Medical Benefits

Stryker's medical benefits are designed to provide comprehensive coverage and freedom of choice while also controlling costs for you and for Stryker. You may use any licensed healthcare provider and receive benefits for medical services that are required for the care of a sickness or an accidental injury.

This section of the Stryker Benefits Summary describes the UnitedHealthcare plans available to most Stryker employees. In specific locations, HMO and other fully insured medical plans are offered as alternatives to the UHC plans. If you are enrolled in one of those medical plans, refer to the *Location-Based Provisions* section and the benefit summary or certificate of coverage provided by the insurance company or HMO for detailed information regarding your covered services and supplies.

Stryker's Medical Options

Stryker offers most employees two UnitedHealthcare PPO plans—the Choice PPO and the Value PPO. However, depending on where you live, you may have alternative options. Your options are described below.

The UnitedHealthcare Choice and Value PPO Plans

A PPO (Preferred Provider Organization) is a managed care arrangement that allows you to choose in- or out-of-network care each time you need a medical service or supply. When you use in-network providers, PPO plans pay a higher percentage of covered charges.

UnitedHealthcare manages Stryker's PPO network. UnitedHealthcare is also the claims administrator for the PPOs and the Out-of-Area plan.

Other Medical Plan Options

While both UnitedHealthcare PPO options are available to employees in most Stryker locations, in the following states, alternative medical plans are offered:

Other Medical Options

If you enroll in an area offering an alternative medical option, see the *Location-Based Provisions* section for more information.

- **Alabama**—The BCBS of Alabama PPO plan is the only medical and prescription plan offered in Alabama. The UnitedHealthcare PPO options are not available in Alabama. If you enroll in the BCBS of Alabama PPO plan, your prescription drug benefits will be provided through BCBS of Alabama.
- **California**—The Kaiser Permanente HMO is offered as an alternative to the UnitedHealthcare PPO options. If you select the HMO, your prescription drug benefits are provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.
- **Hawaii**—The Kaiser Permanente plan is the only medical plan offered in Hawaii. The UnitedHealthcare PPO options are not available in Hawaii. If you enroll in the Kaiser Permanente plan, your prescription drug benefits will be provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.

The Out-Of-Area Plan

You are eligible for the Out-of-Area plan if there are no PPO or HMO networks available in your area. The Out-of-Area plan is an "indemnity" plan, which means that claims are paid at the same benefit level no matter which doctor or hospital you use.

How the UnitedHealthcare PPOs Work

The following explains information you need to know about how the Choice and Value PPOs work, and how using participating or non-participating providers impacts your benefits.

Both plans work the same way, use the same network of providers and offer the same benefits. The only differences are the employee contributions for coverage, the deductibles and the out-of-pocket maximums.

Your Choices for Receiving Care

Each time you need care, you choose between:

- In-network services received from participating providers
- Out-of-network services received from non-participating providers

The plans pay benefits either way, but at a higher level for in-network care. In addition, participating providers file claims and generally handle notification requirements for you.

In-network benefits are based on negotiated fees paid to participating providers. When Covered Health Services are received from out-of-network providers, eligible expenses are based on fees that are negotiated with the provider, a percentage of the published rates allowed by Medicare for the same or similar service, or in rare circumstances, 59% of the billed charge or a fee schedule that is determined at the time of service. When reasonable and customary fee guidelines apply, you are responsible for paying the provider for any difference between the reasonable and customary fee and the provider's actual charge.

Out-of-Network Benefit Exception

Most of the healthcare services you need are available within the network. However, if there is no in-network provider within a 20-mile radius of your home ZIP code, you may be eligible for in-network benefits in connection with specific Covered Health Services. UnitedHealthcare must approve any benefits that fall under this exception **prior to receipt of care**. These benefits are subject to any plan limitations or exclusions outlined in this Benefits Summary.

If a covered service or supply qualifies for the out-of-network benefit exception, benefits are subject to the in-network deductible and are paid at 80% of the in-network benefit level. However, eligible expenses are based on fees that are negotiated with the provider, a percentage of the published rates allowed by Medicare for the same or similar service, or in rare circumstances, 59% of the billed charge or a fee schedule that is determined at the time of service. When reasonable and customary fee guidelines apply, you are responsible for paying the provider for any difference between the reasonable and customary fee and the provider's actual charge.

Participating Providers

All participating providers are carefully selected according to objective requirements and standards. The criteria for doctors include professional credentials, education, medical training and experience and hospital admitting privileges. Whenever possible, doctors are either board certified or board-eligible in their areas. For hospitals, the criteria include accessibility, quality of care, community reputation, available services and cost efficiency. Network managers regularly re-evaluate participating providers to make sure they continue to meet requirements.

Network participation status changes from time to time, so it is important to verify that your doctor or hospital participates with the UnitedHealthcare PPO network before scheduling an appointment or procedure Participating provider information is available via the UnitedHealthcare web site (**www.myuhc.com**) and/or by calling **800 387 7508** toll free.

UnitedHealth Premium℠ Program

UnitedHealthcare designates network physicians and facilities as UnitedHealth Premium Program physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels—quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- Help you make informed decisions on where to receive care
- Provide you with decision support resources
- Give you access to physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria

For details on the UnitedHealth Premium Program, including how to locate a UnitedHealth Premium physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

Eligible Expenses

Eligible expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in "Medical Plan Definitions" on page 46. For certain Covered Health Services, the Plan will not pay these expenses until you have met your annual deductible. Stryker has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the eligible expense will be determined and otherwise covered under the Plan.

Participating providers have agreed to negotiated fees, which help control costs for both you and Stryker. When an in-network provider provides a covered service, the eligible expense is the contracted rate the provider has agreed to accept. When you use in-network providers, you are not responsible for the difference between the negotiated rate and the provider's actual charge.

If you are enrolled in either PPO plan and use out-of-network providers, or if you are enrolled in the Out-of-Area plan, UnitedHealthcare determines eligible expenses by calculating competitive fees in the geographic area where the service is provided. In some cases, out-of-network providers agree to accept rates negotiated by UnitedHealthcare or one of its vendors, affiliates or subcontractors. In these cases, eligible expenses are based on the negotiated rate.

When eligible expenses are lower than the out-of-network provider's charge, you are responsible for paying the difference directly to the provider. This is true even when services or supplies are not available from in-network providers or an in-network doctor has referred you, unless you have been granted an out-of-network benefit exception. Emergency care services are always paid at the in-network benefit level.

Benefits for ambulance services are not subject to eligible expense guidelines.

Your Deductible

A deductible is money you must spend out-of-pocket for covered medical expenses before the plan pays benefits. Your deductible is determined by the plan you choose, the number of people you cover and whether you use in-network or out-of-network providers. See the chart in "Your Medical Benefits" on page 26 for specific deductible amounts. The family deductible may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual deductible amount. The deductible applies to all expenses except:

- Expenses that are subject to a flat dollar copayment, including office visits and emergency room services (See "Your Share in the Cost of Covered Services" on page 25 for more information about copayments.)
- Covered preventive healthcare expenses
- Approved travel and lodging expenses related to organ transplants
- Only expenses incurred for in-network services apply toward the in-network deductible. Likewise, only expenses incurred for out-of-network services apply toward the out-of-network deductible.

Family Deductible Example

When you use in-network doctors and facilities, the annual family deductible is $1,050 under the Choice PPO and $2,250 under the Value PPO. Assume that you enroll in the Choice PPO and have a family of four. Here is an example of how the family deductible might be satisfied:

Participant	Covered Expenses
Employee:	$250
Spouse:	$350
Child #1:	$250
Child #2:	$200
Total:	$1,050

Your Share in the Cost of Covered Services

The plan pays a certain portion of covered medical expenses. The portion you must pay is your coinsurance percentage or a copayment, depending on the type of service provided:

- Coinsurance is a percentage of a covered expense (for example, you pay 20% and the plan pays 80%). You pay your coinsurance share in addition to the deductible.
- A copayment is a fixed charge like $25 or $40 for an office visit. When a flat dollar copayment is required, the covered expense is not subject to the annual deductible. For example, you pay $25 for an office visit with a primary care physician—the plan pays the balance and the annual deductible does not apply.

Your coinsurance share or copayment requirement differs depending on whether you are enrolled in the UnitedHealthcare Choice PPO plan, the UnitedHealthcare Value PPO plan or the Out-of-Area plan. If you are enrolled in a PPO plan, your coinsurance share and copayment requirements differ when you use in-network versus out-of-network providers. See the chart in "Your Medical Benefits" on page 26 for specific coinsurance and copayment amounts.

Your Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay towards the cost of covered medical expenses (including your medical copays, coinsurance and payments toward satisfying the annual deductible) in a calendar year. Your out-of-pocket maximum is based on the plan you are enrolled in and the number of people you cover. If you are enrolled in either PPO plan, the out-of-pocket maximum is also determined by whether you use in-network or out-of-network providers. See the chart in "Your Medical Benefits" on page 26 for specific out-of-pocket maximums.

The individual out-of-pocket maximum is the most that will apply to any one family member. Once you or a covered dependent reaches the individual out-of-pocket maximum, the plan pays 100% of that person's eligible expenses for the rest of the calendar year. Once your family out-of-pocket maximum is reached, the plan pays 100% of eligible expenses for the rest of the calendar year for you and all your covered dependents.

The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual out-of-pocket maximum.

The out-of-pocket maximum includes your medical copays, your share of the coinsurance and payments toward satisfying the annual deductible. It does not include:

- Your contributions toward the cost of medical coverage (your premium)
- Your fixed dollar copayments for prescription drugs
- Temporomandibular joint (TMJ) disorder treatment expenses
- Any amounts over reasonable and customary fee limits or the allowance based on the Minimum Necessary Reimbursement Program (MNRP), as outlined under "Your Choices for Receiving Care" on page 24 and defined in "Medical Plan Definitions" on page 46.
- Notification penalties
- Any amounts over plan limits for organ transplants

Out-of-pocket expenses incurred for in-network services apply toward the in-network out-of-pocket maximum only. Only out-of-pocket expenses incurred for out-of-network services apply toward the out-of-network out-of-pocket maximum.

Your Medical Benefits

The chart below lists the deductibles, coinsurance, copayments and out-of-pocket maximums that currently apply under the UnitedHealthcare Choice and Value PPO plans and the Out-of-Area plan.

Deductibles, Coinsurance, Copayments and Out-of-Pocket Maximums

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Annual Deductible					
Employee	$350	$700	$750	$1,500	$350
Employee + 1	$700	$1,400	$1,500	$3,000	$700
Family	$1,050	$2,100	$2,250	$4,500	$1,050
Your Share in the Cost of Covered Services—After Deductible Unless Noted					
Office visit copayment—primary care	$25; not subject to deductible	40%	$25; not subject to deductible	40%	20%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
Office visit copayment—specialist	$40; not subject to deductible	40%	$40; not subject to deductible	40%	20%
Preventive Care					
Office visits	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)
Other covered services	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)
Emergency Room Visits—After Deductible Unless Noted					
Facility and physician charges	$125; not subject to deductible	$125; not subject to deductible	$125; not subject to deductible	$125; not subject to deductible	$125; not subject to deductible
Inpatient hospital care	20%	40%	20%	40%	20%
Inpatient mental health and substance abuse treatment	20%	40%	20%	40%	20%
Annual Out-of-Pocket Maximum					
Employee	$2,600	$5,200	$3,850	$7,700	$2,600
Employee + 1	$5,200	$10,400	$7,700	$15,400	$5,200
Family	$5,550	$11,100	$8,450	$16,900	$5,550

Benefit Maximums

There is no lifetime benefit maximum for covered individuals.

Emergency Room Care

When you need emergency care and use an emergency room, you pay a $125 copayment and the plan pays the balance of emergency room charges; no deductible applies.

These benefits apply only when you use a hospital emergency room for a true medical emergency. A "true medical emergency" is defined as a serious medical condition or symptom resulting from injury, sickness or mental illness, which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to life or health.

The emergency room copayment is waived if you are admitted to the hospital as an inpatient through the emergency room.

Special Services and Procedures

To ensure you receive the appropriate care in the appropriate setting, the medical plan has a number of special services and requirements. This section describes what you need to know when you need medical care or services.

Notification Requirements

Personal Health Support is a program provided by UnitedHealthcare designed to encourage an efficient system of medical care for you and your covered dependents. You ***must*** notify Personal Health Support before you are admitted to a hospital as an inpatient. In most cases, in-network providers will handle notification requirements for you, but it is your responsibility to ensure that notification takes place. If you are enrolled in either PPO plan and use out-of-network providers or if you are enrolled in the Out-of-Area plan, you are responsible for notifying Personal Health Support.

Important to Remember…

Personal Health Support does not have the ability to make enrollment changes, such as to add a newborn. All enrollment modifications must be directed to your Benefits Representative.

Notification is also required for:

- Inpatient hospitalization
- Mental health or substance abuse treatment
- Emergency services if you are admitted to an out-of-network hospital
- Congenital heart disease
- Maternity care exceeding the standard timeframe
- Reconstructive procedures
- Home healthcare
- Hospice care
- Skilled nursing facility admissions
- Durable medical equipment purchase or rental over $1,000
- Blepharoplasty
- Ligation
- Vein stripping
- Sclerotherapy
- Accidental dental services
- Transplant services
- Breast reconstruction or reduction (except after cancer surgery)

Non-Urgent Admissions or Care

If the admission is for a non-urgent condition, you must call Personal Health Support at least five days before the scheduled admission or treatment date. Working with your doctor, Personal Health Support will decide how many days of confinement or treatment are appropriate and will provide written notice to you and your doctor. If Personal Health Support determines that the proposed admission or treatment is not covered, you and your doctor will be notified.

Notifying Personal Health Support

To contact Personal Health Support when required, call UnitedHealthcare at **800 387 7508**.

Urgent and Emergency Admissions or Care

If the patient's condition requires urgent or emergency admission, you, the patient's physician or the hospital must notify Personal Health Support:

- Before confinement for an urgent admission
- Within 48 hours after confinement because of an emergency admission, unless it is not possible for the physician to notify Personal Health Support within that time. In that case, it must be done as soon as reasonably possible (If the confinement starts on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.)

To Continue Treatment

If your doctor feels it is necessary for the confinement or treatment to continue longer than already approved, you, the physician or the hospital may request additional days by calling Personal Health Support. This request must be made no later than the last day that has already been approved. You must pay for continued treatment days that the reviewer determines are not covered.

Penalties

A $400 penalty will apply if you do not notify Personal Health Support when required. Any penalty amounts you pay will not count toward your deductible or out-of-pocket maximum.

Special Note: Mental Health and Substance Use Disorder Services

To receive the highest level of benefits and to avoid incurring penalties, you must call the Mental Health or Substance Abuse Disorder Administrator for pre-service authorization before obtaining the services listed below:

- **Mental health services.** Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility): intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management
- **Neurobiological disorders.** Inpatient mental health services for Autism Spectrum Disorders (including partial hospitalization/day treatment and services at a residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management
- **Substance use disorder services.** Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

For a scheduled admission, you must notify the Mental Health or Substance Abuse Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including emergency admissions). If you fail to notify the Mental Health or Substance Abuse Disorder Administrator as required, a $400 penalty will apply.

In addition, you must notify the Mental Health or Substance Abuse Disorder Administrator before the following services are received. If you fail to notify the Mental Health or Substance Abuse Disorder Administrator as required, the $400 pre-notification penalty will apply.

- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Psychological testing
- Extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

See "Mental Health, Substance Use Disorder and Neurobiological Disorder Services" on page 38 of "Covered Medical Expenses" for more information about these types of services.

Treatment Decision Support

In order to help you make informed decisions about your healthcare, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions. This program offers:

- Access to accurate, objective and relevant healthcare information
- Coaching by a nurse through decisions in your treatment and care
- Expectations of treatment
- Information on high quality providers and programs

Conditions for which this program is available include:

- Back pain
- Knee and hip replacement
- Prostate disease
- Prostate cancer
- Benign uterine conditions
- Breast cancer
- Coronary disease
- Bariatric surgery

Participation in Treatment Decision Support is completely voluntary and does not cost extra. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Second Surgical Opinions

If your doctor recommends surgery that is covered under the plan, you may want to get a second opinion. This is voluntary and will not affect your benefits. A second surgical opinion may include an exam, X-ray and lab work and a written report by the doctor. It must be performed by a doctor who is not associated or in practice with the physician who recommended the surgery, and who is certified by the American Board of Surgery or other specialty board.

If you are enrolled in either PPO plan and choose to get a second opinion from an in-network provider, you pay a $25 (or $40 for a specialist) office visit copayment and the plan pays the balance. If you receive X-rays and/or lab work, you will also pay 20% of the eligible expense for those services after you have met your deductible. If you use an out-of-network provider for a second opinion, you pay 40% of the eligible expense, including any X-rays or lab work you receive. The annual deductible applies to second surgical expense consultations provided by out-of-network physicians. If you are enrolled in the Out-of-Area plan, you pay 20% of the eligible expense after you have met your deductible for a second surgical opinion consultation, including X-rays and lab work.

MyNurseLine℠

Making sure that you make good healthcare choices for yourself and your family can be challenging. For example, when your child has the flu, should you make a doctor's appointment or use self-care to bring the fever down at home? Or, if your spouse trips and falls, how can you tell if he or she should get an X-ray? MyNurseLine can provide information to help you decide what to do in situations when you may not be sure whether you should go to the emergency room, see your doctor or treat yourself at home.

MyNurseLine also provides information and education about good nutrition, exercise and regular health screenings to help keep you and your family healthy. Call MyNurseLine any time—24 hours a day, 365 days a year at no cost to you—at **888 206 1623**. You can also contact MyNurseLine via **www.myuhc.com**. Be sure to register at **www.myuhc.com** so that you can access special members-only areas, including Live Nurse Chat and Health Topics and Tools.

Covered Medical Expenses

The UnitedHealthcare plan has no pre-existing condition limitation.

The following chart shows plan benefits for each Covered Health Service. Benefits are available only when all of the following conditions are met:

- Covered health services are provided while coverage is in effect.
- Covered health services are provided before the date your coverage under the plan is terminated.
- The person who receives Covered Health Services meets all the plan's eligibility requirements.

Plan Benefits for Covered Medical Expenses

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Hospital Charges: Inpatient and Outpatient Services*—After Deductible Unless Noted					
Room and board charges up to the semi-private room rate	80%	60%	80%	60%	80%
Intensive care unit	80%	60%	80%	60%	80%
Services and supplies, including diagnostic testing, laboratory services and X-rays	80%	60%	80%	60%	80%
Surgery	80%	60%	80%	60%	80%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Emergency Treatment					
Emergency room for medical emergencies and accidental injuries	100% after $125 copayment	100% after $125 copayment	100% after $125 copayment	100% after $125 copayment	100% after $125 copayment
Emergency room for non-emergency conditions	Not covered	Not covered	Not covered	Not covered	
Urgent care/walk-in facility	100% after $40 copayment	60%	100% after $40 copayment	60%	80%
Preventive Care Services (Coverage for preventive care office visits may vary from what is shown in this table. See the chart in "Your Medical Benefits" on page 26 for more information about your share of the cost for preventive care office visits.)					
Routine physical exam	100%; not subject to deductible	60%; not subject to deductible	100%; not subject to deductible	60%; not subject to deductible	100%; not subject to deductible
Other preventive services, including children's immunizations, mammograms, PAP smears, X-rays and lab tests based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and Patient Protection Affordable Care Act (PPACA). Preventive testing services are limited to once per calendar year.	100%; not subject to deductible	60%; not subject to deductible	100%; not subject to deductible	60%; not subject to deductible	100%; not subject to deductible
Doctors and Healthcare Professionals—After Deductible Unless Noted (Primary care physicians, including general practitioners, internists and pediatricians. Gynecologists are also considered primary care physicians for preventive annual exams only.)					
Office visit – primary care physician	100% after $25 copayment	60%	100% after $25 copayment	60%	80%
Office visit – specialist	100% after $40 copayment	60%	100% after $40 copayment	60%	80%
Medical care	80%	60%	80%	60%	80%
Surgery*	80%	60%	80%	60%	80%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Obstetrician or certified nurse	First visit at 100% after $40 copayment; then 80%	60%	First visit at 100% after $40 copayment; then 80%	60%	80%
Allergy testing and treatment	Office visits: 100% after $40 copayment Injections: 80%	60%	Office visits: 100% after $40 copayment Injections: 80%	60%	80%
Physical and occupational therapy	80%	60%	80%	60%	80%
Speech therapy	80%	60%	80%	60%	80%
Chiropractic treatment Medical necessity documentation required after 15 visits per calendar year. If visits exceed 30 in any calendar year, UnitedHealthcare must review and approve additional benefits for chiropractic treatment.	100% after $40 copayment	60%	100% after $40 copayment	60%	80%
Private duty nursing by an RN or LPN	80%	60%	80%	60%	80%
Podiatric treatment Covered only if for systematic disease or diabetes.	100% after $40 copayment	60%	100% after $40 copayment	60%	80%
Other Services—After Deductible Unless Noted					
Ambulance	80%	80%	80%	80%	80%
Anesthetics and their administration	80%	60%	80%	60%	80%
Durable medical equipment (DME)*	80%	60%	80%	60%	80%
Fertility testing Covered only if part of a diagnosis of a medical condition. Treatment is not covered.	80% If part of an office visit: 100% after $40 copayment	60%	80% If part of an office visit: 100% after $40 copayment	60%	80%
Prosthetic and orthotic devices	80%	60%	80%	60%	80%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Injectable drugs not intended for self administration	80%	60%	80%	60%	80%
Mental Health and Substance Abuse Disorder Treatment—After Deductible Unless Noted					
Inpatient*	80%	60%	80%	60%	80%
Residential day care*	80%	60%	80%	60%	80%
Outpatient	100% after $40 copayment	60%	100% after $40 copayment	60%	80%
Special Facilities					
Birthing centers	80%	60%	80%	60%	80%
Home healthcare*	80%	60%	80%	60%	80%
Hospice care—inpatient and outpatient*	80%	60%	80%	60%	80%
Skilled nursing facility*	80%	60%	80%	60%	80%
Reminder: The LifeWorks Employee Assistance Program (EAP) provides free and confidential access to behavioral health professionals 24 hours a day, seven days a week. The EAP also provides up to three face-to-face counseling sessions per issue or problem at no cost to you. Contact LifeWorks at **888 267 8126**.					

* Notification to Personal Health Support or the Mental Health or Substance Abuse Disorder Administrator required.

Maternity Benefits

Stryker's Health Plan covers expenses for hospital stays or birthing centers and obstetrics provided by a doctor or certified nurse-midwife for pregnancy, childbirth or related complications. Newborn expenses, including hospital nursery charges, routine in-hospital pediatric care for a healthy infant and circumcision, also are covered separate from the mother.

Pregnancy-related expenses of employees and dependents must be incurred while the person is covered under the plan. If expenses are incurred after coverage ends, no benefits will be paid. If there are benefits payable from a previous plan, these will be subtracted from benefits payable for the same expenses under this plan.

Expenses related to elective induced abortions and any complication related to an abortion are covered.

If you need to change your healthcare benefit election as the result of the birth of the baby, you must properly change your enrollment via the employee self service web site, My Stryker Info (**https://myinfo.stryker.com**), or by contacting your Benefits Representative and completing an enrollment form, within 30 days of the life event (including the date of the event). You must also provide all of the required dependent documentation within 45 days as requested in order to change your elections on a pre-tax basis. See "Making Changes" in the *Participating in Health Care Benefits* section for more information.

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical plan, you can get valuable educational information and advice by calling **800 387 7508**. This program offers:

- Pregnancy consultation to identify special needs
- Written and online educational materials and resources

- 24-hour toll-free access to experienced maternity nurses
- A phone call from a care coordinator during your pregnancy
- A phone call from a care coordinator approximately four weeks postpartum, to give you information on infant care, feeding, nutrition, immunizations and more

Participation is completely voluntary and *without extra charge*. To take full advantage of the program, you are encouraged to enroll within the *first 12 weeks of pregnancy*. You can enroll any time, up to your 34th week. *To enroll, call* ***800 387 7508***. As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Benefits for Outpatient Rehabilitation Services

Stryker's medical plan covers outpatient rehabilitation services for:

- Physical therapy
- Occupational therapy
- Manipulative treatment (chiropractic and spinal manipulation)
- Speech therapy
- Post-cochlear implant aural therapy
- Vision therapy
- Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

Rehabilitation services must be performed by a licensed therapy provider under the direction of a physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement within two months of the start of treatment.

Recertification of the continued need for spinal manipulations is required after the first 30 visits and will be subject to review by Personal Health Support.

Speech therapy services are covered only when the speech impediment or speech dysfunction results from injury, stroke, congenital anomaly, developmental delay or is required following placement of a cochlear implant.

The plan does not cover any type of therapy, service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Preventive Care Benefits

One of the best ways to prevent illness is to take care of yourself. Regular check-ups and immunizations are important, so preventive care services provided in an outpatient setting are covered.

Eligible preventive care services are covered at 100% without deductibles or copayments. Routine tests and related lab and X-ray expenses are covered once per calendar year.

The plan pays for services for preventive care services provided on an outpatient basis at a physician's office, an alternative facility or a hospital and 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, 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
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and in accordance with the Patient Protection and Affordable Care Act (PPACA).

In general, the plan pays preventive care benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

- Routine physical exam (one per year after age 3)
- Well child care through age 3
- Routine lipid profile
- Routine mammogram
- Routine PAP test
- Additional women's preventive care (per PPACA guidelines):
  - Gestational diabetes screening
  - HPV DNA testing for women age 30 and older
  - Screening for sexually transmitted infections
  - Screening and counseling for HIV
  - Screening and counseling for domestic violence
  - Counseling for and payment of generic FDA-approved contraception methods
  - Counseling for breastfeeding and payment of rental equipment and supplies, except breast pump rentals
- Routine prostate exam
- Routine PSA
- Routine lab tests and X-rays related to covered preventive testing (facility and professional charges)
- Immunizations:
  - Covered childhood immunizations generally include: Diptheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles - mumps-rubella (MMR), Conjugate haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18.
  - The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.

Preventive care benefits do *not* include:

- Services for the diagnosis or treatment of a disease, except for those women's preventive services noted above
- Medicines, drugs, appliances, equipment or supplies, except for those women's preventive services noted above
- Psychiatric, psychological or emotional testing or exams
- Exams related to employment
- Premarital exams
- Vision, hearing or dental exams

HealtheNotes℠

- UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care.

  HealtheNotes℠ provides you and your Physician with suggestions regarding preventive care, testing or medications and potential interactions with medications you have been prescribed and certain treatments.
- In addition, your HealtheNotes℠ report may include health tips and other wellness information. UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process, patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine, as described in Medical Plan Definitions under the definition of Covered Health Services.
- If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician. If you have questions or would like additional information about this service, please call **800 387 7508**.

Cancer Resource Center (CRS)

The Plan pays benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facilities are defined in the "Medical Plan Definitions" on page 46.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by a Personal Health Support Nurse;
- Call CRS toll-free at **866 936 6002**; or
- Visit **www.myoptumhealthcomplexmedical.com**.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays benefits as described under:

- Physician's Office Services - Sickness and Injury
- Physician Fees for Surgical and Medical Services
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments - Outpatient
- Hospital - Inpatient Stay
- Surgery - Outpatient

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that network).

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card, or call the program directly at **866 936 6002**. For information regarding specific benefiters for cancer treatment within the Plan, see under the heading Cancer Resource Services (CRS).

Clinical Trials

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

- Cancer or other 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) which is not life threatening for which, as determined by UnitedHealthcare, a clinical trial meets the qualifying clinical trial criteria
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which UnitedHealthcare determines a clinical trial meets the qualifying clinical trial criteria
- Other disease or disorders which are not life threatening for which, UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria

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 member is clinically eligible for participation in the qualifying clinical trial as defined by the researchers.

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, that clinically appropriately monitoring of the effects of the item or service, or the prevention of the complications
- Covered health services needed for reasonable and necessary care arising from the provision of the investigational item or service

Please remember, that you must notify 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.

Home Healthcare

Covered home healthcare expenses include charges by an approved home healthcare agency for the following services furnished as part of a home healthcare plan:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN), or services from a home health aide, up to the maximum of 120 visits per year
- Respiratory, occupational, speech and physical therapies provided by a home healthcare agency
- Medical supplies, appliances and equipment, drugs and medicines prescribed by a physician and provided by the home healthcare agency, if such items would have been covered under the plan while hospital-confined
- Nutrition counseling or services, or special meals provided by or under the supervision of a registered dietitian or nutritionist

Benefits for home healthcare treatment will be reduced by $400 when UnitedHealthcare is not notified in advance of the first treatment date.

Home healthcare services provided by a social worker or a family member are not covered.

Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are covered by the Plan. Benefits include:

- Non-physician services and supplies received during the inpatient stay
- Room and board in a semi-private room (a room with two or more beds)

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

Benefits for other physician services, including anesthesiologists, consulting physicians, pathologists and radiologists, are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost effective alternative to an inpatient stay in a hospital; and
- You will receive skilled care services that are not primarily custodial care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note:

- The Plan does not pay benefits for custodial care or domiciliary care, even if ordered by a physician, as defined in "Medical Plan Definitions" on page 46.
- Any combination of network benefits and non-network benefits is limited to 120 days per calendar year.

Please remember that you should notify Personal Health Support as follows:

- For elective admissions: five business days before admission
- For Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

If Personal Health Support is not notified, benefits will be reduced by $400.

Mental Health, Substance Use Disorder and Neurobiological Disorder Services

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

Covered neurobiological disorder services include psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

Note: The benefits described here are for the psychiatric component of treatment for Autism Spectrum Disorders only. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories, as described elsewhere in this "Medical Benefits" section.

Mental health, substance use disorder and neurobiological disorder benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic and evaluation assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention
- For substance use disorder only, detoxification (sub-acute/non-medical)

The plan pays benefits for the following services provided on an inpatient basis:

- Partial hospitalization/day treatment
- Services at a residential treatment facility

Benefits also are paid for services provided for intensive outpatient treatment.

The Mental Health or Substance Abuse Disorder Administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis.

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

Please remember that you ***must*** notify the Mental Health or Substance Abuse Disorder Administrator in advance of any treatment to receive benefits for these services. Please call the phone number that appears on your ID card. Without notification, a $400 pre-notification penalty will apply.

Special Mental Health and Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health or Substance Abuse Disorder Administrator may become available to you as part of your mental health and substance use disorder services benefit. The mental health and substance abuse services benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient or a transitional care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your mental illness or substance use disorder that may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health or Substance Abuse Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the covered person and is not mandatory.

Exclusions for Mental Health/Substance Use Disorders

In addition to any exclusions or limits that may be described in "Expenses Not Covered" on page 43, the plan does *not* pay benefits for the following:

- 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 or Substance Abuse 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 considered experimental
  - Not consistent with the Mental Health or Substance Abuse Disorder Administrator's level of care guidelines or best practices as modified from time to time
  - Not clinically appropriate for the patient's mental illness, substance use order or condition based on generally accepted standards of medical practice and benchmarks
- Mental health services as treatments for V-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 other sleep disorders, sexual dysfunction disorders, feeding 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 paraphilias (sexual behavior that is considered deviant or abnormal)
- 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 skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*
- Mental retardation as a primary diagnosis defined 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 Disorders
- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered experimental or investigational or unproven services

Organ Transplant Benefits

UnitedHealthcare offers specialized case management services for individuals who have been recommended for an organ transplant, bone marrow transplant or tissue replacement. UnitedHealthcare must be notified regarding any of these procedures. During the notification process, UnitedHealthcare may recommend that you receive transplant services at a facility that is nationally recognized as a center of excellence for specific organ transplant procedures.

Each case must meet specific criteria. If treatment at a Designated Facility is recommended, covered charges in connection with the transplant procedure will be covered at 80% of the in-network benefit level. Reasonable and customary fee limits will not apply. In addition, you may qualify for reimbursement of travel and lodging expenses.

If treatment at a Designated Facility is recommended *but* you decide to have the transplant procedure performed elsewhere, the plan will pay 60% of covered charges in connection with the transplant procedure. The 60% benefit level will apply even when the facility is considered in-network for other non-transplant procedures.

Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a "Covered Health Service" and cannot be experimental or investigational, or unproven. Examples of transplants for which benefits are available include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy (Not all bone marrow transplants meet the definition of a Covered Health Service.)
- Transplantation of non-human organs is not covered.

Other Transplant Benefits

Charges for the following services are covered:

- Preparation, acquisition, transportation and storage of human organs, bone marrow or human tissue
- Approved travel and lodging expenses in connection with transportation of the organ recipient to the transplant procedure site

Limitations

The plan pays benefits for approved charges incurred by the organ donor and the transplant recipient when both are covered under Stryker's medical plan.

When the organ recipient is covered under Stryker's medical plan but the donor is not, the plan pays benefits for approved charges incurred by the organ donor to the extent that those charges are not covered by any other source.

When only the organ donor is covered under Stryker's medical plan, the plan covers any charges related to donor services up to a maximum benefit of $5,000. This benefit is payable only when the transplant recipient's plan does not cover donor services.

Durable Medical Equipment (DME)

The plan pays for durable medical equipment (DME) that is:

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

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen
- Wheelchairs
- Hospital beds
- Delivery pumps for tube feedings
- Burn garments
- Insulin pumps and all related necessary supplies
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Cranial helmets used to facilitate a successful post-surgical outcome are also covered as DME. **Note:** Only braces that are used to stabilize an injured body part or treat curvature of the spine are considered Durable Medical Equipment and therefore covered under the Plan. Braces that straighten or change the shape of a body part (with the exception of cranial helmets) are considered orthotic devices and are not covered. Dental braces are also excluded from coverage.
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Ostomy supplies. Covered supplies are limited to:
  - Pouches, face plates and belts
  - Irrigation sleeves, bags and ostomy irrigation catheters
  - Skin barriers

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Note: DME is different from prosthetic devices—see "Prosthetic Devices" on page 41.

Benefits are provided for the repair/replacement of a type of durable medical equipment once every calendar year.

Please remember for out-of-network benefits, you must notify Personal Health Support if the purchase, rental, repair or replacement of the equipment will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, benefits will be subject to a $400 reduction.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the covered person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary equipment is only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three-year timeline for replacement.

Benefits also include speech aid devices and trachea-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury. Benefits for the purchase of speech aid devices and trachea-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Hearing Aids

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician, and are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which benefits are available under the applicable medical/surgical Covered Health Services categories in this "Medical Benefits" section, and only 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
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

Prosthetic Devices

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the covered person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

Obesity Treatment

The Plan covers surgical treatment of obesity provided by or under the direction of a physician when all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40;
- You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five years; and
- You are over the age of 21

In addition to meeting the above criteria, the following must also be true:

- You have completed a six-month physician-supervised weight loss program; and
- You have completed a pre-surgical psychological evaluation

Benefits for obesity surgery services are covered only if they meet the definition of a Covered Health Service (see “Medical Plan Definitions” on page 46) and are not considered experimental, investigational or unproven.

Specialty Pharmacy

Specialty drugs are managed differently than every day prescriptions. UnitedHealthcare broadly defines “specialty drugs” as:

- **Self-administered injectable drugs**. These are drugs that can be administered by the patient or a non-skilled caregiver. Self-administered injectable drugs are covered under the pharmacy benefit or may be excluded from coverage; a limited number of self-administered injectable drugs may also be covered under the medical benefit.
- **Injectable drugs** (not intended for self-administration). These are drugs that must be administered by a healthcare professional in a physician’s office or other outpatient setting, usually by infusion or intra-muscular injection. This includes plasma or recombinant-derived products, such as factors to treat hemophilia or immune globulins. Chemotherapy agents are a significant component of this category. Injectable drugs are covered under the medical benefit with the deductible and coinsurance applied.
- **Biotech drugs. These are drugs manufactured through genetic engineering**. This includes oral, self-administered, injectable or infusion products given in an ambulatory setting.
- **Orphan drugs**. These are drugs that have been given a seven-year market exclusivity by the Orphan Drug Act.

Based on stipulations of the pharmaceutical manufacturers, certain specialty medications are only available through select specialty pharmacies.

Patient education materials are provided with specialty medications along with information on how to contact the appropriate specialty pharmacy, which differ by type of medication. Pharmacists are available 24 hours a day, seven days a week, to answer any questions and provide information about the medication, such as administration, storage, general drug information and side effect management.

Certain medical conditions require specialty medications, such as anemia, asthma, cancer, cystic fibrosis, growth hormone deficiency, hemophilia, hepatitis C, HIV/AIDS, immune deficiencies, low white blood cells, multiple sclerosis, osteoporosis, psoriasis, pulmonary hypertension, rheumatoid arthritis and RSV prevention to name a few. Note that some drugs may be excluded from coverage under our plan. Please contact UnitedHealthcare (UHC) Customer Service at **800 387 7508** for more information.

When a patient who needs a specialty medication is identified by UnitedHealthcare, UHC’s specialty pharmacy contacts the physician to provide information, make initial transition plans and obtain a prescription(s). UHC’s specialty pharmacy then contacts the patient to answer any questions and inform him or her of the process. For more information contact UHC Customer Service at **800 387 7508**.

Pharmacy customer service centers are open 24 hours a day, seven days a week, except for Thanksgiving and Christmas. Specialty pharmacies guarantee round-the-clock access to a pharmacist for any medication or administration-related questions.

Expenses Not Covered

The following medical expenses are not covered under the plan.

- Health services and supplies that do not meet the definition of a Covered Health Service. (See "Medical Plan Definitions" on page 46.)
- Services and supplies that are not necessary for the diagnosis, care or treatment of the disease or injury involved
- Services or supplies, other than outpatient mental health counseling, not prescribed, recommended or approved by a licensed healthcare provider (Outpatient mental health counseling services provided by a fully licensed psychologist, licensed clinical social worker or other licensed counselor are covered.)
- The experimental or investigational services or items, with the exception of:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies
- Items and services provided solely to satisfy data collection and analysis needs 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
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial
- Services or supplies that are experimental, investigational or unproven (However, this exclusion will not apply to services or supplies [other than drugs] received in connection with a disease if UnitedHealthcare determines that the disease is expected to cause death within one year in the absence of effective treatment, and the service or supply is effective or shows promise of being effective for that disease. This exclusion will not apply to drugs that have been designated as an investigational new drug or are being studied at the Phase III level in a national clinical trial by the National Cancer Institute, if UnitedHealthcare determines that the drug is effective or shows promise of being effective for the disease.) 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 the treatment, UnitedHealthcare may at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.
- Services, treatment, educational testing or training related to learning disabilities or developmental delays except for speech therapy services
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury
- Treatment of covered healthcare providers who specialize in the mental healthcare field and who receive treatment as part of their training in that field
- Services of a resident physician or intern rendered in that capacity
- Expenses above the eligible expense fee limits set by UnitedHealthcare
- Hospital or other facility expenses for custodial care
- Services and supplies furnished, paid for or for which benefits are provided or required because of a person's past or present service in the armed forces
- Services and supplies furnished, paid for or for which benefits are provided or required under any law of a government (This does not include a plan established by a government for its own employees or their dependents, or Medicaid.)
- Charges for eye refractions or vision examinations
- Charges for eyeglasses or contact lenses to correct refractive errors
- Eye surgery to eliminate refractive errors (such as radial keratotomy or LASIK)
- Services or supplies for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment

- Charges for plastic surgery, reconstructive surgery, cosmetic surgery, liposuction or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply if the service or supply is needed to:
  - Improve the function of a body part (other than a tooth) that is malformed as a result of a severe birth defect or as a direct result of disease or surgery performed to treat a disease or injury
  - Repair an injury as long as surgery is performed in the calendar year of the accident which causes the injury or in the next calendar year
- Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- Charges for sex change surgery or for treatment of gender identity disorders
- Charges for artificial insemination, in-vitro fertilization or embryo transfer procedures
- Charges for reversal of a sterilization procedure
- Charges for surrogate parenting, fees paid for sperm or ovum donation or fees paid for storage of frozen embryos
- Charges for food of any kind, including enteral feedings and other nutritional and electrolyte formulas, infant formula and donor breast milk. This exclusion will not apply if the food is the only source of nutrition, as determined by a physician, or it is specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
- Charges for marriage, family, child, career, social adjustment, pastoral or financial counseling without a medical diagnosis
- Charges for acupuncture, acupressure, aromatherapy, hypnotism, massage therapy, rolfing and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health
- Services provided by a close relative or anyone who resides in the patient's home (Close relatives include the patient's spouse, and any child, sibling or parent of the employee or spouse.)
- Travel and transportation costs associated with an organ transplant, as well as the expenses incurred by an organ donor whether or not the person is covered by the plan, except as described under "Organ Transplant Benefits" on page 40.
- Charges for treatment of an injury or illness due to an act of war (declared or undeclared) or contracted while on duty with any military service for any country
- Charges for treatment of obesity, unless the patient meets specific medical criteria as described under "Obesity Treatment" on page 42.
- Charges for fertility treatment (However, fertility testing may be covered if part of the diagnosis of a medical condition.)
- Charges for insulin syringes, lancets, insulin pen injectors and diabetic test strips (These expenses are covered under the prescription drug plan.)
- Charges for the rental of breast pumps
- Services provided for comfort or convenience such as televisions, telephones, air conditioners, air purifiers, humidifiers, dehumidifiers, beauty or barbershop services or home remodeling to accommodate a health need
- Dental services. This exclusion will not apply to anesthesia and associated hospital and facility charges that are not covered under the dental plan and are provided when, in the opinion of the treating dentist, any of the following criteria apply:
  - The related procedure involves extracting six or more teeth in various quadrants
  - Use of local anesthesia is considered ineffective because of acute infection, anatomic variation, or allergy
  - The procedure involves multiple extractions or restorations for a child under age four
  - There is a concurrent hazardous medical condition
  - The procedure is intended to address extensive oral-facial and/or dental trauma and would be ineffective or compromised if performed using local anesthesia

The benefits described here are covered only for anesthesia and related hospital and facility charges that are not covered by the dental insurance carrier.

- Prescription drugs and over-the-counter medications or supplies (These expenses may be covered under the prescription drug plan.)
- Routine foot care
- Orthotic appliances and devices, except when both of the following are met:
  - The appliance or device is prescribed by a physician for a medical purpose
  - It is custom manufactured or custom fitted to an individual covered person

  Examples of excluded orthotic appliances and devices include but are not limited to cranial bands or any braces that can be obtained without a physician's order (This exclusion does not include diabetic footwear which may be covered for an individual with diabetic foot disease.)
- Health services for organ and tissue transplants except as identified under "Organ Transplant Benefits" on page 40, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines
- Growth hormone therapy
- Domiciliary care
- Liposuction
- Custodial care
- Respite care
- Rest cures
- Psychosurgery
- Wigs
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer
- Personal trainer
- Naturalist
- Holistic or homeopathic care
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered when:
  - Required solely for purposes of career, education, sports or camp, travel employment insurance, marriage or adoption (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)
- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the plan ends
- In the event that a provider waives copayments, coinsurance and/or the annual deductible for a particular health service (No benefits are provided for the health service for which the copayments, coinsurance and/or annual deductible are waived.)
- Charges in excess of any specified limitation
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), if the services are considered to be dental in nature, including oral appliances
- Non-surgical treatment of obesity, including morbid obesity
- 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
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to, spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from an injury, stroke, congenital anomaly or developmental delay

How to Obtain Medical Benefits

You have no claims to file when you use in-network providers. If you are enrolled in the Out-of-Area plan or if you are enrolled in either PPO plan and use out-of-network services, you may be required to file a claim.

If you need to file a claim, contact your Benefits Representative or UnitedHealthcare for a claim form. You can also obtain a claim form online at **www.myuhc.com**. Read the claim form instructions carefully, and fill out each section of the form that applies to you. Be sure to answer all questions and attach all materials specified to ensure complete processing of your claim.

Health Statements

You will receive a Health Statement as an explanation of benefits (EOB) in the mail each month that UnitedHealthcare processes at least one claim for you or a covered dependent. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper health statements by making the appropriate selection on this site.

If your claim for benefits is denied, you have the right to appeal the denial. If you wish to file an appeal, follow the instructions outlined in the *Medical and Rx Claims Procedures* section.

How to Reach UnitedHealthcare

UnitedHealthcare
Stryker Group #: 703997
P.O. Box 740800
Atlanta, GA 30374-0800
www.myuhc.com
800 387 7508

Medical Plan Definitions

Annual deductible

The amount you must pay for covered services in a calendar year before the plan begins paying benefits in that calendar year.

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 (PDDNOS).

Claims administrator

UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the plan (e.g., the claims administrator is responsible for making claim payments according to the terms of the plan).

Clinical Trials

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 or treatment of cancer or other life-threatening disease or condition and which 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 which 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 which 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 Institute 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 Institute 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 written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The plan 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.

Coinsurance

The percentage of eligible expenses you are required to pay toward the cost of certain covered services.

Congenital anomaly

A physical developmental defect that is present at birth and is identified within the first twelve months after birth.

Copayment

The flat dollar charge you are required to pay for office visits and emergency room services.

Cosmetic procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare.

Covered health service

Includes services, supplies or pharmaceutical products which Stryker determines to be:

- Provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance use disorders or their symptoms
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below
- Not provided for the convenience of the covered person, physician, facility or any other person
- Included in *Plan Highlights* and *Additional Coverage Details*; provided to a covered person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*
- Not identified in "Exclusions for Mental Health/Substance Use Disorders" on page 39

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "Scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medial specialty community
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling **800 387 7508**. This information is available to Physicians and other healthcare professionals on UnitedHealthcareOnline.

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
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively

Designated Facility

A hospital that has entered into an agreement with UnitedHealthcare to provide covered services for the treatment of specific diseases or conditions. A Designated Facility may not be located in your geographic area. The fact that a hospital is a network hospital does not mean that it is a Designated Facility.

Durable medical equipment

Medical equipment that meets all of the following conditions:

- Can withstand repeated use
- Is not disposable
- Is used to serve a medical purpose with respect to treatment of a sickness or injury or their symptoms
- Is generally not useful to a person in the absence of a sickness or injury
- Is appropriate for use in the home
- Is not implantable within the body

Eligible expenses

Charges for Covered Health Services that are provided while the Plan is in effect, determined as follows.

- For Network Benefits, eligible expenses are based on contracted rates with the providers.
- For Non-Network Benefits, eligible expenses are based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator.
  - 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 competitive fees in that geographic area. If no fee information is available for a Covered Health Service, the eligible expense is based on 50% of billed charges, except that certain eligible expenses for mental health services and substance use disorder services are based on 80% of the billed charge.
    - For mental health 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 for Covered Health Services that 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. When a rate is not published by *CMS* for the service, the Claims Administrator will use the gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomas Reuters* (published in its Red Book) or *UnitedHealthcare* based on internally developed pharmaceutical pricing resource.

- The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.
- These provisions do not apply if you receive Covered Health Services from a non-Network provider in an emergency or as otherwise arranged by the Claims Administrator. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of eligible expenses in the form of a copay and/or coinsurance.

Eligible expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency

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

Experimental or investigational services

Medical, surgical, diagnostic, psychiatric, mental health, substance abuse disorders or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use,
- Subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the humanitarian use device exemption are not considered to be experimental or investigational), or
- The subject of an ongoing clinical trial that meets the definition of Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Home health agency

A program or organization authorized by law to provide healthcare services in the home.

Hospital

An institution, operated as required by law, which meets both of the following conditions:

- 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

Inpatient stay

An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

Maximum Non-Network Reimbursement (MNRP)

This program establishes a benchmark for payment, including use of rates and methodologies established by Medicare to reimburse non-emergency claims. Stryker's Health and Welfare Plan pays based on 140% of these Medicare established fee limits.

Medicare

Parts A, B, C and D of the insurance program established by Title XVIII of the United States Social Security Act, and as later amended.

Mental health services

Covered health services for the diagnosis and treatment of mental illness. 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 Health Service.

Mental illness

Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the plan.

Network (also called in-network)

When used to describe a provider of healthcare services, this means a provider that has a participation agreement in effect with UnitedHealthcare or an affiliate to provide Covered Health Services to covered persons. The participation status of providers will change from time to time.

Network benefits

Benefits for Covered Health Services that are provided by a network physician or other network provider.

Out-of-network benefits (also called non-network benefits)

Benefits for Covered Health Services that are provided by a non-network physician or other non-network provider.

Physician

Any doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law. Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license is considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that benefits for services provided by that provider are available under the plan.

Plan

The Stryker Corporation Welfare Benefits Plan.

Pregnancy

Includes all of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with pregnancy

Qualified medical child support order (QMCSO)

Any judgment, order or decree issued by a court or state administrative agency that:

- Provides for child support with respect to a plan participant's child or directs the participant to provide coverage under a health benefits plan due to a state domestic relations law, or
- Enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan and which satisfies the requirements to be a QMCSO set out in Section 609 of ERISA.

Skilled nursing facility

A hospital or nursing facility that is licensed and operated as required by law.

Substance abuse services

Covered health services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual 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 covered.

UnitedHealth Premium Program

A program that identifies network physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions. To be designated as a UnitedHealth Premium provider, physicians and facilities must meet program criteria. The fact that a physician or facility is a network physician or facility does not mean that it is a UnitedHealth Premium Program physician or facility.

Unproven services

Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials—two or more treatments are compared to each other and the patient is not allowed to choose which treatment is received

- Well-conducted cohort studies—patients who receive study treatment are compared to a group of patients who receive standard therapy (The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described here.

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may, at its discretion, determine that an unproven service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, UnitedHealthcare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent care center

A facility, other than a hospital, that provides Covered Health Services that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms in order to prevent serious deterioration of your health.