online to the my**Rewards** website or call a Benefits Center representative. If you do not live within the UHC Choice Plus network service area, you will be offered out-of-area coverage options.

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

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

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

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

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

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

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

Medical Plans

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

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for specialist visit
- You are required to meet the deductible before the plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services are covered at 80% in-network or 60% out-of-network after the deductible is met. Out-of-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see page 34.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible network expenses

2 The **Personal Choice Plus plan** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect a Health Savings Account (HSA). The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. If you elect an HSA, Baker Hughes will automatically make a contribution to your HSA ($500 if you elect Individual coverage and $1,000 if you elect Family coverage). This employer contribution is subject to review and change in future years. See the *Health Savings Account* section for more information. The plan's key features are outlined below.

- Nationwide network of providers
- Provides in-network and out-of-network coverage
- No designation of primary care physician or referral required for a specialist visit
- You are required to meet the combined Medical and Prescription Drug deductible before the plan will begin to share in the cost of covered services with you
- Preventive care is covered at 100% in-network (no deductible applies)
- Most services covered at 80% in-network or 60% out-of-network after the deductible is met. Non-network services are subject to Eligible Expense cost limits and you are required to submit a claim form for reimbursement. Eligible Expenses are determined by UHC's reimbursement policy guidelines. For a complete definition of Eligible Expenses, please see page 34.
- The out-of-pocket maximum limits the amount of coinsurance you'll pay for eligible in-network expenses

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

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

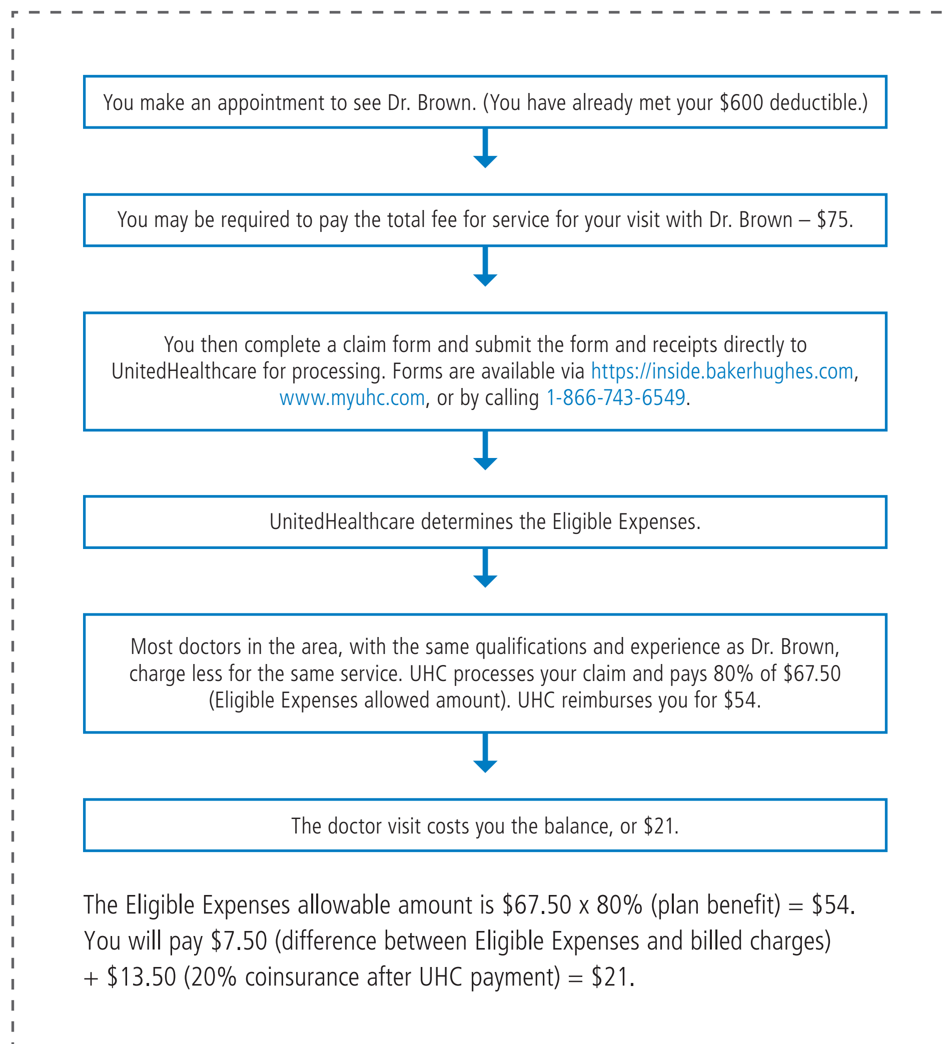
Two Medical Plans

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

2. The **UHC Personal Out-of-Area PPO plan** is a high deductible health plan (HDHP), subject to requirements imposed by the Internal Revenue Code, that charges reduced premiums, but has higher out-of-pocket expenses than the other Medical plan choices. If you enroll in this plan, you have the option to elect a Health Savings Account (HSA). The HSA allows you to pay for eligible, out-of-pocket medical care expenses on a pre-tax basis. If you elect an HSA, Baker Hughes will automatically make a contribution to your HSA ($500 if you elect Individual coverage and $1,000 if you elect Family coverage). This employer contribution is subject to review and change in future years. See the *Health Savings Account* section for more information. The plan pays 80% for eligible health care expenses after you meet the combined Medical and Prescription Drug deductible. Services are subject to the Claims Administrator's Eligible Expenses determination. For non-network services, you are required to submit a claim form for reimbursement. Please note that when you search for providers, you will need to access UHC's Options PPO network.

Out-of-Area PPO Coverage Example

If you have out-of-area coverage and need to see a physician, take a look at your options and how the out-of-area process works. When you have out-of-area coverage, you may choose any physician. In this example, you would be enrolled in *You Only* coverage in the UHC Out-of-Area PPO plan and you would have already met your $600 deductible. You decide to see Dr. Brown, a non-network provider.



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

What is the Cost of these Plans?

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

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

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

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

Online	By Phone – Benefits Center Representative
• go/myrewards (from the Baker Hughes Intranet) • go.bakerhughes.com/myrewards (from a personal computer)	Call the Benefits Center 1-866-244-3539 (within the U.S.) 1-847-883-0945 (worldwide)

Medical Expense Estimator

To assist you with your Medical plan choices, a Medical Expense Estimator is available on the my**Rewards** website. This easy-to-use tool will help you:

- Estimate your annual health care costs under each Medical plan option, and
- Determine which Medical plan is most cost-effective and best meets the needs of you and your family. The estimates are based on the annual premiums for each of the available plan options, and your expected personal health care usage.

Understanding UHC Networks

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

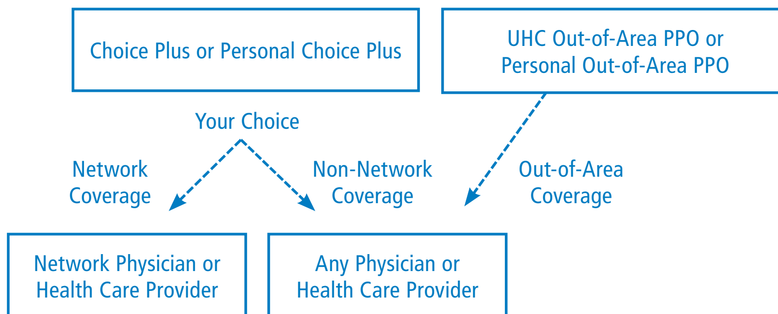
Medical Plan Options	Network
Choice Plus	UnitedHealthcare Choice Plus
Personal Choice Plus	UnitedHealthcare Choice Plus
UHC Out-of-Area PPO	UnitedHealthcare Options PPO
UHC Personal Out-of-Area PPO	UnitedHealthcare Options PPO

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

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

- Go to www.myuhc.com, select "Find Physician, Laboratory or Facility," and follow the instructions on screen;
- Call UHC Member Services at 1-866-743-6549; or
- Go to **myRewards**, select "Find Provider," and follow the instructions on screen.

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



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

Remember…

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

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

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

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

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

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

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

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

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

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

UnitedHealth Premium℠ Program

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

UnitedHealth Premium – Physician and Facility Designation Program

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

UnitedHealth Premium – Hospital Comparison Program

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

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

IMPORTANT

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

Additional Resources

Via my**Rewards**

Via Internet: www.myuhc.com

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

- Make real-time inquiries into the status and history of your health claims
- Obtain Medical and FSA claim forms
- View your eligibility information
- Register using your own password and view personal data online
- Search for providers in your area, including UnitedHealth Premium providers
- Order new or replacement ID cards for the entire family, or print a temporary ID card
- Access health and well-being information and participate in live events, and
- Price various procedures using the UHC Treatment Cost Estimator tool

Customer Service: 1-866-743-6549

Remember…

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

How do the Medical Plans Work?

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

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

Preferred Method

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

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

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

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

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

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

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

   In this case, UHC will review your claim and reimburse you up to the Eligible Expense limits. Your reimbursement will be sent to you along with an explanation of how your claim was processed. Please see page 34 for a complete definition of Eligible Expenses.

   Claim forms can be obtained online at www.myuhc.com, or by calling UHC at 1-866-743-6549, or via https://inside.bakerhughes.com.

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

Out-of-Pocket Expenses and your Bottom Line

The Medical plan options differ by:

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

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

Deductibles

A deductible is an amount you must pay each Medical plan year before the Medical plan begins to share in the cost of covered services with you. When choosing a Medical plan option, consider the premium cost, deductible amount, and how the deductible works for the different plans.

Deductible	Choice Plus and UHC Out-of-Area PPO	Personal Choice Plus and UHC Personal Out-of-Area PPO
Individual	$600	$1,300*
Family	$1,200	$2,600*

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

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

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

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

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

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

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

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

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

Coinsurance

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

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

Note: If you are enrolled in an out-of-area plan (UHC Out-of-Area PPO or UHC Personal Out-of-Area PPO), your in-network and non-network coinsurance applies to the out-of-pocket maximum.

Network Out-of-Pocket Maximum

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

- Non-network expenses (except for out-of-area plans)
- Charges that are not considered covered plan expenses
- Amounts above the Eligible Expenses cost limit
- Prescription drug expenses paid through the Prescription Drug plan (except in Personal Choice Plus and UHC Personal Out-of-Area plans)

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

Remember…

Under the Personal Choice Plus and UHC Personal Out-of-Area PPO, you must meet the combined medical and prescription drug family out-of-pocket maximum if your coverage level is other than *You Only*.

Important Note about the Choice Plus and UHC Out-of-Area PPO Out-of-Pocket Maximum:

Individual Out-of-Pocket Maximum: 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.

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

Important Note about the Personal Choice Plus and UHC Personal Out-of-Area PPO Out-of-Pocket Maximum:

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

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

Annual and Lifetime Maximums

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

IMPORTANT

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

Service	Limitation
Acupuncture	20 visits per calendar year
Chiropractic, Speech, Physical, or Occupational Therapy	40 visits per calendar year
Home Health Care	90 visits per calendar year
Infertility Services	$10,000 lifetime maximum
Nutrition Counseling	Up to 10 visits annually; non-preventive
Skilled Nursing or Extended Care Facilities	60-day limit per calendar year
Temporomandibular Joint Disorder	$500 lifetime maximum; non-surgical only

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

Eligible Expenses

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

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

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

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

- When covered health services are received from a network provider, Eligible Expenses are UHC's contracted fees with that provider.
- When covered health services are received from a non-network provider as a result of an emergency or as arranged by UHC, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For non-network benefits, Eligible Expenses are determined based on:

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

When covered health services are…	…Eligible Expenses are:
Other than pharmaceutical products	Determined based on available data sources of competitive fees in that geographic area
Mental health services and substance use disorder services	• Reduced by 25% for covered health services provided by a psychologist • Reduced by 35% for covered health services provided by a masters level counselor
Pharmaceutical products	Determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.*

*When a rate is not published by CMS for the service, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UHC will use a comparable scale. UHC and OptumInsight are related companies through common ownership by UnitedHealth Group. For information regarding the vendor that provides the applicable gap fill relative value scale information, refer to the UHC website at www.myuhc.com.

Medical Schedule of Benefits

	Choice Plus and UHC Out-of-Area PPO Plans		Personal Choice Plus and UHC Personal Out-of-Area PPO Plans	
	Network or Out-of-Area	Non-Network	Network or Out-of-Area	Non-Network
Deductible*	$600 Individual/$1,200 Family		$1,300 Individual/$2,600 Family**	
Out-of-Pocket Maximum (only network and out-of-area coinsurance applies; non-network coinsurance does not apply)	$3,500 Individual $7,000 Family (includes deductible)	None	$4,000 Individual $8,000 Family** (includes deductible)	None

*Deductible applies to out-of-pocket maximum.

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

IMPORTANT

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

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

Services	Choice Plus and UHC Out-of-Area PPO Plans		Personal Choice Plus and UHC Personal Out-of-Area PPO Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Acupuncture (up to 20 visits per calendar year)	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Allergy Care — Diagnosis and testing	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
— Injections only	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Ambulance — True emergency	100%; no deductible	100%; no deductible	80% after deductible	80% after deductible
— Non-emergency	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
Birthing Center	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Chiropractic, Physical, or Occupational Therapy (up to 40 visits per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Colonoscopy Procedure (diagnostic) — Outpatient surgery (diagnostic office visits subject to deductible and coinsurance)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Services	Choice Plus and UHC Out-of-Area PPO Plans		Personal Choice Plus and UHC Personal Out-of-Area PPO Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Congenital Heart Disease (see *Covered Expenses* section for additional details)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Durable Medical Equipment (items over $1,000 require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Emergency Room (Subject to $100 copay. Copay is waived if admitted.) — True emergency	80% after deductible	80% of Eligible Expenses after deductible	80% after deductible	80% of Eligible Expenses after deductible
— Non-emergency	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Home Health Care (up to 90 visits per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospice	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Hospital Care — Inpatient and outpatient	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Immunizations Child and adult immunizations (routine and travel immunizations covered)	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible
Infertility Services — Must enroll in the Reproductive Resource Services program — Infertility services must be received at designated Center of Excellence (COE) — Lifetime maximum benefit of $10,000 under Medical plan	80% after deductible for COE only	Not covered	80% after deductible for COE only	Not covered
Injections	100%; no deductible	60% of Eligible Expenses after deductible	80%; no deductible	60%; no deductible
Laboratory Services — Office setting, outpatient hospital or independent lab	100%; no deductible	100% of Eligible Expenses; no deductible	80% after deductible	80% of Eligible Expenses after deductible
— Inpatient hospital	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Maternity Care (you or a covered dependent)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Mental Health — Inpatient or outpatient (inpatient and intermediate care services require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible

Services	Choice Plus and UHC Out-of-Area PPO Plans		Personal Choice Plus and UHC Personal Out-of-Area PPO Plans	
	Network or Out-of-Area*	Non-Network*	Network or Out-of-Area*	Non-Network*
Nutrition Counseling (up to 10 visits annually; non-preventive)	100%; no deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Physician's Services — Office setting	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Preventive Care (i.e., annual well woman, well man, and well child services; annual mammogram, annual physical, and colonoscopy)	100%; no deductible	60% of Eligible Expenses after deductible	100%; no deductible	60% of Eligible Expenses after deductible
Radiologist, Anesthesiologist, and Pathologist Services	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Second/Third Surgical Opinions (voluntary)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility (up to 60 days per calendar year)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Speech Therapy (up to 40 visits per calendar year) Certain exclusions apply; contact UHC *Care Coordination*℠ for a pre-determination	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Substance Use Disorder — Inpatient or outpatient (inpatient and intermediate care services require pre-authorization)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
TMJ Non-surgical; excluding prescription drugs ($500 lifetime maximum)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	60% of Eligible Expenses after deductible
Transplant Services **United Resource Network** (U.R.N.)	100% U.R.N. only	60% of Eligible Expenses after deductible	80% after deductible U.R.N. only	60% of Eligible Expenses after deductible
— Travel/lodging ($10,000 lifetime maximum) — Lodging allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child — $200 maximum applies) — Organ search and procurement (except bone marrow, limited to $25,000)	Covered	Not Covered	Covered	Covered
Other Network (not United Resource Network)	80% after deductible	60% of Eligible Expenses after deductible	80% after deductible	80% after deductible
— Travel/lodging ($10,000 lifetime maximum) — Lodging allowance ($150 patient only/$200 patient plus one per day; one additional person allowed if patient is a child — $200 maximum applies) — Organ search and procurement (except bone marrow, limited to $25,000)	Not Covered			

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

*Services received from a non-network provider are subject to Eligible Expense costs. Please see page 34 for a complete definition of Eligible Expenses.

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

Adding it all up

Let's take a look at some real life examples. Below is an example of a hospital bill for $3,000, and how each Medical plan option pays according to the option's deductibles and coinsurance provisions. Let's assume that our sample employee, Joe Baker, is planning to elect *You Only* coverage.

	Choice Plus and UHC Out-of-Area PPO	Personal Choice Plus and UHC Personal Out-of-Area PPO
Deductible	$600/$1,200	$1,300/$2,600*
Hospital Charge (in-network)	**$3,000**	
Joe pays	$600 (Individual deductible applies)	$1,300 (Individual deductible applies)
Amount to apply to coinsurance	$2,400	$1,700
Plan option pays	$1,920 (80% coinsurance)	$1,360 (80% coinsurance)
Joe's coinsurance	$480 (20% coinsurance)	$340 (20% coinsurance)
Joe's cost for claim	$1,080	$1,640

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

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

	Choice Plus and UHC Out-of-Area PPO	Personal Choice Plus and UHC Personal Out-of-Area PPO
Deductible	$600/$1,200	$1,300/$2,600*
Hospital Charge (in-network)	**$3,000**	
Joe pays	$600 (Individual deductible applies)	$2,600 (Family deductible applies)
Amount to apply to coinsurance	$2,400	$400
Plan option pays	$1,920 (80% coinsurance)	$320 (80% coinsurance)
Joe's coinsurance	$480 (20% coinsurance)	$80 (20% coinsurance)
Joe's cost for claim	$1,080	$2,680

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

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

Emergency at or Away From Home

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

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

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

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

What if I am Admitted to a Hospital?

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

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

Medical Coverage Outside the U.S.

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

Preventive Health Services

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

- Preventive health services received from a network provider are covered by the Choice Plus and the Personal Choice Plus plans at 100%.
- No calendar year deductible applies and no other cost-sharing requirement (such as a copay or coinsurance) applies to preventive health services received from a network provider under those plans.
- The benefit includes the costs of services and tests performed during a wellness office visit with a network or out-of-area provider.

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

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

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

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved to the extent such recommendations are considered current under regulations and guidance issued by the Department of Labor and other governmental agencies. For 2015, a listing of these covered services can be found online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

For 2015, a list of the immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be found online as follows:

- For persons aged 0 through 18: http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
- For persons aged 19 or older: http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf
- For persons aged 4 months through 18 years who start late or who are more than one month behind: http://www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.pdf
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For 2015, a list of these services can be found at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3
- With respect to women, to the extent not described in the first bullet, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. For 2015, a list of these services can be found at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=2

As of January 1, 2015, the following preventive health services are provided to women under the Medical plan:

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

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

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

  — Which pump is the most cost-effective;

  — Whether the pump should be purchased or rented;

  — The duration of a rental; and

  — The timing of an acquisition.

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

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

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

Examples of preventive health services are listed below:

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

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

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

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

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

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

Nutrition Counseling

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

Pregnancy Coverage

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

- Limiting the length of a hospital stay for you and your newborn child to less than 48 hours following a vaginal delivery or 96 hours following a Caesarean delivery (if you're discharged earlier, the Medical plan will pay for two post-delivery home visits by a health care provider);
- Requiring a provider to obtain authorization from the Medical plan for prescribing any length of stay described above;
- Denying mother or newborn eligibility or continued eligibility to enroll or 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; and
- Restricting benefits for any portion of such hospital stay to be less than benefits for any stay prior to the birth.

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

Newborn coverage

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

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

Immunizations

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

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

What if I have a Pre-Existing Condition?

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

UHC *Care Coordination*℠ Program

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

You must ensure UHC *Care Coordination*℠ is notified prior to incurring certain covered expenses including:

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

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

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

IMPORTANT: If the *Care Coordination*℠ program is not used, a $300 non-notification penalty will apply.

Notification Requirements

For the **Choice Plus** and **Personal Choice Plus plans**, network providers may notify *Care Coordination*SM before they provide these services to you. However, there are some network benefits for which you are responsible for notifying *Care Coordination*SM. When you choose to receive certain covered services from non-network providers, you are responsible for notifying *Care Coordination*SM before you incur these covered services.

For the **UHC Out-of-Area PPO** and **UHC Personal Out-of-Area PPO plans**, you are responsible for notifying *Care Coordination*SM before you receive certain covered network or non-network services.

For all Medical plan options:

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

Emergency Services

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

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

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

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

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

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

Covered Expenses

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

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

Ambulance

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

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

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

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

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

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

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

Note: Pre-notification is required for non-emergency ambulance service.

Clinical Trials

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

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

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

Congenital Heart Disease

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

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

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

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

Contact *Care Coordination*SM at the telephone number on your ID card for information about CHD services.

Diabetes

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

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

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

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

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

Durable Medical Equipment (DME) and Prosthesis

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

  — Notification required on any expense over $1,000

  — Must meet all of the following criteria:

  - Ordered or provided by a physician for outpatient use
  - Used for medical purposes
  - Not consumable or disposable
  - Not of use to a person in the absence of sickness, injury, or disability
  - Durable enough to withstand repeated use
  - Appropriate for use in the home

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

If you rent or purchase a piece of DME that exceeds this guideline, you may be responsible for any cost differences between the price you rent or purchase and the price UHC has determined is the most cost-effective.

Enteral Feeding

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

Facility/Hospital

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

Hearing

Hearing aids are electronic devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier, and a receiver.

- Cost of hearing aid and associated hearing aid fitting and testing when received in a physician's office. The following requirements apply:
  - The hearing aid must be purchased as a result of a written recommendation by a physician, and
  - The hearing aid must be required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness).
- Benefits do not include bone-anchored hearing aids, except for covered persons who have either of the following:
  - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid, or
  - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

Home Health Care

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

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for covered persons with a congenital, genetic, or early-acquired disorder when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the covered person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the covered person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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

For purposes of this benefit, the following definitions apply:

- **Habilitative services** means occupational therapy, physical therapy and speech therapy prescribed by the covered person's treating physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early-acquired disorder.
- A **congenital or genetic disorder** includes, but is not limited to, hereditary disorders.
- An **early-acquired disorder** refers to a disorder resulting from sickness, injury, trauma or some other event or condition suffered by a covered person prior to that covered person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note that the plan will pay benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke or cancer.

Hospice

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

Infertility Services and Reproductive Resource Services (RRS) Program

Infertility Services

Infertility services are covered under the Medical plan if you are eligible for this benefit. For infertility services to be considered covered health services, you must enroll in the RRS program prior to receiving services, and access services through a provider or facility designated as a Center of Excellence (COE).

Covered Benefits

Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation;
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI);
- Assisted Reproductive Technologies (ART): In Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI);
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) – male factor associated surgical procedures for retrieval of sperm;
- Cryopreservation: Embryos (storage is limited to 12 months). Long-term storage costs (anything longer than 12 months) are not covered under the Medical plan. This includes:
  - Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only;
  - Embryo transportation-related network disruption; and
  - Donor coverage: Associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm (**Note:** The Medical plan does not cover donor charges associated with compensation or administrative services); and
- Fertility Preservation: When planned cancer or other medical treatment is likely to produce infertility/sterility, the Medical plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Eligibility

To be eligible for benefits, you must:

- Have failed to achieve a pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35;
- Have failed to achieve pregnancy following 12 cycles (under age 35) or six cycles (age 35 or over) of donor insemination;
- Have failed to achieve pregnancy due to impotence/sexual dysfunction;
- Have infertility that is not related to voluntary sterilization (**Note:** For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle); or
- Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities, including the surgical recovery of sperm); and
- Not be a child dependent, except when undergoing fertility preservation in preparation for gonadotoxic treatment.

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

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

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

Prior Authorization Requirement

You must enroll with the Reproductive Resource Services (RRS) program as soon as possible. If you fail to enroll with an RRS Nurse as required, you will be responsible for paying all charges and no benefits will be paid.

Reproductive Resource Services (RRS) Program

The Reproductive Resource Services (RRS) program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics designated as Centers of Excellence (COEs).

In order to receive a benefit, you must access services through a provider or facility designated as a COE. If you do not live within a 50-mile radius of a COE, you will need to contact an RRS case manager to determine a network facility prior to starting treatment. For infertility services and supplies to be considered covered health services, contact RRS and enroll with a nurse consultant prior to receiving services.

You or a covered dependent may:

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

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

Licensed Medical Providers

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

Mental Health and Substance Use Disorder Services

Mental health and substance use disorder services include those received on an inpatient or outpatient basis in a hospital and an alternate facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment
- Treatment planning
- Treatment and/or procedures
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention
- Partial hospitalization/day treatment
- Services at a residential treatment facility
- Intensive outpatient treatment

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an inpatient stay is required, it is covered on a semi-private room basis.

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

Notification Requirement

For non-network benefits for a scheduled admission for mental health and substance use disorder services (including an admission for partial hospitalization/day treatment and services at a residential treatment facility), you must provide notification to the Mental Health/ Substance Use Disorder Administrator prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including emergency admissions).

Another requirement when you use non-network benefits is that you must provide notification to the Mental Health and Substance Use Disorder Services Administrator before the following services are received:

- Intensive outpatient treatment programs;
- Psychological testing; and
- Extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.

If you fail to provide notification to the Mental Health and Substance Use Disorder Services Administrator as required, benefits will be subject to a $300 penalty.

Special Mental Health and Substance Use Disorder Programs and Services

As part of your mental health services/substance use disorder benefit, special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you.

The mental health services/substance use disorder benefits and the financial requirements assigned to these programs or services are based on whether the program or service is designated to one of the following categories of benefit use: inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient, or transitional care.

Special programs or services provide access to services that are beneficial to the treatment of your mental illness, which may not otherwise be covered under this Medical plan. Any decision to participate in such a program or service is at your own discretion and is not mandatory.

Morbid Obesity Surgery

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

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

Limitations include:

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

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

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

Prior Authorization Requirement
You must enroll with the Bariatric Resource Services (BRS) program as soon as possible. If you fail to enroll with a BRS nurse as required, you will be responsible for paying all charges and no benefits will be paid. Contact a BRS nurse at 1-888-936-7246.

Neonatal Resource Services

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

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

You or a covered dependent may also:

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

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

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 (U.R.N.) facility, covered expenses will also include up to $10,000 (lifetime maximum) in charges for:
  - — Transportation and lodging to and from the transplant site
- Transportation and lodging 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 lifetime maximum. A companion must be a spouse, family member, or guardian of the patient.
- The transportation and lodging benefit will not be paid if you or your dependent do not have the transplant performed at a U.R.N. 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 the Medical plan. The following provisions are also applicable to the organ and/or tissue transplant benefit under the U.R.N. program. Expenses of a recipient and/or donor are covered only if:
  - — The recipient of the transplant is a covered person under the Medical plan;
  - — Prior notification is provided to 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 Medical plan, the cost will not be a covered expense under the Medical 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;
  - — Inpatient treatment of mental and nervous disorders;
  - — Pregnancy/childbirth for you or a covered dependent;
  - — Administration of general anesthetic other than by the operating surgeon;
  - — Expenses that are related to pregnancy, childbirth, and related medical conditions;
  - — Routine annual wellness exams, including mammograms, gynecological exams, and Pap smears; and
  - — Hyper-alimentation or total parenteral nutrition for persons recovering from or preparing for surgery, or as the sole source of nutrition.

Sterilization

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

Transportation and Lodging (CHD)

Transportation and lodging services are covered only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Care Coordination℠ will assist the patient and family with travel and lodging arrangements. Reimbursement for expenses for travel and lodging for the recipient of CHD Services and a companion are available under the Medical plan as follows:

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

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

Exclusions and Limitations

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

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

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

Alternate Treatments

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

Ambulance

- Transportation for convenience

Comfort or Convenience

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

Dental

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

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

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 the Prescription Drug plan. Refer to the *Prescription Drug plan* 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

Durable Medical Equipment and Prosthetics

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

Experimental or Investigational Services

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

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

Exceptions:

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

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

Foot Care

- Except when needed for severe systemic disease or preventive foot care for a covered person with diabetes:[1]
  - — Routine foot care (including the cutting or removal of corns and calluses);
  - — Nail trimming or cutting; or
  - — Debriding (removal of dead skin or underlying tissue).
- Hygienic and preventive maintenance foot care. Examples include:
  - — Cleaning and soaking the feet;
  - — Applying skin creams in order to maintain skin tone; or
  - — Other services that are performed when there is not a localized illness, injury, or symptom involving the foot[2].
- Treatment of flat feet;
- Any fallen arches, chronic foot strain, or instability or imbalance of the feet;
- Shoe inserts;
- Shoes (standard or custom, lifts and wedges);
- Shoe orthotics;
- Toenails (other than the removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or a neurological condition); or
- Treatment of subluxation of the foot

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

[2]This exclusion does not apply to preventive foot care for covered persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

Home Health Care

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

Medical Supplies and Appliances

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

Mental Health and Substance Use Disorder

In addition to all other exclusions listed under the *Exclusions and Limitations* section, the exclusions listed directly below apply to services described under *Mental Health and Substance Use Disorder Services*.

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
  - — Not consistent with generally accepted standards of medical practice for the treatment of such conditions;
  - — Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered experimental;
  - — Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
  - — Not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
- Mental health services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Mental health services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
- Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Intellectual disabilities as a primary diagnosis as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Mental health services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
- Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder; and
- Any treatments or other specialized services designed for Autism Spectrum Disorder.

The Mental Health/Substance Use Disorder Administrator 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.

Neurobiological Disorders — Mental Health Services for Autism Spectrum Disorders

- Psychiatric services for Autism Spectrum Disorders (excludes diagnostic testing leading up to diagnosis)
- Services to treat maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning
- Services for experimental or unproven treatment modalities, such as Applied Behavior Analysis
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning, such as:
  - — Intensive Behavior Therapies, including Applied Behavior Analysis
  - — Speech, occupation and physical therapy
  - — Respite care
  - — Experimental therapies, such as equine therapy, hippo therapy, chelation therapy, and other specialized services designed for Autism Spectrum Disorders
  - — Tuition for or services that are school-based for children and adolescents

Nutrition

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

Orthotics

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

Physical Appearance

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

This exclusion does not apply to mammography testing.

Reproduction

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

Services Provided Under Another Plan

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

Remember…

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

Transplants

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

Travel

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

Vision and Hearing

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

All Other Exclusions

- Health services and supplies that are not listed as a covered expense
- Charges that exceed Eligible Expense limits
- Education or training, except as provided under the *Covered Expenses* section
- Food supplements, except as provided under the *Covered Expenses* section
- Equipment or supplies made or used for physical fitness, athletic training, or general health upkeep
- Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Medical plan when:

  — Required solely for purposes of education, sports or camp, insurance, marriage or adoption;

  — Related to judicial or administrative proceedings or orders;

  — Conducted for purposes of medical research; or

  — Required to obtain or maintain a license of any type.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the Medical plan ends, including health services for medical conditions arising before the date your coverage under the Medical plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Medical plan
- In the event that a non-network provider waives coinsurance and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the coinsurance and/or annual deductible are waived
- Charges in excess of Eligible Expenses or in excess of any specified limitation
- Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a physical congenital anomaly; speech therapy to treat stuttering, stammering, or other articulation disorders is not covered; speech therapy to treat learning disabilities or developmental delay is not covered
- Outpatient rehabilitation services, spinal treatment, or supplies including, but not limited to, spinal manipulations by a chiropractor or other physician, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring

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

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 deductibles, coinsurance, and non-covered items (as applicable).

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

Claim forms are available from:

- The Baker Hughes Intranet
- www.myuhc.com, or by calling UHC at 1-866-743-6549

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

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

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

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

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

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

Required information for claims includes:

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

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

What is a Health Statement or an EOB?

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

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

Notification of Claims Decision

Urgent Care Claims

Your claim may require immediate action if 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 time frames specified above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Remember…

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

Non-Urgent Care Claims

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

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

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

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

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

What if my Medical Claim is Denied?

If Your Claim is Denied

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

How to Appeal a Denied Claim

- **Level One:** If you wish to appeal a denied claim, including a denied pre-service request for benefits, post-service claim or a rescission of coverage, you must submit your appeal in writing within 180 days after receiving the denial. Your written appeal must include:

  — The patient's name and ID number on the ID card;

  — The provider's name;

  — The date of medical service;

  — The reason you think your claim should be paid; and

  — Any documentation or other written information to support your request.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

— Urgent care*
  - The claimant must be notified of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account medical emergencies, but not later than 72 hours after the receipt of the claim.
  - Urgent appeals must meet one or both of the following criteria:
    – 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 an urgent care request for benefits.*

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

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

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

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

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

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

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.

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

Federal External Review Program

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

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

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

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

An external review request should include all of the following:

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

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

- A standard external review, and
- An expedited external review.

Standard External Review

A standard external review comprises all of the following:

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

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

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

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

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

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

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

Expedited External Review

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

You may make a written or verbal request for an expedited external review if you receive either of the following:

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

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

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

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

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

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

Coordinating Your Medical Plan with Other Benefits

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

How Coordination Works

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

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

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

Example:

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

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

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

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

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

Which Plan Pays First?

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

- A plan that does not provide for coordination of benefits will pay its benefits first.
- A plan that covers a person as an employee will pay its benefits before the plan that covers the person as a dependent, and a plan that covers a person as an active employee is primary over a plan that covers a person who is laid off or a retiree.
- When a child is covered by the plans of both parents, unless they're divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year, regardless of the year of birth, will pay first. However, if the other plan's coordination of benefits provisions do not use this "birthday rule," the other plan's provisions will make the determination as to which pays first.
- If a child's parents are divorced or legally separated:

  — A qualified medical child support court order determines who pays first, otherwise:

    - The custodial parent's plan pays first;
    - The step-parent's plan pays second; and
    - The non-custodial parent's plan pays third.
- If a person whose coverage is provided under a right of continuation pursuant to a federal or state law (e.g. COBRA) is also covered under another plan, the effect on benefits is as follows:

  — The plan covering the person as an employee (or as the employee's dependent) will pay first, and

  — The plan of continuation coverage will pay second.
- When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. For example, if you are a new employee as the result of an acquisition of a business by Baker Hughes and your group health plan coverage continues with your former employer for a period of time after the acquisition, your former employer's plan will pay first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

Coordination with Medicare Secondary Payer Rules

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

Coverage for Active Employees and Spouses who are age 65 or Older and Eligible for Medicare

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

Coverage for Disabled Persons who are Eligible for Medicare

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

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

Coverage for End Stage of Renal Disease

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

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

Your health is important to Baker Hughes. That is why Baker Hughes has partnered with RedBrick Health to offer employees a set of wellness programs called Wellness 360°. All services provided through Wellness 360° are free and confidential. By participating in programs such as these, we can be better health care consumers, take better care of our families and ourselves, and reduce the cost of health care. Please refer to the following table for program eligibility guidelines.

<table>
<tr><th>Programs and Services</th><th>Is Program Voluntary or by Invitation?</th><th>Offered to Employees</th><th>Offered to Spouses</th><th>Offered to Dependents</th><th>Must be in Medical plan to Participate</th></tr>
<tr><td>Health Assessments
www.RedBrickHealth.com/login</td><td>Voluntary</td><td colspan="2">✓</td><td>No</td><td>No</td></tr>
<tr><td>Health Fairs/Health Screening (screenings on site where available)</td><td>Voluntary</td><td colspan="2">✓</td><td>No</td><td>No</td></tr>
<tr><td>Chronic Health Management Programs
Optum (UHC): 1-866-635-9530</td><td>Voluntary, and participants invited based on:
• Medical and Prescription Drug claims data
• Health Assessment feedback</td><td colspan="4">✓</td></tr>
<tr><td>Personal Health Support (UHC Nurse Case Management)
Optum (UHC): 1-866-635-9530</td><td>Voluntary, and participants invited based on:
• Medical and Prescription Drug claims data
• Health Assessment feedback
• Hospital stay</td><td colspan="4">✓</td></tr>
<tr><td>NurseLine
UHC: 1-866-635-9530</td><td>Voluntary</td><td colspan="4">✓</td></tr>
<tr><td>Healthy Pregnancy Program
UHC: 1-888-246-7389</td><td>Voluntary, and participants invited based on:
• Medical claims data</td><td colspan="4">✓</td></tr>
<tr><td>Reproductive Resource Services
UHC: 1-866-774-4626</td><td>Voluntary</td><td colspan="4">✓</td></tr>
<tr><td>Bariatric Resource Services
UHC: 1-888-936-7246</td><td>Voluntary</td><td colspan="4">✓</td></tr>
<tr><td>Redbrick Journeys®
Physical Activity Tracking
Tobacco Cessation Program
www.RedBrickHealth.com/login
1-855-427-5213</td><td>Voluntary</td><td colspan="2">✓</td><td>No</td><td>No</td></tr>
</table>

Wellness 360º Programs are Voluntary and Confidential

We encourage you to choose well, be well, and live better by participating in Wellness 360° programs. All programs are designed to help you manage current health problems and/or help avoid future problems. As indicated in the table on the previous page, you may be invited to join a program based on medical and/or prescription drug claims data or Health Assessment feedback. For other programs, you can volunteer to participate. Whether you are invited or volunteer, the decision to participate is yours.

IMPORTANT

All information will be treated as confidential. This means that none of your personal health information will be shared with Baker Hughes. However, a few of our Wellness 360° vendors may share your health information amongst themselves to be able to invite you to participate in other Wellness 360° programs. All vendors adhere to HIPAA privacy regulations to ensure your information remains private and confidential.

Health Assessments

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

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

After completing a confidential Health Assessment, if your results show you have a health risk that could be improved, you may be invited to participate in one or more of these programs. You will receive an instant invitation if you complete the Health Assessment online and a letter if you complete the Health Assessment via mail. You may also receive a phone call inviting you to participate. If you want to get started right away, you can also enroll by calling RedBrick at 1-855-427-5213.

Health Fairs/Health Screening

Health Fairs are held annually at select locations throughout the U.S. Employees and spouses are encouraged to attend a Health Fair if offered in their area. Health Screenings, which are offered at Health Fairs, entail a short examination that identifies key health numbers like your weight, blood pressure and cholesterol. If a Health Fair is not offered in your area, you may receive an annual well person check-up from your physician. Preventive services are covered at 100% under the Baker Hughes Medical plans when services are received from an in-network provider.

Chronic Health Management Programs

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

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

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

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

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

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

To learn more about the program, call Optum (UHC) at 1-866-635-9530.

IMPORTANT

Claims data is transferred to the Wellness 360° vendors in a manner that complies with HIPAA privacy guidelines.

Personal Health Support (UHC Nurse Case Management)

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

- Provide hospital pre-admission counseling to help you prepare for planned inpatient surgery;
- Help answer your questions and/or plan for any needs you may have after hospital discharge;
- Provide inpatient care advocacy to assist you in receiving the care your physician orders, when you need it, while in the hospital;
- Provide health information when released from a hospital stay of three or more days, or when released with certain chronic conditions, to help you understand and follow discharge instructions and have the support you need;
- Communicate regarding the necessary medication, equipment, and follow-up medical services needed upon your discharge from a hospital stay; and
- Refer members to other Wellness 360° programs.

NurseLine™

You can speak with a registered nurse by calling the UHC NurseLine™ at 1-866-635-9530 (direct) or 1-866-743-6549 (select the Wellness 360° option from the menu). You can also chat with a registered nurse online 24 hours a day at www.myuhc.com; select live nurse chat and follow the on-screen instructions. The NurseLine™ can help you:

- Learn self-care for minor illnesses and injuries;
- Understand diagnosed conditions;
- Discover and evaluate possible benefits and the risks of various treatment options;
- Learn about specific medications;
- Prepare questions for physician visits;
- Develop healthful living habits; and
- Learn to choose the right care at the right time.

Healthy Pregnancy Program

Offered through UHC, this voluntary program provides the mother-to-be with a wealth of information during pregnancy and postpartum. You also receive educational information specific to your pregnancy. Call UHC at 1-888-246-7389 to enroll in this program prior to the 34th week of pregnancy. After you enroll, you will receive 25 points toward your 250 point goal in addition to a $25 gift certificate to Toys R Us™/Babies R Us™. Spouses enrolled in the plan will not receive incentive points but will be eligible to receive the gift certificate.

Remember…

You have 24 hour access to a nurse via telephone or online chat via the UHC NurseLine™.

Reproductive Resource Services

If you are coping with infertility issues, Reproductive Resource Services will help you get the information you need. Our nurses can:

- Provide helpful information about infertility and its treatment;
- Educate you about the causes of infertility, treatment alternatives, and the different kinds of treatment types; and
- Help you navigate the health care system and find the right doctors and facilities for you.

Bariatric Resource Services

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

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

HealtheNote Care Reminders

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

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

HealtheNote reminders will include reminders for the following screenings:

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

Wellness Programs and Services

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

Some steps toward improving your health include: taking the Health Assessment, completing your annual Health Screening, working with a RedBrick health coach, participating in RedBrick Journeys and tracking your physical activity through RedBrick's Boost program.

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

RedBrick Journeys® (dynamic, highly personal and flexible)

Journeys can be accessed online or via a smart phone. Many people find them to be a refreshing, energizing alternative to more traditional online wellness programs. Select a Journey focused on one of the health topics listed below, and you will receive bite-sized, fun steps tailored to your interests. Choose steps you'd like to commit to as part of your Journey. Steps may incorporate activities as well as brief videos. Continue to personalize your experience by giving feedback on the steps you like and the ones you don't.

Get Active

Whether you want to make more of the exercise you already do — or you just want to get over that out-of-breath feeling — there's a Get Active Journey to inspire you. You may even discover "fun" in staying active.

- Discover how walking pumps up your energy
- Crank up the intensity of what you're already doing
- Stay fit when you're on the road
- Sneak in fun ways to keep your whole gang fit

Weigh Less

Enjoy more energy, fewer cravings and, perhaps best of all, looser pants — just by taking small steps that anyone can do. Forget overwhelming weight loss programs that make you count every calorie.

- Try out weight loss habits and repeat the ones that work
- Get portion distortion under control
- Learn about healthy snacks to lose weight and gain energy
- Conquer cravings that sideline your attempts

Eat Healthier

Ever end your day regretting what you ate? Take one small step to feeling better about your diet and embark on an Eat Healthier Journey.

- "Un-supersize" your portions
- Grocery shop for healthy food without breaking the bank
- Power up your energy with smart snacking
- Get the whole family in on the healthier eating game

Stress Less

Stress Less Journeys can help you find both your inner calm and a whole new store of energy. Refine how you eat, sleep and move for higher energy.

- Increase your attention span and focus
- Reframe your thoughts so you can solve problems
- Define and act on your values
- Discover relaxation tricks that work for you

Be Tobacco Free

What if living tobacco free could be less about "quitting" and more about "starting" healthy new habits? That's the power behind Be Tobacco Free Journeys. Wherever you are with tobacco — even if you're not ready to quit — you can dive in. Phone coaching is also available to help you reduce the risk of tobacco-related health conditions such as high blood pressure, heart disease and certain cancers by promoting cessation of all tobacco products.

- Quit date preparation
- Identify tobacco use triggers
- Relapse prevention
- Risk factor education

Sleep Well

Do you find yourself tossing and turning at bedtime? Or waking up wishing you felt more energized? Setting yourself up for a good night's rest is as easy as one, two, three with Sleep Well Journeys.

- Learn how much sleep you need
- Master a bedtime routine
- Create an oasis of rest
- Improve the quality of your sleep

Diabetes Life

Forget hard-to-reach goals and complicated tracking. Diabetes Life Journeys are about simple actions you can take along the path to taking good care of yourself.

- Discover fun ways to change your diet for the better
- Team up more effectively with the pros
- Tame the glucose roller coaster
- Master your medications

Healthy Back

Whether you're trying to ease back pain or learn how to prevent it in the future, Healthy Back Journeys can get you there one small step at a time. Each Healthy Back Journey unfolds uniquely for you, offering small, doable steps to improve posture, build strength and make lifestyle choices that ease the effects of tension and stress.

- Learn why a strong core is important for a healthy back
- Practice safe, gentle strengthening and stretching moves
- Improve your posture

Blood Pressure in Check

Whether you already have high blood pressure or are one of millions with pre-hypertension, you'll find Blood Pressure in Check Journeys for you.

- Find foods that lower blood pressure
- Learn creative, new ways to be more active
- Develop a simple, organized plan to manage your meds

Heart-Healthy Cholesterol

You have good intentions. Now turn those into healthy habits with Heart-Healthy Cholesterol Journeys personalized for you.

- Learn the difference between good fats and bad fats
- Manage your medications with a system that works for you

Live Well with Asthma

Raise your standards for feeling good with Live Well with Asthma Journeys. You can put what you know into practice by taking small steps anyone can do.

- Get ahead of your triggers
- Create or refine your action plan so you're always prepared

RedBrick Boost®

RedBrick Boost encourages participants to make physical activity part of daily life. By tracking your physical activities — from conditioning exercises to dance, and even home activities — you'll see firsthand just how easy it is to maintain an active lifestyle. Once enrolled, you can select from a list of over 200 different activities. Simply keep track of how much time you spend being physically active, enter your time into the online tracker and see the calories you burn.

You can also automatically sync activities with your RedBrick Boost account using approved devices, apps and programs. For example, Fitbit® and Runkeeper™. To learn more, go to your Boost account on the RedBrick website.

Rewards for Healthy Activities

Better health is more rewarding — in more ways than one. Baker Hughes is rewarding you with $250!

Earn rewards while creating your own, personalized path to better health. As a Baker Hughes employee, you are able to earn up to $250 in a medical premium discount by participating in healthy activities with RedBrick. **Employees who earn 250 points by August 31 of the current plan year will earn a $250 Medical plan premium discount for the following year.** Spouses enrolled in a Baker Hughes Medical plan can earn an additional $50 premium discount when they complete the Health Assessment, for a maximum family discount of $300. Discount is applied annually. Employee and spouse must be enrolled in a Baker Hughes Medical plan to receive the discount.

The Health Assessment and Health Screening are required activities to receive your reward.

For more details on important dates and how to earn points toward your premium discount, please log on to www.RedBrickHealth.com/login or contact RedBrick at 1-855-427-5213.

If you believe you are unable to meet a standard to earn these rewards, please call RedBrick at 1-855-427-5213 to inquire about alternative options.

Prescription Drug Plan

Prescription Drug Plan Benefits At-a-Glance

Type of Plan	Prescription Drug plan for members enrolled in a Medical plan option (including out-of-area options)		
Who Pays the Cost	You share the cost of Prescription Drug coverage with Baker Hughes		
Employee Eligibility	Employees and eligible dependents enrolled in one of the following Medical plan options: • Choice Plus plan • Personal Choice Plus plan • UHC Out-of-Area PPO plan • UHC Personal Out-of-Area PPO plan		
When Coverage Begins	Coverage begins on your date of hire or your date of transfer.		
Enrollment Period	Eligible employees are automatically enrolled in the Prescription Drug plan upon enrolling in the Medical plan.		
Cost		**Choice Plus and UHC Out-of-Area PPO**	
		Deductible	N/A
	30-day	Retail – Generic	$7
	30-day	Retail – Preferred Brand	25% ($30 minimum/$60 maximum)
	30-day	Retail – Non-Preferred Brand	30% ($60 minimum/$100 maximum)
	90-day	Mail – Generic	$15
	90-day	Mail – Preferred Brand	25% ($75 minimum/$150 maximum)
	90-day	Mail – Non-Preferred Brand	30% ($150 minimum/$250 maximum)
		Out-of-Pocket Maximum	$2,000 Individual/$4,000 Family
		Personal Choice Plus and UHC Personal Out-of-Area PPO	
		Deductible	Combined with Medical* ($1,300 Individual/$2,600 Family)
	30-day	Retail – Generic	$7 after deductible
	30-day	Retail – Preferred Brand	30% after deductible
	30-day	Retail – Non-Preferred Brand	30% after deductible
	90-day	Mail – Generic	$15 after deductible
	90-day	Mail – Preferred Brand	30% after deductible
	90-day	Mail – Non-Preferred Brand	30% after deductible
		Out-of-Pocket Maximum (includes deductible)	Combined with Medical* ($4,000 Individual/$8,000 Family)
Contact	CVS/caremark: www.caremark.com | 1-877-252-3485		

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

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

Choice Plus and UHC Out-of-Area PPO Medical plans

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

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

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

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

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

Personal Choice Plus and UHC Personal Out-of-Area PPO Medical plans

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

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

	Prescription Drug Coverage	Personal Choice Plus and UHC Personal Out-of-Area PPO
	Deductible (does not apply to certain preventive drugs*)	Combined with Medical ($1,300 Individual/$2,600 Family**)
30-day	Retail – Generic	$7 after deductible
30-day	Retail – Preferred Brand	30% after deductible
30-day	Retail – Non-Preferred Brand	30% after deductible
90-day	Mail – Generic	$15 after deductible
90-day	Mail – Preferred Brand	30% after deductible
90-day	Mail – Non-Preferred Brand	30% after deductible
	Out-of-Pocket Maximum (includes deductible)	Combined with Medical ($4,000 Individual/$8,000 Family**)

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

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

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

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

CVS/caremark National Network of Retail Pharmacies

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

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

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

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

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

If your physician has prescribed certain specialty or biotech medications for you or a covered family member, you'll need to have the prescription filled through CVS/caremark Specialty Pharmacy. You may access the CVS/caremark Specialty Pharmacy through www.caremark.com or by calling 1-877-252-3485.

Additional Resources

my**Rewards**: go/myrewards (from the Baker Hughes Intranet)
go.bakerhughes.com/myrewards (from a personal computer)

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

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

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

Maintenance Choice®

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

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

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

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

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

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

Additional Resources

For questions regarding Maintenance Choice® or to enroll in mail service:
Call: 1-877-252-3485 | Internet: www.caremark.com

Refills

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

Remember…

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

Understanding the CVS/caremark Performance Drug List

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

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

The CVS/caremark list is reviewed quarterly and prescription drugs can move on or off of the list after each review. Brand name drugs may be added to the Performance Drug List throughout the year.

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

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

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

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

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

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

Explanation of terms

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

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

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

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

Clinical Guidelines

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

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

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

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

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

Prior Authorization

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

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

Quantity Level Limits

For some medications, the Prescription Drug 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 FDA has determined to be safe in only limited amounts. Quantity Level Limits are in place for a limited number of medications; however, this clinical guideline may be added to newly approved medication.

Step Therapy Program

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

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

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

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

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

CVS/caremark Specialty Pharmacy

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

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

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

As part of the CVS/caremark Specialty Pharmacy program, CVS/caremark offers personalized care from an experienced Care Team of pharmacists and nurses trained in complex health conditions and the latest medication therapies. You obtain your specialty medications by filling up to two prescriptions through any retail pharmacy that is part of the CVS/caremark national network. Afterward, you must obtain your prescription through a CVS/pharmacy store or the CVS/caremark Specialty Pharmacy. (**Note:** If you live in West Virginia, Oklahoma and Arkansas, you must use the CVS/caremark Specialty Pharmacy after your first two fills.)

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

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

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

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

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

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

Covered Drugs

The following are covered:

- Drugs and medications for which a physician's prescription is required (also called federal legend drugs);
- Legend drugs, which are medications that require a prescription from a licensed health care professional;
- An extemporaneously prepared combination of two or more drug products containing at least one federal legend drug in a therapeutic amount;
- Insulin, needles, and syringes;
- Ostomy supplies;
- Any other drug which, under applicable state law, may only be dispensed by a physician's (or other authorized person's) written prescription;
- Drugs prescribed for infertility purposes are covered up to a $10,000 lifetime maximum; and
- Tobacco cessation medications for up to a 90-day supply (retail pharmacy only; no mail service). Beyond 90 days, participant must be enrolled in the Tobacco Cessation Program (see the *Wellness 360°* section for more information).

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

Exclusions and Limitations

The following are excluded from coverage:

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

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

Filing Prescription Drug Claims

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

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

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

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

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

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

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

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

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

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

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

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

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

Appealing a Denied Claim

1st Level Appeal and Decision

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

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

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

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

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

2nd Level Appeal and Decision

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

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

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

3rd Level External Review

If your claim or appeal for prescription drug benefits is denied on the basis of medical judgment, you may request, in writing, a 3rd level external review within four months of the date you receive notice of the final adverse benefit determination. You are eligible to request a 3rd level external review prior to receiving notice of the final adverse benefit determination:

- Only in the event that the plan fails to adhere to the rules for filing an initial claim and processing a request for a 1st or 2nd level appeal;
- In cases where the violation is attributable to good cause or outside the plan's control; and
- Where there is no existing pattern or practice of non-compliance by the plan.

The request should include your name and your contact information (including mailing address and daytime phone number), your ID number, and a copy of the coverage denial notice. The request for the 3rd level external review and supporting documentation may be mailed or faxed to CVS/caremark at:

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

Within five days of receiving your request for a 3rd level external review, CVS/caremark conducts a "preliminary review" to ensure the request qualifies. Within one day after completing this preliminary review, CVS/caremark notifies you, in writing, that:

- The member's request for a 3rd level external review is complete, and may proceed;
- The request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or
- The request for a 3rd level external review is complete, but not eligible for review.

Referral to IRO. If your request is complete, CVS/caremark assigns the 3rd level external review to one of the IROs with which CVS/caremark contracts. The IRO notifies you of its acceptance of the assignment. You have 10 days to provide the IRO with additional information you want the IRO to consider.

Timing of IRO's Determination. The IRO will provide you and CVS/caremark (on behalf of the plan) with written notice of its final 3rd level external review decision within 45 days after the IRO receives the request for the 3rd level external review.

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

External Review Process (Expedited). If your claim is marked "urgent" by your physician, CVS/caremark processes it as an urgent care claim. In some cases, CVS/caremark may contact the physician to confirm that the claim meets the ERISA requirements for an urgent care claim, but will continue to process the claim as urgent while attempting to do so. To initiate an urgent 3rd level external review, you or your physician should call CVS/caremark Customer Care at 1-877-252-3485. All requests for an expedited review must be clearly identified as "urgent" at submission. The IRO must provide you and CVS/caremark, on behalf of the plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for a 3rd level external review.

Deadline to Commence a Lawsuit. If you file your claim within the required time, complete the entire claims procedure, and your appeal is ultimately denied, you may sue over your claim (unless you have executed a release of your claim). You must, however, commence that suit within the earlier of:

- Two years after you knew or reasonably should have known of the facts behind your claim, or
- Six months after the claims procedure is complete.

Dental Plan

Dental Benefits At-a-Glance

<table>
<tr><td>Type of Plan</td><td colspan="3">Voluntary dental coverage</td></tr>
<tr><td>Who Pays the Cost</td><td colspan="3">You share the cost of dental care coverage with Baker Hughes.</td></tr>
<tr><td>Employee Eligibility</td><td colspan="3">Employees on U.S.-based payroll who are:
• Regular full-time employees or
• Benefits-eligible part-time employees</td></tr>
<tr><td>When Coverage Begins</td><td colspan="3">Enroll and begin coverage on your date of hire or date of transfer.</td></tr>
<tr><td>Enrollment Period</td><td colspan="3">• New hires and employees transferring to a position with U.S. benefits within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default for employees who do not enroll.
• Employees can make changes during Annual Enrollment or if they have a change in status (see the Can I Make Changes After I Enroll? information located in the General Information section). If you do not change the coverage in which you are enrolled during the Annual Enrollment period, you'll receive the same coverage you had the previous year, as long as you remain eligible.</td></tr>
<tr><td>Dental Choices</td><td colspan="3">• CIGNA Enhanced Dental PPO Program</td></tr>
<tr><td>Coverage Level</td><td colspan="3">• You Only
• You + Spouse
• You + Children
• You + Family</td></tr>
<tr><td rowspan="8">CIGNA Enhanced Dental PPO Plan*</td><td>Maximum Benefit</td><td colspan="2">$1,500 (excluding orthodontia)</td></tr>
<tr><td>Deductible</td><td colspan="2">$50 per person/$100 per family</td></tr>
<tr><td>Type of Service</td><td>Plan Pays</td><td>You Pay</td></tr>
<tr><td>Routine Preventive Services</td><td>100% (no deductible)</td><td>0%</td></tr>
<tr><td>Basic Care Services</td><td>80% (after deductible)</td><td>20% (after deductible)</td></tr>
<tr><td>Major Care Services</td><td>50% (after deductible)</td><td>50% (after deductible)</td></tr>
<tr><td>Orthodontia
(for dependent children
up to age 19)</td><td>50% after deductible
(subject to a $1,500 lifetime maximum)</td><td>50% after deductible
(subject to a $1,500 lifetime maximum)</td></tr>
<tr><td>Contact</td><td colspan="3">• CIGNA Enhanced Dental PPO plan at www.mycigna.com or 1-800-542-4293
• myRewards: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer)
• The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)</td></tr>
</table>

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

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

Remember…

The options available to you and your family are available on my**Rewards**, or by calling the Benefits Center. Your Dental plan coverage election is separate from your Medical plan election.

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

Dental Coverage Options

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

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

What is the Cost of these Coverage Options?

You and Baker Hughes share the cost of dental coverage provided under the Dental plan. Your cost of coverage is determined by the level of coverage you choose. To see the Dental plan coverage and costs, log on to my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or at go.bakerhughes.com/myrewards (from a personal computer) or call the Benefits Center.

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

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

Remember…

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

CIGNA Enhanced Dental PPO Program

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

Schedule of Benefits

Annual Maximum Benefit	$1,500 (excluding orthodontia. See below for orthodontia benefits).
Calendar Year Deductible (deductible is waived for preventive and diagnostic services)	
Individual	$50 per person
Family	$100 per family
Dental Expenses	
Preventive and diagnostic services	100% (no deductible)
Basic dental care services	80% (after deductible)
Major dental care services	50% (after deductible)
Orthodontic care (for dependent children up to age 19)	50% (no deductible); $1,500 lifetime maximum per dependent child

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

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

Covered Expenses

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

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

Preventive and Diagnostic Services

There is no deductible for preventive or diagnostic services. The Dental plan pays 100% of the allowable charges for these services under the CIGNA Enhanced Dental PPO Program. Below you'll find examples of some of the dental services covered and the limitations to this coverage.

Service	Limitation
Routine examinations	Twice in a calendar year
Routine cleanings	Twice in a calendar year
Full mouth x-rays	One complete set every 36 months
Bitewing x-rays	Twice in a calendar year
Topical fluoride application	Twice in a calendar year
Emergency treatment	For temporary pain relief, not the same day as any other service, except x-rays

Basic Dental Care Services

Under the CIGNA Enhanced Dental PPO Program, you must satisfy the calendar year deductible for basic dental care services. After the applicable deductible is met, the plan will pay 80% of the allowable charges for the following covered expenses for each covered person for the remainder of the plan year or until the annual maximum benefit is met.

Service	Limitation
Examinations, other than routine	None
Diagnostic x-rays, other than full mouth or bitewing	None
Fillings, other than gold	Composite filling payable only for anterior teeth
Pit and fissure sealants	One time application for dependent children up to age 19
Stainless steel crowns	None
Space maintainers	To replace prematurely lost teeth for dependent children up to age 19
Appliances	Only for prevention of harmful habits
Extractions	None
Oral surgery	None
General anesthetics, pre-medication, local anesthesia, analgesia, or conscious sedation	When medically necessary
Periodontal treatment or surgery of the gums	None
Endodontic treatment of dental pulp, including root canal therapy	None
Repair or recementing of crowns, inlays, onlays, bridgework, or dentures	When performed more than six months after the installation
Relining or rebasing dentures	When performed more than six months after the installation, but limited to one time

Major Dental Care Services

Under the CIGNA Enhanced Dental PPO Program, you must satisfy the calendar year deductible for major dental care services. After the applicable deductible is met, the plan will pay 50% of the allowable charges for the following covered expenses for each covered person for the remainder of the plan year or until the maximum annual benefit is met.

Service	Limitation
Fixed bridge work, partial, or full dentures	• Excludes third molars • No benefits will be paid for adjustments during the first six months after replacement
Add teeth to an existing fixed bridge, partial, or full denture	None
Replace an existing bridgework with a new bridgework	The existing bridgework is certified by the dentist or physician to be at least 10 years old at the time of replacement and cannot be repaired
Replace an existing full denture with a new denture	The existing denture (full or partial) is certified by the dentist or physician to be at least five years old at the time of replacement and cannot be repaired
Crowns (other than stainless steel). Inlays, onlays, or gold fillings to restore teeth	The cost of procedures will only be paid if: • The tooth is fractured or has major decay • The tooth cannot be restored with fillings such as amalgam, plastic, or composite resin
Replace a crown, inlay, onlay, or gold filling	Your dentist or physician must certify that the existing crown, inlay, onlay, or gold filling is at least five years old and cannot be repaired
Dental implants	Initial restorative care or replacement after five years from initial installation

Orthodontic Care

The CIGNA Enhanced Dental PPO Program offers orthodontic care treatment for your eligible dependent children up to age 19, subject to a lifetime maximum of $1,500 per dependent child and includes the following services:

- Examinations
- X-rays
- Surgery
- Extractions
- Active appliance and adjustments of the appliances

To receive benefits for orthodontic care, your dentist must, prior to performing any services, submit in writing a complete outline of the problem, the proposed treatment of that problem, the charges for the treatment, and the length of time for completion of the treatment. This must be submitted in writing to CIGNA before services will be considered a covered expense. Failure of your child's provider to comply with these requirements will result in no benefit being paid under the Dental plan for any services subject to such requirements.

Pre-Treatment Review

The pre-treatment review process lets you and your dentist know what the CIGNA Enhanced Dental PPO Program will pay before treatment begins. If you anticipate having dental expenses of $250 or more, your dentist should submit a written treatment plan and pre-operative x-rays before a course of dental treatment begins so you can fully understand what benefits may be payable under the Dental plan for that course of treatment.

Pre-operative x-rays should be submitted, along with a treatment plan, for multiple crowns, bridgework, or surgical extractions. The process for submitting a treatment plan is easy and convenient. Simply ask your dentist to complete and send a standard Dental plan claim form to the following address:

Connecticut General Life Insurance Company (CIGNA)
Chattanooga Claims Office
P.O. Box 188037
Chattanooga, TN 37422-8037

By submitting the treatment plan before work begins, both you and your dentist will know in advance the benefits that are available for the prescribed treatment.

Dental Expense Timing

Covered Expense	Date Expense Is Considered To Be Incurred
Full or partial dentures	Date of installation
Fixed bridges, crowns, inlays, or onlays	Date of installation
Root canal therapy	Date of completion of procedure
Periodontal surgery	Date surgery is performed

Some procedures are performed over a longer length of time. If you're close to meeting your $1,500 maximum benefit for the year, you may want to reconsider the timing of a procedure to receive the highest benefit possible.

Extended Dental Benefits

If your coverage ends while you're incurring charges due to an ongoing procedure, your benefits will be considered for payment as follows:

Dentures	
Charges will be considered if:	• The impression is made before the date coverage ends; • The denture is ordered before the date coverage ends; and • The denture is placed in the mouth within 90 days from the date coverage ends.
Fixed Bridgework, Crowns, and Inlays	
Charges will be considered if:	• The tooth or teeth are prepared before the date coverage ends; • The impression is taken before the date coverage ends; • The bridgework, crown, or inlay is ordered before the date coverage ends; and • The work is seated in the mouth within 90 days from the date coverage ends.
Endodontic Treatment, Including Root Canal Therapy	
Charges will be considered if:	• The tooth is opened before the date coverage ends, and • The procedure is completed within 90 days from the date coverage ends.

PPO Exclusions and Limitations

No payment will be made under the CIGNA Enhanced Dental PPO Program for expenses incurred for the following:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge, crown, or denture within five years after the date it was originally installed unless:
  - The replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth
  - The bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits
- Any replacement of a bridge, crown, or denture that is or can be made useable according to common dental standards
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
  - Change vertical dimension
  - Diagnose or treat conditions or dysfunction of the temporomandibular joint
  - Stabilize periodontally involved teeth
  - Restore occlusion
- Porcelain or acrylic veneers or crowns or pontics on or replacing the upper and lower first, second, or third molars
- Bite registrations, precision or semi-precision attachments, or splinting
- Instruction for plaque control, oral hygiene, and diet
- Dental services that do not meet common dental standards
- Services that are considered to be medical services
- Services and supplies received from a hospital

In addition, Dental plan benefits under the CIGNA Enhanced Dental PPO Program will be reduced, so that the total payment will not be more than 100% of the charge made for the dental service, when benefits are provided for that service under both the Dental plan and any Medical plan or prepaid treatment program made available by Baker Hughes.

In addition, no payment will be made for expenses incurred by you or any one of your dependents:

- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- For or in connection with an illness that is covered under any Workers' Compensation or similar law
- For charges made by a hospital owned or operated by, or that provides care or performs services, for the United States government, if these charges are directly related to a condition connected to military service
- To the extent that payment is unlawful where the person resides when the expenses are incurred
- For charges that the person is not legally required to pay
- To the extent that they're more than either the applicable contracted fee, applicable Eligible Expenses costs, or applicable scheduled amount
- For charges for unnecessary care, treatment, or surgery

- To the extent that you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law.

How Do I File a Dental Claim?

If you're covered under the **CIGNA Enhanced Dental PPO Program**, you or your provider must submit a claim form to CIGNA when you receive dental treatment and services from a non-network provider.

The CIGNA claim form includes instructions on where and how to file a claim. Read your claim form carefully and make sure you answer all questions and include all required information and documentation.

Once you complete the form, attach all evidence to support your claim, including receipts, and file your claim directly with CIGNA as soon as possible after your treatment. You have 12 months from the date of service or treatment to file a claim for expenses incurred.

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

Connecticut General Life Insurance Company (CIGNA)
Chattanooga Claims Office
P.O. Box 188037
Chattanooga, TN 37422-8037

After you send in your claim and it has been processed by CIGNA, you'll receive an Explanation of Benefits (EOB) statement outlining the Dental plan benefit paid with respect to your claim. If you do not receive an EOB, contact CIGNA member services at 1-800-542-4293. You can also log on to www.mycigna.com to review online EOBs.

As a claimant you are entitled to receive written notice, within 30 days of filing your claim, whether the claim is to be allowed in full or in part, or denied. This time limit may be extended for another 15 days in special cases, but you'll be notified of the reasons for the delay. You may file claims as often as you wish. If you're paid more than you should have been reimbursed for a claim, or if a claim is paid for ineligible expenses, CIGNA may deduct the overpayment from future claims payments made to you.

To process the claim, CIGNA has the right to review a dentist's statement of treatment, study models, x-rays, and any additional evidence considered necessary as evidence on which a claim under the CIGNA Enhanced Dental PPO Program may be based. In considering a claim, CIGNA has the right to require examination of you or your dependents when and as often as may be required.

What is an EOB?

An Explanation of Benefits (EOB) is a statement that is sent to you after you seek treatment or services from a dental care provider. The statement outlines your coverage, the benefits paid to your provider, and any amounts you owe for the treatment or service.

What if My Dental Claim is Denied?

If you are covered under the **CIGNA Enhanced Dental PPO Program** and if your claim is denied in whole or in part, you can call or write to Member Services as listed on your claim form or EOB to see if CIGNA Member Services can help you resolve your issues and questions regarding the denial without you having to file a formal appeal. This procedure is voluntary. You are not required to call CIGNA Member Services before filing a formal appeal. If CIGNA Member Services cannot resolve your issues with respect to the denial of your claim for benefits over the phone, you may file a formal appeal.

Appealing a Denied Claim

If you are not satisfied with the results of a decision regarding your claim, you or your authorized representative may begin the appeals procedure as outlined below.

- **Level One Appeal:** You can appeal a denied claim within 365 days of receiving the notice of your claim denial. To appeal the denial, file a written request for a review of your claim, to the Claims Administrator at the address listed on your EOB or claim form. If you are unable or choose not to write, you may ask the Claims Administrator to register your appeal by telephone, by calling the toll-free number listed on your ID card. You will receive a response in writing with a decision within 30 calendar days upon receipt of your appeal. If more time and/or information is needed, you will receive notification in writing requesting more time (up to 15 calendar days) and to specify if any additional information is needed to complete the review.
- **Level Two Appeal:** If you're dissatisfied with the Level One appeal decision, you may request a second review. To request a second review, follow the same process outlined in Level One. Most requests for a second review will be conducted by a committee (consisting of three people). Anyone involved in the prior decision may not vote on the committee. For appeals involving medical necessity or clinical appropriateness, the committee will consult with at least one dentist in the same or similar specialty as the care under consideration, as determined by CIGNA's dental reviewer. You may present your situation to the committee in person or by conference call. For Level Two appeals, CIGNA will acknowledge in writing that they have received your request and schedule a committee review. The committee review of your claim will be completed within 30 calendar days. If more time is needed, CIGNA will notify you in writing to request more time (up to 15 calendar days) and to specify whether any additional information is needed by the committee to complete the review. You will be notified of the committee's decision within five business days after the committee meeting, and within the committee review time frames above, if the committee does not approve the requested coverage.
- **Voluntary Independent Review Procedure:** If you're not fully satisfied with the decision of CIGNA's Level Two appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is made up of people who are not employed by CIGNA or any of its affiliates. A decision to use the voluntary level of appeal will not affect your rights to any other benefits under the Dental plan. There is no charge for you to initiate this IRO process and CIGNA will abide by the decision of the IRO. In order to request a referral to an IRO, certain conditions apply. The reason for the denial must be based on a medical necessity or a clinical appropriateness determination by CIGNA. Administrative, eligibility, or benefit coverage limits or exclusions are not eligible for review under this process. To request a review, you must notify CIGNA within 180 days of your receipt of the CIGNA Level Two appeal review denial. CIGNA will then forward the file to the IRO. The IRO will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CIGNA's Dentist reviewer, the review shall be completed within three days. The IRO program is a voluntary program arranged by CIGNA.

Notice of Benefit Decision on Appeal

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

1. Specific reasons for denial;
2. Reference to the specific Dental plan provisions on which the decision is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information, including any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment, or other similar exclusion or limit; and
4. A statement describing any voluntary appeal procedures offered by the Dental plan and your right to bring civil action in court.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review.

If the Claims Administrator fails to follow the claims appeals procedures as outlined above, you have the right to bring a civil action to court. In most instances, you may not initiate a legal action against the Dental plan until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Remember…

All decisions concerning exclusions and limitations under the Dental plan will be made at the sole discretion of the Claims Administrator.

Additional Resources — CIGNA

Via myRewards

- Search for providers in the CIGNA network

Via Internet: www.mycigna.com

- Download a claim form
- Find claim status and detail

Customer Service: 1-800-542-4293

Vision Plan

Vision Benefits At-a-Glance

Type of Plan	Vision plan for all eligible employees
Who Pays the Cost	You share the cost of vision care coverage with Baker Hughes.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. • There is no default coverage for employees who do not enroll. Employees can make changes during Annual Enrollment or if they have a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not change the coverage in which you are enrolled during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Plan Information	You may choose any provider, however, if you use doctors and facilities in the VSP network, your vision expenses are generally lower.
Contact	• VSP at www.vsp.com • VSP customer service at 1-800-877-7195 or 1-916-635-7373 (worldwide) • my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

What is the Cost of the Vision Plan?

You and Baker Hughes share the cost of coverage provided under the Baker Hughes Incorporated Vision Program (the Vision plan). To see your cost, log on to my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or at go.bakerhughes.com/myrewards (from a personal computer) or call the Benefits Center at 1-866-244-3539.

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

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

How Does the Vision Plan Work?

The Baker Hughes Vision plan is funded through an insurance policy issued by VSP and is designed to pay benefits to help you and your family take care of your vision needs. By encouraging regular vision exams and helping you pay for necessary vision expenses, the Vision plan helps you maintain your vision at a reasonable cost.

	Website	Telephone
VSP	www.vsp.com	1-800-877-7195 or 1-916-635-7373 (worldwide)

For Questions Contact:

VSP operates a nationwide network of eye-care providers. Network doctors provide services at pre-negotiated fees, which are usually lower than the fees charged by non-network doctors.

You and the Vision plan share the cost when you receive vision care. You pay a copay or receive an allowance depending on the type of service you receive. Refer to the *Vision Schedule of Benefits* section for more information.

A **copay** is the flat dollar amount you pay when you use the VSP network. For example, you will be charged a $10 copay for an annual eye examination when you visit a VSP network doctor (the Vision plan generally pays the remaining portion of the allowable cost). Copays must be paid each time a service is rendered or materials are prescribed and filled.

An **allowance** is the set dollar amount the Vision plan pays toward your eye care in a calendar year. You will be responsible for all charges over the Vision plan allowance. You'll receive 20% off the amount over your allowance through VSP network providers. Refer to the *Vision Schedule of Benefits* section.

Through the Vision plan, you'll save on eye exams, prescription eyeglasses (lenses and frames), and contact lenses. Additionally, you'll receive extra discounts on additional pairs of eyeglasses and sunglasses, including lens options through VSP network doctors, and discounts on laser eye surgery through VSP contracted surgery facilities. You simply make an appointment to see any eye care provider when you need eye care, keeping in mind you'll receive the most value from VSP network doctors.

If your provider is in the VSP network, you pay the applicable copay and expense based on the type of service you receive. Your VSP doctor will submit a claim electronically to VSP, which will pay your doctor for eligible services.

If you choose a provider who is not in the VSP network, you must pay for care at the time of service and submit a claim form to VSP for reimbursement. The Vision plan will reimburse you at the out-of-network reimbursement level minus the copays.

All covered expenses are subject to provisions shown in the *Vision Schedule of Benefits* section.

Remember…
If you're covered under the Vision plan, you will not receive an identification card. If you use a VSP network provider, they will submit claims on your behalf. If you use a non-network provider, you will need to pay for care at the time of service and you will need to submit a claim form for reimbursement. Claim forms are available online at www.vsp.com, or by calling VSP at 1-800-877-7195 or 1-916-635-7373 (worldwide).

Vision Network

VSP has a national network of participating doctors and offers low, fixed prices for services. To locate a participating doctor:

- Ask your local doctor if he or she participates in the VSP network;
- Log on to the VSP website at www.vsp.com and use the doctor search feature; or
- Call VSP member services at 1-800-877-7195 or 1-916-635-7373 (worldwide).

> **Tip!** If you or a covered dependent are away from home (for example, a child away at school) you can use any VSP network doctor in the United States.

How the Process Works Using a VSP Preferred Provider

When you make your appointment, identify yourself as a VSP member; provide your name and confirm your date of birth. The doctor's office will contact VSP for authorization and confirm the Vision plan benefits and coverage amounts.

The cost of a routine eye examination and standard lenses (single vision, lined bifocal, lined trifocal) are covered in full under the Vision plan when provided through a VSP preferred provider or network doctor after you pay the necessary copays.

When you arrive for your appointment, you'll pay the $10 copay for your routine eye examination. If the doctor prescribes corrective lenses for prescription eyeglasses, you'll be responsible for the additional $25 materials copay (lenses and frame). You'll receive a $200 allowance toward the purchase of your frames. You'll receive a 20% discount off the amount over your allowance. You will be responsible for paying any amount above the allowance.

If the doctor prescribes contact lenses, you will receive a $150 allowance that can be applied toward the contacts and the contact lens exam (fitting and evaluation). You'll receive a 15% discount off the cost of the contact lens exam (fitting and evaluation). You will be responsible for paying any amount above the allowance.

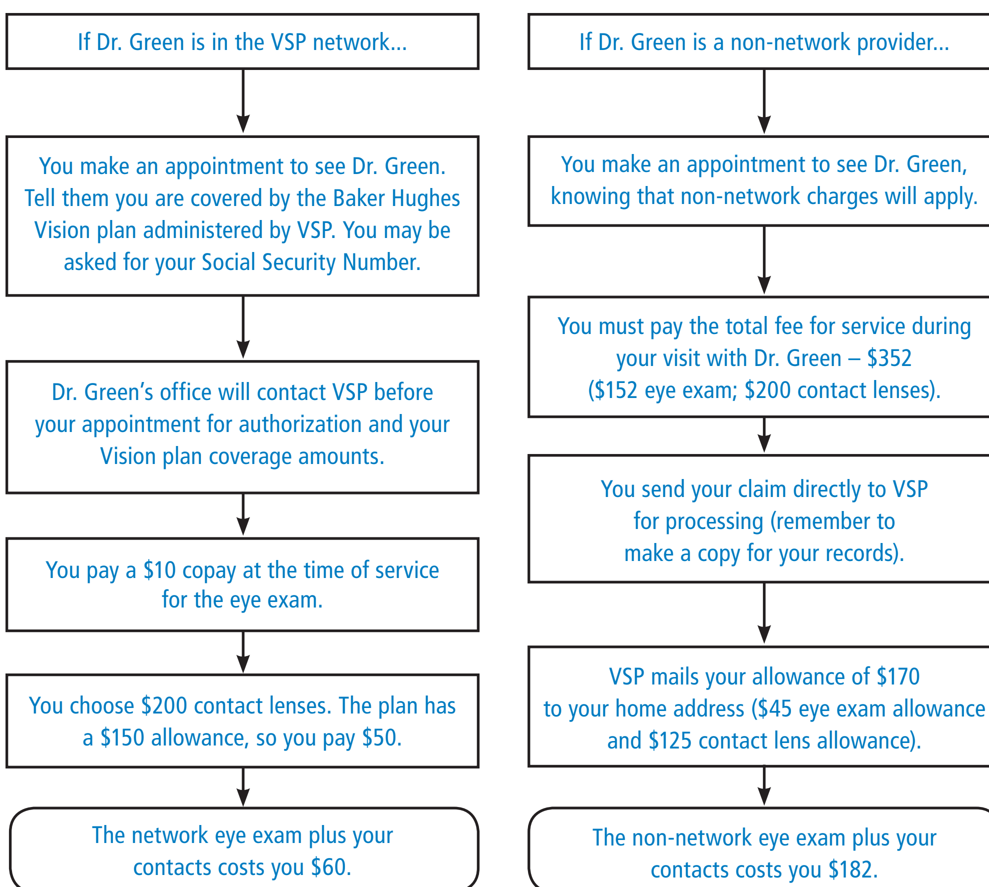
Using your Benefits Outside the VSP Network

If you choose a provider outside the VSP network, you are responsible for paying all charges at the time of your appointment. You will then be responsible for submitting an itemized statement of services to VSP for reimbursement under the Vision plan. The reimbursement amounts are shown on the *Vision Schedule of Benefits* section. You may contact VSP for instructions regarding your claim filing.

Example:

Before you make an appointment to see an eye care provider, take a look at the options you have and how the VSP process works when you choose to obtain services from a VSP preferred provider versus when you choose to obtain services outside the network.

You make an appointment to see Dr. Green for an annual eye exam and contact lens fitting.



Note: Dollar amounts are for illustrative purposes only and may not reflect actual costs.

Vision Schedule of Benefits

You are eligible for each of these benefits once in a calendar year. Please note that you may receive either one pair of glasses or contact lenses in a calendar year, not both.

Benefit	Copay	Coverage from a VSP Network Doctor	Out-of-Network Reimbursement
Eye Exam*	$10	Covered in full	$45 allowance
Lenses	$25 copay (applies to lenses and frames)	• Single vision, lined bifocal, lined trifocal and polycarbonate lenses are covered in full	Allowance: • $30 for single vision lenses • $50 for lined bifocal lenses • $65 for lined trifocal lenses
	$20 copay	• Tints/photochromic lenses-transitions	
Frames	N/A	• $200 allowance for a wide selection of frames • $220 allowance for featured frame brands • $70 allowance at Costco • 20% off amount over your allowance	$70 allowance
Contact Lenses	N/A	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation)	$125 allowance

*Eye exams must be performed by an ophthalmologist or optometrist and must include a complete analysis of your eyes and related structures to identify diagnosis for glasses or contact lenses.

You pay additional costs for the following:

- Blended lenses
- Contact lenses, except as noted above
- Oversize lenses
- Photochromic lenses, except Pink No. 1 and Pink No. 2
- Progressive multifocal lenses
- Coating of the lens or lenses
- Laminating of the lens or lenses
- Frames that cost more than the allowance

Note: When you receive care or services at a VSP network doctor location, you must pay any cost above your allowances under the Vision plan, including sales tax and any non-covered expenses.

Visually Necessary

Visually necessary lenses are those needed following cataract surgery or to correct extreme visual activity problems that cannot be corrected with eyeglasses or lenses for certain eye conditions. (The conditions covered include aphakia, anisometropia, high anetropia, nystagmus, keratoconus, and other eye conditions that make contact lenses necessary.)

When visually necessary contact lenses are obtained from a VSP network doctor, they will be covered in full minus the $25 materials copay when certain criteria is met. When visually necessary contact lenses are obtained from a provider outside the network, the Vision plan will provide an allowance toward the cost as outlined below. Coverage for visually necessary contact lenses — regardless of whether they are obtained from a VSP network doctor or not — are subject to review to determine if certain conditions are met.

	VSP Network Doctor	Non-VSP Network Doctor
Professional fees and materials	Covered in full	Up to $210

Exclusions

No benefits are paid for services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a +50 diopter power)
- Two pair of glasses instead of bifocals
- Lenses and frames previously paid for under the Vision plan that are lost or broken will not be replaced except at the intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye exam or corrective eyewear required by an employer as a condition of employment
- Corrective vision treatment of an experimental nature

How Do I File a Vision Plan Claim?

If you use a VSP preferred provider or network doctor, he or she will submit claims on your behalf. You're only responsible for applicable copays and amounts over your Vision plan allowances.

If you use a provider outside the network, you must submit a claim to VSP for reimbursement. To file a claim, send VSP the following information:

- An itemized statement of services you received;
- Include your name, address, phone number, date of birth, employer name (Baker Hughes), your member identification number (last four digits of your Social Security Number); and
- If the claim is for a dependent, your dependent's name, address, phone number, and your relationship to the covered dependent (such as spouse or child); and
- Copies of your receipts.

Send your claim to:
VSP
P.O. Box 997105
Sacramento, CA 95899-7105

File your claim directly with VSP as soon as possible after the date of treatment. Benefits will only be paid for those expenses incurred during the current or previous calendar year.

Once your claim is processed and approved, you'll be reimbursed according to the *Vision Schedule of Benefits* section.

Remember…
It's always a good idea to keep a copy of your claim form, receipts, and all supporting evidence for your records.

Remember…

A participant Advocacy service is available through the Benefits Center. The Advocacy service assists you with Vision plan access or claim issues that you have not been able to resolve on your own. Call the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide) for more information.

What if My Vision Plan Claim is Denied?

If your claim is denied, in whole or in part, you can call or write to VSP member services at 1-800-877-7195 to see if VSP member services can help you resolve your issues and questions regarding the denial without you having to file a formal appeal. This procedure is voluntary. You are not required to call VSP member services before filing a formal appeal. If VSP member services cannot resolve your issues with respect to the denial of your claim for benefits over the phone, you may file a formal appeal.

Appealing a Denied Claim

If you are not satisfied with the results of a decision regarding your claim, you may begin the appeals procedure as outlined below.

You or your doctor may initiate an appeal within 180 days of an initial determination through the VSP Member Appeals Department. Appeals may be submitted orally or in writing to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

You may submit written comments, documents, records, and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial claim.

You may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to your appeal. Your appeal will be reviewed by a person who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

If you disagree with the resolution of your appeal, you have the right to a second level appeal. Within 60 days of receipt of VSP's final determination, you may submit your appeal along with any further documentation to the address listed above. VSP will respond within the appropriate time period for the type of claim. This response will include the reasons for the decision and references to the plan provisions on which the decision was based.

If VSP fails to follow the claims appeals procedures as outlined above, you have the right to bring a civil action to court.

Additional Resources

Via my**Rewards**
Via Internet: www.vsp.com

- Search for providers in the VSP network
- View your personalized eye-care coverage
- Access eye health and wellness information

Customer Service: 1-800-877-7195

Coordination of Benefits for the Vision Plan

If you or your covered dependents have coverage under another vision plan in addition to your coverage under the Baker Hughes Vision plan, you may choose to receive separate services from each plan independently, or you may choose to have the plans pay for the same date of service.

If you choose to have the plans pay for the same service, one of the plans will pay the benefits first, making that plan primary. The other plans will pay benefits next. In this case, the other plans will be the secondary payer. The rules below help determine which plan pays first.

How Coordination Works

If the Baker Hughes Vision plan is primary, it will pay or provide its benefits as if the other plans do not exist.

If the Vision plan is the secondary plan, you will receive allowances (exam, lenses, and frame) "that will be used to pay up to, but not more than the billed amount. Only services used on the primary benefit may be used for coordinating services on the secondary benefit. Secondary allowances are applied first to the same service or product on the primary plan. Vision benefits may only be coordinated with services provided for vision care.

How to Determine if Your Baker Hughes Vision Plan is Primary

When you or your covered dependents have coverage under another vision plan in addition to coverage under the Baker Hughes Vision plan, VSP must determine the order of assignment.

- A plan that does not provide for coordination of benefits will pay its benefits first.
- A plan that covers a person as an employee will pay its benefits before the plan that covers the person as a dependent, and a plan that covers a person as an active employee is primary over a plan that covers a person who is laid off or a retiree.
- If you are a dependent child and are covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody has the primary plan, or the parent decreed by the court to be responsible has the primary plan.
- If a person whose coverage is provided under a right of continuation pursuant to a federal or state law (e.g. COBRA) is also covered under another plan, the effect on benefits is as follows:

  — The plan covering the person as an employee (or as the employee's dependent) will pay first, and

  — The plan of continuation coverage will pay second.
- When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. For example, if you are a new employee as the result of an acquisition of a business by Baker Hughes and your vision plan coverage continues with your former employer for a period of time after the acquisition, your former employer's plan will pay first. A new plan is not established when coverage by one carrier is replaced within one day by that of another.

Flexible Spending Accounts

Flexible Spending Accounts At-a-Glance

Type of Plan	Voluntary H&W benefit (Flexible Spending Accounts)
Who Pays the Cost	You can elect to have Baker Hughes set aside pre-tax money into Health Care or Dependent Day Care Flexible Spending Accounts based on your expected health care and dependent day care costs.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits must enroll within 31 days of their date of hire or transfer. You can enroll after you receive your first paycheck. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or during the year if you have a qualifying change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you participate in an FSA and do not properly change your contribution amount during Annual Enrollment, you will automatically continue participating in that FSA and your contribution will default to the prior year's contribution amount. To stop contributing to an FSA, you must actively elect $0 during the next Annual Enrollment period.
Contact	UnitedHealthcare: • www.myuhc.com • 1-866-743-6549

	Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account
Eligible Dependents	See the Eligible Dependents chart in the *HCFSA* section	See the Eligible Dependents chart in the *DCFSA* section
Eligible Expenses	See the chart in the *Eligible Health Care Expenses* section	Qualifying expenses that allow you and your spouse, if any, to work, look for work, or attend school full time. For examples, see the *DCFSA* section and IRS Publication 503 at www.irs.gov.
Minimum Contribution	$60	$300
Maximum Contribution	$2,500	• $5,000 for single taxpayers and for married taxpayers filing a joint tax return* • $2,500 for married taxpayers filing separate returns*

*Contributions cannot exceed the lesser of your or your spouse's earned income. Or, if your spouse is a full-time student or is disabled, you can contribute up to $3,000 for one dependent or $5,000 for two or more dependents.

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

Flexible Spending Accounts

The Baker Hughes Flexible Spending Accounts (FSAs) are designed to help you save on out-of-pocket health care and dependent day care expenses by using pre-tax dollars to pay your share of eligible expenses.

There are two separate accounts:

- Health Care Flexible Spending Account — for out-of-pocket health care expenses for you and your eligible dependents
- Dependent Day Care Flexible Spending Account — for dependent care expenses, such as day care (not health care)

Health Care and Dependent Day Care Flexible Spending Accounts are completely separate, and are designed for different types of expenses. Deposits to your Dependent Day Care FSA **cannot** be used to reimburse yourself for health care expenses incurred by you or your dependents. Likewise, deposits to your Health Care FSA **cannot** be used for dependent day care expenses.

Participation is entirely voluntary. You can have both a Health Care FSA and a Dependent Day Care FSA, just one account, or no account at all. You do not have to be covered under a Baker Hughes Medical plan to take advantage of the reimbursement accounts.

Please note that the amount you elect to contribute to a Flexible Spending Account is divided by the number of pay periods in a calendar year or pay periods left in the year. If your goal amount is not equally divisible by the number of pay periods, your actual contributions may be slightly more than your goal amount. You will be reimbursed from the FSA up to the elected goal amount.

Once you make your election, you cannot change your contribution during the year unless you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).

Eligible expenses for a plan year must be incurred by December 31 of that plan year, and claims for reimbursement of eligible expenses must be filed no later than March 31 of the following year.

Remember…
Any unused amounts in your FSA will be forfeited if claims are not filed by March 31 of the following year. Eligible expenses must be incurred by December 31 of the plan year.

Tax Savings with the Flexible Spending Accounts

In general, Flexible Spending Accounts save you money by allowing you to pay for eligible expenses with pre-tax dollars. The amount you save depends on the income tax and Social Security tax you do not have to pay. With FSAs, you figure out how much you want to contribute for a calendar year, and the money is taken out of your paychecks in equal amounts before taxes. You do not pay federal income tax, Social Security tax, and in most cases, state income tax on the amounts you decide to contribute. Plan carefully as you decide how much to set aside for the year, because you forfeit all money you don't use by the end of the year.

IMPORTANT

Claims processed by the Baker Hughes Medical plan and Prescription Drug plan are filed Automatically with the FSA Administrator. If you choose to file these claims manually, the automatic claim filing feature must be turned off each plan year by going to www.myuhc.com or by calling UnitedHealthcare at 1-866-743-6549.

Health Care Flexible Spending Account

What Can the Health Care FSA Do For You?

Use the Health Care FSA to help bridge the gap between what your health care plan pays and what you pay.

- Spread the cost of services over the year. You can be reimbursed for eligible expenses before the money is in your account, up to the total amount you elect to contribute for the year.
- Reduce the cost of eligible health care expenses. Use your pre-tax contributions to pay for eligible health care expenses such as your deductible, medical and prescription drug coinsurance, or other expenses not covered by your Medical, Prescription Drug, Vision, or Dental plans. The amount you save is determined by the amount of income tax and Social Security tax you do not have to pay.
- **Save time with automatic filing of Medical and Prescription Drug claims.** Once claims are processed by the Baker Hughes Medical and/or Prescription Drug plans, they are filed automatically with the FSA Administrator, UnitedHealthcare. You do not have to file these claims manually. Reimbursement will be sent to your home address on file with Baker Hughes, or you can set up direct deposit online at www.myuhc.com. If you prefer to process these types of claims manually, you can turn off the automatic claim initiation feature online at www.myuhc.com or by calling UnitedHealthcare at 1-866-743-6549. Dental, vision, and other expenses will need to be filed manually with the FSA Administrator for reimbursement.

Eligible Dependents*

You may submit eligible expenses to your Health Care FSA for the following:

- You Only
- Your Spouse
- Eligible dependents

An eligible dependent is one who qualifies as a "qualifying child" or a "qualifying relative" for federal income tax purposes. The table below briefly summarizes requirements for a "qualifying child" and a "qualifying relative."

Eligible Dependents	Qualifying Child	Qualifying Relative
Relationship to Employee	Examples include your: • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece The individual cannot be the qualifying child of any other person.	Examples include your: • Son/daughter • Grandchild • Stepchild • Nephew/niece • Brother/sister • Parent • Stepbrother/stepsister • Grandparent • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Residency Requirements	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico	Is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico
Age Requirement	• Younger than you, under age 26, regardless of full-time student status **OR** • Any age if permanently and totally disabled	No requirement applicable
Support Requirement	Will not provide over half of his or her own support for the year	You will provide over half of the individual's support for the year.
Income Limitations	No limitation applicable for individual being claimed. If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	Will have gross income for the year less than $3,800
Joint Return Limitation	If married, will not file a joint federal income tax return with his or her spouse	If married, will not file a joint federal income tax return with his or her spouse

*The information provided in the table above does not include all the requirements for a "qualifying child" or a "qualifying relative" for federal income tax purposes. For more information on those requirements, see Section 152 of the Internal Revenue Code and IRS Publication 502, which are available on the IRS website at www.irs.gov.

How the Health Care FSA Can Save You Money

Here is an example of the tax savings you can realize when you use the Health Care FSA. In this example, a person saves $500 in taxes.

	Using a Health Care FSA	Paying Health Care Expenses After-Tax
Gross Annual Income Payments for expenses using pre-tax dollars (deposit in Health Care FSA)	$30,000 -$2,000	$30,000 -$0
Taxable Wages Amount of tax to pay (assumes 25%)	$28,000 -$7,000	$30,000 -$7,500
Take-Home Pay Payment for expenses using after-tax dollars	$21,000 -$0	$22,500 -$2,000
Spendable Income Additional spendable income from tax savings	$21,000 **$500**	$20,500 **$0**

Example assumes a combined federal and state tax rate of 25%. The higher your tax rate, the more you can potentially save with a Flexible Spending Account.

Consider This...

Want to see how easy it is to generate over $100 in out-of-pocket medical costs? Consider just these routine expenses:

Eligible Expense	Health Care FSA	Total
Prescription Drugs	1 formulary brand medication at $30/mo	$30
Doctor Visits	1 network doctor visit (assuming deductible not met)	$65
Dental Care	1 filling @ $80 (you pay 20% after deductible)	$16 coinsurance after deductible
Vision Care	1 eye exam	$10 copay
Total		**$121**

How Much Should You Contribute? Use the Cost Estimator.

If you are newly eligible for benefits, or if you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section), you can use the online Cost Estimator to help you estimate how much you should contribute to the Health Care Flexible Spending Account. The Cost Estimator will also allow you to estimate your tax savings from participating in the FSA. To access the tool, simply log on to my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer). This tool is also available during each Annual Enrollment period.

Afraid of the "Use it or Lose it" Requirement? Here's How You Can Avoid it … and Save Money.

If you do not use all of the money in your Health Care FSA by the end of the year, you lose what is left in your account. If you are like many people who are missing out on savings because you are afraid of the "use it or lose it" requirement, estimate conservatively. Elect to contribute only the money you are reasonably sure to use during the year.

Did you know…

If you participate in a Health Care FSA, you cannot elect to contribute to a Health Savings Account (HSA).

Eligible Health Care Expenses

The IRS provides information that can help you determine which health care expenses are eligible for reimbursement. For detailed information, see IRS Publication 502, which is available on the IRS website at www.irs.gov.

Here are some examples of **eligible**, reimbursable health care expenses:

Medical

- Acupuncture
- Alcoholism or chemical dependency treatment
- Birth control pills and devices, or sterilization
- Charges that exceed a medical plan's limits, including amounts above Eligible Expense limits
- Crutches (purchase or rental)
- Deductibles and coinsurance
- Fees charged by medical professionals for medical care including chiropractors, Christian Science practitioners, midwives, osteopaths, practical nurses, psychiatrists, psychoanalysts (medical care only), and psychologists (medical care only)
- Home health care, including nurses and attendants
- Lab tests and x-rays
- Nursing home confinement for medical care
- Nursing service by a registered nurse or licensed vocational nurse
- Physical therapy, speech therapy, occupational therapy, and other health-related therapy
- Prescription drugs, if not covered by another plan
- Private duty nursing
- Routine physical exams and other preventive care not covered by other health plans
- Smoking cessation programs and smoking cessation drugs available only by prescription
- Syringes, needles, and injections
- Vaccinations and immunizations
- Vitamins prescribed by a physician for treatment of a medical condition
- Wheelchairs and other necessary equipment for the disabled
- Wigs (purchased upon advice of a physician for the mental health of a patient with loss of hair due to medical reasons)

Vision	Hearing
• Eye exams • Eyeglasses, including tinting • Contact lenses • Contact lens solutions and products • Radial keratotomy, laser eye surgery (LASIK), or similar surgery to correct vision • Special equipment, training and dogs for the blind	• Hearing exams • Hearing aids and repair • Special equipment, training and dogs for the deaf

Examples of Over-the-Counter (OTC) items that require a prescription to qualify for FSA purchase or reimbursement:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrheal medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine anti-fungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointment for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

If I get a prescription for an OTC medicine, how do I use my FSA to pay for it?

If you buy the medicine off the shelf you will need to submit an FSA claim form, a copy of your receipt and your provider's prescription, for the medicine you purchased. The prescription must include:

- Your name
- Name of medicine
- Dosage and form
  — Quantity prescribed
  — Instructions
- Signature of the provider who wrote the prescription

If you ask a pharmacist to fill the prescription, you will need to submit an FSA claim form with your receipt. Ask for a receipt that includes:

- Prescription number
- Your name
- Date of purchase
- Dollar amount

For more information visit www.healthcare.gov, the federal government's health care reform website designed to help you understand the Health Care Reform law and how it will affect you. Or visit www.irs.gov/publications/p502 for more detailed information about eligible expenses for reimbursement.

Ineligible Health Care Expenses

Here are some examples of **ineligible** health care expenses:

Health Care Flexible Spending Account

- Bottled water
- Cosmetic surgery (except for the correction of birth defects, accidental disfigurement, or reconstruction following mastectomy)
- Cosmetics, toiletries, toothpaste
- Custodial care in an institution, such as a nursing home
- Electrolysis
- Funeral, cremation, or burial expenses
- Health club dues or exercise equipment
- Household and domestic help
- Items that are not medically necessary
- Licensed practical nurse (LPN) for the care of a healthy newborn
- Marriage or family counseling
- Maternity clothes and diaper services
- Premiums for health, automobile, life, disability, or accident insurance
- Social activities, such as dance lessons or classes
- Special school tuition for a child with discipline or emotional problems
- Uniforms
- Vacation or travel taken for general health purposes
- Weight loss and fitness programs for general health purposes (except in cases of morbid obesity)

Over-the-Counter

- Bath products, cleansers, soap
- Creams, lip balm, lipstick, lotions, moisturizers
- Deodorants/anti-perspirants
- Feminine hygiene
- Foot care products
- Hair care products
- Hair removal products
- Medicine dispensers
- Powders
- Shaving and grooming products
- Snoring aids
- Stimulants (to stay awake)
- Sunscreen, sunless tanning, after-sun products

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Health Care FSA coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Health Care FSA by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the Health Care FSA. If an employee's Military Service is for a period of time of less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the Health Care FSA.

An employee may continue Health Care FSA coverage under the USERRA for up to the lesser of:

- The 24 month period beginning on the date of the employee's absence from work, or
- The day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the Health Care FSA, if the employee returns to a position of employment, the employee's Health Care FSA will be reinstated.

You should call the Plan Administrator if you have questions about your rights to continue the Health Care FSA under the USERRA.

Dependent Day Care Flexible Spending Account

What Can the Dependent Day Care FSA Do For You?

The Dependent Day Care FSA allows you to pay for day care expenses with pre-tax dollars so that you and your spouse (if any) can work or attend school full time. This account allows you to:

- Reduce the cost of eligible dependent care expenses (not health care expenses). The amount you save is determined by the amount of income tax and Social Security tax you do not have to pay.
- Help manage your day care expenses. Money must be in your account before you can be reimbursed. For example: If you have made contributions to your account totaling $300, you can be reimbursed only for up to $300 worth of eligible expenses.

Eligible Dependents*

You may be reimbursed under the Dependent Day Care Flexible Spending Account for qualifying dependent care expenses you incur for a spouse, a child, or other individual if that individual qualifies as a "qualifying individual" for federal income tax purposes. The table below briefly summarizes requirements for a spouse, a child, or other individual to be a "qualifying individual."

Eligible Dependents	Spouse	Qualifying Child	Other Qualifying Person
Relationship to Employee	Your spouse	Examples include your: • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece The individual cannot be the qualifying child of any other person.	Examples include your: • Son/daughter • Stepchild • Brother/sister • Stepbrother/stepsister • Grandchild • Nephew/niece • Parent • Grandparent • Uncle/aunt • Son-in-law/daughter-in-law The individual cannot be the qualifying child of any other person.
Disability Criteria	Is physically or mentally not able to care for himself or herself	No disability criteria required	Is physically or mentally not able to care for himself or herself
Residency Requirement	Will live with you for more than half of the year	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico	Will live with you for more than half of the year and is a U.S. citizen or national or a resident of the U.S., Canada, or Mexico
Age Requirement	No requirement applicable	Is under the age of 13 when the care is provided	No requirement applicable
Support Requirement	No requirement applicable	If you are not the parent of the qualifying child, your adjusted gross income must be higher than the highest adjusted gross income of any parent of the qualifying child.	You will provide over half of the individual's support for the year.

*The information provided in the table above does not include all the requirements for a "qualifying individual" for federal income tax purposes. For more information on those requirements, see Sections 21 and 152 of the Internal Revenue Code and IRS Publications 503 and 501, which are available on the IRS website at www.irs.gov.

Eligible Day Care Expenses

The IRS provides information that can help you determine which day care expenses are eligible for reimbursement. For detailed information, see IRS Publication 503, which is available on the IRS website at www.irs.gov.

Here are some examples of **eligible**, reimbursable dependent care expenses:

Dependent Day Care Flexible Spending Account

- A qualified day care center, nursery school, or summer day camp
- A housekeeper whose duties include day care
- Someone who cares for an elderly or incapacitated dependent
- A babysitter inside or outside your home
- A relative who cares for your dependents, as long as that relative is not one of your dependents for whom you can claim an exemption or one of your children under age 19

Remember, you'll need to provide a tax ID number or the Social Security Number of the care provider when you fill out your reimbursement request.

Ineligible Day Care Expenses

Here are some examples of **ineligible** dependent care expenses:

Dependent Day Care Flexible Spending Account

- Care provided by your children who are under the age of 19, or by anyone you claim as a dependent for federal income tax purposes
- Charges for the services of a care provider who has no Social Security or taxpayer identification number
- Child support payments
- Care for days not worked — including time off or holidays — or days when eligibility requirements are not met
- Education and food from first grade on
- Expenses for care received before you were covered by the Dependent Day Care FSA
- Food, clothing, education, transportation, or entertainment (food and education will be covered if provided by the nursery school or day care center as part of its preschool care services)
- Residential care, such as a nursing home
- Tuition or overnight camp

IMPORTANT

If you do not use all of the money in your Dependent Day Care FSA by the end of the year, what is left in your account will be forfeited.

How Much Should You Contribute?

Estimate Your Day Care Expenses

If you have never used a Dependent Day Care FSA, estimate conservatively until you are comfortable with how it works. If you are newly eligible for benefits, or if you have an eligible change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section), you can use the Cost Estimator on my**Rewards** to help you estimate how much you should contribute to the Dependent Day Care FSA. The Cost Estimator will also allow you to estimate your tax savings from participating. This tool is also available during each Annual Enrollment period.

Dependent Day Care FSA vs. Income Tax Credit

The payment method that is best for you depends on your individual situation. In some cases, using the Dependent Day Care FSA can save you more. In other cases, you may save more by taking a credit on your federal income tax return. In most cases, if you are married and your family's federal income tax bracket is more than 15% (family income exceeds $74,900 for 2015), your savings will be greater through the Dependent Day Care Flexible Spending Account. To help you determine whether the Dependent Day Care FSA or the tax credit is better for your particular situation, you may want to consult a tax specialist, contact the IRS at www.irs.gov, or call 1-800-TAX-FORMS and ask for Publication No. 503.

How the Flexible Spending Accounts Work

Although the accounts cover different types of expenses, they generally operate in the same way:

1. When you're first hired, and during each Annual Enrollment period, estimate your expected eligible expenses for health care and/or dependent day care for the following year. **You can enroll in one account or both, depending on your needs and your family's needs.**
2. Designate the amount you want to contribute.
3. The amount you choose to contribute is automatically deducted, in equal amounts, from your paychecks on a pre-tax basis throughout the year. Benefit deductions are taken over 24 pay periods (instead of 26). Your contributions are then deposited into the FSAs that you select.
4. When you incur an eligible expense during the year, you file a claim form for reimbursement (eligible Baker Hughes medical and prescription drug expenses are automatically filed for you). A claim form is available online on the Baker Hughes Intranet, or at www.myuhc.com. Refer to *Filing a Reimbursement Request* below for more information.
5. Reimbursement from your Flexible Spending Accounts is based on when the eligible expense was incurred rather than when the eligible expense was paid. Expenses must be incurred by December 31 of a calendar year to be reimbursed from the FSA for such year. Claims must be filed no later than March 31 of the following year.

IMPORTANT

If you do not change the contribution amount during the next Annual Enrollment period, you will automatically continue participating and your contribution will default to the prior year's contribution amount.

Filing a Reimbursement Request

When you have eligible expenses of $25 or more, submit your claim using a UnitedHealthcare (UHC) FSA claim form and include supporting documentation (the provider's Explanation of Benefits [EOB] or detailed receipts) as proof of services rendered. Submit the claim form by fax or mail as instructed on the claim form. Claim forms are available at www.myuhc.com or the Baker Hughes Intranet at https://inside.bakerhughes.com. If you do not have access to the Internet, call UHC at 1-866-743-6549 to request a copy of the claim form.

You may file claims for reimbursement of covered expenses at any time during the year in which they are incurred and no later than March 31 of the following year. The expenses must have been incurred during the calendar year covered by the FSA.

Reimbursements are typically processed and paid via check within two to three weeks. If you prefer to receive reimbursements directly into your bank account, log on to www.myuhc.com and set up direct deposit.

Claim activity and account balance information will be provided in a monthly Health Statement, as well as in quarterly statements. You can access these statements, as well as Explanations of Benefits (EOB) for each processed claim at www.myuhc.com.

Changing Your Contribution Amounts

IRS regulations do not permit you to stop or change the amount you contribute to a Flexible Spending Account during the calendar year unless you meet one of the following conditions:

A. With regard to both a Health Care FSA and a Dependent Day Care FSA, one of the following changes in status events occurs:

- An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
- An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, and the commencement of or return from an unpaid leave of absence.
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the Health Care FSA or Dependent Day Care FSA.

B. For individuals who participate in the Health Care FSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your Health Care FSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
- If the Health Care FSA receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child, then the Health Care FSA Plan Administrator may change your election. The new election will provide coverage for that child if the order requires you to provide coverage for the child under the HCFSA, or permit you to cancel your child's coverage under the HCFSA, if the order requires your former spouse to provide coverage and that coverage is provided.

C. For individuals who participate in a Dependent Day Care FSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider, or
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify Baker Hughes within 31 days of the above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event and that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCFSA election).

Changes in contribution amounts made during the plan year are effective as of the first of the month following the date that you notify Baker Hughes of the change in status.

Notification of Claims Decision

Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Plan Administrator will notify you of the plan's benefit determination within a reasonable time period, but not later than:

- Baker Hughes Incorporated Health Care Flexible Spending Account plan (the HCFSA plan): 30 days after receipt of the claim by the plan. The Plan Administrator may extend this period for up to 15 days, as long as the extension is necessary due to matters beyond the control of the HCFSA plan and the Plan Administrator notifies you in writing or electronically before the initial 30-day period expires.
- Baker Hughes Incorporated Dependent Day Care Flexible Spending Account plan (the DDCFSA plan): 90 days after receipt of the claim by the DDCFSA plan. The Plan Administrator may extend this period for up to 90 days, as long as the extension is necessary due to matters beyond the control of the DDCFSA plan and the Plan Administrator notifies you in writing or electronically before the initial 90-day period expires.

The notice to you will state the reason for the extension and the date by which the plan expects to provide a decision. If the extension is necessary because you failed to submit the information necessary to decide the claim, the notice of extension will describe the required information. You then have 45 days from the date you receive the notice to provide the specified information.

UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final. The table below describes the time frames in an easy-to-read format that you and UnitedHealthcare are required to follow for the HCFSA plan.

Remember…
If you enroll in a Baker Hughes Medical plan and contribute to a Health Care FSA, eligible medical and prescription drug claims processed by UnitedHealthcare and prescription drug claims processed by CVS/caremark will automatically be processed through the Health Care FSA. This saves you the time and paperwork associated with submitting a claim manually. If you prefer to process these types of claims manually, you can turn off the automatic claim initiation feature online at www.myuhc.com or by calling UHC at 1-866-743-6549.

Claim Denial and Appeals

	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	 **30 days** **30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Manner and Content of Notification of Claims Decision

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

- The specific reasons for the adverse decision;
- Reference to the specific plan provisions on which the decision is based;
- A description of any additional material or information needed for you to complete the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse claims decision;
- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either: (1) a copy of such rule, guideline, protocol, or other criteria, or (2) a statement that a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request; and
- If the adverse claims decision was based on a medical necessity or experimental treatment or similar exclusion or limit, either: (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge to you upon request.

What if My Flexible Spending Account Claim is Denied?

If Your Claim is Denied

If you have a question or concern about a claim reimbursement determination, you may call a UnitedHealthcare customer service representative at 1-866-743-6549 to discuss, on an informal basis, your questions regarding the determination. You may also call the number on the back of your medical ID card. If the Flexible Spending Account customer service representative cannot resolve the issue to your satisfaction, you may request an appeal as described below. This procedure is voluntary. You are not required to call UnitedHealthcare customer service before filing a formal appeal.

- **Level One:** You, your eligible dependent, or authorized representative can appeal a denied FSA claim within 180 days after you receive notification of the claim denial. If you wish to request an appeal of a denied claim for reimbursement, you, your eligible dependent, or authorized representative must submit your appeal in writing to UnitedHealthcare at the following address:

  UnitedHealthcare
FSA Appeals
P. O. Box 981512
El Paso, TX 79998-1178

  — Your appeal must include:

  - The patient's name and identification number (or Social Security Number);
  - A description of the claim determination that you are appealing;
  - The reason you believe your claim should be reimbursed; and
  - Any documentation or other written information to support your appeal.

  A qualified individual who was not involved in the initial benefit decision being appealed will be designated to review the appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for reimbursement.

  The Level One appeal will be conducted, and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for appeal of a denied claim.

- **Level Two:** If you are not satisfied with the Level One appeal decision, you have the right to request a second level of appeal from Baker Hughes. Your Level Two appeal request must be submitted in writing within 60 days from receipt of the Level One appeal decision to Baker Hughes at the following address:

  Baker Hughes Incorporated
  Attn: Employee Benefits Department — Appeals
  P.O. Box 4740
  Houston, TX 77210-4740

  The Level Two appeal will be conducted, and you will be notified by Baker Hughes of the decision in writing within 30 days from receipt of a request for a Level Two appeal.

  Baker Hughes has the exclusive right to interpret and the discretionary authority to administer the FSA plans, and these decisions are conclusive and binding.

Notice of Benefit Decision on Appeal

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

1. Specific reasons for denial;

2. Reference to the specific plan provisions on which the decision is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information, including any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment, or other similar exclusion or limit; and

4. A statement describing your right to bring civil action in court under Section 502(a) of ERISA if you are not satisfied with the decision on review. In most instances, you may not initiate a legal action for benefits until you have completed the Level One and Level Two appeal processes.

Any other questions about the process for requesting a review should be addressed to UnitedHealthcare at 1-866-743-6549.

IRS Rules and Other Limitations

Federal tax law restricts your Flexible Spending Account in several important ways:

- **No transfers.** Once you designate amounts for your Health Care and Dependent Day Care FSAs, you may not move money between those accounts. For example, suppose you designate $400 to each account for the year (total of $800) and you actually spend $200 for health care and $600 for dependent day care. The $200 of health care expenses would be reimbursed from your Health Care FSA. You could receive reimbursement for only $400 of the dependent day care expenses from your Dependent Day Care FSA. The other $200 of dependent day care expenses would not be reimbursed, and the remaining $200 in your Health Care FSA would be forfeited after the end of the calendar year.
- **Forfeitures.** If you do not incur eligible expenses during the calendar year for all of the money in your account (and file reimbursement claims for all of the money in your account by March 31 of the following year), you'll lose any money left over in your account. This means that careful planning is important in determining the amount you want to put into each account.
- **Changes.** You cannot stop, increase, or decrease your Flexible Spending Account contributions until the next Annual Enrollment period, except in certain situations involving a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section).

Dependent Day Care Flexible Spending Account

If you're single, you can use your Dependent Day Care FSA to care for a dependent while you work. If you're married, you can use the account if the expenses are to care for a dependent while you work and:

- To enable your spouse to work, or look for work;
- To enable your spouse to study as a full-time student for at least five calendar months during the year; or
- To provide care for your dependents if your spouse is incapable of self care.

Note: If you're a highly compensated employee, your contributions to the accounts may be reduced or suspended.

Remember…
In order to give Flexible Spending Accounts their tax-free status, the IRS provides guidance to help you determine which health care and dependent day care expenses are eligible. Eligible expenses for a calendar year must be incurred by December 31 of that year and claims must be filed no later than March 31 of the following year.

What if I Go On a Leave of Absence?

Refer to the *Leave of Absence* section in this SPD for details.

When Coverage Ends

Your coverage ends on the date your employment with Baker Hughes terminates. If you leave Baker Hughes, you'll have until March 31 of the following year to submit claims for reimbursement. Your claims must be for qualifying expenses incurred through your date of termination of employment.

If you terminate employment and would like to continue participating in the HCFSA plan, you and your covered dependents will be allowed to continue participating as authorized by COBRA. This coverage can continue for the remainder of the year in which you terminate if the amounts you must pay to continue coverage are less than the remaining benefits you can receive under the HCFSA plan. However, contributions for continuation of coverage will be on an after-tax basis and include a 2% administrator fee. Participation in a Health Care FSA cannot continue past the end of the year in which your employment terminates.

If you do not elect to continue participation under COBRA coverage, only claims incurred through your date of termination of employment can be submitted for reimbursement.

Note: You cannot continue participation in the DDCFSA plan Dependent Day Care FSA under COBRA.

Things To Consider

Health Care Flexible Spending Account	Dependent Day Care Flexible Spending Account
• If you contributed to a Health Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount. In addition, please remember that contributions in 2015 will be limited to $2,500. • It might be helpful to review your health care expenses in recent years. Do you have recurring, predictable expenses? Also consider any anticipated changes that might affect your out-of-pocket expenses next year, such as a new baby. • If you're changing your medical and/or dental coverage, consider how this will affect your out-of-pocket expenses such as the deductibles, coinsurance, and out-of-pocket maximums — all of which are eligible for reimbursement under the account. • If you're enrolled in a Health Savings Account (HSA), you are not eligible to participate in a Health Care FSA.	• If you contributed to a Dependent Day Care FSA this year, that same amount may not meet your needs next year. Re-evaluate your needs and consider whether you underestimated or overestimated your expenses this year before deciding on a contribution amount. • What dependent day care expenses do you expect to have during the next calendar year? • Do you have any dependents becoming ineligible this year (for example, turning age 13)? • Will your dependent day care expenses change during the summer months and holidays? • Are you better off taking the federal income tax credit or using the account? As a general guideline, if you are married and your family's tax bracket is more than 15% (family income exceeds $74,900 for 2015), you'll save more through the Dependent Day Care Flexible Spending Account. You may want to check with a financial advisor to see which alternative is best for you and your family.

IMPORTANT

Because of the tax advantages provided by these accounts, they're subject to certain Internal Revenue Code and regulation limitations. It is important to plan carefully. If you do not use all of the FSA money during the year, the Internal Revenue Code and regulation requires you to forfeit the balance in your account. You cannot carry over a credit to the next year for money left in your account at the end of the year, you cannot transfer balances between the two accounts, nor can that money be refunded to you. Focus on predictable amounts of expenses when determining if this will work for you.

Note:

- If you claim health care expenses for reimbursement under your Health Care Flexible Spending Account, you cannot claim them as itemized deductions on your federal tax return.
- Because you pay no Social Security taxes on the amounts set aside in your account, participating in the account may slightly reduce future Social Security benefits. In most cases, the tax savings from participating should be greater than any loss of Social Security benefits.

Additional Resources

Via my**Rewards**

Via Internet: www.myuhc.com

- Track a claim online or access your claims history
- Locate a list of eligible expenses
- Estimate annual expenses using the FSA calculator
- Download a claim form
- Sign up for Electronic Funds Transfer/Direct Deposit
- Find more information about how FSA plans work

Customer Service: 1-866-743-6549

Health Savings Account

Health Savings Account At-a-Glance

Type of Plan	Voluntary H&W benefit (Health Savings Account)
Who Pays the Cost	You contribute to this account on a pre-tax basis, and then you can use the HSA to pay for qualified medical expenses incurred by you and your covered tax dependents. You control your HSA funds and decide whether to use them for current medical expenses or to save your HSA funds for the future. **Note:** An employee does not have to provide coverage for a dependent under a Baker Hughes Medical plan to use the HSA dollars for a dependent's qualifying medical expenses. The dependent only needs to be a qualifying tax dependent.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees or benefits-eligible part-time employees, and • Enrolled in the Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plans Individuals are eligible to contribute to an HSA if: • They are covered by the Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plans • They are **not** contributing to a Health Care Flexible Spending Account (FSA) • They are **not** covered by another health plan including a Health Care Flexible Spending Account • They are **not** enrolled in Medicare or TRICARE and have not received Department of Veteran Affairs benefits in the preceding 3 months • They can **not** be claimed as a dependent on another taxpayer's tax return
When Participation Begins	Enroll and begin coverage on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits and electing the applicable Medical plan within 31 days. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). You will need to re-elect your HSA contribution amount at each Annual Enrollment period.
Minimum Contribution	N/A
Maximum Contribution*	• $3,350 for You Only • $6,650 for You + Spouse • $6,650 for You + Children • $6,650 for You + Family If you are age 55 or older, special catch-up contributions will allow you to contribute an extra $1,000 in 2015.
Contact	• UnitedHealthcare via www.myuhc.com or at 1-866-743-6549 • Optum Bank via www.optumbank.com or at 1-800-791-9361

*The maximum contribution amounts listed here include the Baker Hughes contribution (see below).

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

Employer contribution

When you elect to enroll in one of the Baker Hughes high deductible health plans (Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plans), Baker Hughes will automatically deposit an employer contribution into your HSA ($500 if you elect Individual coverage or $1,000 if you elect Family coverage). This contribution is subject to review and change in future years.

Benefits of an HSA

An HSA works with your high deductible health plan to help you plan, save and pay for medical care.

HSAs offer triple tax savings:*

- The money you put in is not included in your taxable income for federal income tax purposes up to the limit allowed by the Internal Revenue Code.
- Your savings grow tax-free.
- Any money you take out to pay for qualified medical expenses is not included in your taxable income for federal income tax purposes.

An HSA is like no other savings account. With an HSA, **you are in charge**. You decide:

- How much you will contribute to your account (subject to certain limits imposed by the Internal Revenue Code);
- When you want to use your savings to pay for or reimburse yourself for qualified medical expenses;
- What bank will administer your account (if it is a new account, through your employment with Baker Hughes, the HSA will be set up with Optum Bank); and
- Whether or not to invest some of your savings in mutual funds for greater potential long-term growth.

The money in your HSA is always yours — there is no "use it or lose it" rule. All amounts in your HSA belong to you, and the unspent balance remains in your account until spent. Your account is portable and will not be forfeited even if you:

- Change jobs
- Change medical coverage
- Become unemployed
- Move to another state
- Get married or divorced

*State tax treatment of HSAs varies. Go to www.myuhc.com or consult your state's department of revenue to find out more.

Will a Health Savings Account Work For You?

You are eligible to participate in the HSA if:

- You are enrolled in the Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plans;
- You and your spouse are **NOT** contributing to a Health Care Flexible Spending Account (FSA);
- You are **NOT** covered by another health plan including a Health Care Flexible Spending Account;
- You are **NOT** enrolled in Medicare or TRICARE, and have not received Department of Veteran Affairs benefits in the preceding 3 months; and
- You can **NOT** be claimed as a dependent on another taxpayer's tax return.

Similar to the FSA, each year at Annual Enrollment you elect the amount you want to contribute to the HSA. Once you elect the amount to contribute, deductions will be taken from your paycheck on a pre-tax basis.

See the following chart for a comparison of Flexible Spending Accounts versus Health Savings Accounts.

	Health Care Flexible Spending Accounts	Health Savings Accounts
Pre-Tax	Yes	
Tax-Free Interest	No	Yes
Expense Types	Most qualified medical care expenses	
Availability of funds in the account	Available on day one	Funds must accumulate before available for use
Forfeit at the end of the year	Yes	No, accumulated amounts roll over from year to year
Portable	No	Yes

You can use your HSA funds to pay for qualified medical expenses, even if an expense is not covered by your health plan. For example, few health plans cover the cost of acupuncture, but HSAs can. Your HSA dollars also apply not only to you, but also to your **spouse and dependents, even if they are not covered by your high deductible health plan**.

A list of qualified medical expenses is provided by the IRS, and it includes a wide range of dental, vision and medical expenses. You should become familiar with the list and consult it as needed to determine if an expense can be paid for with your HSA. Some covered eligible expenses include:

- Deductibles and coinsurance under the Medical, Prescription Drug, and Dental plans;
- Vision care expenses, such as eye exams, glasses, contacts, and laser eye surgery;
- Hearing care expenses, including exams and necessary hearing aids; and
- Certain over-the-counter medication and drugs that have been prescribed by your physician or other provider that are purchased for medical care, including those used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

Visit www.irs.gov/publications/p502 for more detailed information about eligible expenses for reimbursement.

Generally you cannot use your HSA to pay for health insurance premiums, but there are exceptions.
You may use your HSA to pay for:

- Individual Long-Term Care insurance policies;
- COBRA coverage;
- Health plan coverage while receiving unemployment benefits; and
- If age 65 or older, any health insurance except a Medicare supplement policy (A-J), such as Medigap coverage.

Visit www.irs.gov/publications/p969 for detailed IRS information about HSAs.

If You Participate in a Health Care FSA

You have the option to participate in the Health Savings Account (HSA) or the Health Care Flexible Spending Account (FSA), but you cannot participate in both accounts due to limitations imposed by the Internal Revenue Code.

The Dependent Day Care FSA is provided under a separate plan from the Health Care FSA. You may be eligible to make contributions to the Dependent Day Care whether or not you choose to participate in the Health Savings Account (HSA) or Health Care Flexible Spending Account.

Fees

Baker Hughes pays the HSA set-up fee and monthly service fees for each participating employee for HSAs administered by Optum Bank. These fees cover a debit card and a monthly statement at no additional cost. The debit card can be used at merchant locations, with no transaction charge, for eligible purchases up to your available account balance. ATM cash withdrawals using your card, to reimburse yourself for eligible expenses, are subject to a fee of $1.50 per transaction. For more information on the other fees associated with the account, contact Optum Bank, the administrator of the HSA.

Note: In order to contribute pre-tax dollars through Baker Hughes to your Health Savings Account, you must be enrolled in one of the Baker Hughes high deductible health plans (Personal Choice Plus or UHC Personal Out-of-Area PPO Medical plans), however, you can make contributions to any other HSA you have up to the allowable maximum contribution.

Additional Resources

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

Online banking through Optum Bank
is accessible 24/7 and includes:

- Account balances and transaction history
- Interest rate and payment information
- Beneficiary information
- Contribution maximum
- Account statements

Customer Service: 1-866-743-6549

Using the HSA

1. Once your account is open and deposits have been made to your account, you can start using your HSA. You are 100% vested and have total control over the funds in your account as soon as they are deposited. You decide whether to spend your HSA funds for current medical expenses, or to pay the cost of those expenses out-of-pocket so you can save your HSA money for the future.

2. Your funds will earn tax-free interest. The interest rates are set by Optum Bank and are subject to change by Optum Bank without notice. Once your account balance reaches $2,000, you will have the option to invest your HSA funds into different investment fund choices. Further information on these funds is available from Optum Bank.

3. When you incur an eligible medical expense, (reference the *Medical plan* section for information on how the Personal Choice Plus or Personal Out-of-Area plans work), you can, depending on your balance, use:

   - Your Health Savings Account MasterCard Debit Card℠ at a doctor's office, pharmacy, or health care facility that accepts MasterCard debit cards to pay for care at the time of service. **However, you cannot spend the funds before they are deposited into the account.** If you do not have the full amount to cover your expense in the account, you can pay for the expense out-of-pocket and reimburse yourself at a later date.
   - Your Health Savings Account MasterCard Debit Card℠ at any ATM displaying the MasterCard logo. There are fees imposed by Optum Bank on reimbursements made by using an ATM withdrawal.
   - Online bill payment at www.myuhc.com.

4. You have access to online monthly statements at www.myuhc.com to track your account balance and activity. If you prefer to have statements mailed to your home, notify Optum Bank. You can opt out of electronic statements at www.myuhc.com or by calling Customer Service at 1-866-743-6549.

5. At the end of every year, any unused amounts in the HSA will automatically roll over for use in the next year. In the event you terminate employment with Baker Hughes, you may take your HSA with you from employer to employer or roll into another individual HSA.

6. Keep in mind that you must be able to substantiate your medical expenses. If you withdraw funds from your HSA for reasons other than eligible medical expenses, you will have to include that amount as taxable income and pay a 20% additional tax on that amount.

Contribution Limits

	Health Savings Accounts (HSAs)
Minimum Contribution	N/A
Maximum Contribution (includes Baker Hughes contribution)	• $3,350 for You Only • $6,650 for You + Spouse • $6,650 for You + Children • $6,650 for You + Family

- Your annual HSA contribution cannot exceed the maximum contribution listed above unless you are age 55 or older and making "catch-up" contributions. However, individuals who enroll during the year (after January) and remain eligible to make contributions on December 1 of that same year may contribute the full annual contribution limit allowed for that year. Individuals who make contributions under this provision must remain eligible for the 12 months following the end of the year. Otherwise, your contributions will be included as income and subject to a 10% penalty.
- Individuals 55 and older can make additional catch-up contributions until they enroll in Medicare. Catch-up contributions will allow you to contribute an extra $1,000 in 2015. These catch-up contributions must be made through payments sent directly to Optum Bank. You will be entitled to take an above-the-line tax deduction for the year on these payments. **You cannot contribute to an HSA if you are enrolled in Medicare.**
- If you have contributed an amount into your HSA that exceeds your maximum allowable contribution for the year, you may withdraw the excess amount and any earnings on the excess amount prior to the due date, including extensions, of your tax return for the year the contribution was made (which is generally the following year). However, you must pay income tax on your excess contributions and income tax on any earnings on the excess contribution. There is no additional tax or other penalty on withdrawals of excess contributions that are made in a timely manner.
- If you do not withdraw the excess contribution to your HSA in a timely manner, you must pay a 6% excise tax on the excess contribution and on any earnings on the excess contribution. If in the next year you decreased your maximum contribution by the amount of your excess contribution made the year before, you do not have to pay the 6% excise tax again. If, however, you leave the excess contribution in, and do not decrease your maximum contribution by the amount of your excess contribution made the year before, you will have to pay the 6% excise tax each year the excess contributions and earnings remain in the HSA.

Health Savings Account Funding Rules

When considering your annual contribution amount, keep in mind the employer contribution is included in the annual plan maximum. If you are enrolled in the Personal Choice Plus or Personal Choice Plus Out-of-Area PPO and elect to participate in the Health Savings Account, Baker Hughes will provide an annual lump sum contribution to your Health Savings Account ($500 if you elect Individual coverage or $1,000 if you elect Family coverage).

- The employer-funded contribution will be applied during the first pay period of January at the start of a new plan year.*
- If your employment terminates, the funds in your HSA, including the employer contribution, will continue to be owned and controlled by you. If you are rehired during the same plan year, you will not be eligible for additional employer funding upon reinstatement of your employment.
- If you are hired after January 1 of the current plan year, the annual employer-funded contribution will be prorated based on your date of hire.

*The company reserves the right to discontinue employer-funded contributions to the Health Savings Account or change the funding rules at any time.

Eligible Expenses

In order to allow HSAs to retain their tax-free status, the IRS determines which medical care expenses are eligible. It is very important that you save all of your medical care receipts and records of withdrawals from your HSA for tax reporting to the IRS. Please refer to the charts in the *Flexible Spending Account* section for some examples of eligible, reimbursable medical care expenses.

Ineligible Expenses

Any funds you withdraw from your HSA that are not used for qualified medical expenses will be subject to federal income tax at your income tax rate plus an additional tax of 20%. You should save all of your receipts and records of withdrawals for tax reporting to the IRS. If you use your funds for non-qualifying expenses, you must report those withdrawals accordingly. You are responsible for maintaining all records associated with your HSA — neither Baker Hughes nor Optum Bank are responsible for documenting how you use the amounts that are distributed from your HSA.

Withdrawals that were made for what you reasonably thought were qualified medical expenses, but turned out not to be, may be eligible to be returned to the HSA on or before April 15th following the year in which you mistakenly withdrew the funds. Contact Optum Bank for more information.

Please refer to the chart in the *Flexible Spending Account* section for some examples of expenses the IRS considers ineligible for reimbursement.

IMPORTANT

Be sure to keep your receipts and medical records. You are responsible for saving receipts and keeping track of all expenses paid from your HSA funds, in case you need to prove to the IRS that distributions from the HSA were for qualified medical expenses.

If these records verify that you paid qualified medical expenses using your HSA, you are not required to include the amounts withdrawn to pay such expenses in your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified medical expenses, you may need to report the distribution as taxable income on your tax return. Baker Hughes and UnitedHealthcare will not verify that distributions from your HSA are for qualified medical expenses.

The IRS will likely request receipts during a tax audit. Baker Hughes, Optum Bank, UnitedHealthcare, and the Claims Administrator are not responsible or liable for the misuse of HSA funds or for the use of HSA funds for non-qualified medical expenses.

You can download an expense tracking worksheet through www.myuhc.com to help you maintain your records or you may use your own money management software. If you use your HSA funds to pay for goods or services that aren’t qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and possibly an additional 20% tax. Consult your tax advisor to determine how your HSA is impacted by your unique tax situation.

What if I go on a Leave of Absence?

If you go on an unpaid leave of absence, HSA deductions will cease. However, if you continue to be covered under the Personal Choice Plus or UHC Personal Out-of-Area Medical plans, you can continue to make contributions to your HSA by sending in contributions directly to Optum Bank. Contact Optum Bank directly by calling 1-866-743-6549. Upon return from an unpaid leave, contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide) to arrange for your contributions to start back up.

When Coverage Ends

If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the high deductible health plan in which you were enrolled. You can use HSA funds on a tax-free basis for qualifying medical expenses incurred AFTER the establishment of your HSA, as long as these expenses are not paid or reimbursed through another health plan.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are received by you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the Medical plan and COBRA premiums while COBRA coverage is in effect.

Employee Assistance Program

EAP At-a-Glance

Type of Plan	Voluntary Health & Welfare service
Who Pays the Cost	EAP benefits are paid by Baker Hughes and are free to all eligible employees.
Employee Eligibility	All eligible employees, their dependents, and household members*
When Coverage Begins	Coverage begins on your date of hire or date of transfer
Enrollment Period	No enrollment necessary
Plan Information	Confidential counseling, legal and financial consultation, and referrals to help you respond to personal issues or concerns
Benefits	• In person (face-to-face) counseling with a provider in your area (up to five sessions per issue or concern, per year) • 24-hour, seven days a week crisis counseling, consultation, and referral services • Nationwide community resource referral • Legal and financial consultation services
Contact	• Magellan Behavioral Health at www.magellanhealth.com/member • Magellan Behavioral Health counselors at 1-800-424-5915 or 1-314-387-4700 (worldwide) (24 hours a day, seven days a week) • my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

*Household member is defined as an individual who physically resides in the household of an employee on a permanent basis, or an eligible dependent of an employee, whether or not residing with the employee.

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

How the EAP Works

Baker Hughes EAP is designed to provide you, your dependents, and other members of your household with professional and confidential counseling and/or legal and financial consultation and referral to help you respond to personal issues and concerns, such as marital and family problems, stress, emotional concerns, substance abuse, and conflicts at work. By calling the EAP phone number or accessing the website, you can begin receiving counseling or referral information about issues you may be facing. **Your use of the EAP and your information will be kept confidential by Magellan except as required by law.**

How to Use the EAP

1. Log on to Magellan's website at www.magellanhealth.com/member

2. When accessing the website for the first time, select new user and enter "18004245915" when prompted. Follow the directions for creating a user ID and password.

Call Magellan's dedicated, confidential, toll-free line at 1-800-424-5915, 24 hours a day, seven days a week.

Additional Resources

Via my**Rewards**

Via Internet: www.magellanhealth.com/member

- Learn about available services and programs
- Find information and tools to help with life's challenges
- Get a referral to see a counselor

Customer Service: 1-800-424-5915
1-314-387-4700 (worldwide)

Magellan's master's-degreed professionals are available 24 hours a day, 7 days a week for crisis counseling, consultation, or referral for clinical services. When you call the EAP, a Magellan representative will:

- Ask you questions to help identify the problem and how it is affecting you;
- Find out what solutions you have tried and explore other solutions and resources; and
- Help you develop a plan to solve the problem.

If you desire to work on your problem through in-person sessions with an EAP counselor or if it appears that your problem cannot be adequately addressed in a telephone consultation, the Magellan representative will refer you to an EAP counselor or another resource in your community, as appropriate.

Cost

Baker Hughes pays the full cost of participation in the EAP. There are no premiums, copays, coinsurance, or deductible payments applicable to EAP services. Magellan pays EAP counselors directly; you should not make any payment to a provider for EAP services or make any agreement with an EAP counselor to pay the counselor for EAP services. You will be responsible for paying for services that you obtain (i) without having Magellan open an EAP case with a particular EAP counselor, or (ii) without your completing an electronic referral request through Magellan's online EAP self-referral process.

Personal Consultation Services

The EAP provides confidential assessment, counseling, and referral services to help with issues or problems that could potentially affect your health, relationships, and job performance. You and each of your eligible dependents are eligible to participate in up to five in-person sessions per problem each calendar year (as considered clinically necessary by the EAP). If you obtain in-person counseling for a problem together with an eligible dependent, such as your spouse, the total number of in-person sessions for which you and the other person are eligible for that problem is still five. The number of sessions does not double simply because two persons participate in counseling or triple because three persons participate. There is no lifetime maximum on the number of sessions.

The EAP counselor will help you evaluate and work through your problem. In many cases, the problem is resolved within the five in-person sessions available through the EAP. However, if more sessions or other health care services are needed, you may be referred to an outside source for assistance; such referral may take place as soon as the EAP counselor recognizes that handling your problem through the EAP is not appropriate. When referral is needed, you will be referred to a community resource or a provider who may be covered under your medical/mental health benefits.

In-person EAP services are available only through the nationwide network of independent EAP counselors with whom Magellan contracts. A directory of EAP providers is available on Magellan's website. At your request, and free of charge, Magellan will send you a hard copy of the directory information; contact Magellan at 1-800-424-5915.

In addition to providing support for personal issues, Magellan provides consultations to supervisors with employees experiencing personal problems. Supervisor consultations may be accessed 24 hours a day, seven days a week through Magellan's toll-free number.

Web-based Services

You can visit Magellan's website, www.magellanhealth.com/member, 24 hours a day for confidential, anonymous access to educational materials, self-help tools, a directory of EAP counselors, guidance in preparing for a session with a counselor, and other resources.

The website has a library of wellness tips with information, including:

Family, Children, Teens	Workplace	Violence
• Single parenting • Elder care • Dealing with kids and gangs • Helping children with dieting issues • Communication • Setting rules your family can live by • Helping preschoolers prepare to learn • Enjoyable car travel • On blending families • Autism support services	• Change • Surviving downsizing • Job burnout • Balancing home and work • Time management • Understanding what you want: What motivates you on the job? • Balancing on a tightrope • Building workforce trust • Diversity earns rewards	• School violence: coping with anxiety • Helping children cope with school violence • Identifying behaviors linked to school violence • Violence awareness • Understanding workplace violence • Spotting the warning signs of workplace violence • Understanding domestic violence
International Support	**General Topics**	**Substance Abuse and Other Addictions**
• Moving to a new country — the four phases of culture shock • Moving overseas with your child • Choosing the right overseas school	• Change • Depression • Grief • Overcoming anxiety • Procrastination • Anger management • Time management • Stress management • Commuter stress • Giving your self-esteem a boost • Seasonal affective disorder	• When someone you care about has an addiction problem • Substance abuse warning signs • Dealing with co-dependency • Drugs and teens • Cyberspace addiction **Coping with Traumatic Events** • Children and disasters • Preparing for future emergencies • Responding to tragedy and ongoing threats

Legal and Financial Consultation Services

The EAP also provides you and your eligible dependents with free initial legal and financial consultations for such matters as:

- Wills and inheritance concerns
- Divorce, custody, adoption matters
- Basic financial/retirement planning, savings, investments
- Consumer issues
- Real estate questions
- Criminal matters
- Debt management
- Budgeting/family financial issues
- Insurance
- Identity theft

You may access the legal and financial consultation services through the EAP toll-free number, 1-800-424-5915. Legal consultation services are available telephonically and in person; financial consultation services are available only telephonically. If you need continued legal assistance after the initial consultation, you can choose whether to retain the attorney at your expense, seek alternative counsel, or adopt an alternative plan of action. If you retain the consulting attorney, you will be entitled to a 25% reduction in fees from the consulting attorney's normal fees. You are fully responsible for payment of these fees.

You may also access an online library of articles on legal issues, legal forms that can be downloaded for your use, and other resources for legal and financial guidance through Magellan's website, which may be accessed as described in the *Personal Consultation Services* section.

There is no restriction on the number of times you may use the legal and financial consultation services. However, you may not access legal and financial consultation services on a continuing basis in order to undertake your own representation.

Work-Life Services

The EAP also provides telephone consultation, information, education and referral services in connection with child care, elder care, parenting issues, children with special needs, schooling and education, teen and young adult issues and adoption assistance.

A Work-Life consultant will discuss your work-life needs with you telephonically and send you a packet of educational materials. If you are looking for dependent care or educational resources, the Work-Life consultant will research resources in your area and send you a list of at least three licensed, certified or registered dependent care providers with confirmed vacancies in your area that match your needs, to the extent available.

The telephone consultation, educational materials, and referral list are provided to you at no charge. You will be financially responsible for the dependent care arrangement that you select.

If you choose to obtain elder care or child care, it will be up to you to evaluate each dependent care resource to determine the right arrangement for your loved one and to monitor the quality and appropriateness of the arrangement. The EAP does not endorse or recommend any of the dependent care resources identified. While Magellan makes reasonable efforts to ensure the accuracy of the information provided about dependent care resources, the information is obtained from those resources and Magellan cannot guarantee the accuracy of the information. The final decision about your dependent care arrangements is yours.

An online library of articles and tools on work/life issues is also available through Magellan's website, which may be accessed as described in the *Personal Consultation Services* section.

Autism Assist Services

The Autism Assist personalized service navigation provides parents or caregivers with helpful and individualized assistance. It can perform an assessment to determine the child's current condition and can recommend which resources may benefit the child most.

The Rethink Autism® website offers a personalized curriculum, video-based training for parents or caregivers, access to qualified support staff and can act as a primary connector to the child's care team.

Exclusions and Limitations

The EAP does not include any of the services or charges listed below.

- Services by providers who are not part of Magellan's EAP counselor network
- EAP sessions that were not accessed through Magellan (either through the toll-free telephone access line or the online self-referral service) for the particular problem
- More than five in-person EAP sessions per problem per year
- Treatment for any problem or condition that cannot be resolved in brief counseling (for example, any condition that requires inpatient treatment or more than five outpatient sessions)
- Psychiatric services or similar medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis) and prescription drugs
- Inpatient treatment
- Counseling; evaluation or preparation of recommendations for use in child custody proceedings, child abuse proceedings, criminal proceedings, Workers' Compensation proceedings, or any legal actions of any kind or otherwise required by any state or federal judicial officer or other governmental official or agency
- Evaluations for fitness for duty determinations or excuses for leaves of absence or time off
- Psychological, psychiatric, neurological, educational, or IQ testing
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skill disorders, language disorders, mental retardation, motor skill disorders, or communication disorders; behavioral training; cognitive rehabilitation
- Medication or medication management or treatment of any condition for which medication is required
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), or obtaining any kind of insurance coverage
- Testimony in legal proceedings or creation of records for legal proceedings or other preparation for legal proceedings
- Services or supplies rendered by a family member
- Services rendered before coverage became effective or after coverage ends
- Guidance on suing Baker Hughes
- Acupuncture
- Biofeedback or hypnotherapy
- Direct treatment for mental retardation, learning disabilities, or autism
- Aversion therapy
- Sleep therapy
- Legal assistance for employment issues, commercial enterprise, second opinions or third-party advice, such as a relative's legal problem, matters considered frivolous or harassing by the consulting attorney, matters involving Magellan, Baker Hughes, the legal services vendor or its plan attorneys, or any matter that would involve a violation of ethical rules

- Recommendation or endorsement of a specific attorney to represent you; the final decision regarding whether a particular attorney is suitable for your needs can only be made by you
- Services or supplies not needed for treatment or not approved by your EAP counselor
- Treatment for any physical illness
- Treatments or procedures considered experimental or investigational in nature as determined by Magellan

Reimbursement of Claims

Magellan pays EAP counselors directly. You do not have to file EAP claims. There are no copays, coinsurance, or deductibles. You should not make any payment to a provider for EAP services. You should not make any agreement with an EAP counselor to pay the counselor for EAP services. However, you will be responsible for paying for services that you obtain (i) without having Magellan open an EAP case with a particular EAP counselor, or (ii) your completing an electronic referral request through Magellan's online EAP self-referral process.

Claim Determinations

If you are receiving an ongoing course of EAP counseling, Magellan will notify you in advance if it intends to terminate or reduce the number of EAP sessions that can be provided so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. EAP services do not include urgent care services. Examples of urgent care services may include: danger to self or other, bipolar in manic phase, detoxing, etc.

If Magellan determines that you need urgent care, Magellan will provide telephonic crisis counseling; a care manager will make the decision to make an appropriate referral to a hospital and/or emergency resources in the community. Magellan does not make claim determinations relating to urgent care.

If a claim for EAP benefits is wholly or partially denied, and you authorize written communication to you, Magellan will provide written notice of the denial to you or your authorized representative. This notice of the decision will:

- Give the specific reason or reasons for the denial decision;
- Identify plan provisions on which the decision is based;
- Describe any additional material or information necessary for an appeal review and an explanation of why it is necessary;
- Explain the review procedure, including time limits for appealing the decision and to sue in federal court;
- Identify your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision; and
- Identify your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate).

If you do not authorize written notice, Magellan will furnish this information to you or your authorized representative by telephone.

Appeals of Adverse Determinations

If you believe your claim for EAP benefits was denied in error, you may appeal the decision. Your appeal must be submitted in writing within 180 days following your receipt of a denial notice to Magellan Behavioral Health, P.O. Box 2128, Maryland Heights, MO 63043. Your appeal should state the reasons why you feel your claim for EAP benefits is valid and include any additional documentation that you feel supports your claim for EAP benefits. You can also include any additional questions or comments. You may submit written comments, documents, records and other information relating to your appeal, whether or not the comments, documents, records or information were submitted in connection with the initial claim for EAP benefits. On your request, Magellan will make relevant documents available to you.

The review of the initial decision will consider all new information, whether or not it was presented or available for the initial decision. The person who conducts the appeal review will be different from the person or persons who originally denied your claim for EAP benefits and will not report directly to the original decision maker or prior reviewer.

You or your authorized representative will be notified of the appeal decision within 30 days of Magellan's receipt of the request for appeal.

Appeal Decisions

If you authorize written communication, Magellan will give you or your authorized representative the decision on the appeal in writing. If the denial is upheld on appeal, the notice will include the following information:

- The specific reason or reasons for the denial decision;
- Identification of plan provisions on which the decision is based;
- Notice of your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
- Notice of your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate);
- Notice of your right to receive, free of charge, upon your request, reasonable access to, and copies of, all documents, records and other information relevant to the appeal; and
- Notice of your right to bring a civil lawsuit under ERISA §502(a).

If you do not authorize written notification, Magellan will furnish this information to you or your authorized representative by telephone.

If you do not agree with the final decision of Magellan, you may bring a lawsuit in federal district court. You may not initiate a legal action for the benefits unless you utilize all available appeal processes, as described above.

Protection

Protection benefits provide financial protection for you and your family in the event of an accident, disability, or death. These benefit plans include:

- Short-Term Disability
- Long-Term Disability
- Basic Life Insurance
- Supplemental Life Insurance
- Basic Accidental Death & Dismemberment Insurance
- Voluntary Accidental Death & Dismemberment Insurance
- Business Travel Accident Insurance Plan
- Long-Term Care
- Legal Plan
- Critical Illness Plan

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

Designate a Beneficiary for your Protection Benefits.

You need to designate one or more beneficiaries for the following benefits:

- Basic Life Insurance
- Supplemental Life Insurance
- Basic AD&D Insurance
- Voluntary AD&D Insurance

Make sure you have the birth date and Social Security Numbers of your beneficiaries. If you don't designate a beneficiary, the benefit will be paid according to the terms and conditions of the plan.

You can designate a beneficiary online or via the telephone.

Via Internet: http://bakerhughes.com/myrewards

Via Telephone: 1-866-244-3539

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

Short-Term Disability

Short-Term Disability At-a-Glance

Type of Plan	Payroll practice that provides income replacement if an employee becomes disabled because of outpatient surgery, hospitalization, or is unable to work for more than seven consecutive calendar days due to illness, pregnancy, or injury
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Short-Term Disability coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary.
Coverage	100% of benefits base pay weeks 1 through 6 and 75% weeks 7 through 26, or terms of a union agreement, if applicable. Pay is based on a 5 day, 40-hour week.
Elimination Period	Benefits begin on the first day of disability due to outpatient surgery or hospitalization, or after seven consecutive days for illness, pregnancy, or injury. **Note:** The elimination period can be satisfied with partial and/or total days of disability.
When Coverage Begins	Coverage begins on your first day of active work.
Contact	• To initiate a claim: Call Sedgwick at 1-877-423-8677 or go online at www.sedgwick.com (enter Client Number 8504) • For information about Short-Term Disability, visit my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer). • For questions regarding Short-Term Disability, contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

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

What is Short-Term Disability?

Baker Hughes Short-Term Disability (STD), administered by Sedgwick, allows you to continue to receive a percentage of your benefits base pay when you're unable to work as a result of an illness or injury that occurs either on or off the job. Short-Term Disability also pays benefits when you're unable to work as a result of pregnancy or illness. If you're eligible, Baker Hughes will automatically enroll you for coverage, and your coverage will begin on your first day of work. This benefit does not cost you anything; Baker Hughes pays the full cost.

Definition: **Disabled or Disability** means that either:

- You're prevented from performing the material and substantial duties of your regular occupation and you aren't working in any occupation that you are qualified to do based on your level of education, training, or experience,

OR

- You're working, but due to injury or sickness, you are unable to earn more than 80% of your regular pay in any occupation for which you are qualified based on your level of education, training, or experience.

  To be disabled, you must be under the regular care of a physician. Your physician must be someone other than you or a family member, and his or her specialty or expertise must be appropriate to treat your disability.

If you remain approved for disability benefits for more than 26 weeks (the 26-week elimination period equals 180 days total), Sedgwick may transition you to Long-Term Disability coverage with MetLife, if eligible. See the *Long-Term Disability Plan* section for more information.

What is the Cost of Short-Term Disability?

You do not contribute anything to receive STD coverage. Baker Hughes pays 100% of the cost of the benefit.

When Does Coverage Start?

Baker Hughes provides you with STD coverage on the first day you report to work. No enrollment is necessary.

The elimination period begins on the day you become disabled. The elimination period is a period of continuous disability which must be satisfied before you begin receiving STD benefit payments. The elimination period can be satisfied with both partial and/or total days of disability. You can use your sick leave until your STD benefit payments begin.

If your disability is a result of a hospitalization or outpatient surgery, payment of the STD benefit begins on the day that you are admitted into the hospital or outpatient facility. If your disability is a result of illness, pregnancy, or injury, STD benefit payments will begin after seven consecutive calendar days.

Definition: **Elimination Period** means a period of continuous disability that must be satisfied before you will begin to receive disability benefit payments. Your elimination period begins the day you become disabled.

STD Schedule of Benefits

Minimum benefit payment:	None
Amount of benefit:	100% of benefits base pay for weeks 1 through 6 75% of benefits base pay for weeks 7 through 26
Elimination period:	None for hospitalization or outpatient surgery 7 days for illness, pregnancy, or injury
Maximum period of coverage:	Up to recovery, 26 weeks (the 26-week elimination period equals 180 days total), or the date you are no longer disabled, whichever is earlier

Note: Your Short-Term Disability benefits may be reduced by other disability income benefits. See below for an explanation of other disability income benefits.

Note: If you are receiving Workers' Compensation benefits due to an occupational disability and the amount of your Workers' Compensation award is less than your regular pay, you may also be eligible to receive STD benefit payments.

All STD benefit payments are taxed as ordinary income. Deductions normally taken from your paycheck will continue to be deducted from your STD benefit payments. If your STD benefit payment is not enough to cover the entire cost of your benefit deductions, the benefit deduction will go into arrears and be recovered from your pay when you return from STD.

Other Disability Income Benefits

Your STD benefit payments may be reduced (offset) by other disability income benefits you're eligible to receive, such as:

- State disability benefits;
- Social Security disability benefits for either you or your dependents;
- Workers' Compensation benefits; and
- Damages for loss of income that you recover from a third party as a result of your disability, such as no-fault auto insurance.

If you receive other disability income benefits in addition to STD benefits from Baker Hughes, an overpayment may result. **As a condition of receiving STD benefits, you agree to return or pay back any overpayments to Baker Hughes.**

If you are receiving Workers' Compensation benefits due to an occupational disability and the amount of your Workers' Compensation award is less than your regular pay, you may also be eligible to receive STD benefit payments.

If the amount of your other disability income benefits is greater than your regular pay, you will not receive STD benefit payments.

Note: After 26 weeks, you may be eligible to receive LTD benefit payments. Contact MetLife as soon as possible to ensure you understand the qualifications for being considered disabled under the LTD plan and to ensure prompt payment of LTD benefits.

STD and FMLA

If you have a qualified Family and Medical Leave Act (FMLA) absence from work that is due to your illness, you may also qualify for STD benefits. For more information on how STD and FMLA coordinate, please contact Sedgwick at 1-877-423-8677.

Note: STD leave will be applied against your 12-week FMLA leave period (if eligible), which is calculated on a "rolling back" basis. The "rolling back" period applies to determine how much of the 12-week leave entitlement has not been used during the immediately preceding 12 months.

How to Calculate Your STD Payment

Short-Term Disability pay is based on a 5 day, 40 hour work week regardless of an employee's standard work schedule. Benefits base pay for disability is your Pre-disability Earnings excluding any overtime, lead pay, shift differentials, and any other premium pay.

1. Calculate the regular STD benefit payment, and
2. Subtract any other disability income benefits for which you're eligible.

Example:

Paul is an STD-eligible employee. He wakes one day, not feeling well and running a temperature. After notifying his boss, he doesn't go to work. Two days later, after not feeling any better, Paul visits his physician and is told that he has bacterial pneumonia and can't return to work for another three weeks. After speaking with his boss, Paul contacts Sedgwick to apply for Short-Term Disability. Sedgwick confirms the disability, approving benefits for a three-week disability duration. Paul is away from work a total of three weeks.

Paul's regular biweekly pay when he becomes disabled is $1,800. Because his disability results from an illness, his STD benefits start after he is unable to work for seven days. Paul receives $1,800 total in STD benefits.

First 7 days	STD waiting period (If Paul is an hourly employee, he can use sick pay, no pay, or vacation during this time)
Next 7 days	$900 weekly benefit
Final 7 days	$900 weekly benefit
Total STD benefit payment to Paul	**$1,800**

Mental Illness and Substance Abuse

If your disability is approved, Short-Term Disability pays benefits for mental illness or substance abuse for a maximum of 26 weeks.

Recurrent Disability

A recurrent disability is one that is related to an earlier disability for which you received a benefit. A recurrent disability is considered part of your earlier disability claim if, after receiving STD benefits, you:

- Return to your regular job on a full-time basis for less than 15 days, and
- Perform all the regular and essential duties of your job.

If you return to your regular job on a full-time basis for 15 days or more and then become disabled again, this will be treated by Sedgwick as a new period of disability. If your disability is a result of an illness, injury, or pregnancy, you must complete another seven-day elimination period.

Light Duty and Workplace Modification

During your disability, you may be able to return to work through participation in light duty or workplace modification. During this time, you will continue to receive 100% of regular pay for time worked and up to 100% of benefits base pay for time off (STD benefits) from weeks 1 through 6. From weeks 7 through 26, you will continue to receive 100% of regular pay for time worked and up to 75% of benefits base pay for time off (STD benefits).

Note: Short-Term Disability does not pay benefits if you refuse to participate in light duty or workplace modification.

How Long Will STD Benefit Payments Continue?

STD benefit payments continue up to recovery or (the 26-week elimination period equals 180 days total), whichever is earlier, or until the date we are notified by Sedgwick of the first of the following:

- You fail to furnish proof that you're continuously "approved" as disabled;
- You're no longer under the regular care of a physician;
- You refuse to be examined, if an examination is required;
- You fraudulently misrepresent your need for disability;
- You return to any work other than work approved by Baker Hughes;
- You refuse to participate in light duty or workplace modification; or
- You die.

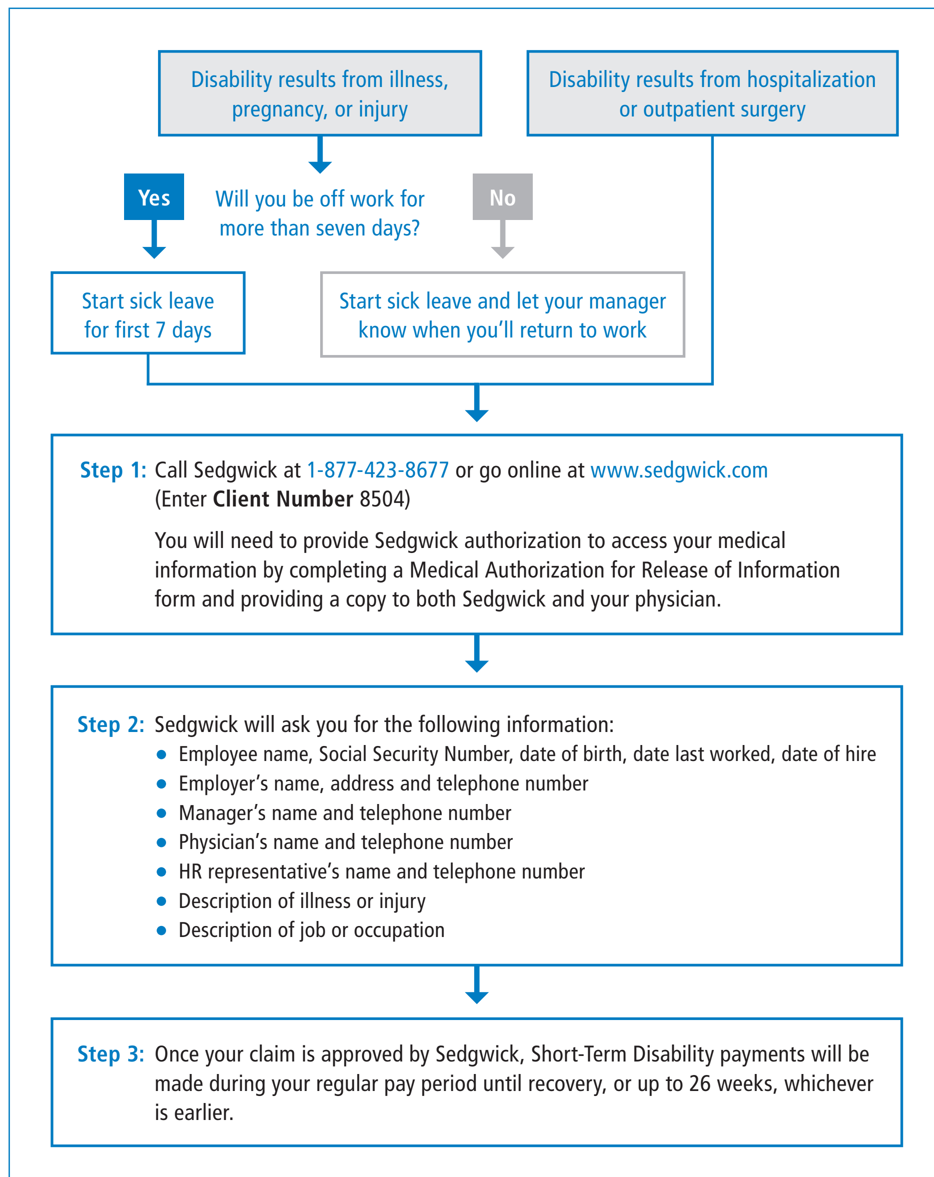
Note: If you separate from service from the Company and are on an approved disability claim at the time of separation from service, your benefits will continue.

Continuation of Benefits While on STD

Your H&W benefits will continue while you are receiving STD benefit payments except in the event of termination of employment. Deductions will be taken as usual. If your employment with Baker Hughes is terminated while you are receiving STD benefit payments, your H&W benefits will also terminate. You may be eligible to continue your benefits through COBRA if you had coverage before your disability began. Refer to the *Benefits Rights* section for more information.

If you have questions regarding your benefits or benefit deductions while you are receiving STD benefit payments, please contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

Short-Term Disability Process



STD Exclusions

What Is Not Covered

Short-Term Disability does not pay benefits if your disability is caused by, contributed to, or resulting from:

- Committing or attempting to commit a felony;
- Elective plastic surgery (complications related to plastic surgery are a covered benefit).

In addition, benefits are not payable for any period during which:

- You are confined to a penal or correctional facility;
- You are not under the care of a physician; or
- You are not eligible for coverage under Short-Term Disability.

Termination of Coverage

Your STD coverage will end when:

- You do not provide requested medical information to Sedgwick;
- Baker Hughes stops providing Short-Term Disability;
- You retire;
- You cease to be eligible for coverage; or
- You die.

How Do I File a Short-Term Disability Claim?

Call Sedgwick at 1-877-423-8677 or go online at www.sedgwick.com
(enter **Client Number** 8504) as soon as possible to file an STD claim.

When you call to file your claim, Sedgwick will ask you for the following information:

- Name, Social Security Number and/or Employee ID with leading zeros, date of birth, date last worked, and date of hire
- Employer's name, address, and phone number
- Manager's name and phone number
- Physician's name and phone number
- HR representative's name and phone number
- Description of illness or injury
- Description of job or occupation

Note: If you are unable to call, a family member, close friend, or your HR manager can make the call for you.

Sedgwick will review the requested information and determine whether your claim is approved or denied. If your claim is approved, bi-weekly STD benefit payments will be made directly to you through the Baker Hughes payroll.

Periodically, Sedgwick may request additional information about your disability. Remember, it is ultimately your responsibility to ensure all requested information is provided to Sedgwick. Your physician's failure to provide necessary medical documentation may result in a delay or suspension of your STD benefit payments.

You will not receive benefit payments, STD pay, and elimination period pay until your claim is approved.

Medical Authorization

When filing a claim for STD benefits, you must provide Sedgwick authorization to access your medical information by completing a Medical Authorization for Release of Information form and providing a copy to your physician.

You can obtain the Medical Authorization for Release of Information form by calling Sedgwick at 1-877-423-8677.

Disability Claims Denial Notice

You will receive written notice of Sedgwick's claim decision. If your claim is denied, the notification will include:

- Specific reasons for the denial;
- Specific provisions on which the decision is based;
- A description of any additional material or information necessary for the claim to be completed, as well as an explanation of why such material or information is necessary;
- A description of the review procedures and their applicable time limits;
- A description of any internal rules, guidelines, protocols, or other similar criteria instrumental in the decision-making, or a statement that the decision was based on the applicable items mentioned above. In this case, Sedgwick provides you with copies of the applicable material upon request (free of charge); and
- An explanation of the scientific or clinical judgment used in the decision regarding medical necessity, experimental treatment, or similar exclusion or limit. The decision applies the terms of the benefit to your medical circumstances, or you will receive a statement that an explanation will be provided upon request (free of charge).

Appealing a Denied Disability Claim

Appeals must be in writing and should be submitted to the Appeals Unit address below:

Sedgwick
Appeals Unit
P.O. BOX 14446
Lexington, KY 40512-446

Complete the Baker Hughes STD Appeal Form and include the following information:

- Claim Number
- Employee name
- Address
- Telephone Information
- Physician Information
- Reasons for requesting the appeal
- Additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim.

The appeal decision will be communicated directly to you and/or your duly authorized representative.

You, or your authorized representative, will have 180 days after receiving notice that your disability claim is denied to appeal the decision in writing to Sedgwick, as well as submitting any information relevant to the claim (e.g., written comments, documents, records).

In addition, Sedgwick provides you with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

At the first level of appeal the claimant submits additional proof of disability to the original claims adjuster. If this additional information changes the decision of the denial, then the claim resumes payments. If not, then the claim would go to the second step of appeals as outlined below.

A plan fiduciary, who had no role in the initial claim denial, reviews your appeal. The review is independent and will not give the original denial any special consideration.

If a medical judgment is involved, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved and who had no role in the initial claim denial.

Sedgwick notifies you of the appeal decision within 45 days after Sedgwick receives your request for review. If there are special circumstances requiring delay, you will be notified of the final decision no later than 90 days after your request for review is received.

Special Circumstances Requiring Delay of Appeal Decision

Under normal circumstances, you will be notified in writing of the final decision within 45 days of the date your request for review is received. If there are special circumstances requiring delay, the period can be extended (before the end of the original 45-day period) as the result of matters beyond the control of Sedgwick. Any notice for extension before the end of the original 45-day period will further explain:

- The reason for the extension and when Sedgwick expects to rule on your claim;
- Standards on which the right to a benefit is based;
- Unresolved issues that prevent a decision on the claim; and
- Additional information needed to resolve those issues.

Please note that you will be notified of the final decision no later than 90 days after your request for review is received.

How Short and Long-Term Disability Benefits Work Together

Short-Term and Long-Term Disability benefits work together. Short-Term Disability benefits are payable for the first 26 weeks of disability, and then, if you continue to be disabled, Long-Term Disability benefits take over. Each has different provisions, but both are offered to protect you and your family from loss of income in the event of an injury or illness that does not allow you to work. Sedgwick will transfer your information to MetLife at 18 weeks or the point where your claim could extend beyond 26 weeks. You do not need to initiate an LTD claim; it is done automatically.

Long-Term Disability

Long-Term Disability At-a-Glance

Type of Plan	Welfare benefit plan that provides income replacement if an employee continues to be disabled for more than 26 weeks (the 26-week elimination period equals 180 days)	
Who Pays the Cost?	Baker Hughes pays 100% of the cost of your Core LTD coverage. However, you pay the additional cost if you elect LTD Buy-up coverage.	
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees • Union employees, if applicable	
Eligible Dependents	None	
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).	
Enrollment Period	**Core coverage:** • No enrollment necessary	**Buy-up coverage:** • New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you'll default to Core coverage. • Employees can make changes during Annual Enrollment or if you have a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• Core coverage • Buy-up coverage	
Coverage*	**Core coverage:** • If disabled, the Core coverage will pay you 50% of your pre-disability earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the *LTD Schedule of Benefits* section for the maximum period payable if you're 62 or older when your disability occurs. • Maximum monthly benefit is $15,000 per month. • Mental and nervous disabilities are covered for up to 24 months. • Alcohol and substance abuse disabilities are covered for up to 24 months.	**Buy-up coverage:** • If disabled, Buy-up coverage will pay you 60% of your pre-disability earnings for as long as you're disabled or until you reach age 65, whichever occurs first. See the *LTD Schedule of Benefits* section for the maximum period payable if you're 62 or older when your disability occurs. • Maximum monthly benefit is $15,000 per month. • Mental and nervous disabilities are covered for up to 24 months. • Alcohol and substance abuse disabilities are covered for up to 24 months.
Elimination Period	26-week elimination period (which equals 180 days total). (During this time, you may be eligible for Short-Term Disability benefits. See *Short-Term Disability* section for details.) The LTD elimination period is the greater of the Short-Term Disability maximum benefit period or 180 days.	
Contact	• For questions regarding LTD benefit payments: Call MetLife Insurance at 1-877-423-8677 (prompt 4). • For questions regarding your benefits while on LTD: Contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide). • For information regarding the plan, visit my**Rewards** at go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer). • For questions regarding the plan, contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).	

*Pre-disability earnings means gross salary or wages as reported in the payroll system that you were earning from Baker Hughes as of your last day of active work before your disability began.

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

What is Long-Term Disability?

Becoming permanently disabled or having an extended disability can have devastating financial implications by taking away your ability to make a living. While some people can get by without working for a few months, few people can afford to stop working altogether for an extended period of time. That's where the Baker Hughes Long-Term Disability plan (the LTD plan) can help you. The LTD plan benefit picks up generally where your Short-Term Disability (STD) benefit leaves off and offers coverage for you if you are disabled because of a qualifying illness or injury. You will receive Core LTD coverage at no cost. However, you may purchase additional LTD coverage. The LTD plan is funded by an insurance policy issued by MetLife.

Definition: **Disability or Disabled** means that due to sickness or as a direct result of accidental injury:

- You are receiving appropriate care and treatment and complying with the requirements of such treatment, and
- You are unable to earn:
  - — During the Elimination Period and the next 24 months of sickness or accidental injury, more than 80% of your pre-disability earnings at your own occupation from any employer in your local economy, and
  - — After such period, more than 80% of your pre-disability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified taking into account your training, education, and experience.

For purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

Note: On each anniversary of your disability, MetLife will increase your pre-disability earnings by the lesser of the current annual percentage increase in Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) or 10%.

What is the Cost of the LTD Plan?

LTD coverage under Core coverage is available at no cost to you. If you elect additional LTD coverage under Buy-up coverage, you pay the cost of the additional benefit. Your contribution is automatically deducted from your paycheck on a before-tax basis.

When Does Coverage Start?

If you're either a newly hired regular full-time employee or a benefits-eligible part-time employee (scheduled to work at least 20 hours per week), you're eligible to enroll for Buy-up coverage under the LTD plan. You will automatically receive Core LTD coverage, which is effective on your first day of active work. However, you must elect additional Buy-up coverage within 31 days from your date of hire. If you enroll within 31 days from your date of hire, your coverage will be effective on your first day of active work.

If you do not enroll within 31 days from your date of hire, you'll lose your right to elect Buy-up coverage until the following Annual Enrollment period or you experience a qualified change in status as defined in the *General Information* section.

When do LTD Benefit Payments Start?

Your LTD benefit payments will begin after a qualifying illness or injury has forced you to be away from work for 180 days. The Long-Term Disability elimination period is stated as the greater of the Short-Term Disability maximum benefit period or 180 days, and the elimination period can be satisfied with both partial and total days of disability.

Disability coverage generally will be continuous from Short-Term Disability to Long-Term Disability.

Definition: **Elimination Period** means a period of continuous disability that must be satisfied before you will begin to receive disability benefit payments. Your elimination period begins the day you become disabled. Your elimination period for LTD benefits is the greater of 180 days or the date your STD benefits end. The Long-Term Disability elimination period is stated as the greater of the Short-Term Disability maximum benefit period or 180 days.

LTD Schedule of Benefits

Minimum benefit payment: $25 per month*

Maximum benefit payment: $15,000 per month

Amount of benefit: Core coverage: 50% of your pre-disability earnings**

Buy-up coverage: 60% of your pre-disability earnings**

Maximum period of coverage: Up to age 65, or until you're no longer disabled, whichever is earlier. Mental and nervous disabilities are covered for up to 24 months. Alcohol and substance abuse disabilities are covered for up to 24 months as well.

*Subject to overpayment and rehabilitation incentives.
**Pre-disability earnings means gross salary or wages, as reported in the payroll system, that you were earning from Baker Hughes as of your last day of active work before your disability began.

If you become eligible for LTD benefits on or after age 62 due to an accidental injury or illness, the following table applies.

Age at Disability Onset	Maximum Benefit Period Core Coverage or Buy-up Coverage
Prior to age 62	Up to age 65
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

All LTD benefit payments are taxable income for federal income tax purposes.

Note: Your LTD benefit payments may be reduced by other disability income benefits and sources of income. See below for an explanation of other sources of income.

Evidence of Insurability (EOI)

You will not be required to provide Evidence of Insurability (EOI) to receive LTD coverage, however, pre-existing condition exclusions will apply (see the *LTD Exclusions* section).

A pre-existing condition is a medical condition for which medical treatment or advice was rendered, prescribed, or recommended within three months prior to your effective date of coverage. A condition will not be considered pre-existing if it causes a disability that begins after you've been covered under the LTD plan for a period of 12 months. LTD benefits may not be payable if a pre-existing condition exists.

Other Disability Income Benefits and Sources of Income

Your LTD benefit payments may be reduced (offset) by other disability income benefits paid, payable, or for which there is a right under:

- The Social Security Act (including amounts for which your dependents may qualify because of your disability);
- Any Workers' Compensation or occupational disease act or law, or any other law which provides compensation for an occupational injury or sickness;
- Occupational accident coverage provided by or through Baker Hughes;
- Any statutory disability benefit law;
- Any pension or disability plan of any other nation or political subdivision thereof;
- The Railroad Retirement Act;
- The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
- The Canada Old Age Security Act; or
- Any Public Employee Retirement System plan, or any State Teachers' Retirement System plan, or any plan provided as an alternative to any of the above acts or plans.

In addition, your LTD benefit payments may be reduced (offset) by the following sources of income:

- Retirement benefits paid under the Social Security Act;
- Retirement benefits paid under the Baker Hughes Pension Plan;
- Disability benefits paid under any no-fault auto vehicle coverage;
- Any income that you receive from working while disabled to the extent that such income reduces the amount of your monthly benefit as described in Rehabilitation Incentives. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source;
- Recovery amounts that you receive for loss of income as a result of claims against a third party by judgment, settlement, or otherwise including future earnings;
- Any income received for disability under a group insurance policy to which Baker Hughes has made a contribution, such as benefits for loss of time from work due to any disability;
- Installment payments for permanent total disability;
- A government compulsory benefit plan or program;
- A self-funded plan, or other arrangement if Baker Hughes contributes toward it or makes payroll deductions for it;
- Any sick pay, vacation pay or other salary continuation that Baker Hughes pays to you;
- Occupational disease laws;
- Laws providing for maritime maintenance and cure; or
- Unemployment insurance law or program.

If you receive any of the benefits described above in addition to LTD benefit payments from MetLife, an overpayment may result. As a condition of receiving LTD benefit payments, you agree to return or pay back any overpayments, including lump-sum awards.

Note: After you have been disabled for five full months, you may be eligible for Social Security benefits. If Social Security assistance is appropriate for you, MetLife will provide you with the services of an advocate — at no charge to you — to help you apply for and secure Social Security benefits.

IMPORTANT

Please note that your LTD benefit payment will be offset by other disability income benefits to which you are entitled **even if you do not apply for the other disability income benefits**.

Family Social Security Integration

Any disability or retirement benefits paid to your dependents because of your disability or retirement will be deducted from your monthly benefit payment.

Example:

Joe earns $4,000 pre-disability earnings each month. He elected Buy-up coverage. After exhausting his STD benefits, Joe's disability is approved for LTD benefits by MetLife.

Joe's maximum LTD benefit would be $2,400 per month (60% X $4,000), less tax.

Joe receives a Social Security award for himself of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by MetLife of $1,900 per month ($2,400 – $500).

Joe also receives a Social Security benefit for his dependents of $500 per month. This results in an adjusted disability benefit under the LTD plan that would be paid by MetLife of $1,400 per month ($1,900 – $500).

How to calculate your LTD benefit payment:

1. Calculate the LTD plan's regular LTD benefit payment.
2. Subtract any other income benefits for which you or your eligible dependents are eligible.

Mental Disorder Limitation

If you're disabled due to a mental disorder, of any type, benefits will not be payable beyond 24 months. Confinement in a hospital or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit. There is a mental or nervous limitation of the lessor of 24 months or the maximum benefit period per occurrence. The following conditions are excluded from this limitation: Schizophrenia, dementia and organic brain disease.

Alcohol and Substance Abuse

If you're disabled due to alcohol and/or substance abuse, benefits will not be payable beyond 24 months, recovery, or when you cease to participate in a recovery program for alcohol, drug or substance abuse or an addiction recovery program recommended by a physician (whichever is applicable), or you complete such recovery program.

Recurrent Disability

A recurrent disability is a disability that is related to a prior disability for which you received a monthly LTD benefit. It's considered part of your prior disability if, after receiving LTD benefits, you return to your regular job on a full-time basis for less than 180 days and then are disabled again due to the same or a related condition. If your disability is recurrent, you will not need to satisfy a new elimination period.

If you return to your regular job for more than 180 days and become disabled again, you'll start a new disability claim and will be subject to:

- A new 26-week elimination period (which may be covered by Short-Term Disability benefits); the Long-Term Disability elimination period is stated as the greater of the Short-Term Disability period or 180 days;
- A new maximum period payable; and
- Any other provisions of the LTD plan that are in effect on the date your disability recurs.

Work Incentive Benefit

After the first 24 months following your elimination period, your monthly LTD benefit payment will be reduced by 50% of the income received from participation in rehabilitative employment. Examples of rehabilitative employment include:

- Any employment undertaken by you while receiving LTD benefit payments, and
- Any vocational rehabilitation training program approved by MetLife.

While you are disabled we encourage you to work. If you work while you are disabled and receiving monthly benefits, your monthly benefits will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any, and
- Reduced by other income as defined in the *Other Disability Income Benefits and Sources of Income* section.

The work incentive benefit will cease on the earliest of the following:

- The date you're no longer disabled, or
- The end of the maximum period payable.

Note: MetLife will provide vocational rehabilitation services as reasonably required to assist in returning you to gainful employment. Vocational rehabilitation services may include job modification, job retraining, or job placement.

Note: The LTD plan will not pay further benefits if you refuse to participate in rehabilitative employment.

Rehabilitation Incentive

If you participate in a rehabilitation program, we will increase your monthly benefit by an amount equal to 10% of the monthly benefit. We will do so before we reduce your monthly benefit by any other income.

Work Incentive

While you are disabled, we encourage you to work. If you work while you are disabled and receiving monthly benefits, your monthly benefit will be adjusted as follows:

- Your monthly benefit will be increased by your rehabilitation program incentive, if any, and
- Reduced by other income as defined in the section titled *Other Disability Income Benefits and Sources of Income*.

Your monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100% of your pre-disability earnings as calculated in the definition of disability.

Limit on Work Incentive

After the first 24 months following your elimination period, we will reduce your monthly benefit by 50% of the amount you earn from working while disabled.

Family Care Incentive

If you work or participate in a rehabilitation program while you are disabled, we will reimburse you for up to $400 for monthly expenses you incur for each family member to provide:

- Care for your or your spouse's child, legally adopted child, or child for whom you or your spouse are legal guardian and who is:
  - — Living with you as part of your household;
  - — Dependent on you for support; and
  - — Under age 13.

The child care must be provided by a licensed child care provider who may not be a member of your immediate family or living in your residence.

- Care to your family member who is:
  - — Living with you as part of your household;
  - — Chiefly dependent on you for support; and
  - — Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.
- Care to your family member may not be provided by a member of your immediate family.

We will make reimbursement payments to you on a monthly basis starting with the first monthly benefit payment until you have received 24 monthly benefit payments. Payments will not be made beyond the maximum benefit period. We will not reimburse you for any expenses for which you are eligible for payment from any other source. You must send proof that you have incurred such expenses.

Moving Expense Incentive

If you participate in a rehabilitation program while you are disabled, we may reimburse you for expenses you incur in order to move to a new residence recommended as part of such rehabilitation program. Such expenses must be approved by us in advance. You must send proof that you have incurred such expenses for moving. We will not reimburse you for such expenses if they were incurred for services provided by a member of your immediate family or someone who is living in your residence.

Presumptive Disability Benefits

If your injury causes any of the following losses within 100 days after the date of the injury, you are guaranteed a minimum of the presumptive disability benefit payment. The employee does not need to have any disability other than the qualifying loss to qualify for the benefit described below. The duration of your presumptive disability benefit is based on the type of loss that you suffer, and will be for the period outlined in the following chart:

Type of Loss	Months Payable
• Both hands, both feet, the sight of both eyes, or any combination • One hand and one foot • One hand or one foot and the sight of one eye	46 months
• One hand or one foot	23 months
• The sight of one eye	15 months
• Thumb and index finger or either hand	12 months

The presumptive disability benefit payment is equal to the net LTD monthly benefit and is payable as indicated above or until your date of death, whichever is earlier. This benefit is paid in addition to any disability benefit payments you may be receiving.

If more than one of the above-mentioned losses results from one accident or injury, you will be paid for the loss with the greater number of months payable.

If you remain eligible, you may also receive LTD benefit payments after payment of the presumptive disability.

How Long Will LTD Benefit Payments Continue?

LTD benefit payments continue up to age 65 for Core coverage and Buy-up coverage or until the date of the following:

- You're no longer disabled;
- You fail to furnish proof that you continue to be disabled;
- You're no longer under the regular care of a physician;
- You refuse to be examined, participate in any rehabilitative employment, or receive recommended treatment that is generally acknowledged by physicians to cure, correct, or limit the disabling condition;
- Your monthly earnings exceed 80% of your pre-disability earnings;
- The date benefits end as specified in the mental and nervous and drug and alcohol provisions;
- You reach the maximum period of coverage; or
- You die.

Note: If your disability or illness occurs on or after age 62, see the *LTD Schedule of Benefits* section for more details.

Date Benefit Payments End

Your disability benefit payments will end on the earliest of:

- The end of the maximum benefit period;
- The date benefits end as specified in the mental and nervous and drug and alcohol provisions;
- The date you are no longer disabled;
- The date you die;
- The date you cease or refuse to participate in a rehabilitation program that we require and that is approved by your physician;
- The date you fail to have a medical exam requested by MetLife; or
- The date you fail to provide required proof of continuing disability.

While you are disabled, the benefits described in this section will not be affected if:

- Your insurance ends, or
- The group policy is amended to change the plan of benefits for your class.

Continuation of Benefits While on LTD

During the period you are receiving disability benefits under the LTD plan, you may continue certain Baker Hughes Medical plan coverage and Basic Life insurance coverage. You will be required to pay your share of the cost for your Medical plan coverage, which will be billed to you monthly by the Benefits Center.

If you continue coverage under a Baker Hughes Medical plan while you are receiving disability benefits under the LTD plan and you are, or later become, eligible to enroll for medical benefits under Medicare, you must enroll in both Parts A and B of Medicare as soon as you are eligible to enroll. If (1) you are eligible to enroll for medical benefits under Medicare, (2) you are not actively working for Baker Hughes, and (3) you have been receiving disability benefits from Baker Hughes plans for more than six months, the benefits you are eligible to receive under the Baker Hughes Medical plan will be determined as if Medicare was providing your primary medical coverage, regardless of whether you enroll in Medicare Parts A and B. In that case, your Baker Hughes Medical plan coverage will only pay benefits to the extent the plan provides a higher level of benefit than Medicare. The Baker Hughes Medical Plan Administrator will process your medical claims only after receiving the Medicare Explanation of Benefits. If you do not enroll in Medicare Parts A and B, the administrator will process your claims by estimating the amount Medicare would have paid and will pay only the amount that is payable under the Baker Hughes Medical plan that exceeds the amount that would have been paid by Medicare.

You will continue Voluntary AD&D coverage under premium waiver if you had coverage before your disability began and if you remain disabled.

You may elect to continue Dental, Vision, and your Health Care Flexible Spending Account through COBRA if you had coverage before your disability began. Refer to the *Benefits Rights* section for more information on COBRA.

If you are enrolled in the Supplemental Life insurance plan, your coverage will end when you are on LTD. You may be eligible to continue your coverage by converting it to an individual policy. For more information, contact Minnesota Life at 1-866-293-6047.

If your employment with Baker Hughes terminated before you transitioned to LTD benefits, you are not eligible for continuation of Medical or Basic Life insurance benefits. In this event, you may be eligible to continue Medical coverage through COBRA and convert your Basic Life insurance coverage to an individual policy. For more information on converting your Basic Life insurance coverage, contact Minnesota Life at 1-866-293-6047.

If you have questions regarding your benefits while you are receiving LTD benefit payments, please contact the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide).

LTD Exclusions

What is Not Covered

The LTD plan does not pay benefits if your disability is caused by, contributed to, or results from:

- A pre-existing condition. A condition for which medical treatment or advice was rendered, prescribed, or recommended within three months prior to your effective date of coverage by the LTD plan. A condition shall no longer be considered pre-existing if it causes disability that begins after you have been covered under the LTD plan for a period of 12 months;
- War, whether declared or not, or any act of war;
- Committing or attempting to commit a felony;
- Mental illness after 24 months;
- Alcohol, drug or substance abuse or addiction after 24 months, recovery or when you cease to participate in a recovery program recommended by a physician;
- Attempted suicide or self-inflicted injury or illness; or
- Elective plastic surgery (complications related to plastic surgery are a covered benefit).

In addition, benefits are not payable for any period during which:

- You are confined to a penal or correctional facility;
- You are not under the care of a physician; or
- You are not eligible for coverage under the LTD plan.

Termination of Coverage

Your LTD plan coverage will end when:

- You do not provide requested medical information to MetLife;
- You cease to be eligible for coverage;
- You qualify for retirement benefits from Baker Hughes; or
- Baker Hughes terminates the LTD plan.

Date Your Insurance Ends

Your insurance coverage from MetLife under the LTD plan will end on the earliest of:

For All Coverages:

- The date the group policy coverage from MetLife under the LTD plan ends; or
- The date insurance ends for your class; or
- The end of the period for which the last premium has been paid for you.

For Disability Income Insurance: Long-Term Benefits:

- The date you cease to be in an eligible class. You will cease to be in an eligible class on the date you cease active work in an eligible class, if you are not disabled on that date; or
- The date you retire in accordance with the date your employment ends; or
- The date your employment ends.

How do I File a Long-Term Disability Claim?

If You Were Receiving STD Benefit Payments…

If you are already receiving STD benefit payments and continue to be eligible for disability coverage, Sedgwick automatically transitions your claim to LTD benefits coverage through MetLife.

If You Were Not Receiving STD Benefit Payments…

If you are disabled for the duration of the 26-week LTD plan elimination period and were not receiving STD benefit payments, you must call MetLife at 1-877-423-8677 (prompt 4) to initiate a claim for LTD benefits. The Long-Term Disability elimination period is stated as the greater of the end of the Short-Term Disability maximum benefit period or 180 days.

Note: You are encouraged to call MetLife at the beginning of your disability to ensure you understand the qualifications for being considered disabled under the LTD plan and also to ensure prompt payment of LTD payments, should you be eligible.

MetLife may ask you for the following information:

- Name, Social Security Number
- HR representative's name and phone number
- Employee ID with leading zeros, date of birth
- Description of illness or injury, date last worked, and date of hire
- Description of job or occupation
- Employer's name, address, and phone number
- Manager's name and phone number
- Physician's name and phone number

You may need to provide MetLife with written authorization to access your medical information by completing an authorization form and providing a copy to both MetLife and your physician.

You can obtain an authorization form by calling MetLife at 1-877-423-8677 (prompt 4).

Note: If you are unable to call, a family member, close friend, Human Resources representative, or your manager can make the call for you.

Note: It is ultimately your responsibility to ensure all requested information is provided to MetLife. Failure of your physician to provide necessary medical documentation may result in a delay or suspension of your LTD benefit payments.

Responding to Your Disability Claim

MetLife will notify you in writing about whether your claim has been approved or denied within a reasonable period of time, but not later than 45 days of receiving your claim. This period can be extended for up to another 30 days if you are notified (before the end of the original 45-day period) that the extension is necessary due to matters beyond the control of the LTD plan.

The 30-day extension period can be extended for up to an additional 30 days if you are notified (before the end of the first 30-day extension period) that the extension is necessary due to matters beyond the control of the LTD plan. Any notice for an extension will explain:

- The reason for the extension and when MetLife expects to rule on your claim, and
- Additional information needed to resolve those issues.

If an extension is required because you need to provide the information necessary to resolve claim issues, you will have 45 days from the time you receive the extension notice to provide the additional information. If you do not provide the requested information on or before the end of such 45-day period, your benefit claim will be denied by MetLife.

Disability Claims Denial Notice

You will receive written notice of MetLife's claim decision under the LTD plan. If your claim is denied, the notification will include:

- Specific reasons for the denial;
- Specific LTD plan provisions on which the decision is based;
- A description of any additional material or information necessary for the claim to be completed, as well as an explanation of why such material or information is necessary;
- A description of the LTD plan's appeal procedures and their applicable time limits, including your right to bring a civil action in court under Section 502(a) of ERISA following a claims denial on review;
- A description of any internal rules, guidelines, protocols, or other similar criteria that was relied upon in the decision-making, or a statement that the decision was based on the applicable items mentioned above. The LTD plan will provide you with copies of the applicable material upon request to the LTD plan (free of charge); and
- An explanation of the scientific or clinical judgment used in the decision regarding medical necessity, experimental treatment, or similar exclusion or limit. The decision will apply the terms of the LTD plan to your medical circumstances, or will include a statement that you will be provided an explanation upon request to the LTD plan (free of charge).

Appealing a Denied Disability Claim

Appeals must be in writing and should be submitted to the claim department address below:

MetLife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
Fax Number: 1-800-230-9531
Toll-free Number: 1-877-423-8677 (prompt 4)

You should include the following information in writing:

- Employee name;
- Name of the LTD plan;
- Reference to the initial decision;
- Reasons for requesting the appeal; and
- Additional documentation in support of the request. This includes objective medical information relevant to the issues and time period surrounding the claim.

The appeal decision will be communicated directly to you and/or your duly authorized representative.

You, or your authorized representative will have 180 days after receiving notice that your disability claim is denied to appeal the decision in writing to MetLife. You can submit any information relating to the claim (e.g., written comments, documents, records). All comments, documents, records, and other information submitted by you or your authorized representative relating to your benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

In addition, MetLife provides you with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. MetLife provides this information upon request and free of charge.

If the claimant submits additional proof of disability, the additional information will be reviewed first by the original claims adjuster. If this additional information changes the decision of the denial, then the claim decision will be revised. If any portion of the original claim denial remains, then the appeal of the claim denial would go to the second step of appeals as outlined below.

A plan fiduciary, who had no role in the initial claim denial and is not subordinate of the original claims adjuster who made the decision on the claim, reviews your appeal. The review is independent and will not give the original denial any special consideration.

If a medical judgment is involved, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial. The LTD plan will identify the medical or vocational experts whose advice was obtained. The health care professional consulted for the appeal will be an individual who was not consulted in connection with the initial claim denial and is not the subordinate of any health care professional who was consulted in connection with the initial claim denial.

MetLife notifies you of the appeal decision within a reasonable period of time, but not later than 45 days after MetLife receives your request for review. You will be notified in writing of any extension before the end of the original 45-day period if special circumstances require an extension of time for processing.

Such notice will state the special circumstances and the date by which the benefit decision on appeal will be made. If an extension is required, MetLife will notify you of its decision within 90 days after MetLife's receipt of your request for review.

Disability Appeal Denial Notice

MetLife will send you a written notice of MetLife's decision under the LTD plan regarding your appeal of a denied disability claim. If your appeal is denied in whole or in part, the notification will include:

- Specific reasons for the denial of the appeal;
- Reference to the specific LTD plan provisions on which the decision is based;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of such specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the decision, and that a copy thereof will be provided free of charge to you upon request to the LTD plan;
- If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the LTD plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request to the LTD plan;
- A statement that you are entitled to receive, upon request to the LTD 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; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

You and MetLife can also seek other voluntary alternative dispute resolution options, such as mediation. Contact your local U.S. Department of Labor office and your State insurance regulatory agency to find out what resources are available.

If MetLife fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in court.

Basic Life Insurance

Basic Life At-a-Glance

Type of Plan	Welfare plan that provides Basic Life insurance
Premium Contributions	Baker Hughes pays 100% of the cost of your coverage. No premium contributions are required from you for this coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary. However, if you wish to limit your coverage to $50,000 to avoid imputed income, you may do so within 31 days of your date of hire or transfer to a position with U.S. benefits. You can also make changes during Annual Enrollment or if you have a qualified status change (see the *Can I Make Changes After I Enroll?* information in the *General Information* section).
Coverage Options	• Coverage equal to 1x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000) • Coverage is reduced by 50% the first of the year following your 70th birthday. • You may limit your coverage to $50,000 to avoid imputed income.
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

Your Basic Life Insurance Coverage

Employee life insurance provides valuable financial protection for your family. If you die, your life insurance benefit can replace your income for a period of time and also help your family pay for expenses incurred as a result of your death. Because life insurance is such an important benefit, Baker Hughes provides Basic Life insurance coverage under the Baker Hughes Incorporated Life Insurance program (the Basic Life plan) at no cost to you, and no enrollment is necessary. Basic Life insurance coverage provides peace of mind for you and basic financial security to you or your beneficiaries in the event you die.

What is the Cost of the Basic Life Plan?

No premium contributions are required from you for this coverage.

When Does Coverage Begin?

The Basic Life plan provides you with Basic Life insurance coverage on the first day you are actively at work. No enrollment is necessary.

Definition: **Actively at Work** means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business or at other places Baker Hughes business requires you to travel.

How Does the Basic Life Plan Work?

Basic Life insurance is provided to all eligible employees at no cost to you. Your benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefit programs. This **does not** include overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later. Coverage increases due to changes in your benefits base pay are effective each January 1. All increases are subject to the actively-at-work requirements.

If you die while covered by the Basic Life plan, your beneficiaries will receive a benefit based on your annual benefits base pay and age, as follows:

Your Age When You Die	Benefit Amount
• Under Age 70	1x benefits base pay or $50,000 if coverage is capped to avoid imputed income, • Rounded to the next higher $1,000 (if not already a multiple thereof), and • Minimum $50,000; maximum $500,000.
• Age 70 or Over	Coverage is reduced by 50% the first of the year following your 70th birthday.

Imputed Income

If your Basic Life insurance coverage is greater than $50,000, the value of this employer-paid coverage in excess of $50,000 is considered "imputed income" and subject to income tax.* To avoid imputed income, you can elect to reduce your benefit by capping your Basic Life insurance coverage at $50,000 during an election period.

*The imputed income is added to your total annual compensation reported to the Internal Revenue Service (IRS). It appears on your W-2 statement and is taxable at your regular income tax rate.

Example:

Jose is 30 years of age and receives Basic Life insurance coverage of 1x his annual benefits base pay, which is $60,000. Imputed income is calculated on the value of $10,000 (or the difference between his coverage and $50,000) and equals approximately 40 cents per month. This amount will be included on his W-2 statement as taxable income.

Tip! If you have previously capped your coverage to avoid imputed income, you may remove the cap from the benefit during any Annual Enrollment period or during certain qualified changes in status, so long as you provide satisfactory Evidence of Insurability.

Naming a Beneficiary

You must name a beneficiary for your Basic Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary, you may:

- Name one or more beneficiaries
  Note: If you select more than one beneficiary, you must choose the percentage of benefits that are to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (This is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Minnesota Life at 1-866-293-6047.

If You Become Terminally Ill

If you become terminally ill while covered under the Basic Life plan, you may apply for an accelerated benefit. Subject to approval by the Basic Life insurance provider, Minnesota Life, this allows you to receive the full or a partial amount of your Basic Life insurance benefit before you die.

Definition: **Terminally Ill** means that due to accident or sickness, you are expected to have less than 12 months to live.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Minnesota Life that your life expectancy, because of sickness or accident, is 12 months or less. That evidence must include certification by a physician. Minnesota Life reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Minnesota Life's physician will prevail. Minnesota Life retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

The following conditions also apply:

- Coverage must be in force;
- Application must be made in writing and in a form which is satisfactory to Minnesota Life. Minnesota Life will provide the required form;
- You must be the sole owner of the coverage; and
- Your coverage must not have an irrevocable beneficiary or absolute assignment.

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The minimum benefit is $10,000 and the maximum is the amount equal to your Basic Life insurance coverage (which cannot exceed $500,000). If you die before all payments have been made, Minnesota Life will pay the remainder to your named beneficiaries.

In no event will the amount of the accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Basic Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Basic Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force. The remaining amount of your benefit after a partial acceleration has been taken must be at least $25,000.

If you elect to receive accelerated benefits, Minnesota Life will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit.

Accelerated Benefit Amount Calculation and Payment

Minnesota Life will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy.

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you, unless you validly assign them otherwise. If you die before all payments have been made, Minnesota Life will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Minnesota Life.

Filing a Basic Life Claim

To claim benefits, your beneficiary who is entitled to benefits in the case of your death (or you, in the case of an accelerated benefit), the claimant, must contact the Baker Hughes Employee Benefits Department at our corporate office at 713-439-8600 or 1-800-229-7447 and request the forms required to initiate a claim for benefits. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process in the case of your death, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of your death, to the following address:

Baker Hughes Incorporated
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, TX 77210-4740
Phone: 713-439-8600 or 1-800-229-7447

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Minnesota Life. After Minnesota Life has processed the claim, the claimant will be notified by Minnesota Life in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic Life plan are fully-insured and payable solely by Minnesota Life. Therefore, to receive a benefit, the claimant must provide the information required by Minnesota Life.

Claims Denial Procedure

If all or part of a claim for benefits is denied, Minnesota Life will notify the claimant in writing within 90 days (45 days for any disability claims) of receiving the claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims) where an extension is necessary due to matters beyond the control of the Basic Life. The claimant will be notified in writing of this extension within the original review period.

The notice of extension will include the reason for the extension and the date when Minnesota Life expects to rule on the claim, and, in the case of an extension for a disability claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Basic Life plan within 45 days of the date on the notice the plan may close the claim.

Any denial of a claim for benefits will be provided by Minnesota Life and consist of a written explanation which will include:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and an explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

For disability claims only, the following will also be included:

- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision, and
- An explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusions or treatment applying the terms of the plan to the claimant's medical circumstances, if applicable.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the plan by filing a written request for a full and fair review to Minnesota Life. Send your written appeal of a claim denial to the following address:

Minnesota Life Insurance Company
Group Division Claims
P.O. Box 64114
St. Paul, MN 55164-0114

In connection with such a request, documents pertinent to the administration of the Basic Life plan may be reviewed by the claimant. The claimant may submit written comments, documents, records and other information relating to the claim, and issues outlining the basis of the appeal may be submitted in writing.

During the claims appeal procedure, the claimant can write or call Baker Hughes and ask to see all Basic Life plan documents affecting the claim. In addition, the claimant may have an attorney or other representative write letters or otherwise act on the claimant's behalf, but Baker Hughes and Minnesota Life reserve the right to require written authorization from the claimant. A claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of an appeal of a claim:

- The appeal will not give the original denial any special consideration and will be conducted by a named fiduciary of the Basic Life plan who is neither the individual who denied the claim nor the subordinate of such individual;
- If a medical judgment is involved in deciding the appeal, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- The Basic Life plan will identify to the claimant the medical or vocational experts whose advice was obtained; and
- The health care professional consulted for the appeal will be an individual who was not consulted in connection with the original review and denial of the claimant's claim and is not the subordinate of any health care professional who was consulted in connection with the original review and denial of the claimant's claim.

A request for a review must be filed within 60 days (180 days for any disability claims) of the claimant's receipt of the written notice of denial of a claim. The full and fair review will be held and a decision will be rendered by Minnesota Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). The claimant will be notified in writing of this extension within the original appeal determination and review period.

The notice of extension will include the reason for the extension and the date when Minnesota Life is to rule on the appeal and a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. When the time frame to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the plan within 45 days of the date on the notice, the Basic Life plan will close the appeal at the end of that period.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Written notification of the Basic Life plan's decision on a disability or non-disability appeal shall be provided to the claimant and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent Basic Life plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits; and
- A statement of the right to sue in federal court under Section 502(a) of ERISA.

For disability claims only, it will also include:

- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- Explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Legal Action Following Appeals

After completing all mandatory appeal procedures, the claimant has the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Basic Life plan after two years from the date the Basic Life plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Basic Life plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the amount payable under the Basic Life plan is paid to your beneficiaries by Minnesota Life. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse; otherwise
- Your naturally born or legally adopted children in equal shares; otherwise
- Your surviving parents in equal shares; otherwise
- Your siblings in equal shares; otherwise
- Your estate.

The benefit will be paid in a single sum or by any other method agreeable to Minnesota Life and your beneficiaries. Minnesota Life will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Minnesota Life based on current short-term market rates, but never less than 0.1% compounded annually, or the minimum required by state law, whichever is greater.

When Does Coverage End?

Conversion of Basic Life Insurance

Your Basic Life insurance coverage will end if you retire or otherwise terminate employment with Baker Hughes or are no longer eligible for the coverage.

If your Basic Life insurance coverage ends because you move out of an existing eligible class or you are no longer in an eligible class, but the group policy continues, you will have 60 days after your coverage ends to apply to convert your coverage to a new individual life policy offered by Minnesota Life and to pay the first required premium. Evidence of Insurability (EOI) will not be required. The premium for the converted policy will be based on your age, class of risk, and amount of coverage.

If you die during the 31-day period allowed for conversion, Minnesota Life will pay a death benefit regardless of whether or not an application for coverage under the individual policy has been submitted.

Porting Your Basic Life Insurance

If you leave Baker Hughes or retire, you may be able to take your Basic Life insurance with you and continue to pay group term rates directly to Minnesota Life. Rates may be higher than you paid as an active employee.

You cannot continue your coverage if:

- You have attained the age of 70;
- You have converted your insurance to an individual policy; or
- Due to a sickness or injury, you were not actively at work on the date prior to your termination of employment or retirement.

There are maximums on the amount of coverage that can be ported. To learn more about your portability options, please call Minnesota Life at 1-866-293-6047.

If the Basic Life Plan is Terminated

If the Basic Life plan ends, you may convert to an individual policy as stated above. However, the converted policy will be limited to the lesser of:

- The amount of Basic Life insurance coverage you had under the Basic Life plan (less any life insurance amount you become eligible for under another group policy within 31 days after the Basic Life plan ends), and
- $10,000.

The converted policy will be effective 31 days after the group insurance provided under the policy terminates. If you should die during the conversion period, the amount of Basic Life insurance you could have converted under the policy will be paid to your beneficiary.

Converting or Porting Your Coverage

For more information, or to convert or port your coverage, contact Minnesota Life at 1-866-293-6047.

Supplemental Life Insurance

Supplemental Life At-a-Glance

Type of Plan	Welfare plan that provides Supplemental Life insurance
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
Eligible Dependents	• Lawful spouse • Qualified dependent child
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer (must be actively at work). If changes are made during Annual Enrollment, coverage goes into effect the following January 1.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. You must elect employee coverage in order to elect spouse and/or dependent child coverage. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a change in status (see the *Can I Make Changes After I Enroll?* information in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year. **Note:** You may need to provide Evidence of Insurability (EOI) for yourself and your spouse (if spouse coverage is elected).
Coverage Options	• **Employee:** Coverage equal to 1x to 6x annual benefits base pay up to a maximum of $2.5 million multiplied and then rounded to the next higher $1,000 if not already a multiple thereof. Coverage is reduced by 50% the first of the year following your 70th birthday. • **Spouse:** You can choose from the following options: — $25,000 — $150,000 — $50,000 — $200,000 — $75,000 — $250,000 — $100,000 **Note:** The amount of spouse coverage cannot exceed 100% of your combined Basic and Supplemental Life insurance. • **Children:** $10,000 for each eligible dependent
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

Your Supplemental Life Insurance Coverage

You may purchase additional life insurance coverage for yourself and coverage for your spouse and your eligible dependents. The Baker Hughes Incorporated Supplemental Life insurance program (the Supplemental Life plan) provides you with an additional benefit if you, your spouse, or your dependents were to die.

What is the Cost of the Supplemental Life Plan?

You pay for the full cost of this coverage through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within 31 days of becoming eligible for coverage, your coverage begins on your first day of active work if you are a new hire or existing employee transferring to a position with U.S. benefits; or the following January 1 if you enroll during the Annual Enrollment period. If you elect coverage that requires Evidence of Insurability (EOI), you will be covered at the highest level of coverage possible without EOI pending a decision by the provider, Minnesota Life.

Definition: Actively at Work means that you are actively at work fully performing the customary duties of your Baker Hughes regularly scheduled hours at the normal place of business, or at other places Baker Hughes business requires you to travel.

How Does the Supplemental Life Benefits Base Pay Plan Work?

Supplemental Life insurance is available to all eligible employees. However, you must enroll and pay the full cost of this benefit. Just like Basic Life insurance, your Supplemental Life insurance benefit is based on your annual benefits base pay. Benefits base pay is made up of your base salary, including any before-tax contributions you make through the benefits programs. Benefits base pay does not include overtime, bonuses, commissions, premium pay or any other additional compensation. Your benefits base pay and age are used as part of the premium calculation.

Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

If you die while covered by the Supplemental Life plan, your beneficiaries will receive a benefit based on your elected amount or approved EOI coverage amount. If a spouse or a dependent dies while covered by the Supplemental Life plan, you will receive a benefit based on the amount of coverage elected during enrollment or approved EOI coverage amount.

Coverage Level	Benefit Options You May Elect
Employee Under Age 70	Coverage equal to 1x to 6x annual benefits base pay multiplied and then rounded to the next higher $1,000 if not already a multiple thereof up to a maximum of $2.5 million
Employee Age 70 or Over	Coverage is reduced by 50% beginning the first of the year following your 70th birthday.
Spouse	• $25,000 • $50,000 • $75,000 • $100,000 • $150,000 • $200,000 • $250,000 **Note:** The amount of spouse coverage cannot exceed 100% of your combined Basic and Supplemental Life insurance.
Dependent Children	$10,000 per covered child

Note: You must elect employee coverage and be approved (if applicable) in order to elect spouse and/or dependent coverage.

Remember…

If both you and your spouse work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse as your dependent (or vice versa),

OR

- Both choose to enroll in benefits as employees.

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

Remember…

If you do not elect coverage as a new hire or when you first transfer to a position with U.S. benefits, and decide to elect Supplemental Life insurance during a future enrollment period, you will be required to provide Evidence of Insurability for yourself and your spouse (if elected) for any amount of coverage elected.

Evidence of Insurability

If you enroll in Supplemental Life insurance coverage within 31 days of first becoming eligible, you may elect coverage up to the guarantee issue amounts without providing Evidence of Insurability (EOI). Guarantee issue is the maximum amount of insurance an employee or spouse can receive without EOI when first eligible under the Supplemental Life plan, provided enrollment is made in a timely manner within the initial enrollment period.

The guarantee issue amounts are as follows:

- **Employee Supplemental Life:** $250,000
- **Spouse Life:** $25,000
- **Child Life:** $10,000 (EOI does not apply regardless of when election is made)

Example:

Tom is a new hire whose annual benefits base pay is $100,000, and he elects three times salary. Tom is covered up to the guarantee issue amount of $250,000 until a decision is made on his EOI. If approved, he will receive the full benefit amount he elected of three times ($300,000) coverage. If the EOI is denied, coverage will remain at the guarantee issue amount of $250,000.

If you do not enroll in coverage when first eligible, you will be required to submit EOI for any future enrollment.

If you enroll in coverage when first eligible and then elect to increase your coverage during future enrollments, EOI will generally be required for amounts above the guarantee issue or when increasing coverage by more than one level. All coverage increases are subject to the actively-at-work requirements. Refer to the chart below for additional details.

	Election Period	Election	EOI Required?
Employee	During new hire enrollment period or newly eligible enrollment period	Any election less than or equal to the guarantee issue of $250,000	No
		Any election above the guarantee issue of $250,000	Yes
	After new hire enrollment period or newly eligible enrollment period	Any election for one multiple that does not exceed the guarantee issue of $250,000	No
		Any election for more than one multiple	Yes
		Any election for one multiple that exceeds the guarantee issue of $250,000	
		Any election after the benefit amount has exceeded the guarantee issue of $250,000	
		Any election from "No Coverage" to any elected multiple	
		Any amount over the guarantee issue of $250,000 for the first time due to an increase in benefits base pay	
Spouse	During new hire enrollment period or newly eligible enrollment period	Any election up to the guarantee issue of $25,000	No
		Any election above the guarantee issue of $25,000	Yes
	After new hire enrollment period or newly eligible enrollment period	Any election amount, including new elections	Yes
		Any election from "No Coverage" to any elected amount	Yes
Dependent Children	No EOI required for coverage		No

Providing EOI Documentation

If you are required to provide Evidence of Insurability, you will receive a packet from Minnesota Life in the mail after you enroll. The packet will contain the information you need to complete EOI either online or by mail. **Until a decision has been made on your coverage, you or your spouse will be covered at the highest level of coverage possible without EOI.** If EOI is approved, the Supplemental Life and/or Spouse Life insurance coverage at the higher coverage level will become effective on the day the EOI decision is made, or according to the Supplemental Life plan rules as long as you remain eligible and are actively at work. If the election requiring EOI was made during Annual Enrollment, the coverage will be effective the later of the date the EOI decision was made, or January 1 following Annual Enrollment. If an exam or tests are required to complete the EOI process, Minnesota Life will arrange for the needed services at no cost to you.

Remember…

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

Naming a Beneficiary

You must name a beneficiary for your Supplemental Life insurance benefits. You may name anyone as your beneficiary. If you wish to name more than one person, you must indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries, who will receive benefits in the event your primary beneficiaries die before they receive benefits.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary you may:

- Name one or more beneficiaries
  Note: If you select more than one beneficiary, you'll need to choose the percentage of benefits that are to be paid to each beneficiary.
- Name a beneficiary that you cannot change in the future without his or her written consent (this is called an irrevocable beneficiary). You may also transfer ownership of your coverage. (This is called an absolute assignment.) To name an irrevocable beneficiary or execute an absolute assignment, you will need to contact Minnesota Life at 1-866-293-6047.
- You're automatically the beneficiary for your dependent's (spouse and children) Supplemental Life insurance benefits.

If You Become Terminally Ill

If you become terminally ill while covered under the Supplemental Life plan, you may apply for an accelerated benefit. Subject to approval by the insurance provider, Minnesota Life, this allows you to receive the full or a partial amount of your Supplemental Life insurance benefit before you die.

Definition: **Terminally Ill** means that due to sickness or accident, you are expected to have less than 12 months to live.

Proof

To be considered for an accelerated benefit, you will need to submit evidence satisfactory to Minnesota Life that your life expectancy, because of sickness or accident, is 12 months or less. That evidence must include certification by a physician. Minnesota Life reserves the right to ask for independent medical verification of a terminal condition. In the case of a difference of opinion, the opinion of Minnesota Life's physician will prevail. Minnesota Life retains the right to have a medical examination done, at its own expense and as often as reasonably required while accelerated benefits are being considered or paid, to verify your medical condition.

The following conditions also apply:

- Coverage must be in force, and all premiums due must be fully paid;
- Application must be made in writing and in a form which is satisfactory to Minnesota Life. Minnesota Life will provide the required form;
- You must be the sole owner of the coverage; and
- Your coverage must not have an irrevocable beneficiary or absolute assignment.

Coverage

If you are approved for an accelerated benefit, you have the option to receive the full or a partial accelerated benefit amount. The minimum benefit is $10,000 and the maximum is the amount equal to your Supplemental Life insurance coverage (which cannot exceed $1 million when combined with Basic Life). If you die before all payments have been made, Minnesota Life will pay the remainder to your named beneficiaries.

In no event will the amount of the Supplemental Life plan accelerated benefit you receive, plus the amount your beneficiary receives at the time of your death, exceed the amount of your Supplemental Life insurance benefit.

Note: Benefits received under the accelerated benefit option are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to accelerated benefit payments are complex, and you are advised to consult with a qualified tax advisor before requesting or receiving an accelerated benefit.

If you elect to accelerate the full benefit amount, your coverage under the Supplemental Life plan will end. If you elect a partial accelerated benefit, coverage will remain in force and premiums will be reduced accordingly. The remaining amount of your benefit after a partial acceleration is taken must be at least $25,000.

If you elect to receive accelerated benefits, Minnesota Life will send you a statement which illustrates the effects of the accelerated benefit payment on your benefit under the Supplemental Life plan.

Accelerated Benefit Amount Calculation and Payment

Minnesota Life will multiply the benefit coverage amount by an accelerated benefit factor to determine the accelerated benefit available. The accelerated benefit factor will take into consideration your age, gender, and certain other assumptions, which may change from time to time, including but not limited to assumptions about:

- Expected future premiums, and
- Your life expectancy.

The accelerated benefit will be paid in one lump sum or in any other mutually agreeable manner. All accelerated benefits will be paid to you, unless you validly assign them otherwise. If you die before all payments have been made, Minnesota Life will pay the remainder to your named beneficiary. Payment will be made in one lump sum which will be the present value of the payments that remain, using an interest rate determined by Minnesota Life.

Filing a Supplemental Life Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the Baker Hughes Employee Benefits Department at our corporate office at 713-439-8600 or 1-800-229-7447 and request the forms required to initiate a claim for benefits. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of the covered person's death, to the following address:

Baker Hughes Incorporated
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, TX 77210-4740
Phone: 713-439-8600 or 1-800-229-7447

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Minnesota Life. After Minnesota Life has processed the claim, the claimant will be notified by Minnesota Life in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Supplemental Life plan are fully-insured and payable solely by Minnesota Life. Therefore, to receive a benefit, the claimant must provide the information required by Minnesota Life.

Claims Denial Procedure

If all or part of a claim for benefits is denied, Minnesota Life will notify the claimant in writing within 90 days (45 days for any disability claims) of receiving the claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims where an extension is necessary due to matters beyond the control of the Supplemental Life plan). The claimant will be notified in writing of this extension within the original review period.

The notice of extension will include the reason for the extension and the date when Minnesota Life expects to rule on the claims and, in the case of an extension for a disability claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Supplemental Life plan within 45 days of the date on the notice the plan may close the claim.

Any denial of a claim for benefits will be provided by Minnesota Life and consist of a written explanation which will include:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

For disability claims only, the following will also be included:

- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision, and
- An explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the Supplemental Life plan by filing a written request for a full and fair review to Minnesota Life. Send your written appeal of a claim denial under the Supplemental Life plan to the following address:

Minnesota Life Insurance Company
Group Division Claims
P.O. Box 64114
St. Paul, MN 55164-0114

In connection with such a request, documents pertinent to the administration of the Supplemental Life plan may be reviewed by the claimant. The claimant may submit written comments, documents, records and other information relating to the claim and issues outlining the basis of the appeal.

During the claims appeal procedure, the claimant can write or call Baker Hughes and ask to see all Supplemental Life plan documents affecting the claim. In addition, the claimant may have an attorney or other representative write letters or otherwise act on the claimant's behalf, but Baker Hughes and Minnesota Life reserve the right to require written authorization from the claimant.

A claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of an appeal of a claim:

- The appeal will not give the original denial any special consideration and will be conducted by a named fiduciary of the Supplemental Life plan who is neither the individual who denied the claim nor the subordinate of such individual;
- If a medical judgment is involved in deciding the appeal, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- The Supplemental Life plan will identify to the claimant the medical or vocational experts whose advice was obtained; and
- The health care professional consulted for the appeal will be an individual who was not consulted in connection with the original review and denial of the claimant's claim and is not the subordinate of any health care professional who was consulted in connection with the original review and denial of the claimant's claim.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

A request for a review must be filed within 60 days (180 days for any disability claims) of the claimant's receipt of the written notice of denial of a claim. The full and fair review will be held and a decision will be rendered by Minnesota Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). The claimant will be notified in writing of this extension within the original appeal, determination and review period.

The notice of extension will include the reason for the extension and the date when Minnesota Life expects to rule on the appeal and a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. When the time frame to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the plan within the 45 days of the date on the notice, the Supplemental Life plan will close the appeal at the end of that period.

Notice of Benefit Decision on Appeal

Written notification of the Supplemental Life plan's decision on a disability or non-disability appeal shall be provided to the claimant and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent Supplemental Life plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits; and
- A statement of the right to sue in federal court under Section 502(a) of ERISA.

For disability claims only, it will also include:

- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- An explanation of any scientific or clinical judgement made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Legal Action Following Appeals

After completing all mandatory appeal procedures, the claimant has the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Supplemental Life plan after two years from the date the Supplemental Life plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Supplemental Life plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Supplemental Life plan is paid to your beneficiaries by Minnesota Life. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, the benefits on your life will be paid to the first surviving class in the following order:

- Your lawful spouse; otherwise
- Your naturally born or legally adopted children in equal shares; otherwise
- Your surviving parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

The benefit will be paid in a single sum or by any other method agreeable to Minnesota Life and the beneficiaries. Minnesota Life will pay interest on the death benefit from the date of death until the date of payment, at an annual rate determined by Minnesota Life based on current short-term market rates, but never less than 0.1% compounded annually, or the minimum required by state law, whichever is greater.

Note: Supplemental Life benefits for the employee and covered dependents will not be paid to the beneficiary if you or the covered dependent spouse commits suicide within 24 months of electing coverage.

When Does Coverage End?

Conversion of Supplemental Life Insurance

Your Supplemental Life insurance coverage will end if you retire or otherwise terminate employment with Baker Hughes or are no longer eligible for the coverage.

If your Supplemental Life insurance coverage ends because you move out of an eligible class, or you are no longer in an eligible class, but the group policy continues, you will have 60 days after your coverage ends to apply to convert your coverage to a new individual life policy offered by Minnesota Life and to pay the first required premium. Evidence of Insurability (EOI) will not be required. The premium for the converted policy will be based on your age, class of risk, and amount of coverage.

If you die during the 31-day period allowed for conversion, Minnesota Life will pay a death benefit regardless of whether or not an application for coverage under the individual policy has been submitted.

Porting Basic Life Insurance

If you leave Baker Hughes or retire, you may be able to take your Basic Life insurance with you and continue to pay group term rates directly to Minnesota Life. Rates may be higher than you paid as an active employee.

You cannot continue your coverage if:

- You have attained the age of 70; or
- You have converted your insurance to an individual policy; or
- Due to a sickness or injury, you were not actively at work on the date prior to your termination of employment or retirement.

There are maximums on the amount of coverage that can be ported. To learn more about your portability options, please call Minnesota Life at 1-866-293-6047.

If the Supplemental Life Plan is Terminated

If the Supplemental Life plan ends, you may convert your coverage to an individual policy as stated above. However, the converted policy will be limited to the lesser of:

- The amount of Supplemental Life insurance coverage you had under the Supplemental Life plan (less any life insurance amount you become eligible for under another group policy within 31 days after the Supplemental Life plan ends), and
- $10,000.

The converted policy will be effective 31 days after the group insurance provided under the policy terminates. If you should die during the conversion period, the amount of Supplemental Life insurance you could have converted under the policy will be paid to your beneficiary.

Portability Option of Supplemental Life Insurance

If you leave the Company or retire, you may be able to take your Employee Supplemental Life, Spouse Supplemental Life and/or Child Supplemental Life insurance with you and continue to pay group term life rates directly to Minnesota Life. Rates may be higher than you paid as an active employee. If you elect to continue your own insurance, you can also continue insurance on your spouse and/or children.

Converting or Porting Your Coverage

For more information or to convert or port your coverage, contact Minnesota Life at 1-866-293-6047.

Basic AD&D Insurance

Basic AD&D At-a-Glance

Type of Plan	Welfare plan providing Accidental Death & Dismemberment insurance.
Who Pays the Cost	Baker Hughes pays 100% of the cost of your Basic AD&D insurance.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
Eligible Dependents	None
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary
Coverage Options	• Coverage equal to 1x your annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $500,000). This coverage amount is referred to as the principal sum by the insurance provider (and for purposes of this *Basic AD&D insurance* section). **Note:** If you elect to cap your Basic Life insurance coverage at $50,000, your Basic AD&D coverage will also be capped at $50,000.
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, or any other pay premium. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

Your Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can provide you financial protection in addition to the protection you have through life insurance. Basic Accidental Death & Dismemberment coverage is provided under the Baker Hughes Incorporated Accidental Death & Dismemberment program (the Basic AD&D plan).

What is the Difference Between Life and Accidental Death & Dismemberment (AD&D) Insurance?

Both Life and AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a death benefit; however, AD&D only pays if the cause of death was accidental.
- AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses.

Who pays the Cost of the AD&D Plan?

You do not contribute anything to receive Basic AD&D insurance coverage. It is paid 100% by Baker Hughes.

When Does Coverage Begin?

The Basic AD&D plan provides you with Basic AD&D insurance coverage on the first active day of work. No enrollment is necessary.

IMPORTANT

If you have elected to cap your Basic Life insurance coverage at $50,000, your Basic Accidental Death & Dismemberment coverage will also be capped at $50,000.

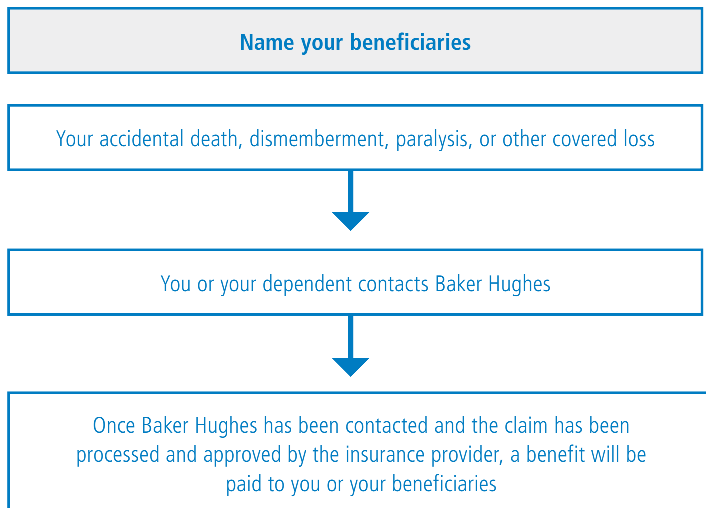
How Does Basic AD&D Insurance Work?

Basic AD&D insurance coverage provides financial protection for your family if you die accidentally. The Basic AD&D plan also pays a benefit to you if you lose a limb, lose your sight or hearing, or become paralyzed as the result of an accident. Basic AD&D plan benefits are payable **in addition** to benefits from Basic Life insurance, Voluntary Accidental Death & Dismemberment insurance, and the Business Travel Accident insurance plan (if applicable).

Your Basic AD&D insurance coverage amount is equal to your Basic Life insurance coverage amount.

Definition: **Accident or Accidental** means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the person is insured under the policy which is in force and is the direct cause of loss.

How Does the AD&D Process Work?



Protection

Naming a Beneficiary

You need to name a beneficiary for your Basic AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

If you do not name a beneficiary under the Basic AD&D insurance plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that is to be paid to each beneficiary.
- You may assign your rights to a benefit under the Basic AD&D plan, called an absolute assignment, if you make the assignment in writing in a manner required by the insurance provider. You can make the assignment irrevocable. To make an absolute assignment, contact Chubb at 1-877-297-4225 for the required form. The assignment must be filed with the Baker Hughes Benefits Center and the insurance provider and provided at the time of the claim or at any other time required by the insurance provider.

Remember…

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

What Losses are Covered by Basic AD&D Insurance?

The amount of your Basic AD&D plan benefit is based on the type of loss that you suffer, as shown in the following chart. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

Example:

Assuming that your maximum AD&D benefit is $45,000, the following benefit amounts would apply to the losses listed:

Type of Accidental Loss	Benefit
• Life • Both hands, both feet, the sight of both eyes, or any combination • One hand and one foot • One hand or one foot and the sight of one eye • Speech and hearing	$45,000
• One hand, one foot, or the sight of one eye • One arm or one leg • Speech or hearing (in both ears)	$22,500
• Thumb and index finger of the same hand	$11,250

If you suffer multiple losses as the result of one accident, only the single largest benefit will be payable. For example, if you lost an arm, your thumb, and index finger (on the other arm), you would receive a maximum benefit of $22,500.

If a covered loss occurs as a result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amount, which when totaled, exceeds the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Defining Loss

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by Chubb Group of Insurance Companies (Chubb).

Loss of foot means complete severance, through or above the ankle joint, even if the foot is later reattached.

Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least three fingers and the thumb on the same hand, even if the hand, fingers, and/or thumb are later reattached.

Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness can't be corrected by any aid or device, as determined by a physician.

Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.

Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.

Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints, of the thumb and index finger of the same hand as determined by a physician, even if one or both are later reattached.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than 365 days, as determined by a physician.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days, as determined by a physician.

Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than 365 days, as determined by a physician.

If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage at the time of the accident.

If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by this plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible, but in no event later than 365 days from the date of loss.

What Losses are not Covered by AD&D Insurance?

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft, or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide or intentionally self-inflicted injury.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.

This insurance does not apply to an accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, as defined by the laws of the jurisdiction where the accident occurred, at the time of the accident.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of any narcotic at the time of an accident. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a physician.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.

This insurance does not apply to any accident, accidental bodily injury or loss when:

- The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss, or
- There is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

Additional Basic AD&D Benefits

Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days of the accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within the first 30 days following the accident, the Basic AD&D plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% payment of the loss-of-life benefit whichever is earlier. The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal sum amount is paid in full
- The date of recovery or death

If you die within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Psychological Therapy Expense

The Basic AD&D plan pays a benefit to you if a physician determines the need for you to have psychological therapy after you have suffered a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 1% of the principal sum to a maximum of $30,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Basic AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverage.

Rehabilitation Expense

The Basic AD&D plan pays a benefit to you if you suffer a loss covered under the plan which prevents you from performing all the duties of your regular occupation and requires you to obtain rehabilitation, as determined by a physician approved by Chubb.

The benefit pays for Reasonable and Customary rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 1% of the principal sum to a maximum of $30,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Basic AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverage.

Seat Belt

If you die as the result of a private passenger automobile accident and you were wearing a seat belt at the time, the Basic AD&D plan will pay an additional benefit of 10% of your principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- You were an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer's instructions.

The seat belt benefit is payable in addition to any other applicable benefit amounts under your Basic AD&D insurance coverages.

Definition:

Accidental Bodily Injury means bodily injury, which is:
— Accidental;
— The direct cause of a loss; and
— Occurs while a person is insured under the policy issued by Chubb under the Basic AD&D plan, which is in force.

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:
— Osgood-Schlatter's disease;
— Bursitis;
— Chondromalacia;
— Shin splints;
— Stress fractures;
— Tendinitis; and
— Carpal tunnel syndrome.

Filing a Basic AD&D Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the Baker Hughes Employee Benefits Department at our corporate office at 713-439-8600 or 1-800-229-7447 and request the forms required to initiate a claim for benefits. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Incorporated
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, TX 77210-4740
Phone: 713-439-8600 or 1-800-229-7447

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Chubb. After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Basic AD&D plan are fully-insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of Baker Hughes receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Basic AD&D plan within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the Basic AD&D plan. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send it to the following address:

Chubb Group of Insurance Companies
Claims Service Center 600 Independence Parkway
P.O. Box 4700
Chesapeake, VA 23327-4700

Upon receipt of the claimant's request, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records and other information relevant to the claimant's claim for benefits;
- A statement of the right to sue in federal court under Section 502(a) of ERISA;
- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- Explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Basic AD&D plan after two years from the date the Basic AD&D plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Basic AD&D plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Basic AD&D policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- You spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

When Does Coverage End?

Your coverage under the Basic AD&D plan will end if:

- Your employment ends
- The plan terminates
- You are no longer eligible

Conversion of Coverage

If your coverage is terminated for any reason, other than termination of the policy, your insurance may be converted to an individual policy up to the amount for which you are insured, subject to a minimum of $50,000 and a maximum of $100,000, whichever is less. To take advantage of the conversion of coverage, you must make an application and submit the required premium within 90 days following the date your insurance terminates.

Coverage will not be in effect after the date your insurance terminates until your application for conversion is received. The cost of the converted policy will be based upon the commercial insurance company's individual policy rates in effect at the time of application. For more information about conversion of AD&D benefits call 1-877-297-4225.

Voluntary AD&D Insurance

Voluntary AD&D At-a-Glance

Type of Plan	Welfare plan providing Voluntary Accidental Death & Dismemberment insurance.
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer (must be actively at work).
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days of becoming eligible for coverage. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • You can make changes during Annual Enrollment or if you have a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Level	• You Only • You + Family • No Coverage
Coverage Options	**Employee Coverage:** You can choose from the following coverage amounts: • $25,000 • $50,000 • $100,000 • $150,000 • $200,000 • $250,000 Amounts in excess of $150,000 may not exceed 10x your annual benefits base pay. Your coverage amount is referred to as the principal sum by the insurance provider (and for purposes of this *Voluntary AD&D Insurance* section). **Employee + Family Coverage:** Based on the employee coverage levels above, if you elect family coverage, the spouse and children benefit is as follows: • Spouse only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse and children — 40% of employee coverage amount for your spouse and 10% of employee coverage amount up to $20,000 per child
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, or other pay premium. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

Your Voluntary Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance is a way to increase your family's financial security in the event of accidental death, dismemberment, paralysis, or other covered losses. This benefit can give you financial protection in addition to the protection you have through life insurance. Voluntary Accidental Death & Dismemberment coverage is provided under the Baker Hughes Incorporated Voluntary Accidental Death & Dismemberment program (the Voluntary AD&D plan).

IMPORTANT

If both you and your spouse work at Baker Hughes, you may:

- Choose to enroll yourself as the employee and your spouse as your dependent (or vice versa)
- Both choose to enroll in benefits as employees
- Eligible children may be enrolled as dependents of either you or your spouse, but not both.

What is the Difference Between Life and Voluntary Accidental Death & Dismemberment (AD&D) Insurance?

Both Life and AD&D insurance coverage help protect your family's financial security in the event of death. However, there are some basic differences between these plans.

- Both pay a benefit if you or a covered family member dies. However, AD&D only pays if the cause of death was accidental.
- AD&D premiums are lower because the incidence of an accidental death is much lower than that of death from natural causes.
- AD&D also pays benefits when an accident results in the loss of a limb, paralysis, or other covered losses.

Voluntary AD&D insurance should not be considered a substitute for life insurance; however, it can provide valuable additional protection, especially at younger ages when responsibilities are greatest and availability of funds is not.

Who Pays the Cost of the Voluntary AD&D Plan?

If you decide to enroll yourself, or yourself and your dependents, in the Voluntary AD&D plan, you'll pay the full cost through after-tax payroll deductions.

When Does Coverage Begin?

If you enroll within the specified time frame in Voluntary AD&D insurance coverage, your coverage begins on your first active day of work if you're a new hire or an existing employee transferring to a position with U.S. benefits, or the following January 1 if you enroll in this plan during the Annual Enrollment period.

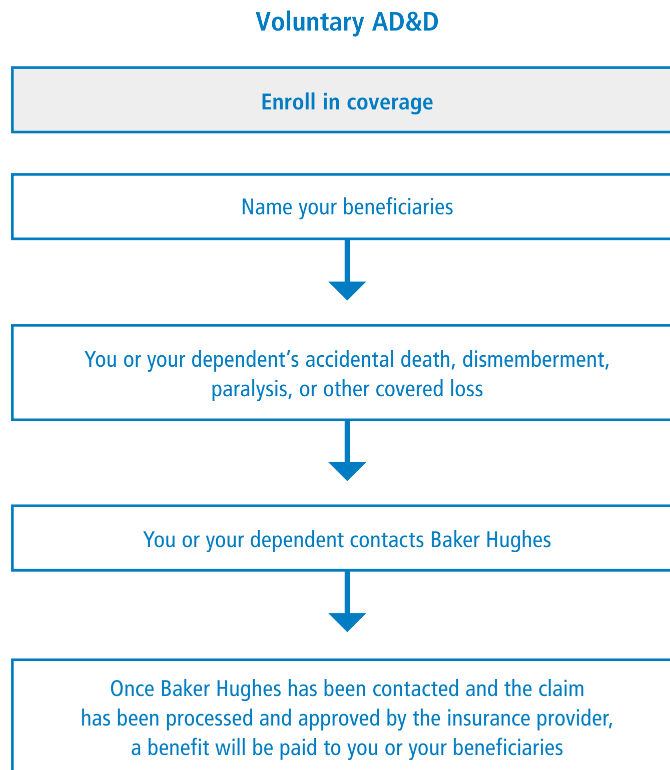
How Does Voluntary AD&D Insurance Work?

If you choose to participate in the Voluntary AD&D plan, the plan pays a benefit to you or your beneficiaries if you or a covered family member suffer accidental death, dismemberment, paralysis, or other covered losses.

Schedule of Benefits for Voluntary AD&D Insurance	
Employee Coverage	You can choose from the following coverage amounts (the principal sum): • $25,000 • $50,000 • $100,000 • $150,000 • $200,000 • $250,000 Amounts in excess of $150,000 may not exceed 10x your annual benefits base pay.
Employee + Family Coverage	Based on the employee coverage levels above, if you elect family coverage, the spouse and children benefit is as follows: • Spouse only — 50% of employee coverage amount • Children only — 15% of employee coverage amount, up to $20,000 per child • Spouse and children — 40% of employee coverage amount for your spouse and 10% of employee coverage amount up to $20,000 per child

Definition: Accident or Accidental means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the insured person is insured under the policy which is in force and is the direct cause of loss.

How Does the Voluntary AD&D Process Work?



Note: You're automatically the beneficiary for your dependent's loss-of-life benefits.

Naming a Beneficiary

You need to name a beneficiary for your Voluntary AD&D insurance benefit. You may name anyone as your beneficiary. If you wish to name more than one person, you may indicate the amount of your benefit you want each person to receive. You may also name secondary beneficiaries who will receive benefits in the event your primary beneficiaries die before they receive benefits.

If you do not name a beneficiary under the Voluntary AD&D plan, benefits will be paid to the beneficiary named under the Basic Life insurance plan.

Definition: A **beneficiary** is the person or persons or your estate that will receive a benefit when you die.

Note: When naming a beneficiary:

- You may name one or more beneficiaries. If you select more than one beneficiary, you'll need to choose the amount of benefits that are to be paid to each beneficiary.
- You may assign your rights to a benefit under the Voluntary AD&D plan called an absolute assignment, if you make the assignment in writing in a manner required by the insurance provider. You can make the assignment irrevocable. To make an absolute assignment, contact Chubb at 1-877-297-4225 for the required form. The assignment must be filed with the Baker Hughes Benefits Center and the insurance provider and provided at the time of the claim or at any other time required by the insurance provider.
- You're automatically the beneficiary for your dependents (spouse and children).

Remember…

It's a good idea to review your beneficiary information from time to time. If you have a status change, you may want to re-evaluate or update your beneficiary information.

What Losses are Covered by Voluntary AD&D Insurance?

The amount of your Voluntary AD&D plan benefit is based on the type of loss that you or your covered dependent suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one of the above-mentioned losses results from one accident, only the single largest benefit will be payable.

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, which when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Defining Loss

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by Chubb.

Loss of foot means complete severance, through or above the ankle joint, even if the foot is later reattached.

Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least three fingers and the thumb on the same hand, even if the hand, fingers and/or thumb are later reattached.

Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness can't be corrected by any aid or device, as determined by a physician.

Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.

Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.

Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints, of the thumb and index finger of the same hand as determined by a physician, even if one or both are later reattached.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than 365 days, as determined by a physician.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than 365 days, as determined by a physician.

Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than 365 days, as determined by a physician.

If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage at the time of the accident.

If your body is not found or recovered after one year from the date of the disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by this plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible, but in no event later than 365 days from the date of loss.

What Losses are not Covered by Voluntary AD&D Insurance?

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft, or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide, or intentionally self-inflicted injury.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to an accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, as defined by the laws of the jurisdiction where the accident occurred, at the time of the accident.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of any narcotic at the time of an accident. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a physician.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.

The Voluntary AD&D plan and the insurance provided under the plan does not apply to any accident, accidental bodily injury or when:

- The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss, or
- There is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

Additional Voluntary AD&D Benefits

Coma Coverage

If an accidental bodily injury causes a coma (as determined by a physician) within 90 days of the accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within 30 days following the accident, the Voluntary AD&D plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% payment of the loss-of-life benefit amount, whichever is earlier.

The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date of recovery or death
- The date the principal sum amount is paid in full

If you or a covered family member dies within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Child Care Expense

If you enroll in Voluntary AD&D insurance coverage under the plan and elect to cover your eligible dependents, the plan will provide child care expense up to 5% of the principal sum up to $12,500 for each eligible dependent child up to the $200,000 maximum benefit amount if you die accidentally while you and your eligible dependents are covered under the plan, and:

- Your dependent child is under the age of thirteen years for whom child care expenses are incurred within 365 days of your death, and
- You elected insurance under the plan for such dependent child, and the insurance is in effect on the date of the accident.

Child care expense means the actual incurred costs for the care and supervision of your dependent child who is less than age thirteen.

The Voluntary AD&D plan will reimburse child care expenses for each eligible dependent child. However, the total payment for each dependent child and all dependent children will not exceed the maximum benefit amount of $200,000 for child care expense, regardless of the number of dependent children for whom payment is made.

If, on the date of your death, while covered under the Voluntary AD&D plan, you have coverage under this plan for a dependent child, but do not have any dependent children eligible for child care expense payments, then the plan will pay the alternate benefit amount of $2,500. If the alternate benefit amount is paid, then the plan will not make any further payments for child care expense.

Child care expenses shall be paid to the person who incurs such expenses for the dependent children. The alternate benefit amount of $2,500 in lieu of child care expense reimbursement shall be paid to the named beneficiary.

In the event of a common accident, only one benefit amount for child care expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for child care expense is payable in addition to any other applicable benefit amounts payable under your Voluntary AD&D insurance coverage.

Education Expense

If you enroll in Voluntary AD&D insurance coverage and elect to cover your eligible dependents, the plan will reimburse education expense up to $5,000 annually for each eligible dependent up to the $200,000 maximum benefit amount if you die accidentally while you and your eligible dependents are covered under the plan, and:

- Your dependent is enrolled as a full-time student at an institution of higher learning on the date of your death; an institution of higher learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth grade; or
- Subsequently enrolls as a full-time student at an institution of higher learning within 730 days following the date of your death; and
- Incurs education expense.

Education expense payments for each eligible dependent child will be available. However, the total annual payment for each dependent child will not exceed the $5,000 annual benefit amount for education expense.

The education expense payment is limited to four consecutive years for each eligible dependent child. In no event will the total payment exceed the maximum benefit amount of $200,000.

If, on the date of your death while covered under the Voluntary AD&D plan, you have coverage for a dependent child, but do not have any dependent children eligible for education expense payments, the plan will pay the alternate benefit amount of $2,500. If the alternate benefit amount is paid, then no further payments for education expense will be paid.

In the event of a common accident, only one benefit amount for education expense shall be paid. This benefit amount will be determined using your coverage amount.

The benefit amount for education expense shall be paid to the person who incurs the expense. The alternate benefit amount in lieu of education expense reimbursement shall be paid to the named beneficiary.

The benefit amount for education expense is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Psychological Therapy Expense

The Voluntary AD&D plan pays a benefit if a physician determines the need for you or a covered family member to have psychological therapy after you have suffered a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 2% of the principal sum to a maximum of $5,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Voluntary AD&D plan coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Rehabilitation Expense

The Voluntary AD&D plan pays a benefit if you or your covered family member suffers a loss while covered under the plan if the loss prevents the insured person from performing all the duties of his or her regular occupation and requires rehabilitation, as determined by a physician approved by Chubb.

The benefit pays for Reasonable and Customary (R&C) rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 2% of the principal sum to a maximum of $5,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Voluntary AD&D insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Voluntary AD&D insurance coverage.

Seat Belt Coverage

If you or a covered family member dies as the result of a private passenger automobile accident and the insured person was wearing a seat belt at the time, the Voluntary AD&D plan will pay an additional benefit of 10% of the principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- The insured person was an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

If it cannot be determined if the insured person was wearing a seat belt at the time of the accident, a limited alternate benefit of $3,000 will be paid in addition to the accidental loss-of-life benefit.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer’s instructions.

Definition:

Accidental Bodily Injury means bodily injury, which is:
— Accidental;
— The direct cause of a loss; and
— Occurs while a person is insured under the policy issued by Chubb under the Voluntary AD&D plan, which is in force.

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:
— Osgood-Schlatter’s disease;
— Bursitis;
— Chondromalacia;
— Shin splints;
— Stress fractures;
— Tendinitis; and
— Carpal tunnel syndrome.

Spouse Employment Training Expense

The Voluntary AD&D plan will reimburse your spouse up to $5,000 for spouse employment training expense, if you die accidentally while you and your spouse are covered under the plan, and your surviving spouse incurs employment training expense within three years following the date of your death.

Spouse employment training expense means the actual costs incurred by a spouse for tuition, fees, room and board billed by an institution of higher learning. These costs must be incurred by your spouse to attend an institution of higher learning for the purpose of obtaining or refreshing skills needed for employment.

An institution of higher learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12th) grade. Spouse employment training expense also means costs for required books or course supplies.

The benefit amount for spouse employment training expense will be paid to your spouse who incurs the expense. The benefit amount for spouse employment training expense is payable in addition to any other applicable benefit amounts under the Voluntary AD&D plan.

Filing a Voluntary AD&D Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the Baker Hughes Employee Benefits Department at our corporate office at 713-439-8600 or 1-800-229-7447 and notify us of the loss and request the forms required to initiate a claim for benefits. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Incorporated
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, TX 77210-4740
Phone: 713-439-8600 or 1-800-229-7447

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will forward the claim to Chubb. After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Voluntary AD&D plan are fully insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of Baker Hughes receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. The notice of extension will include the reason for the extension and the date when Chubb expects to rule on the claim, a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. It shall also specify a time frame, no less than 45 days, in which the necessary information must be provided by the claimant. When the time frame to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Voluntary AD&D plan within 45 days of the date on the notice, the plan may deny the claim. If this extension is made because the claimant must furnish additional information to complete the claim, the claimant will have at least 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant is required to provide to complete the claim and explanation of why it is needed; and
- An explanation of the plan's claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the claim.

Appealing the Denial of a Claim

The claimant or a duly authorized representative may appeal any denial of a claim for benefits under the Voluntary AD&D plan. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send it to the following address:

Chubb Group of Insurance Companies
Claims Service Center
600 Independence Parkway
P.O. Box 4700 Chesapeake, VA 23327-4700

Upon receipt of the claimant's request, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

All comments, documents, records, and other information submitted by the claimant or the claimant's authorized representative relating to the benefit claim will be taken into account during the appeal without regard to whether such information was submitted or considered in the initial determination regarding such benefit claim.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents, records, and other information relevant to the claimant's claim for benefits;
- A statement of the right to sue in federal court under Section 502(a) of ERISA;
- Any internal rule, guidelines, protocol or similar criterion that was relied on in making the adverse decision;
- Explanation of any scientific or clinical judgment made to determine medical necessity or experimental treatment or similar exclusion or limit applying the terms of the plan to the claimant's medical circumstances, if applicable; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the *Benefits Rights* section for more details. No such action may be filed against the Voluntary AD&D plan after two years from the date the Voluntary AD&D plan gives the claimant a final determination on the appeal. Also, no legal action may be brought if the claimant does not file a claim for a benefit under the Voluntary AD&D plan and seek timely review of a denial of that claim.

Payment of Benefits

After a claim is approved, the benefit amount payable under the Voluntary AD&D policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for your loss-of-life, will be paid to you. Benefits for loss-of-life will be paid to your beneficiaries. If you do not name a beneficiary, benefits will be paid to the beneficiary named under the Basic Life plan. If a beneficiary is not named under the Basic Life plan, or if your beneficiary is not living at the time of your death, benefits will be paid to the first surviving class in the following order:

- Your spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

When Does Coverage End?

Your coverage under the Voluntary AD&D plan will end if:

- Your employment ends
- You are no longer eligible; or
- The plan terminates

Conversion of Coverage

If your coverage is terminated for any reason, other than termination of the policy, your insurance and your dependent's insurance may be converted to individual policies up to the amount for which you are insured or $250,000, whichever is less. To take advantage of conversion of coverage, you must make an application and submit the required premium within 90 days following the date your insurance terminates.

Coverage will not be in effect after the date your insurance terminates until your application for conversion is received. The cost of the converted policy will be based upon the commercial insurance company's individual policy rates in effect at the time of application. For more information about conversion of Voluntary AD&D benefits call 1-877-297-4225.

Business Travel Accident Insurance Plan

Business Travel Accident Insurance Plan At-a-Glance

Type of Plan	Welfare plan that provides Business Travel Accident insurance for employees traveling on company business
Who Pays the Cost	Baker Hughes pays 100% of the cost of your business travel insurance.
Employee Eligibility	All employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	No enrollment necessary. You are automatically covered when traveling on business for Baker Hughes.
Coverage Options	• Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $3 million*). Your coverage amount is referred to as the principal sum by the insurance provider (and for purposes of this *Business Travel Accident insurance* section). • Maximum for spouse during relocation in connection with the relocation of the employee is $25,000. • Maximum for eligible dependent children during relocation in connection with the employee is $10,000.
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

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

Definition: Benefits Base Pay means your base salary including any before-tax contributions you make through the benefits program. It does not include any overtime, bonuses, commissions, or other pay premium. Your benefits base pay is determined in September of the prior year, or your date of hire, whichever is later.

Your Business Travel Accident Insurance

The Baker Hughes Incorporated Business Travel Accident program (the Business Travel Accident plan) is designed to provide you accident insurance when traveling on authorized Baker Hughes business. "Baker Hughes business" means all circumstances arising from or occurring while you are traveling on assignment by or at the direction of Baker Hughes, including relocation. Relocation means assignment to a new regular place of employment that is more than 50 miles from the prior place of employment.

What is the Cost of the Business Travel Accident Plan?

You do not contribute anything to receive Business Travel Accident insurance coverage. It is paid 100% by Baker Hughes.

When Does Coverage Begin?

Baker Hughes provides you with Business Travel Accident insurance coverage on the first day of active work. No enrollment is necessary. You must be traveling on authorized Baker Hughes business to receive a benefit.

How Does the Business Travel Accident Insurance Plan Work?

With the Business Travel Accident insurance plan, you have the following coverage:

Schedule of Benefits for Business Travel Accident Insurance	
Employee	Up to 5x annual benefits base pay rounded to the next higher $1,000 if not already a multiple thereof (minimum $50,000; maximum $3 million)
Spouse	Maximum for spouse during relocation in connection with the relocation of the employee is $25,000.
Dependent Children	Maximum for dependent children during relocation in connection with the employee is $10,000.

The coverage amount is referred to as the principal sum by the insurance provider. If you suffer accidental death, dismemberment paralysis, or other covered losses while traveling on authorized Baker Hughes business or during relocation for a Baker Hughes assignment, the plan will pay a benefit that is a percentage of the principal sum, depending on the type of covered loss. The plan will also pay a benefit if your spouse or dependent children suffer accidental death, dismemberment, paralysis, or other covered losses.

Definition: **Accident or Accidental** means a sudden, unforeseen, and unexpected event happening by chance, independent of illness, disease, or other body malfunction or surgical treatment thereof, arises from a source external to an insured person, occurs while the insured person is insured under the policy issued by Chubb under the Business Travel Accident plan which is in force and is the direct cause of loss.

Note: The Business Travel Accident plan does not cover you while you're routinely commuting to/from work.

What Losses are Covered by Business Travel Accident Insurance?

The amount of your Business Travel Accident insurance benefit is based on the type of loss that you, your spouse, or dependent children suffer, as shown in the chart below. No benefit will be payable for a loss which is not shown in this chart:

Covered Loss	Benefit Payable
• Life • Speech and hearing • Speech and one of: hand, foot, or sight of one eye • Hearing and one of: hand, foot, or sight of one eye • Both hands, both feet, sight of both eyes, or a combination of any two of a hand, a foot, or sight of one eye • Quadriplegia	100% of principal sum
• Paraplegia	75% of principal sum
• One hand or one foot or sight of one eye • Speech or hearing • Hemiplegia	50% of principal sum
• Thumb and index finger of the same hand • Uniplegia	25% of principal sum

If more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $15 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

If a covered loss occurs as the result of war and more than one insured person suffers a loss in the same accident, the maximum limit of insurance is $10 million. If the benefit amounts, when totaled, exceed the maximum limit, the maximum limit will be divided proportionally among the recipients, based on each applicable benefit amount.

Note: The maximum benefit payable for one accident cannot exceed 100% of five times your benefits base pay or $3 million, whichever is less.

In the event you incur more than one loss in any one accident, only the single largest benefit is payable for all injuries.

Example:

If you lose a thumb and index finger on the same hand and hearing (in both ears), you would receive 50% of your principal sum.

Defining Loss

Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than 365 days as determined by a physician approved by the insurance provider.

Loss of foot means complete severance through or above the ankle joint, even if the foot is later reattached.

Loss of hand means complete severance, as determined by a physician, of at least four fingers at or above the metacarpal phalangeal joint on the same hand or at least 3 fingers and the thumb on the same hand, even if the fingers and/or thumb are later reattached.

Loss of hearing means permanent, irrecoverable, and total deafness, as determined by a physician, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a physician.

Loss of life means death, including clinical death, determined by the local governing medical authorities, where such death occurs within 365 days after an accident.

Loss of sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of sight in an eye means the permanent loss of vision in one eye. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a physician.

Loss of speech means the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices, as determined by a physician.

Loss of thumb and index finger means complete severance through the metacarpal phalangeal joints of the thumb and index finger of the same hand, even if one or both are later reattached.

Paraplegia means complete and irreversible loss of all motion and all practical use of both legs, that lasts longer than 365 days, as determined by a physician.

Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs, that lasts longer than 365 days, as determined by a physician.

Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg, that lasts longer than 365 days, as determined by a physician.

If you're unavoidably exposed to severe weather elements as a result of a covered accident, and you suffer a covered loss as a result of this exposure, benefits will be paid according to your level of coverage, at the time of the accident.

If your body is not found or recovered after one year from the date of your disappearance, stranding, sinking, or wrecking of the conveyance in which you were covered as an occupant at the time of the accident, you'll be presumed dead and benefits will be paid to your beneficiaries as defined by this plan.

Timing of Loss

The loss must occur within 365 days of the accident. Proof of loss must be provided as soon as reasonably possible, but in no event later than 365 days from the date of loss.

Exclusions

This insurance does not apply to any accident, accidental bodily injury, or loss caused by or resulting from, directly or indirectly, an insured person riding as a passenger in, or exiting any aircraft while acting or training as a pilot or crew member, except while acting or training as a pilot or crew member on an owned aircraft, leased aircraft or operated aircraft. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's emotional trauma, mental or physical illness, disease, pregnancy, childbirth or miscarriage, bacterial or viral infection, bodily malfunctions, or medical or surgical treatment thereof. This exclusion does not apply to an insured person's bacterial infection caused by an accident or by accidental consumption of a substance contaminated by bacteria.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person's suicide, attempted suicide, or intentionally self-inflicted injury.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, a declared or undeclared war in Canada, the United States, and the insured person's jurisdiction of permanent residence.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person participating in military action in the armed forces of any country or established international authority. However, this exclusion does not apply to the first 60 consecutive days of active military service with the armed forces of any country or established international authority.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being intoxicated, at the time of an accident. Intoxication is defined by the laws of the jurisdiction where such accident occurs.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, any occurrence while an insured person is incarcerated after conviction.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person being under the influence of a narcotic at the time of an accident. This exclusion does not apply if any narcotic or controlled substance is taken and used as prescribed by a physician.

This insurance does not apply to any accident, accidental bodily injury or loss caused by or resulting from, directly or indirectly, an insured person traveling or flying on any aircraft engaged in specialized aviation activities.

This insurance does not apply to any accident, accidental bodily injury or loss when:

- The United States of America has imposed any trade or economic sanctions prohibiting insurance of any accident, accidental bodily injury or loss, or
- There is any other legal prohibition against providing insurance of any accident, accidental bodily injury or loss.

Additional Business Travel Accident Benefits

Coma Coverage

If accidental bodily injury causes a coma (as determined by a physician) within 90 days of an accident, the coma continues for at least 30 consecutive days, and it causes confinement to a hospital or other licensed facility to receive medically necessary treatment for coma, prescribed and supervised by a physician within 30 days following the accident, the Business Travel Accident insurance plan pays a monthly benefit equal to 2% of the principal sum. The coma coverage benefit begins after the first 30 consecutive days of coma and continues until recovery, death, or 100% of the loss-of-life benefit amount, whichever is earlier. The monthly benefit will continue as long as the coma continues or until the earliest of:

- Failure to prove continuation of coma
- The date the principal benefit amount is paid in full
- The date of recovery or death

If you or a covered family member dies within 365 days after the accident, a lump sum will be paid equal to the principal sum, less any benefit amount for coma already paid.

If an insured person suffers multiple losses (including a coma) as the result of one accident, only the single largest benefit will be payable.

Psychological Therapy Expense

The Business Travel Accident insurance plan pays a benefit if a physician determines the need for you or a covered family member to have psychological therapy after suffering a loss covered under the plan due to accidental bodily injury. The benefit pays for Reasonable and Customary (R&C) psychological therapy charges incurred within two years from the date of loss, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The psychological therapy expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Rehabilitation Expense

The Business Travel Accident insurance plan pays a benefit if you or a covered family member suffers a loss covered under the plan which prevents the insured person from performing all the duties of his or her regular occupation and requires rehabilitation, as determined by a physician approved by the insurance provider.

The benefit pays for Reasonable and Customary (R&C) rehabilitation therapy charges incurred within two years from the date of the accidental bodily injury, up to 2% of the principal sum to a maximum of $10,000. However, the benefit amount will be offset by amounts already paid or payable by any other plan. Your Business Travel Accident insurance coverage will only pay the portion of eligible fees that are not reimbursable by other plans.

The rehabilitation expense benefit is payable in addition to any other applicable benefit amounts under your Business Travel Accident insurance coverage.

Seat Belt and Occupant Protection Device Coverage

If you or a covered family member dies as the result of a private passenger automobile accident and the insured person was wearing a seat belt at the time, the Business Travel Accident insurance plan will pay an additional benefit of 10% for seat belt and 10% for occupant protection device. The overall maximum additional benefit for both is 20% of the principal sum to a maximum of $50,000 as long as:

- The vehicle had seat belts that were properly secured at the time of the accident;
- The insured person was an occupant of the private passenger automobile;
- The vehicle was not being used for a race or contest of any type; and
- Seat belt use at the time of an accident was listed as part of an official report of such accident or certified, in writing, by an investigating police officer.

If it cannot be determined if the insured person was wearing a seat belt at the time of the accident, a limited alternate benefit of $2,000 will be paid in addition to the accidental loss-of-life benefit.

Seat belt means a lap or lap and shoulder restraint device or a child restraint device, which meets the published standards of the U.S. National Highway Transportation Safety Board and has been installed in accordance with the manufacturer’s instructions.

The plan will also pay a benefit for an occupant protection device if you or a covered family member is positioned in a seat protected by a properly deployed occupant protection device. An occupant protection device means either an air bag, which inflates for added protection to the head and chest areas, or any other personal safety restraint system other than a seat belt recognized by the U.S. National Highway Transportation Safety Board. The occupant protection device benefit will only be paid if a benefit is paid for seat belt coverage, other than the alternate benefit amount.

Verification of actual use of the seat belt and proper operation of the occupant protection device at the time of an accident must be part of an official report of such accident or be certified, in writing, by an investigating police officer.

Definition:

Accidental Bodily Injury means bodily injury, which is:
— Accidental;
— The direct cause of a loss; and
— Occurs while a person is insured under this policy, which is in force.

Accidental bodily injury does not include conditions caused by repetitive motion injuries, or cumulative trauma not a result of an accident, including, but not limited to:
— Osgood-Schlatter's disease;
— Bursitis;
— Chondromalacia;
— Shin splints;
— Stress fractures;
— Tendinitis; and
— Carpal tunnel syndrome.

Filing a Business Travel Accident Claim

To claim benefits, you or your beneficiary who is entitled to benefits (the claimant) must contact the Baker Hughes Employee Benefits Department at our corporate office at 713-439-8600 or 1-800-229-7447 and notify us of the loss and request the forms required to initiate a claim for benefits. Baker Hughes will mail the appropriate forms to the claimant.

To initiate the claims process, the claimant must complete the required forms and mail them along with any required documentation (i.e., certified death certificate) as soon as reasonably possible, but in no event later than 365 days from the date of loss, to the following address:

Baker Hughes Incorporated
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, TX 77210-4740
Phone: 713-439-8600 or 1-800-229-7447

The claimant should read the instructions on the forms carefully, answer all questions, and attach any required documentation when the completed forms are returned.

Once Baker Hughes has received the completed forms and all required documentation from the claimant, Baker Hughes will file the claim with Chubb Group of Insurance Companies (Chubb). After Chubb has processed the claim, the claimant will be notified by Chubb in writing if any benefits are denied in whole or in part, or if any additional information is required.

The benefits provided under the Business Travel Accident insurance plan are fully insured and payable solely by Chubb. Therefore, to receive a benefit, the claimant must provide the information required by Chubb.

Claims Denial Procedure

If all or part of the claim for benefits is denied, Chubb will notify the claimant in writing within 45 days of receiving the claim. Chubb may require more time to review the claim if necessary due to circumstances beyond its control. If this should happen, Chubb must notify the claimant in writing that its review period has been extended. Chubb may extend its review period twice for an additional period of up to 30 days for each extension. If this extension is made because the claimant must furnish additional information, the extension period will begin when the additional information is received. The claimant will have up to 45 days to furnish the requested information.

During the review period, Chubb may require additional information regarding the claim. If additional information is required, Chubb must notify the claimant in writing stating the information needed and explaining why it is needed.

If the claim is denied, in whole or part, Chubb must provide the claimant with a written notice of denial within the review period (including any extension periods) which must include the following information:

- The specific reasons for the denial;
- Reference to the pertinent plan provisions upon which the denial is based;
- A description of any additional information the claimant might be required to provide and an explanation of why it is needed; and
- An explanation of the plan's claim review procedure.

Appealing the Denial of a Claim

The claimant or an authorized representative may appeal any denial of a claim for benefits. The appeal request must be submitted in writing to Chubb within 180 days from the date the claimant receives the denial. If the claimant does not make this request within that time period, the claimant will have waived the right to appeal. To file a written appeal of a claim denial, send it to the following address:

Chubb Group of Insurance Companies
Claims Service Center
600 Independence Parkway
P.O. Box 4700 Chesapeake, VA 23327-4700

Upon receipt of the claimant's request, Chubb must conduct a prompt and complete review of the claim. This review will give no deference to the original claim determination and will be conducted by an individual or committee who had no part in the original claim decision. During that review, the claimant or authorized representative may submit documents or other information in support of the appeal.

Chubb will have 45 days from the date it receives the claimant's appeal request to review the claim and notify the claimant of its decision. Under special circumstances, Chubb may require more time to conduct its review of the appeal. If this occurs, Chubb must notify the claimant in writing that its review has been extended for an additional 45 days.

Notice of Benefit Decision on Appeal

Upon reaching a final decision, Chubb must notify the claimant or authorized representative, in writing, of the results of the review and, if an adverse determination, will include the following:

- Explanation of the specific reasons for the denial;
- A specific reference to pertinent plan provisions on which the denial was based;
- A statement regarding the claimant's right, upon request and free of charge, to reasonable access to review or copy pertinent documents; and
- A statement of the right to sue in federal court.

For disability claims only, it will also include:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision, and
- Explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical circumstances, if applicable.

Legal Action Following Appeal

After completing all mandatory appeal procedures, the claimant has the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA).

Payment of Benefits

After a claim is approved, the benefit amount payable under the Business Travel Accident policy will be paid to you or your beneficiaries in a lump sum if you suffer a covered loss within 365 days after the accident causing the loss.

All benefits, except for your loss-of-life, will be paid to you. Benefits for your loss-of-life will be paid to the beneficiary designated by you. If no such designation has been established, then the benefits will be paid to the first surviving class in the following order:

- You spouse; otherwise
- Your children, in equal shares; otherwise
- Your parents, in equal shares; otherwise
- Your siblings, in equal shares; otherwise
- Your estate.

This coverage only applies to those accepted prior to December 31, 2011.

Long-Term Care

Long-Term Care At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides protection for your assets and for you and your family against the costs associated with long-term care
Who Pays the Cost	You pay the full cost of coverage.
Contact	• my**Rewards**: go/myrewards (from the Baker Hughes Intranet) or go.bakerhughes.com/myrewards (from a personal computer) • The Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide)

What is Long-Term Care?

Long-Term Care coverage is designed to help protect you, your family, and your assets from the costs associated with Long-Term Care through affordable group rates. The plan provides resources to help pay for expenses such as nursing home care, informal care, and community-based professional care stemming from accident, illness, or aging.

The plan offers three different Daily Maximum Benefit (DMB) amounts along with two different Lifetime Maximum Benefit (LMB) amounts to satisfy your individual needs. The plan also has a built in Buy-up coverage to help keep coverage current with the costs of inflation, or you can choose to purchase (during enrollment) the automatic benefit increase which increases your DMB by 5% compounded annually each year.

This coverage only applies to those accepted prior to December 31, 2011.

Covered Expenses

Coverage includes expenses related to nursing home care, alternate care facility care, community-based professional care, a stay-at-home benefit, and informal care.

Community-based professional care includes:

- Home health care
- Adult day care
- Hospice care (not under stay-at-home benefit)
- Homemaker services by a licensed provider (not under stay-at-home benefit)

The stay-at-home benefit can be used to pay for the following expenses not ordinarily covered by individual policies:

- Care planning visit
- Home safety checks
- Home modification
- Provider care checks
- Emergency response system
- Hospice care
- Durable medical equipment
- Homemaker services by a licensed provider
- Caregiver training

Coverage Options

Daily Maximum Benefit (DMB)

Baker Hughes provides three different Daily Maximum Benefit (DMB) amounts to account for the various needs of our employees and their family members.

Daily Maximum Benefit	Option 1	Option 2	Option 3
Nursing Home	$100	$200	$300
Alternate Care Facility	$100	$200	$300
Community-Based Professional Care	$75	$150	$225
Informal Care	$25	$50	$75

Note: When deciding on an amount, you should consider the costs associated with living in different regions of the country.

This coverage only applies to those accepted prior to December 31, 2011.

Lifetime Maximum Benefit (LMB)

The Lifetime Maximum Benefit (LMB) amount is the amount of money payable for all covered services received while you are insured, except for the stay-at-home benefit which is funded separately. If you only use a portion of your DMB, then your LMB could extend beyond the 3 or 5 years.

Lifetime Maximum Benefit	Option 1	Option 2	Option 3
3 Years	$109,500	$219,000	$328,500
5 Years	$182,500	$365,000	$547,500

Yearly Inflation Costs

There are two different types of inflation options offered to account for rising costs from future increases to inflation:

- **Automatic Benefit Increase (ABI):** ABI automatically increases your benefit by 5% compounded annually to adjust for inflation with no annual increase in premium.
- **Future Purchase Option (FPO):** If you do not elect ABI, you will still have the option to increase your benefit amount every 3 years under the Future Purchase Option (FPO). The increase will not be less than 5% compounded annually over the 3-year period. If you elect to increase your amount during the FPO period, your original DMB will continue to be under your original rate, while the inflation portion will be charged based on your age at the time of the offer.

When Coverage Ends

If you become ineligible to participate in Long-Term Care through the Company, you will automatically receive a bill from John Hancock to continue your coverage. You will be responsible for coordinating premium payments directly with John Hancock should you choose to continue your coverage.

Existing Policy Holders (prior to 12/31/2011)

If you currently are insured and have any questions about Long-Term Care coverage, contact John Hancock directly at 1-888-389-6300.

Legal Benefit

The Legal Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan providing legal advice and assistance.
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	• Coverage begins on your date of hire or date of transfer (must be actively at work).
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Family • No Coverage
Contact	Legal Access Plans: 1-888-416-4313

Note: This benefit summary is intended to highlight the Legal Plan's benefits and should not be relied on to determine coverage. Please refer to the certificate of coverage issued upon enrollment for a more complete explanation of your coverage. If this benefit summary conflicts with the certificate of coverage, the certificate of coverage will prevail.

Overview

The Legal Plan provides benefits for both in-network and out-of-network assistance with your personal legal matters; from complex litigation, such as divorce and bankruptcy, to the more basic, such as drafting a lease agreement or updating a Will.

What is the Cost of the Plan?

If you decide to enroll yourself or your family in the Legal Plan, you'll pay the cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your coverage level.

When Does Coverage Begin?

If you elect the Legal Plan, coverage begins on the first active day of work if you're a new hire or an existing employee transferring to a position with U.S. benefits, or on January 1 after you elect it during Annual Enrollment.

What is Covered by the Legal Plan?

The chart below summarizes a few of the popular services offered under the plan, and the maximum benefits when you seek coverage in or out of network.

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Advice and Consultation			
Document Review (up to 6 pages)	Unlimited	100%	$60
Financial Helpline			N/A
Initial Law Office Consultation	One hour per calendar quarter		$60/consultation
Legal Helpline; Online Legal Access	Unlimited		N/A
Consumer Matters			
Document Preparation (e.g., simple deed, promissory note, consumer dispute correspondence, installment sales agreement, simple affidavit, lease agreement [tenant only], time share agreement)	One use per year (One of each document)	100%	$60/document
General Power of Attorney	One use per year		Employee – $40/document Family member – $60/document
Life Insurance Claims	Up to $2,000*		Up to $2,000*
Small Claims Court Representation	Up to 2 hours		$120
Will, Codicil, Trust and Probate			
Living Trust Document	One use per year	100%	$240
Living Will, Health Care Power of Attorney			$40
Probate of Small Estate	Up to 2 hours		$120
Will or Codicil (includes member, spouse, family member)	One per year per person		$90/document
Will (complex)		25% discount	Not covered
Residential Matters			
Landlord/Tenant Dispute	Up to $2,000*	100%	Up to $2,000*
Purchase of Primary Residence, including Document Preparation and Closing	One per year		$420
Refinancing Primary Residence			$150
Sale of Primary Residence			$240

*Subject to managed case rules

Benefit	Frequency or Maximum	In-Network	Out-of-Network
Financial Matters			
Bankruptcy Chapter 7 or 13	Up to defined in-network or out-of-network maximums	Up to $750*	Up to $660*
Debt Collection Defense			
• Pre-litigation defense activities	One use per year	100%	$120
• Trial defense		Up to $700*	$480*
Identity Theft – Prevention/Recovery Assistance • Initial consultations with trained specialists (consultations can also be online) • Recovery document preparation/review by a local attorney • Personal ID recovery package	Four per year	100%	Not covered
Tax Audit Representation	Up to $2,000*		Up to $2,000*
Family Law			
Divorce/Separation – Uncontested	Up to 10 hours	100%	Divorce – $500 Separation – $200 Consent/default divorce – $300
Divorce – Contested	Up to $2,000*		Up to $2,000*
Guardianship/Conservatorship	One use per year		$400
Juvenile Court Proceedings			$375
Name Change			$200
Uncontested Government Agency Adoptions			$300
Uncontested Stepparent Adoptions			$300
Civil/Criminal Defense			
Civil Litigation Defense	One use per year/up to $2,000*	100%	Up to $2,000*
Criminal Defense			
• Administrative proceeding (regarding suspension or revocation of license)	One use per year	100%	$200
• Misdemeanor defense		Up to $2,000*	Up to $2,000*
Miscellaneous Law Office Services			
Miscellaneous Law Office Services	Unlimited	25% discount from fee	Not covered

*Subject to Managed Case Rules

Note: Do not rely on this chart alone. It merely summarizes your benefits. Call the Baker Hughes Benefits Center at 1-866-244-3539 or Legal Access Plans at 1-888-416-4313 for a more complete explanation of your coverage.

IMPORTANT

Plan coverage may not include supplemental fees such as filing fees, court fees, etc.

Elder Parent Coverage

Parents of the plan member and the member's spouse are eligible for certain benefits under the Legal Plan. The benefits specified below extend not only to the member's parents and the member's spouse's biological parents, but to their step-parents and adoptive parents as well.

Elder Parent Coverage includes:

- Legal Advisor Helpline – Advise and consultation with a plan attorney by toll-free telephone.
- Financial Helpline – Financial consultation by toll-free telephone.
- Simple Will preparation – One simple Will per eligible parent.
- Living Will preparation – One living Will per eligible parent.

Exclusions include: any employment or labor related matter; class action suits; any matter related to preparation or filing of tax returns; matters related to securities, trademarks, copyrights, or patents; business or commercial interests; and frivolous matters. A full listing of all exclusions is provided in the policy provided to each member.

Some costs may not be covered, such as: costs associated with covered legal services, including but not limited to, all fines, court costs, penalties, sanctions, expert witness fees, bonds, bail bonds, attorney fees, exhibits, deposition costs, filing fees, transcripts, postage, telephone, photocopying, recording fees, messengers, judgments, jury fees, court reporter fees, investigative costs, and all other incidental and out-of-pocket legal and litigation costs.

Contacting a Legal Plan Representative

Prior to receiving any legal services, you must first contact the Legal Plan call center. A Personal Access Specialist will match you to an available network attorney. You may choose to use a network attorney and receive the network benefits of the plan, or pay more when you go out-of-network. No matter your decision, you should contact Legal Plan prior to incurring any legal expenses.

When Does Coverage End?

Coverage in the Legal Plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The plan terminates
- You do not make the required contributions

If you are interested in continuing your coverage once your employment with Baker Hughes ends, contact Legal Access Plans directly.

When Coverage Ends

If you become ineligible to participate in Legal Access Plans coverage through the Company, you will receive a letter from Legal Access Plans to continue coverage outside of Baker Hughes. You must contact Legal Access Plans within 31 days from the date your coverage ended to elect to continue coverage.

Critical Illness Plan

Critical Illness Plan At-a-Glance

Type of Plan	Voluntary Welfare benefit plan that provides benefits for critical illness
Who Pays the Cost	You pay the full cost of coverage.
Employee Eligibility	Employees on U.S.-based payroll and U.S. expatriates who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer. Employee **must be actively at work** on the effective date. If the employee is not on active duty, the coverage will be effective on the day the employee returns to active duty.
Enrollment Period	• New hires and employees transferring to a position with U.S. benefits, within 31 days. If you do not enroll, you will not be able to obtain coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if you have a change in status. If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year.
Coverage Options	• You Only • You + Spouse • You + Children • You + Family
Benefit Amount Option	• $15,000 • $30,000
Maximum Benefit	Lifetime maximum benefit amount is 300% of the elected benefit amount.
Contact	MetLife: 1-800-438-6388

Note: The information represented in this Summary Plan Description merely summarizes your benefits. Please read the full disclosure document posted on my**Rewards** or call MetLife at 1-800-438-6388 for more details. If this benefit summary conflicts with the certificate of coverage issued upon enrollment, the certificate of coverage shall prevail.

Overview

Critical Illness insurance coverage provides a lump sum payment if the covered person is diagnosed with certain specified diseases for the first time after insurance takes effect, or if the covered person has certain specified surgeries for the first time after insurance takes effect.

Critical Illness insurance coverage helps offset expenses not reimbursed by other types of insurance such as copays, deductibles, mortgage payments, child care and other household expenses. This supplemental insurance option complements your existing medical and disability income insurance coverage by providing you with a lump-sum payment upon diagnosis of a covered illness.

Coverage is guaranteed provided the employee is actively at work on the coverage effective date. If the employee is not on active duty, the coverage will be effective on the day the employee returns to active duty.

Benefits for covered conditions

Covered Condition	Initial Benefit	Recurrence Benefit
Alzheimer's Disease	100% of benefit amount	None
Coronary Artery Bypass Graft	100% of benefit amount	50% of benefit amount
Full Benefit Cancer	100% of benefit amount	50% of benefit amount
Partial Benefit Cancer	25% of benefit amount	12.5% of benefit amount
Heart Attack	100% of benefit amount	50% of benefit amount
Kidney Failure	100% of benefit amount	None
Stroke	100% of benefit amount	50% of benefit amount
Listed Conditions	25% of benefit amount	None

Listed Condition or Listed Conditions mean any of the following diseases:

- Addison's disease (adrenal hypofunction)
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebrospinal meningitis (bacterial)
- Cerebral palsy
- Cystic fibrosis
- Diphtheria
- Encephalitis
- Huntington's disease (Huntington's chorea)
- Legionnaire's disease
- Malaria
- Multiple sclerosis (definitive diagnosis)
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle cell anemia (excluding sickle cell trait)
- Systemic lupus erythematosus (SLE)
- Systemic sclerosis (scleroderma)
- Tetanus
- Tuberculosis

Critical Illness example:

Say you enroll in the $15,000 coverage and you or a covered dependent has a heart attack.
If you are enrolled in the Personal Choice Plus plan:

Critical Illness	Benefit Impact
Your estimated out-of-pocket costs (deductible, coinsurance) would be	$6,500
The Critical Illness plan would pay an Initial Benefit of	$15,000
If the same person had another heart attack, the Recurrence Benefit would be	$7,500

Health Screening Benefit

If a covered person takes one of the screening/prevention measures listed below while insured under this plan and after the insurance has been in effect for 30 days, MetLife will pay a $100 health screening benefit upon submission of proof that such measure was taken. MetLife will pay one health screening benefit per covered person per calendar year.

The screening/prevention measures for which a health screening benefit may be paid are:

- Blood test to determine total cholesterol
- Blood test to determine triglycerides
- Breast MRI
- Breast ultrasound
- Breast sonogram
- Carotid doppler
- Colonoscopy
- Digital Rectal Exam (DRE)
- Echocardiogram
- Electrocardiogram (EKG)
- Endoscopy
- Fasting blood glucose test
- Fasting plasma glucose test
- Flexible sigmoidoscopy
- Hemoccult stool specimen
- Mammogram
- Pap smears or thin prep pap test
- Prostate-specific antigen (PSA) test
- Serum cholesterol test to determine LDL and HDL levels
- Stress test on bicycle or treadmill
- Two hour post-load plasma glucose test
- Virtual colonoscopy

Payment of this benefit will not reduce the total benefit amount.

What is the Cost of the Plan?

If you decide to enroll in the Critical Illness plan, you'll pay the full cost of the plan. The cost you're responsible for is called the premium — a monthly amount determined by your age and coverage level.

When Does Coverage End?

Coverage in the Critical Illness plan will end on the earliest of the following dates:

- Your employment ends
- You are no longer eligible
- The plan terminates
- You do not make the required contributions

When Coverage Ends

If you become ineligible to participate in Critical Illness coverage through the Company, you will receive a letter from MetLife to continue coverage outside of the group plan at the same group premium rates. You must contact MetLife within 31 days from the date your coverage ended to elect to continue coverage.

Benefits Rights

Important Benefits Rights

Please read this section carefully. It contains information concerning the Baker Hughes Health & Welfare benefit plans described in this SPD, and it includes important facts and information about your rights as a plan participant.

This SPD is designed to inform you about benefits that Baker Hughes provides and how you may receive them. However, your participation in any of the benefit plans is not a guarantee of continued employment. The Company reserves the right to retain employees at its own discretion, regardless of benefits offered to them. Nothing in this SPD should be interpreted as a limitation of or restriction on that right. Also, in general, you cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit under any Baker Hughes Health & Welfare benefit plan.

Importance of a Current Address

Because benefit-related information is mailed to you, you must notify your local human resources representative of any change to your current address. Otherwise, you may not receive important information about your benefits.

If you provided a personal email address on my**Rewards** you will also need to update your email address should it change.

Remember, if you terminate employment and are entitled to benefits under a Baker Hughes Health & Welfare benefit plan, you must keep the Benefits Center informed of your current mailing address. If not, your benefits related information may not reach you.

Keeping Your Health Information Private

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Baker Hughes group health plans (the Health Plans) are required to protect the confidentiality of your private health information, and to provide individuals with notice of its legal duties and privacy practices with respect to that information.

The Health Plans, and Baker Hughes Incorporated (as Plan Sponsor), will not use or disclose health information protected by HIPAA, except when such use or disclosure is necessary for treatment, payment, Health Plan operations (collectively known as TPO), or as permitted or required by other state and federal law. All of the Health Plans' business associates (organizations who have a contract with Baker Hughes Incorporated 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 Health Plans will not use or disclose Protected Health Information for employment-related actions and decisions (or in connection with any other Company employee benefit plan), unless they have obtained your written authorization for such use and disclosure.

Protected Health Information (PHI) is "individually identifiable" health information, including genetic information, related to your physical or mental health or condition, services provided to you, or payments made for your care, which is created or received by a Health Plan, a health care clearinghouse, or a health care provider and that is transmitted by electronic media or maintained in an electronic format, or transmitted or maintained in any other form or medium. Under HIPAA, you have rights with respect to your Protected Health Information, including:

How the Health Plans may use your Protected Health Information

In order to manage your health effectively, the Health Plans are permitted by law to use and disclose your Protected Health Information in certain ways, without your consent or authorization, as follows:

For treatment. So that you receive the right treatment and care, your Protected Health Information may be used as providers coordinate or manage your health care services. For example, your information may be used when your physician consults with a specialist regarding your condition.

For payment. To make sure that claims are paid correctly and you receive the benefits you are entitled to, your Protected Health Information may be used and disclosed to determine plan eligibility and responsibility for coverage and benefits. For example, your information may be used when a Health Plan confers with another health plan to resolve a coordination of benefits issue.

For health care operations. To ensure quality and efficient plan operations, your Protected Health Information may be used in a number of ways, including Health Plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, when a Health Plan contacts you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Health Plan.

Your Protected Health Information may also be disclosed to certain designated employees of Baker Hughes Incorporated (the plan sponsor) in connection with these activities. Baker Hughes Incorporated has designated a limited number of employees of its affiliates who are the only ones permitted to access and use your Protected Health Information for plan operations and administration. When appropriate, there are two types of Protected Health Information that may be shared with other Baker Hughes Incorporated employees and its affiliates' employees:

- Enrollment/dis-enrollment data – information on whether you participate in the Health Plan or whether you have enrolled or dis-enrolled from a Plan option (e.g., HMO), and
- Summary health information – summaries of claims from which names and other identifying information have been removed for purposes of obtaining premium bids from health plans or modifying, amending, or terminating a Health Plan.

Baker Hughes Incorporated agrees not to use or disclose your Protected Health Information for any purposes not authorized by the HIPAA privacy regulations.

Permitted Uses and Disclosures

Federal regulations allow use and disclosure of your Protected Health Information by the Health Plans, without your authorization, for several additional purposes.

- Public health activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect, or domestic violence
- Oversight activities of a health oversight agency authorized by law
- Judicial and administrative proceedings
- Law enforcement activities
- To a coroner or medical examiner
- Research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Workers' Compensation or similar programs that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law

In Special Situations…
The Health Plans may disclose your Protected Health Information to a family member, relative, close family friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care. The Health Plans may also use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, the Health Plans will use sound judgment to determine what is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

The Health Plans are prohibited from using or disclosing your Protected Health Information when it is considered genetic information for underwriting purposes except to the extent that a Health Plan is an issuer of long-term care policies.

Uses of Protected Health Information Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described on the previous pages, the Health Plans are required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the group health plan has already undertaken an action in reliance upon your authorization.

- **Psychotherapy notes.** Save for certain limited exceptions, the Health Plans must obtain authorization for any use or disclosure of your psychotherapy notes.
- **Marketing.** The Health Plans must obtain authorization for all treatment and health care operations communications where it receives financial remuneration for making the communications from a third party whose product or service is being marketed.
- **Sale of Protected Health Information.** The Health Plans must obtain an authorization for any disclosure that is a sale of Protected Health Information. Such an authorization must state that the disclosure will result in remuneration to the Plan.

Your Rights Regarding Protected Health Information

You have certain rights regarding your Protected Health Information. To exercise the rights described below, you must send a written request to the Benefits Department listed at the end of this notice.

Access: You have the right to inspect and receive a copy of your Protected Health Information, with limited exception. You have the right to request a readily-producible form in which your Protected Health Information may be delivered. If the Health Plans use or maintain an electronic health record of your Protected Health Information, you may obtain a copy in an electronic format, and, if you choose, direct the Health Plans to transmit a copy to a party you designate. The Health Plans may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, the Health Plans may deny your request to see your Protected Health Information. You may be entitled to have a licensed health care professional review that denial.

Disclosure accounting: You have the right to request an accounting of certain disclosures made by the Health Plans during the six years prior to your request (however, you are not entitled to an accounting of disclosures made for payment, treatment, or health care operations, disclosures you authorized in writing, or other disclosures for which federal law does not require us to provide an accounting).

Restriction: You have the right to ask a Health Plan to restrict how your Protected Health Information is used and disclosed for treatment, payment, and health care operations. You may also ask the Health Plan to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. The Health Plan is not, however, required to agree to such requests. You have the right to restrict certain disclosures of Protected Health Information to the Health Plans when you pay out of pocket in full for health care items or services.

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). If the request is denied, you have the right to add a statement of your disagreement to your Protected Health Information.

Right to a paper copy of the notice: If you agree to receive notice of your rights under HIPAA electronically, you have the right to request and obtain a paper copy of those rights from the Health Plan.

Right to Notice of Breach of Unsecured Protected Health Information. You have the right to receive notice in the event that unsecured Protected Health Information identifying you has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Health Plan or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the plan, please contact:

Baker Hughes Incorporated
Privacy Officer – Corporate Benefits Department
P.O. Box 4740
Houston, Texas 77210-4740
Tel: 1-800-229-7447 or 1-713-439-8600 (worldwide)

The Health Plans will not retaliate against any individual for filing a complaint as described above.

The Health Plans maintain a privacy notice (i.e., Notice of Privacy Practices), which provides a complete description of your rights under HIPAA's privacy rules. The most recent version of the privacy notice is located on the Baker Hughes Intranet (https://inside.bakerhughes.com). The Health Plans are required to abide by the terms of the notice currently in place, which went into effect on January 1, 2015. The Health Plans reserve the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information that it maintains. The Health Plans will provide individuals with a revised notice on the Baker Hughes Intranet.

If you don't have Intranet access, contact your local human resources representative or 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 Health Plan and Baker Hughes Incorporated are treated as separate and independent entities that must exchange information to coordinate your plan coverage. For the purpose of obtaining summary health information from vendors and to report summary health information to Baker Hughes Incorporated, 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 Incorporated. PHI will only be shared with Baker Hughes Incorporated if Baker Hughes Incorporated has certified that it will:

- Not further use or disclose PHI other than as permitted, as required by the plan documents, or as required by law;
- Ensure that anyone or any organization to which Baker Hughes Incorporated provides PHI agrees to the same restrictions and conditions that apply to Baker Hughes Incorporated;
- Not further use or disclose PHI for employment actions or decisions;
- Not further use or disclose PHI in connection with any Company benefits;
- Report to the Health Plan any PHI use or disclosure that has not met HIPAA requirements;
- Make PHI available to an individual according to HIPAA's access requirements;
- Make PHI available for amendment, and incorporate amendments according to HIPAA's privacy rules;
- Make available any information required for an accounting of disclosures;
- Make available to the U.S. Department of Health and Human Services the Company's internal practices, books, and records relating to the use and disclosure of PHI from the group health plan to determine the plan's compliance with HIPAA;
- Return or destroy PHI received from the Health Plan for the purposes for which the disclosure was made when no longer needed; and
- Ensure an adequate separation between the Health Plan and the Company.

You May Obtain a Copy of the Notice of Privacy Practices

The Notice of Privacy Practices for the Health Plans explains how the plans use and disclose the Protected Health Information of individuals covered by the plan. Baker Hughes has previously provided you with a copy of that notice. The Health Plans are required by HIPAA to periodically advise you of the availability of the Notice of Privacy Practices adopted by the Health Plans and how to obtain a copy. The most recent version of the Notice of Privacy Practices is located on the Baker Hughes Intranet (https://inside.bakerhughes.com). If you don't have Intranet access, contact your local human resources representative to obtain the privacy notice or the Baker Hughes Incorporated privacy officer:

Baker Hughes Incorporated
Privacy Officer – Corporate Benefits Department
P.O. Box 4740
Houston, Texas 77210-4740
Tel: 1-800-229-7447 or 1-713-439-8600 (worldwide)

Special Enrollment Rights

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

Special Enrollment Due to Loss of Other Medical Coverage

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

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

Special Enrollment Due to Acquisition of a Dependent

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

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

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

Special Enrollment for Certain Changes in Medicaid or CHIP Coverage

If you or your eligible dependent are eligible to enroll in one of the group health plans described in this SPD but are not enrolled, you or your eligible dependent will be entitled to enroll for coverage under the plan if:

- You or your eligible dependent were covered under a Medicaid plan or under a state child health plan and that coverage was terminated because you or your eligible dependent lose eligibility for that coverage, or
- You or your eligible dependent become eligible under a Medicaid plan or under a state child health plan for assistance with your premium payments due under one of the group health plans described in this SPD.

However, you must request enrollment in the plan not later than 60 days after the date of termination of the Medicaid plan or state child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

Some states have a Medicaid plan or a child health plan (CHIP) that can help pay for employer-provided group health plan coverage like that provided by the group health plans described in this SPD. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health plan premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact that program to find out if premium assistance is available to you.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state's Medicaid or CHIP program to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for coverage under the plan.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical plan and the option offered under the Medical plan are in compliance with this law.

Under the Act, the Medical plan and the Claim Administrators that offer mastectomy coverage under the options offered under the plan must for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

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

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

Coverage for Maternity Hospital Stay

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

Reimbursement and Subrogation

If you or a dependent (or your or the dependent's guardian or estate) (each, a benefit recipient) receives a benefit payment from a Baker Hughes funded plan as a result of an injury or illness for which the benefit recipient has, may have, or asserts any claim or right to recovery against a third party (such as an insurance company or the employer of the person who caused the injury or some other person affiliated with them) then any payment under the plan for such benefit will only be made on the condition and with the understanding that the Baker Hughes funded plan will be reimbursed. For these purposes, a Baker Hughes funded plan means a Baker Hughes Health & Welfare benefit plan that was not provided or funded through an insurance policy or HMO or DMO.

The reimbursement will be made to the Baker Hughes funded plan or Claims Administrator of the plan by the benefit recipient, their legal counsel, or other person who holds a recovery payment received with respect to the claim or right of recovery to the extent of, but not exceeding, the total amount payable from any insurance policy or contract or any third party, plan, or fund as a result of judgment or settlement.

In addition to the right of reimbursement, the Baker Hughes funded plan has the right to enforce any claim or right to recovery that the benefit recipient has, may have, or asserts against a third party or parties in connection with an injury or illness when the plan pays benefits with respect to that injury or illness. This process of enforcing the rights of benefit recipients after payment of plan benefits is called subrogation.

Under the Baker Hughes funded plan, a benefit recipient and their legal counsel and other affiliates have a duty to cooperate fully with the plan, the Claims Administrator of the plan and Baker Hughes in asserting and protecting the plan's right of reimbursement and subrogation. All such persons also have a duty to sign and deliver original papers and documents, provide information, and take all other actions necessary for the plan or Claims Administrator to fully protect the plan's rights. Each benefit recipient agrees to provide all such necessary assistance as a condition of participation in a Baker Hughes funded plan, including cooperation and information submitted to Workers' Compensation, liability insurance carriers, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

Each Baker Hughes funded plan and the Claims Administrator for the plan may seek reimbursement for the reasonable value of services and benefits provided to a benefit recipient from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages, and
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as third parties).

Remember…

A participant Advocacy service is available through the Benefits Center. The Advocacy service assists you with access or claim issues that you have not been able to resolve after initial contact with the Claim Administrator's customer service. The participant Advocacy service is available for the following benefit plans:

- All Medical plans
- Prescription Drug plan
- Dental plan
- Vision plan
- Health Care Flexible Spending Account
- Health Savings Account
- Employee Assistance Program

Call the Benefits Center at 1-866-244-3539 (toll-free in the U.S.) or 1-847-883-0945 (worldwide) for more information.

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

- That the Baker Hughes funded plan will be reimbursed in full before any amounts (including attorneys fees incurred by the benefit recipient or affiliate) are deducted from the recovery proceeds for any reason, without regard to the sufficiency of the recovery;
- That the amount of the Baker Hughes funded plan's reimbursement will not be reduced by virtue of any characterization of the recovery proceeds in any settlement agreement or other agreement. For example, the Baker Hughes funded plan's right of recovery will not be negatively affected by virtue of the fact that a settlement agreement allocates a portion of the recovery proceeds to attorneys' fees, future medical costs, pain and suffering, a special needs trust, or otherwise;
- That the Baker Hughes funded plan and Claims Administrator will have a first priority lien on any and all recovery proceeds recovered until the plan has been reimbursed in full for any benefits paid under the plan with respect to the injury or illness, whether or not the benefit recipient is fully compensated for his or her loss;
- That regardless of whether or not you have been fully compensated, the Baker Hughes funded Plan and Claims Administrator may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Baker Hughes funded plan;
- That no doctrine, including the "make whole" doctrine or the "common fund" doctrine, will apply to qualify the Baker Hughes funded plan's right of reimbursement;
- That the benefit recipient will be responsible for all attorneys' fees incurred by him or her in seeking a recovery against a third party or parties and the Baker Hughes funded plan will have no liability with respect to such attorneys' fees;
- To assign to the Baker Hughes funded plan or Claims Administrator of the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits provided, plus reasonable costs of collection;
- That no action will be taken that will frustrate or impede the Baker Hughes funded plan's right of reimbursement or subrogation;
- To notify the Baker Hughes funded plan and Claims Administrator of the plan as soon as administratively practicable, in writing, of the existence of any potential third party liability with respect to any injury or illness for which the plan may pay benefits;
- To promptly notify the Baker Hughes funded plan and Claims Administrator of the plan of any developments of which he or she is aware that may impact the plan's reimbursement or subrogation rights;
- To not enter into any settlement or compromise agreement concerning recovery proceeds without the prior express approval of Baker Hughes Incorporated;
- To not dispose of any recovery proceeds before the Baker Hughes funded plan has been reimbursed in full;
- That any recovery proceeds held by the person will be deemed to be held in constructive trust for the benefit of the Baker Hughes funded plan until the plan's reimbursement rights with respect thereto have been satisfied in full. Any person who holds such recovery proceeds in a constructive trust for the benefit of the Baker Hughes Funded Plan will be subject to liability under ERISA if he or she disposes of such recovery proceeds prior to the satisfaction of the Baker Hughes funded plan's reimbursement rights;
- That any person who holds recovery proceeds in constructive trust for the Baker Hughes funded plan is a fiduciary with respect to the plan within the meaning of ERISA and will comply with the fiduciary standards of ERISA with respect to such recovery proceeds until the plan's reimbursement rights relating to such recovery proceeds have been satisfied in full;
- To cooperate in protecting the legal rights of the Baker Hughes funded plan or Claims Administrator of the plan to subrogation and reimbursement;

- That you will do nothing to prejudice the Baker Hughes funded plan or Claims Administrator rights under the plan, either before or after the need for services or benefits under the plan;
- That the Baker Hughes funded plan or Claims Administrator may take necessary and appropriate action to preserve their rights under the plan's subrogation provisions, including filing suit in your name;
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Baker Hughes funded plan or Claims Administrator may reasonably request from you; and
- If a benefit recipient or their affiliate described above fails to comply with a benefit recipient's duties and obligations with respect to the Baker Hughes funded plan's reimbursement and subrogation rights, the benefit recipient's benefits under the plan may, in the discretion of the Plan Administrator and as permitted by applicable law, be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to the benefit recipient (including his or her dependents or any persons claiming through them) until the plan has recovered an amount equal to the amount of recovery proceeds it would have been reimbursed had the plan's reimbursement rights been complied with in full or until the plan's subrogation provisions are complied with.

The coverage of any person under a Baker Hughes funded plan is conditioned upon the understanding that such person, on behalf of himself or herself and any person claiming through him or her, agrees to and will comply with all of the plan's reimbursement and subrogation rights.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the plan may pay the other plan the amount owed.

If the plan pays you more than it owes, you should pay the excess back promptly. Otherwise, Baker Hughes may recover the amount in the form of benefits payable under any Baker Hughes funded benefit plans, including this plan. Baker Hughes also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to the *Refund of Overpayments* section (see next page).

Refund of Overpayments

If the plan pays for benefits for expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, must make a refund to the plan if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the covered person, but all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person;
- All or some of the payment the plan made exceeded the benefits under the plan; or
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the covered person agrees to help the plan get the refund when requested.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount owed, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits for the covered person that are payable under the plan; (ii) future benefits that are payable to other covered persons under the plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the plan. The plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in certain of the Baker Hughes Health & Welfare plans, you're entitled to certain rights and protections under 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you'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 publications hotline of the Employee Benefits Security Administration.

COBRA

Tip! You and your dependents should take the time to read this section carefully to understand your COBRA rights. If you have any questions after reading this section, please contact my**Rewards** at go/myrewards from the Baker Hughes Intranet or at go.bakerhughes.com/myrewards from a personal computer. You may also call 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 *Leave of Absence* section) is not a qualifying event under COBRA. However, a COBRA qualifying event will occur on the last day of the FMLA leave if:

- You (or your dependent) are covered under the group health plan on the day before the FMLA leave begins;
- You do not return to employment with Baker Hughes at the end of the FMLA leave; and
- You (or your dependent) would otherwise qualify for COBRA coverage.

If the above requirements are met, COBRA coverage would continue for up to 18 months from the last day of your FMLA leave.

Type of Coverage Available Under COBRA

Continuation of coverage under the Medical, Dental, 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 children born to you or placed for adoption by you during the COBRA period may be enrolled immediately for the duration of the COBRA period, including any extended coverage in the event of multiple qualifying events.

COBRA Period

COBRA allows you to continue your coverage under a group health plan for up to the periods described below (other than the Health Care Flexible Spending Account to which special rules described in the section titled *Special COBRA Rules for the Health Care Flexible Spending Account* apply):

<table>
<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>
<tr><td>Your death</td><td>Your spouse and/or dependent children</td><td rowspan="4">36 months</td></tr>
<tr><td>Your divorce or legal separation</td><td>Your spouse and/or dependent children</td></tr>
<tr><td>Your children are no longer eligible for benefits under the group health plan</td><td>Your child</td></tr>
<tr><td>Your eligibility for Medicare benefits</td><td>Your spouse and/or dependent children</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 children</td><td>• 18 months generally
• 29 months, if you, your spouse, or your child covered under the group heath plan qualify for Social Security disability benefits due to a disability that existed the day of the qualifying event or began within the first 60 days of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage
• 36 months for a spouse and children, if another qualifying event (other than bankruptcy of your employer) occurs during the initial 18-month or 29-month coverage period, as applicable, the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred and notice of the second qualifying event is properly given by the spouse or dependent child to the group health Plan Administrator
• 36 months for the spouse and children, if you were entitled to receive Medicare within 18 months before your termination of employment or reduction of work hours</td></tr>
</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 pay the premium for your coverage in a timely manner;
- You become entitled to Medicare after making your COBRA coverage election;
- You become covered under another group health plan, 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 conditions 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.

Coverage Options besides COBRA Coverage

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the health insurance marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.healthcare.gov.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) generally prohibits group health plans from using the genetic information of plan participants to discriminate in providing coverage or benefits. The Baker Hughes group health plans are administered by Baker Hughes to comply with the applicable requirements of GINA.

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) is issued with respect to your child, that child will be eligible for coverage as required by the order.

A QMCSO is a judgment, decree, or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage for a child and relates to benefits under a group health plan, and satisfies all of the following:

1. The order recognizes or creates a child's right to receive group health 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 Time, 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 Health & Welfare benefit plans described in this SPD are administered and funded in different ways. Some of the plans are funded through insurance with participant and/or Company contributions as described in the separate sections. Others are funded wholly by participant and/or Company contributions.

Plan Administrator

Baker Hughes Incorporated, the Plan Administrator, has discretionary authority to interpret plan provisions, construe unclear terms, determine eligibility for benefits, and otherwise make all decisions and determinations regarding administration of the Baker Hughes Health & Welfare benefit plans described in this SPD. By participating in the 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
Attn: Employee Benefits Department
2929 Allen Parkway, Suite 2100
Houston, TX 77019-2118
Phone: 713-439-8600 or 1-800-229-7447

OR

Baker Hughes Incorporated
Attn: Employee Benefits Department
P.O. Box 4740
Houston, Texas 77210-4740
713-439-8600 or 1-800-229-7447

Note: The Short-Term Disability plan is not covered by ERISA.

Claims Administrator

For some of the Baker Hughes Health & Welfare benefit plans described in this SPD, Baker Hughes has delegated authority to third party administrators to administer benefit claims under the plan. The Claims Administrator for each benefit plan is listed on the following pages. Subject to Baker Hughes' overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret plan provisions and is the named fiduciary to determine benefit claims.

Cost of Administering the Plans

Baker Hughes intends to pay certain expenses of administering the Baker Hughes Health & Welfare benefit plans described in this SPD except for the Supplemental Life plan, Voluntary AD&D plan, Critical Illness insurance plan, the Legal Plan, and Long-Term Care plan, which are paid wholly by the employee.

Contributions to the Plans

Baker Hughes offers some welfare benefit 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 Baker Hughes Health & Welfare benefit plans described in this SPD are individually identified by name and number as shown in the following table. Each of those plans, other than the STD plan, are offered under the Baker Hughes Incorporated Welfare benefits plan (the Welfare benefits plan). The records of each plan are kept on a calendar-year basis.

Claims Administrators

Employer or Plan Administrator/ Sponsor	Baker Hughes Incorporated Attn: Employee Benefits Department 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
Plan Sponsor's Employer Identification Number (EIN)	76-0207995
Plan Name	Baker Hughes Incorporated Welfare benefits plan
Plan Number	501
Plan Year	The plan year begins January 1 and ends December 31.
Agent For Service of Legal Process	Baker Hughes Incorporated General Counsel P.O. Box 4740 Houston, TX 77210-4740 OR 2929 Allen Parkway, Suite 2100 Houston, TX 77019-2118
Plan	**Medical Plan**
Plan Name	Baker Hughes Incorporated Comprehensive Major Medical plan
Plan Type	Welfare plan providing comprehensive medical benefits
Type of Administration	Self insured
Plan Number	701368
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555
Plan	**Prescription Drug Plan**
Plan Name	Baker Hughes Incorporated Prescription Drug program
Plan Type	Welfare plan providing prescription medication benefits
Type of Administration	Self insured
Plan Number	1424
Benefit Administrator	CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Plan	Dental Plan
Plan Name	Baker Hughes Incorporated Group Dental Care plan
Plan Type	Welfare plan providing comprehensive dental benefits
Type of Administration	Self insured
Plan Number	3215512
Benefit Administrator	CIGNA 1111 Market Street Chattanooga, TN 37402

Plan	Vision Care Plan
Plan Name	Baker Hughes Incorporated Vision program
Plan Type	Welfare plan providing comprehensive vision benefits
Type of Administration	Fully insured
Plan Number	12210899
Benefit Administrator	Vision Service Plan 12222 Merit Drive, Suite 1410 Dallas, TX 75251

Plan	Flexible Spending Accounts
Plan Name	Baker Hughes Incorporated Health Care Flexible Spending Account plan and Baker Hughes Incorporated Dependent Day Care Flexible Spending Account plan
Plan Type	Welfare plan for the use of pre-tax money for health and dependent day care costs
Type of Administration	Self insured
Plan Number	705742
Benefit Administrator	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan	Health Savings Account
Plan Name	Health Savings Account
Plan Type	Welfare plan accumulating pre-tax money for medical expenses if you participate in an HDHP
Plan Number	701368
Benefit Administrator	Optum Bank P.O. Box 271629 Salt Lake City, UT 84127-1629
Plan	**Employee Assistance Program**
Plan Name	Baker Hughes Incorporated Employee Assistance Program
Plan Type	Welfare service providing referral services
Type of Administration	Fully insured
Plan Number	BAHC
Benefit Administrator	Magellan Health Services 14100 Magellan Plaza Maryland Heights, MO 63043
Plan	**Short-Term Disability**
Plan Type	Payroll practice providing income replacement
Type of Administration	Self insured
Plan Number	88110
Benefit Administrator	Sedgwick P.O. Box 14030 Lexington, KY 40512-4030
Plan	**Long-Term Disability**
Plan Name	Baker Hughes Incorporated Long-Term Disability plan
Plan Type	Welfare plan providing long-term disability benefits
Type of Administration	Fully insured
Plan Number	98046-1-G
Benefit Administrator	Metropolitan Life Insurance Company 1 Madison Avenue New York, NY 10010
Plan	**Basic and Supplemental Life insurance**
Plan Names	Baker Hughes Incorporated Life insurance program Baker Hughes Incorporated Supplemental Life insurance program
Plan Type	Welfare plan providing Basic and Supplemental Life insurance
Type of Administration	Fully insured
Plan Number	33800-G
Benefit Administrator	Minnesota Life 400 Robert Street North St. Paul, MN 55101-2098

Plan	Basic and Voluntary Accidental Death & Dismemberment
Plan Names	Baker Hughes Incorporated Accidental Death & Dismemberment program Baker Hughes Incorporated Voluntary Accidental Death & Dismemberment program
Plan Type	Welfare plan providing Basic and Voluntary Accidental Death & Dismemberment insurance
Type of Administration	Fully insured
Plan Number	6477-93-96
Benefit Administrator	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700
Plan	**Business Travel Accident Insurance**
Plan Name	Baker Hughes Incorporated Business Travel Accident program
Plan Type	Welfare plan providing Business Travel Accident insurance
Type of Administration	Fully insured
Plan Number	6477-59-66
Benefit Administrator	Chubb Group of Insurance Companies Claims Service Center 600 Independence Parkway P.O. Box 4700 Chesapeake, VA 23327-4700
Plan	**Long-Term Care**
Plan Name	Baker Hughes Incorporated Long-Term Disability plan
Plan Type	Voluntary benefit plan providing protection for your assets, yourself, and your family against the costs associated with long-term care
Type of Administration	Fully insured
Plan Number	471
Benefit Administrator	John Hancock Life Insurance Company John Hancock Place P.O. Box 111 Boston, MA 02117
Plan	**Legal Plan**
Plan Type	Voluntary plan providing legal advice and assistance
Plan Number	602482
Benefit Administrator	Legal Access Plans, LLC 5850 San Felipe, Suite 600 Houston, TX 77057
Plan	**Critical Illness**
Plan Type	Voluntary Welfare benefit plan that provides benefits for critical illness
Plan Number	0098046
Benefit Administrator	MetLife 500 Schoolhouse Road Johnstown, PA 15904

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 Claims Disputes

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

Exhaustion of Administrative Remedies
You may not file suit in court or seek arbitration concerning a claim for benefits until you have exhausted your claims and appeals procedures under the plan.

Venue for Litigation
Venue for litigation will be in Houston, Texas.

Controlling Law
Subject to the provisions of ERISA that may be applicable and provide to the contrary, the plan will be construed, regulated and administered under the laws of the state of Texas. All provisions of the plan will be construed, regulated and administered in accordance with the laws of Texas, and, to the extent applicable, by the laws of the United States.

Limitations on Legal Actions
You may not bring any action (whether litigation or arbitration) pertaining to a claim for benefits under the plan following the earlier of (1) 365 days after the final denial of your claim for benefits, or (2) the applicable limitations period under ERISA (which is the limitations period under Texas contract law).

Assignments of Benefits

No benefits under the plan may be assigned by you (except for assignments expressly authorized by the administrator) or may be subject to attachment by, interference with, or control of any of your creditors, or may be taken or reached by any legal or equitable process in satisfaction of any of your debts or liabilities prior to your actual receipt of benefits under the plan. Any attempted conveyance, transfer, assignment, mortgage, pledge, or encumbrance of plan benefits prior to payment to you will be void, whether that conveyance, transfer, assignment, mortgage, pledge, or encumbrance is intended to take place or become effective before or after any payment. The sponsor, the employers, the Administrative Committee, insurer, HMO or DMO will never under any circumstances be required to recognize any conveyance, transfer, assignment, mortgage, pledge or encumbrance by you of plan benefits, or to pay any money or thing of value to any of your creditors or assignees. (These prohibitions against the alienation of your plan benefits will not apply to assignments under Qualified Medical Support Orders.)

Payments to Minors and Incompetents

If any person entitled to receive any benefits under the plan is a minor or is determined by the Administrative Committee, in its sole discretion, to be incompetent, the Administrative Committee in its discretion may pay such benefits to the duly appointed guardian or conservator of such person or to any third party who is authorized (as determined in the discretion of the Administrative Committee) to receive any benefit under the plan for the account of such participant or dependent. Such payment will operate as a full discharge of all liabilities and obligations of the Administrative Committee and all other persons under the plan with respect to such benefits.

No Vested Right to Benefits

No person will have any right to, or interest in, any benefits provided under the plan, except as specifically provided under the plan.

Name and Address Changes

You are responsible for notifying the Administrative Committee of any change in your name or address. If any check in payment of a benefit hereunder (which was mailed to your last address of the payee as shown on the Administrative Committee's records) is returned unclaimed, further payments under the plan will be discontinued until the Administrative Committee directs otherwise.

Change in Marital Status

You must inform the plan as to any change in your marital status and until so informed the plan will be entitled to rely on your assertion of marital status as originally established.

Modifications of the Plan

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

No Oral Modifications
No person has the authority to orally modify the plan or this Summary Plan Description. So, neither you nor any person claiming through you may rely upon any oral representations of any person concerning the coverage or benefits provided under the plan, and no separate contract will be created with any person as a result of the oral statement.

Written Modifications
The plan is comprised of only the official plan document and this Summary Plan Description (to the extent not inconsistent with the official plan document, as amended in writing by the sponsor from time to time). You are not entitled to rely on any written document other than the official plan document and this Summary Plan Description (to the extent not inconsistent with the official plan document) with regard to the coverage or benefits provided under the plan. No separate contract will be created with the sponsor as a result of any other written document relating to welfare benefits (within the meaning of ERISA) unless the other written document is approved and signed by the director, Total Rewards, of the sponsor.

Plan's Right of Reimbursement

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

- **General.** If you (or your guardian or estate) receive any plan benefits as a result of an injury or illness for which you (or your guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the plan for such benefits will only be made on the condition and with the understanding that the plan will be reimbursed. Such reimbursement will be made by you (or your guardian or estate, legal counsel or other party who holds the recovery proceeds) to the extent of, but not exceeding, the total amount payable from (1) any policy or contract issued by any insurance company or carrier, or (2) any third party, plan, or fund as a result of judgment or settlement.

By electing coverage and accepting benefits under the plan, you, on behalf of yourself (or your guardian or estate or legal counsel or person claiming through him or her [collectively, "interested persons"]) are deemed to acknowledge and agree that the plan will be reimbursed in full before any amounts (including but not limited to attorneys' fees incurred by you or interested persons) are deducted from the recovery proceeds (the proceeds) for any reason, without regard to the sufficiency of the recovery. The amount of the plan's reimbursement will not be reduced by virtue of any characterization of the 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 proceeds to attorneys' fees, future medical costs, pain and suffering, a special needs trust, or otherwise.

The plan will have a first priority lien on any and all 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 participant or dependent is fully compensated for his or her loss. No doctrine, including but not limited to the "make whole" doctrine or the "common fund" doctrine, will apply to qualify the plan's right of reimbursement. You will be responsible for all attorneys' fees incurred by you in seeking a recovery against a third party or parties; the plan will have no liability with respect to such attorneys' fees.

- **Duty of cooperation.** You on behalf of yourself and each interested person are deemed to agree to cooperate fully with the plan and the employer in asserting and protecting the plan's right of reimbursement. You on behalf of yourself and each interested person are deemed to agree to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the plan's reimbursement right. You on behalf of yourself and each interested person are deemed to agree to refrain from taking any action that would frustrate or impede the plan's right of reimbursement.
- **Duty to notify the Administrative Committee of potential third party liability by third party.** You are deemed to agree on behalf of yourself and each interested person to notify the Administrative Committee 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.
- **Obligation to keep Administrative Committee apprised of developments.** You are deemed to agree on behalf of yourself and each interested person to promptly notify the Administrative Committee of any developments of which you are aware that may impact the plan's reimbursement rights.
- **No settlement or compromise without the assent of the employer**. You are deemed to agree on behalf of yourself (or your guardian or estate or legal counsel) to not enter into any settlement or compromise agreement concerning proceeds without the prior express approval of the employer.
- **No disposition of proceeds until plan has been reimbursed in full.** You are deemed to agree on behalf of yourself (or your guardian, estate, legal counsel or other representative) to not dispose of any proceeds before the plan has been reimbursed in full.

- **Constructive trust.** You are deemed to agree on behalf of yourself and each interested person that any proceeds held by any such 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 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 proceeds prior to the satisfaction of the plan's reimbursement rights. You are deemed to agree on behalf of yourself and each interested person that any person who holds proceeds in 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 proceeds until the plan's reimbursement rights relating to such proceeds have been satisfied in full.
- **Forfeiture, withholding or offset of benefits.** If you or an interested person fails to comply with the provisions of this requirement of this *Plan's Right of Reimbursement* section, at the Administrative Committee's discretion, your benefits under the plan may be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to you until the plan has recovered an amount equal to the amount of proceeds it would have been reimbursed had this section been complied with in full.
- **Coverage under the plan is conditioned upon agreements under this section.** The coverage of you under the plan is conditioned upon the understanding that you agree to and will comply with all of the terms of this section.

Plan's Right of Subrogation

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan you agree to the following provisions.

- **General.** If you (or your guardian or estate) receive any plan benefits as a result of an injury or illness for which you (or your guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the plan for such benefits will only be made on the condition and with the understanding that the plan will be subrogated to, and may enforce your rights against the third party or parties in connection with such illness or injury. The plan's rights specified in this *Plan's Right of Subrogation* section are in addition to, not in lieu of the plan's rights specified in the *Plan's Right of Reimbursement* section.
- **Duty of Cooperation.** You on behalf of yourself and each interested person are deemed to agree to cooperate fully with the plan and the employer in asserting and protecting the plan's right of subrogation. You, on behalf of yourself and each interested person, are deemed to agree to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the plan's subrogation right. You, on behalf of yourself and each interested person, are deemed to agree to refrain from taking any action that would frustrate or impede the plan's right of subrogation.
- **Obligation to keep Administrative Committee apprised of developments.** You, on behalf of yourself and each interested person, are deemed to agree to promptly notify the Administrative Committee of any developments of which you are aware that may impact the plan's subrogation rights.
- **Forfeiture, withholding or offset of benefits.** If you or an interested person fail to comply with the requirements of this section, at the Administrative Committee's discretion, your benefits under the plan may be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to you until the provisions of this section are complied with.
- **Coverage under the plan conditioned upon agreements under this section.** Your coverage under the plan is conditioned upon the understanding that you agree to and will comply with all of the terms of this section.

Benefit Administrators and Claims Payers

Baker Hughes Incorporated has contracts with Benefit Administrators and claims payers. These providers are independent contractors and Baker Hughes is not responsible for any acts or omissions of any of these organizations, their providers, or independent contractors, including the quality of goods and services provided through any health care provider or program.

Plan Amendment or Termination

Although Baker Hughes Incorporated intends to continue the Baker Hughes Health & Welfare benefit plans described in this SPD, Baker Hughes Incorporated reserves the right to terminate or amend all or any of those plans in whole or in part at any time and for any reason. Baker Hughes Incorporated's right to amend or terminate those plans includes, but is not limited to, changes in the eligibility requirements, premiums, or other payments charged, benefits provided, and termination of all or a portion of the coverage provided under the plan. If a plan is so amended or terminated, you'll be subject to all the changes effective as a result of such amendment or termination, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination.

Baker Hughes Incorporated reserves the right to modify, amend, or terminate a plan, in whole or in part, if changes in the law or other conditions make it necessary.

Glossary of Terms

Glossary of Terms

Term	Definition	Section
Accident	An unforeseen and unavoidable event resulting in an injury that is not due to any fault of the covered person, excluding any work-related injuries.	All plans
Actively at Work or Active Work	You are working at your normal work location or on assignment for the Company and you are performing the material and substantial duties of your Baker Hughes occupation.	Protection
Amendment	Any attached written description of additional or revised provisions or benefits to a plan. Amendments are subject to all conditions, limitations, and exclusions of the plan, except for those that are specifically amended.	Benefits Rights
Annual Enrollment Period	The period each year during the fall when a U.S.-payroll based full-time or benefits-eligible, part-time employee is eligible to change benefit coverage elections.	All plans
Appropriate and Regular Care	You are regularly visiting a physician as frequently as medically required to meet your basic health needs. The effect of the care should be of demonstrable medical value for your disabling conditions to effectively attain and/or maintain maximum medical improvement.	STD, LTD
Assisted Reproductive Technology	The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve pregnancy. Examples of such procedures are: • In Vitro Fertilization (IVF) • Gamete Intrafallopian Transfer (GIFT) • Pronuclear Stage Tubal Transfer (PROST) • Tubal Embryo Transfer (TET) • Zygote Intra Fallopian Transfer (ZIFT)	Medical
Autism Spectrum Disorders	A group of neurobiological disorders that includes autistic disorder, Rhett's syndrome, Asperger's disorder, childhood disintegrated disorder, and pervasive development disorders not otherwise specified.	Medical
Beneficiary	A person or estate named in writing by the participant to receive benefits provided by the plan if the participant dies. The designation must be on file with Baker Hughes Incorporated at the time of death to be effective.	Protection
Benefits	Your right to payment for services that are available under the plan. Your right to benefits is subject to the terms, conditions, limitations, and exclusions of the plan, including this SPD and any applicable amendments.	All plans
Benefits Base Pay	The amount that is determined in September of the prior year, or your date of hire, whichever is later for certain benefit calculation purposes. For disability, pay is frozen as of the day prior to the first day of disability.	All plans
Birthing or Birthing Center	A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests: • It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located, or • It meets all of the following requirements: — It is operated and equipped in accordance with any applicable state law. — It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity. — It has the ability to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders. — It is operated under the full-time supervision of a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Registered Graduate Nurse (R.N.). — It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications. — It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary. — It is expected to discharge or transfer patients within 24 hours following delivery. A birthing center that is part of a hospital, as defined herein, will be considered a birthing center for the purposes of this plan.	Medical

Term	Definition	Section
Brand Name Drug	Drugs manufactured under a registered trade name or trademark.	Prescription Drug
Care Coordination[SM]	A program provided by UnitedHealthcare designed to encourage an efficient system of care for covered persons by identifying and addressing possible unmet covered health care needs.	Medical
Center of Excellence	A facility or provider that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the plan to provide covered health services for the treatment of specified diseases or conditions. A Center of Excellence facility or provider may or may not be located within your geographic area. To be considered a Center of Excellence, a facility or provider must meet certain standards of excellence and have a proven track record of treating specified conditions.	Medical
Claims Administrator	The person designated by Baker Hughes Incorporated to administer claims under a plan described in this SPD.	All plans
COBRA	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.	Group health plans
Coinsurance	The percentage of eligible expenses shared between the participant and a plan. The coinsurance is applied to eligible expenses after the deductible or deductibles have been met, if applicable.	Medical, Dental, Prescription Drug
Company	Baker Hughes Incorporated and its affiliated companies that have adopted this plan on behalf of their employees.	All plans
Confinement	A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center resulting from an illness or injury diagnosed by a physician. Later stays will be considered part of the original confinement unless there was either complete recovery during the interim from the illness or injury causing the initial stay or the latter stay results from a cause or causes unrelated to the illness or injury causing the initial stay.	Medical
Contribution	The amount that the employee pays toward the cost of coverage to participate in a plan described in this SPD.	All plans
Coordination of Benefits	You and your dependents may have health coverage under a Baker Hughes provided plan and another plan. In such cases, subject to applicable law, coordination of benefit rules determine which plan is primary — meaning, which plan pays first and to what extent.	Health
Copay	A cost-sharing arrangement where you or your dependent pays a set amount to a provider for a specific service at the time the service is provided.	Medical, Prescription Drug, Vision
Covered Expenses	The items of expense for which benefits may be paid are called covered expenses.	Health
Covered Person	A person who is eligible for and enrolled in coverage under a Baker Hughes Health & Welfare plan described in this SPD upon satisfying the eligibility and participation requirements.	All plans
Custodial Care	Services that: • Are non-health related, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring, and ambulating); or • Are health-related that do not seek to cure, or that are provided during periods when the medical condition of the patient who requires the services is not changing; or • Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.	Medical
Date of Disability	The date that it is determined your injury or sickness impairs your ability to perform your regular occupation.	STD, LTD
Deductible	The amount you must pay for covered expenses in a plan year before the plan begins to share in the cost of covered services.	Medical, Prescription Drug, Dental

Term	Definition	Section
Dental Care Provider	A dentist, dental hygienist, physician, practitioner, or nurse whose profession is the care of teeth and surrounding tissue.	Dental
Dentist	A person acting within the scope of his or her license, holding the degree of Physician of Medicine (M.D.), Physician of Dental Surgery (D.D.S.), or Physician of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state of jurisdiction where the services are rendered.	Dental
Disability Earnings	The benefit amount you earn after a disability begins. It does not include Social Security, sick pay, salary continuance payments, or any other disability payment you receive as a result of your disability. Any lump-sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.	STD, LTD
Durable Medical Equipment	Medical equipment that is all of the following: • Can withstand repeated use • Is not disposable • Is used to serve a medical purpose • Is generally not useful to a person in the absence of a sickness, injury, or their symptoms • Is appropriate for use in the home	Medical
EAP	The Employee Assistance Program (EAP). This is a confidential counseling, legal and financial consultation and referral service available to all employees and their household members. The program is accessed by a dedicated toll-free number or website and puts employees in touch with master's-degreed counselors (up to 8 sessions per issue or concern, per year) and legal services (telephone consultation and referral only) at no charge.	EAP
Eligible Expenses	Baker Hughes has delegated to UHC the discretion and authority to decide whether a treatment or supply is a covered health service and how Eligible Expenses will be determined and otherwise covered under the Medical plan. UHC determines Eligible Expenses for covered health services as outlined below. Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines. UHC develops these guidelines at its discretion, after evaluating and validating all provider billings using one or more of the following methodologies: • As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS); • As reported by generally recognized professionals or publications; • As used for Medicare; and • As determined by medical staff and outside medical consultants pursuant to any other appropriate source or determination that UHC accepts. **For network benefits**, Eligible Expenses are based on the following: • When covered health services are received from a network provider, Eligible Expenses are UHC's contracted fees with that provider. • When covered health services are received from a non-network provider as a result of an emergency or as arranged by UHC, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law. **For non-network benefits**, Eligible Expenses are determined based on: • Negotiated rates agreed to by the non-network provider and either UHC or one of UHC's vendors, affiliates or subcontractors, at UHC's discretion, or • If rates have not been negotiated, then one of the following amounts: — For covered health services other than pharmaceutical products, Eligible Expenses are determined based on available data sources of competitive fees in that geographic area; — For mental health services and substance use disorder services, the Eligible Expense will be reduced by 25% for covered health services provided by a psychologist and by 35% for covered health services provided by a masters level counselor; — When covered health services are pharmaceutical products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market; or — When a rate is not published by CMS for the service, UHC uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UHC will use a comparable scale. UHC and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to the UHC website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.	Medical

Term	Definition	Section
Elimination Period	A period of continuous disability that must be satisfied before you will begin to receive disability benefit payments.	STD, LTD
Emergency or True Emergency	A serious medical condition or symptom resulting from injury, sickness, or mental illness that both: • Arises suddenly, and • In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.	All plans
ERISA	Employee Retirement Income Security Act of 1974, as amended.	All plans, except STD
Excluded Drug	These are drugs that are not covered under the formulary due to more cost-effective and clinically appropriate products out in the market. If you choose to utilize these products, you would be responsible for 100% of the cost of the medication.	Prescription Drug
Experimental and/or Investigational Services	Medical, surgical, diagnostic, psychiatric, 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 that 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.	Medical, Prescription Drug, Dental, Vision
FMLA	Family and Medical Leave Act of 1993. The act generally requires employers with 50 or more employees to provide eligible employees with up to 12 weeks of unpaid, job-protected leave each year for births, adoptions, foster care placement, illness, and injury.	All plans
Full-time Student	A person who is enrolled in and attending, full time, a recognized course of study or training at one of the following: • An accredited high school; • An accredited college or university; or • A licensed vocational school, technical school, beautician school, automotive school, or similar training school. Full-time student status is determined in accordance with the standards set forth by the educational institution.	All plans
Gainful Employment or Gainfully Employed	The performance of any occupation for wages, remuneration, or profit, for which you are qualified by education, training, or experience on a full-time or part-time basis, for the employer or another employer, and which Baker Hughes approves and for which Baker Hughes reserves the right to modify approval in the future.	STD, LTD
Generic Drug	A drug that is no longer under patent protection and may be a lower-cost equivalent of a brand medication. The U.S. Food and Drug Administration (FDA) requires that all generic drugs have the same active ingredients, strength and dosage form as the brand name equivalents.	Prescription Drug
Gross LTD Monthly Benefit	The benefit shown in the *Schedule of Benefits* that applies to you.	STD, LTD
Health & Welfare Plans	The Baker Hughes Health & Welfare benefit plans described in this SPD.	All plans

Term	Definition	Section
Health Care Provider	A physician, practitioner, nurse, hospital, or specialized facility.	Medical
Home Health Care Agency	A program or organization authorized by law to provide health care services in the home.	Medical
Hospice Care Team	A group of trained medical personnel, homemakers, and counselors.	Medical
Hospital or Health Care Facility	An institution, operated as required by law, that both: • Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of physicians. • Has 24-hour nursing services. A hospital is not primarily a place for rest, custodial care, or care of the aged, and is not a nursing home, convalescent home, or similar institution.	Medical, STD, LTD
Illness	Physical sickness, disease, or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.	Medical
Indexed Covered Earnings	For the first 12 months disability benefits are payable, indexed covered earnings are equal to covered earnings. After that period, indexed covered earnings will be an employee's covered earnings plus an increase applied on each anniversary of the date monthly benefits became payable. The amount of each increase will be the lesser of 10% of the employee's indexed covered earnings during the preceding year of disability, or the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.	LTD
Injury	Bodily damage other than sickness, including all related conditions and recurrent symptoms.	Medical, STD, LTD, AD&D, BTA
Inpatient	An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility, or inpatient rehabilitation facility.	Medical
Inpatient Rehabilitation Facility	A hospital (or a special unit of a hospital that is designated as an inpatient rehabilitation facility) that provides physical therapy, occupational therapy, and/or speech therapy on an inpatient basis, as authorized by law.	Medical
Intensive Care	A service that is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance prescribed by the attending physician.	Medical
Intensive Outpatient Treatment	A structured outpatient mental health or substance use disorder treatment program that may be free-standing or hospital-based and provides services for at least three hours per day, two or more days per week.	Medical
Intermediate Care	Mental health or substance use treatment that encompasses the following: • Care at a residential treatment facility; • Care at a partial hospitalization/day treatment program; or • Care through an intensive outpatient treatment program.	Medical
Leave of Absence	An authorized absence from an employee's normal work schedule.	All plans
Lifetime	The period of time during which covered participants may receive certain benefits of the plan (or any prior or successor plan of the plan sponsor).	All plans

Term	Definition	Section
Material and Substantial Duties	The necessary functions of your regular occupation that cannot be reasonably omitted or altered.	STD, LTD
Maximum Benefits	The maximum amount that Baker Hughes will pay for benefits during the entire period of time that you are enrolled under the plan, or any other plan of the plan sponsor.	All plans
Maximum Period Payable	As shown in the *Schedule of Benefits*, the longest period of time that Baker Hughes will make payments to you for any one period of disability.	STD, LTD
Medicare	Parts A, B, C, and D of the insurance program established by Title XVIII of the United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.	Health
Mental Health Services	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.	Medical
Mental Illness	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.	Medical, STD
Military Service	Service in the Army, Navy, Air Force, Marine Corps, Coast Guard, or any other recognized branch of service pertaining to the military.	All plans
Monthly Benefit and Maximum Period Payable	That benefit and those periods shown in the *Schedule of Benefits* that apply to you.	LTD
Net LTD Monthly Benefit	Your gross Long-Term Disability monthly benefit less any deductible sources of income.	LTD
Network	When used to describe a provider of health care services, this means a provider has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to participate in the network. This does not include providers who have agreed to discount their services. A provider may enter into an agreement to provide only certain covered expenses, but not all covered expenses, or to be a network provider for only some of the plan's products. In this case, the provider will be a network provider for the health services and products included in the participation agreement, and a non-network provider for other health services and products. The participation status of providers is subject to change throughout the plan year.	Medical, Prescription Drug, Vision, Dental
Network Provider	A physician, hospital, pharmacy, or other health care provider who participates in the network and has agreed to provide services to plan participants pursuant to a negotiated arrangement. A list of the network providers is available through all Baker Hughes-sponsored plans.	Health
Non-Network Provider	A physician, hospital, or other health care provider that does not have a network agreement in effect with the Claims Administrator at the time services are rendered.	Health
Non-Preferred Drug	A brand drug that is not on the CVS/caremark Performance Drug List and processes at a tier 3 copay/coinsurance. Generally speaking, these are higher-cost medications that have recently come to the market. In most cases, an alternative preferred medication (brand or generic) is available.	Prescription Drug
Nurse	A person holding the License of Registered Nurse (R.N.), Licensed Vocational Nurse, or Licensed Practical Nurse who is practicing within the scope of the license.	Health
Oral Surgery	Necessary procedures for surgery in the oral cavity, including pre-operative and post-operative care.	Dental

Term	Definition	Section
Organ and/or Tissue Procurement	All professional, facility, ancillary, transportation, and other services necessary to acquire a transplantable human organ or to procure bone marrow or stem cells including but not limited to: expenses associated with listing on a UNOS-approved waiting list; the surgical removal of a donor organ from a living person or a human cadaver; the storage and preservation of a donor organ; transportation expenses associated with procuring a human organ; and the harvesting or apheresis, cryopreservation, and storage of bone marrow or stem cells from a covered person or a related or unrelated donor, including any fees associated with locating an unrelated donor through the National Marrow Donor Program.	Medical
Other Plans	Any of the following plan types that provide health benefits or services for medical care or treatment: • Group policies or plans, whether insured or self-insured (this does not include school accident-type coverage); • Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group; • Group insurance and group subscriber contracts; • Uninsured arrangements of group coverage; • The medical benefits coverage in a group or individual automobile "no fault" and traditional automobile "fault" type contract; or • Medicare and other government benefits, except a state plan under Medicaid and except as mandated by federal law.	All plans
Out-of-Area	Refers to a geographic area where the Medical plan does not offer sufficient network access to contracted providers. Eligibility for out-of-area plans is determined by the employee's home zip/postal code on file with the Company.	Medical
Out-of-Pocket Maximum	The maximum amount of network coinsurance you pay each plan year for covered services. Once you reach the out-of-pocket maximum, benefits are payable at 100% of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any of the following: • Non-network expenses (except for UHC Out-of-Area plans; non-network coinsurance applies) • Deductibles • Any charges for non-covered expenses • Charges that exceed eligible expenses • Amounts above Reasonable and Customary limits • Copays	Medical, Prescription Drug
Outpatient	A covered person will be considered to be an outpatient if he or she is treated at: • A hospital as other than an inpatient; • A physician's office, laboratory, or x-ray facility; or • An ambulatory surgical facility and the stay is less than 24 consecutive hours.	Medical
Partial Hospitalization/ Day Treatment	A structured ambulatory program that may be a free-standing or hospital-based program and that provides services for at least 20 hours per week.	All plans
Physician	Any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is properly licensed and qualified by law. **Note:** Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that we describe a provider as a physician does not mean that benefits for services from that provider are available to you under the plan. A physician cannot be yourself or an immediate member of your family.	All plans
Placed for Adoption	The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.	General Information

Term	Definition	Section
Plan Administrator	Baker Hughes Incorporated or its designee	All plans
Plan Sponsor	Baker Hughes Incorporated	All plans
Plan Year	January 1 through December 31, the 12-month period of time on which the plan's records are maintained.	All plans
Preferred Drug	A brand drug that is on the CVS/caremark Performance Drug List and/or processes at a tier 2 copay/coinsurance. These drugs have been determined to be either more effective than or just as effective as another product in the same therapeutic class.	Prescription Drug
Pregnancy	Includes all of the following: • Prenatal care • Postnatal care • Childbirth • Any complications associated with pregnancy	Medical
Prescription Drug	Drugs and medicines which require a prescription by a physician to dispense and are approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury.	Prescription Drug
Preventive Care	Services that contribute to the prevention of a condition or disease, such as: annual well woman, well man, and well child exams.	Medical, Dental
Qualified Beneficiary	A qualified beneficiary is an individual who, on the day before a qualifying event, has Baker Hughes Medical, Dental, Vision, EAP and/or Health Care Spending Account coverage. A qualified beneficiary can be: • The covered employee or retiree; • The covered spouse of a covered employee or retiree; • The covered dependent child of a covered employee or retiree; • 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 • A covered spouse or dependent dropped in anticipation of a divorce or legal separation (upon receiving notice of the divorce or legal separation, COBRA continuation coverage will be made available effective on the date of the divorce or legal separation).	COBRA
Reasonable and Customary	Reasonable and Customary (R&C) is the standard cost for a service in a geographic area. When a member utilizes a non-network provider for services, R&C costs are the basis for determining the amount considered by the plan. The member may be responsible for any amounts above R&C, in addition to any other plan responsibility, such as deductible and/or coinsurance.	Medical, Dental
Regular Occupation	The occupation that you are performing for income or wages on your date of disability. It is not limited to the specific position you held with your employer.	STD, LTD
Rehabilitative Employment	Any gainful employment undertaken by you while receiving monthly benefits under the plan. Any planned vocational rehabilitation training program operated or sponsored by a private, nonprofit organization which regularly provides vocational rehabilitation training for disabled persons and approved by the Claims Administrator prior to your participating in it.	LTD
Reproductive Resource Services	A program administered by UHC or its affiliates made available to you by Baker Hughes. The RRS program provides: • Specialized clinical consulting services for you and your enrolled dependents that provide education on infertility treatment options, and • Access to specialized network facilities and physicians for infertility services.	Medical
RRS	See Reproductive Resource Services (RRS).	Medical

Term	Definition	Section
Residential Treatment Facility	A facility which provides a program of effective mental health services or substance use services treatment and which meets all of the following requirements: • It is established and operated in accordance with applicable state law for residential treatment programs; • It provides a program of treatment under the active participation and direction of a physician and is approved by the Mental Health/Substance Use Administrator; • It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and • It provides at least the following basic services in a 24-hour per day, structured environment: room and board; evaluation and diagnosis; counseling; and referral and orientation to specialized community resources. A residential treatment facility that qualifies as a hospital is considered a hospital.	Medical
Retail Network Pharmacy	A pharmacy which contracts with the Claims Administrator for the Prescription Drug plan to fill or refill your prescription when you present a valid Prescription Drug plan ID card.	Prescription Drug
Semi-Private Room	A room with two or more beds. When an inpatient stay in a semi-private room is a covered expense, the difference in cost between a semi-private room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a semi-private room is not available.	Medical
Sickness	Sickness- or disease-causing disability that begins while your coverage is in force.	STD, LTD
Skilled Nursing Facility	A hospital or nursing facility that is licensed and operated as required by law.	Medical
SPD	This Summary Plan Description, which describes the Baker Hughes Incorporated Health & Welfare benefits plans.	All plans
Substance Abuse	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.	Medical
Substance Abuse Services	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.	Medical
Surgery	Any operative procedure performed in the treatment of an injury, disease, or illness by instrument or cutting procedure through any natural body opening or incision.	All plans

Term	Definition	Section
Total Disability or Totally Disabled	An employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a dependent's, or retired person's, inability to perform the normal activities of a person of like age and sex.	LTD
Unproven Services	Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the plan may consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, the plan must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.	Medical, Prescription Drug, Dental, Vision
Urgent Care	Must meet one or both of the following criteria: • A delay in treatment that could seriously jeopardize life or ability to regain functionality, and/or, • In the opinion of a physician with knowledge of the medical condition, could cause severe pain.	Medical
War	The term war means declared or undeclared war or any armed conflict resisted by any country.	Protection

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