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. Additional information about your medical options is also available at **http://totalrewards.stryker.com**.

Stryker's Medical Options

Stryker offers most employees two UnitedHealthcare PPO plans—the Choice PPO and the Value PPO, and two UnitedHealthcare HSA plans—the Basic HSA Plan and the Premium HSA Plan. However, depending on where you live, you may have alternative options.

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

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.

If you enroll in a traditional UHC PPO plan (including the UHC Choice, UHC Value or UHC Out-of-Area plan), you will not be eligible to participate in a Healthcare Savings Account (HSA).

The UnitedHealthcare Basic and Premium HSA Plans

The Basic and Premium HSA Plans work much like the traditional PPOs. You choose in- or out-of-network care each time you need a medical service or supply. When you use in-network providers, the HSA plans pay a higher percentage of covered charges.

The HSA plans offer a tax-advantaged health savings account (HSA), which gives you more control over how you spend and save your healthcare dollars. See the "Health Savings Accounts" section for more information.

If you enroll in an UHC HSA plan, you will not be eligible to participate in a Healthcare FSA.

Other Medical Plan Options

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

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

Other Medical Options

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

The Out-of-Area Plan

You are eligible for the Out-of-Area plan if there are no satisfactory PPO or HMO networks available in your area. Benefits are payable for covered health services that are provided by or under the direction of a physician or other provider regardless of their network status. This plan does not provide a network benefit level or a out-of-network benefit level.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to out-of-network providers who have agreed to discounts negotiated from their charges on certain claims for covered health services. See the definition of "Shared Savings Program" in"Medical Plan Definitions" on page 72 for additional information .

How the UnitedHealthcare Plans Work

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

Both the UHC Choice and Value PPO plans work the same way, use the same network of providers and cover the same services. The differences are the employee contributions for coverage, the deductibles and the out-of-pocket maximums.

The UHC Basic and Premium HSA medical plans work similarly in that they use the same network of providers and cover the same services. However, there are differences in the employee contributions, deductibles, co-insurance and out-of-pocket maximums. In addition there are no co-pays with the HSA plans.

Covered Health Services

The healthcare service, supply or pharmaceutical product is only a covered health service if it is considered Medically Necessary. See "Medical Plan Definitions" on page 72 to understand how the Plan defines a covered health service. The fact that a physician or other provider has performed or prescribed a procedure or treatment does not mean that it is a covered service under the Plan.

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 prior authorization 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, 50% 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 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, 50% 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 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.

UnitedHealthcare's credentialing process confirms public information about the provider's licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a network physician to provide and coordinate all of your future covered health services.

If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single network physician for you.

In the event that you do not use the selected network physician, benefits will not be paid.

UnitedHealth Premium℠ Program

To help you make more informed choices about your health care, the UnitedHealth Premium® program recognizes network physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium® Physician, log onto **www.myuhc.com** or call the 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 72. 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.

With the UnitedHealthcare Plans

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits. For covered services provided by an in-network provider, you are not responsible for any difference between eligible expenses and the amount the provider bills.

For covered services provided by an out-of-network provider (other than emergency health services or services otherwise arranged by UnitedHealthcare), you will be responsible to the out-of-network physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an eligible expense as described below.

For out-of-network benefits, you are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for eligible expenses. Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines.

For **in-network** benefits, eligible expenses are based on the following:

- When covered services are received from an in-network provider, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered services are received from an out-of-network provider as a result of an emergency or as arranged by UnitedHealthcare, Eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For **out-of-network** benefits, eligible expenses are based on either of the following:

- When covered services are received from an in-network provider, eligible expenses are determined, based on:
  - Negotiated rates agreed to by the out-of-network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
    - Eligible expenses are determined based on 140% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of CMS for the same or similar laboratory service.
      - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
      - For Pharmaceutical Products, UnitedHealthcare uses 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, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
    - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the eligible expense is based on 50% of the provider's billed charge.
  - For Mental Health Services and Substance-Related and Addictive Disorder Services the eligible expense will be reduced by 25% for covered services provided by a psychologist and by 35% for covered services provided by a masters level counselor.

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

IMPORTANT NOTE: Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here.

Shared Savings Program

With certain out-of-network providers, UnitedHealthcare may obtain a discount to their billed charges through a Shared Savings Program. This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge.

Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the out-of-network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID card.

Keep in mind, Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare.

With the Out-of-Area Plan

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits. For covered health services from out-of-network providers, you are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for eligible expenses. Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines.

Eligible expenses are based on the following:

- When covered services are received from an **in-network provider**, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered services are received from an out-of-network provider as a result of an emergency or as arranged by the claims administrator, Eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When covered health services are received from an **out-of-network provider**, eligible expenses are determined, based on:
  - Negotiated rates agreed to by the out-of-network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible expenses are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market
    - When a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
      - For services other than pharmaceutical products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
      - For pharmaceutical products, UnitedHealthcare uses 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, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the eligible expense is based on 50% of the provider's billed charge.

- For **Mental Health and Substance-Related and Addictive Disorder** services the eligible expense will be reduced by 25% for covered services provided by a psychologist and by 35% for covered services provided by a master's level counselor.

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

IMPORTANT NOTE: Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here.

Your Deductible

A deductible is money you must spend out-of-pocket for covered 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 38 for specific deductible amounts.

With the UnitedHealthcare Choice and Value Plans, 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.

With the UnitedHealthcare HSA plans, the total family deductible must be met before the Plan covers any expenses. No one family member's expenses are capped at an individual deductible amount.

The deductible applies to all expenses except:

- Expenses that are subject to a flat dollar copayment, such as office visits and emergency room services under the Choice and Value PPO plans (See "Your Share in the Cost of Covered Services" on page 37 for more information about copayments.)
- Covered preventive healthcare expenses
- Approved travel and lodging expenses
- Expenses that exceed the R&C or MNRP guidelines, where applicable
- Your contributions toward the cost of medical coverage (your premium)
- The amounts of any penalty you incur by not obtaining prior authorization as required
- 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

Assume that you enroll in the Choice PPO plan and have a family of four. When you use in-network doctors and facilities, the annual family deductible is $1,050 under the Choice PPO plan. 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

Assume that you enroll in the Basic HSA plan and have a family of four. When you use in-network doctors and facilities, the annual family deductible is $5,000 under the Basic HSA plan. With the HSA plans, the total family deductible must be met before the Plan covers any expenses. No one family member's expenses are capped at an individual deductible amount.

Here is an example of how the family deductible might be satisfied:

Participant	Covered Expenses
Employee:	$1,000
Spouse:	$2,750
Child #1:	$750
Child #2:	$500
Total:	$5,000

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, with the UHC Choice and Value PPO plans, 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 under the UHC Choice and Value PPOs. When a flat dollar copayment is required, the covered expense is not subject to the annual deductible. For example, with the UHC Choice and Value PPOs, you pay $25 for an office visit with a primary care physician—the Plan pays the balance and the annual deductible does not apply. There are no copays in the Basic or Premium HSA medical plans.

Your coinsurance share or copayment requirement differs depending on the Plan you elect. If you are enrolled in a UnitedHealthcare PPO or HSA medical plan, your coinsurance share (and copayment, if applicable) requirements differ when you use in-network versus out-of-network providers. See the chart in "Your Medical Benefits" on page 38 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 and prescription drug copays, coinsurance and payments toward satisfying the annual deductible) in a calendar year.

Under the PPOs, your prescription drug copays will only count toward your in-network out-of-pocket maximum. With the HSA Plans, prescription costs count toward meeting your medical plan deductible and out-of-pocket maximum.

Please note that plan members can receive discounts on certain weight-loss prescription drugs that are not covered by the Plan. Your costs for such discounted, noncovered prescription drugs, are not applied toward meeting your deductible or out-of-pocket maximum.

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 one of the PPO or HSA plans, 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 38 for specific out-of-pocket maximums.

The individual out-of-pocket maximum is the most that will apply to any one family member, regardless of which UnitedHealthcare plan you choose. 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.**

Family Out-of-Pocket Maximum Example

Assume that you enroll in the Choice PPO plan and have a family of four. When you use in-network doctors and facilities, the annual family out-of-pocket maximum is $6,250 under the Choice PPO plan. Here is an example of how the in-network family out-of-pocket maximum might be satisfied:

Participant	Covered Expenses
Employee:	$2,950
Spouse:	$2,000
Child #1:	$1,000
Child #2:	$300
Total:	$6,250

The out-of-pocket maximum includes your medical copays (including those for covered health services available in *Your Prescription Drug Benefits)*, 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)
- 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 32 and defined in "Medical Plan Definitions" on page 72.

- The amounts of any penalty you incur by not obtaining prior authorization as required
- 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 (your share), 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 -- PPO and Out-of-Area Plans

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	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%
Physician, Lab & X-ray services	20%	40%	20%	40%	20%
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)

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	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 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-related and addictive disorder treatment	20%	40%	20%	40%	20%
Annual Out-of-Pocket Maximum					
Employee	$2,950	$5,900	$4,250	$8,500	$2,950
Employee + 1	$5,900	$11.800	$8,500	$17,000	$5,900
Family	$6,250	$12,500	$9,250	$18,500	$6,250

The chart below lists the deductibles, coinsurance (your share), and out-of-pocket maximums that currently apply under the UnitedHealthcare Basic and Premium HSA Plans

Deductibles, Coinsurance and Out-of-Pocket Maximums -- HSA Plans

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Annual Deductible				
Employee	$1,500	$3,000	$2,500	$5,000
Employee + 1	$3,000	$6,000	$5,000	$10,000
Family	$3,000	$6,000	$5,000	$10,000
Your Share in the Cost of Covered Services—After Deductible Unless Noted				
Office visit copayment—primary care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Office visit copayment—specialist	20% after deductible	40% after deductible	30% after deductible	50% after deductible

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Preventive Care				
Office visits	$0 (Plan pays 100% of eligible expenses)	40% after deductible	$0 (Plan pays 100% of eligible expenses)	50% after deductible
Other covered services	$0 (Plan pays 100% of eligible expenses)	40% after deductible	$0 (Plan pays 100% of eligible expenses)	50% after deductible
Emergency Room Visits—After Deductible				
Facility and physician charges (for a true medical emergency)	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Inpatient hospital care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Inpatient mental health and substance-related and addictive disorder treatment	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Annual Out-of-Pocket Maximum				
Employee	$5,000	$10,000	$6,450	$12,900
Employee + 1	$10,000	$20,000	$12,900	$25,800
Family	$10,000	$20,000	$12,900	$25,800
2018 HSA Contribution from Stryker*				
Employee	$500		$250	
Employee + 1	$1,000		$500	
Family	$1,000		$500	

* Refer to the "Health Savings Accounts" section for additional details. Direct Temps and employees scheduled to work less than 20 hours who have measured as eligible for medical coverage during their measurement period are not eligible for the company contribution. Also, employees hired between December 2 and December 31 are not eligible to receive the company contribution. In addition, the company contribution is not guaranteed each year and will be reviewed on an annual basis.

Benefit Maximums

There is no lifetime benefit maximum for covered individuals.

Emergency Room Care

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

With the HSA medical plans, emergency room care is subject to the deductible and coinsurance.

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.

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.

UHC Health Advantage Program

The UHC Health Advantage Program is dedicated to prevention, education, and ensuring that you receive age/condition-appropriate care from the highest quality and most cost-effective providers. A Personal Care Nurse will be notified when you or your physician calls the toll-free number on your ID card to notify UnitedHealthcare of an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign a Personal Care Nurse to help you navigate the healthcare system and get the most appropriate care for your condition. This assigned nurse will identify your needs, answer questions, explain options, and may refer you to specialized care programs. The Personal Care Nurse will provide you with his or her telephone number so that you may call them with questions about your condition, to set goals, or to discuss your overall health and wellbeing.

In addition to the Personal Care Nurse, the UHC Health Advantage Program team includes social workers and dieticians who will provide support and education to you or your covered family members. They will also ensure that you make the best use of your healthcare resources. Whether you have an upcoming hospital stay, a new diagnosis, or are having trouble managing a condition or benefit, this team is available to help guide you to make the best-informed decision.

Personal Care Nurses are specially trained to help you find your way around a complex healthcare system by:

- Answering questions about your diagnosis or treatment plan;
- Explaining the Plan benefits;
- Educating you about the available treatment options for specific conditions and helping you make informed decisions about your health care. The program includes access to relevant healthcare information, nurse coaching, and information on high quality providers and programs available to you;
- Providing support following an emergency room visit to ensure necessary follow-up care is received and to help avoid subsequent emergency room visits;
- Counseling you before a hospitalization or surgery to help you prepare for the hospitalization, plan for any follow-up care needs, and ensure you have the information and support you need for a successful recovery;
- Serving as a bridge between the hospital and home after an inpatient hospital stay. The Personal Care Nurse is there to help you confirm medications, assist with the acquisition of necessary medical equipment, and ensure that follow-up services are scheduled for a safe transition to home care;
- Helping with the coordination of specialists, hospitals, and pharmacies as well as any in-home care and/or equipment you may require;
- Helping you understand and access disease prevention and condition management tools, wellness information, and other resources;
- Providing specialized support for those with complex maternity needs and those who are being treated for cancer;
- Coaching, motivating, and empowering you to improve your health status;
- Ensuring that you get the right level of care and support when you need it;
- Providing counseling and support for behavioral health needs; and
- Helping you play an active role in your own care.

While the UHC Health Advantage Program will help you navigate the healthcare system, your primary care physician and other medical professionals will remain responsible for your medical care.

Prior Authorization Requirements for the UnitedHealthcare Plans

Care Management

When you seek prior authorization as required, UnitedHealthcare will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare requires prior authorization for certain covered health services. In general, your network primary physician and other in-network providers are responsible for obtaining prior authorization before they provide these services to you. There are some benefits, however, for which you are responsible for obtaining prior authorization as indicated in this SPD.

It is recommended that you confirm with the claims administrator that all covered health services listed below have been prior authorized as required. Before receiving these services from an in-network provider, you may want to contact the claims administrator to verify that the hospital, physician and other providers are in-network providers and that they have obtained the required prior authorization. Network facilities and in-network providers cannot bill you for services they fail to prior authorize as required. You can contact the claims administrator by calling the number on the back of your ID card.

When you choose to receive certain covered health services from out-of-network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-network provider intends to admit you to a network facility or refers you to other in-network providers.

To obtain prior authorization, call the number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

In most cases, in-network providers are responsible for obtaining prior authorization from the claims administrator or contacting UnitedHealthcare by calling a health advisor before they provide these services to you. However, you are responsible for obtaining prior authorization from the claims administrator prior to receiving a service.

Services for which you are required to obtain prior authorization are identified in the benefit descriptions throughout this SPD. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization and any applicable penalties.

Contacting UnitedHealthcare or a health advisor is easy.

Simply call the number on your ID card.

Services that require prior authorization include:

- Non-emergency ambulance transportation;
- Clinical trials;
- Congenital heart disease surgeries;
- Diabetes services for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item);
- Durable medical equipment, including DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item);
- Gender dysphoria services, including both surgical treatment and non-surgical treatment;
- Home health care services;
- Hospice care (as described below);
- Hospital inpatient stays (as described below);
- Outpatient lab, X-ray and diagnostic services (with the exception of major diagnostic and imaging services);
- Mental health services, neurobiological disorders - autism spectrum disorder services, substance-related and addictive disorders services (as described under "Mental Health, Substance-Related and Addictive Disorder and Neurobiological Disorder Services" on page 60;
- Obesity surgery;
- Genetic testing (BRCA);
- Inpatient stay for the mother and/or newborn following delivery;
- Prosthetic devices that exceed $1,000 per device;
- Reconstructive procedures (as described below);
- Skilled nursing facility/inpatient rehabilitation facility services;
- Outpatient surgery for blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries, cochlear implant and orthognathic surgeries;

- Therapeutic treatments (outpatient), such as dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy, and MRI-guided focused ultrasound; and
- Transplantation services.

Prior Authorization Requirement for Hospital inpatient stays

Please remember for out-of-network benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including emergency admissions) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, benefits will be subject to a $400 penalty.

Prior Authorization Requirement for Hospice Care

For out-of-network benefits you must obtain prior authorization from the claims administrator five business days before admission for an inpatient stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

Prior Authorization Requirement for Reconstructive Services

For out-of-network benefits for:

- A scheduled reconstructive procedure you must obtain prior authorization from the claims administrator five business days before a scheduled reconstructive procedures is performed.
- A non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained from the claims administrator as required, or notification is not provided, benefits will be subject to a $400 penalty.

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 UHC. 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 obtain authorization as required. Any penalty amounts you pay will not count toward your deductible or out-of-pocket maximum.

Special Note: Mental Health and Substance-Related and Addictive Disorder Services

To receive the highest level of benefits and to avoid incurring penalties, you must call the claims 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.** 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; Intensive behavioral therapy, including Applied Behavior Analysis (ABA).
- **Substance-related and addictive 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

See “Mental Health, Substance-Related and Addictive Disorder and Neurobiological Disorder Services” on page 60 of “Covered Medical Expenses” for more information about these types of services.

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 the UnitedHealthcare Choice or Value 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 HSA or Out-of-Area plans, you pay the applicable coinsurance for the eligible expense after you have met your deductible for a second surgical opinion consultation, including X-rays and lab work.

Clinical Programs and Resources

Stryker believes in giving you the tools you need to be an educated health care consumer. To that end, Stryker has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members;
- Manage a chronic health condition; and
- Navigate the complexities of the health care system.

Note

Information obtained through the services identified in this section is based on current medical literature and on physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Stryker are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Stryker has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis;
- A minor sickness or injury;
- Men’s, women’s, and children’s wellness;
- How to take prescription drugs safely;
- Self-care tips and treatment options;
- Healthy living habits; or
- Any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library’s over 1,100 recorded messages, with over half in Spanish.

NurseLine℠ is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine℠.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLine℠ toll-free any time, 24 hours a day, seven days a week. You can count on NurseLine℠ to help answer your health questions.

With NurseLine℠, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, and seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com.**

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called 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 health care information;
- Coaching by a nurse through decisions in your treatment and care;
- Expectations of treatment; and
- Information on high quality providers and programs.

Conditions for which this program is available include:

- Abnormal Uterine Bleeding
- Benign Prostatic Hyperplasia
- Breast Cancer
- Endometriosis
- Hip Pain
- Knee Pain
- Low Back Pain
- Overweight and Obesity
- Prostate Cancer
- Shoulder Pain
- Stable Angina
- Asthma
- Allergies (seasonal, pet, mold)
- Cardiac Imaging
- Gastro Esophageal Reflux Disease
- Hypertension
- Influenza
- Migraine Headache
- Osteoporosis
- Sinusitis
- Sleep Apnea
- Urinary Tract Infection
- Uterine Fibroids
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Osteoporosis Screening
- Prostate Cancer Screening

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 contact the number on the back of your ID card.

UHC's Member Website: www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website;
- Research a health condition and treatment options to get ready for a discussion with your physician;
- Search for in-network providers available in your plan through the online provider directory;
- Access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;

- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on the UHC member website, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims;
- View eligibility and plan benefit information, including copays and annual deductibles;
- View and print all of your Explanation of Benefits (EOBs) online; and
- Order a new or replacement ID card or print a temporary ID card.

Condition Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- Access to educational and self-management resources on a consumer website;
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care; and
- Toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition;
  - medication management and compliance;
  - reinforcement of on-line behavior modification program goals;
  - preparation and support for upcoming physician visits;
  - review of psychosocial services and community resources;
  - caregiver status and in-home safety;
  - use of mail-order pharmacy and in-network providers.

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

Cancer Support

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**.

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, 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.

If your physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. 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 the number on the back of your ID card.

Healthy Back Program

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- Education on back-related information and self-care strategies;
- Management of depression related to chronic back pain; 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.

Maternity Support Program

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

This program offers:

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

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Travel and Lodging Assistance Program

Travel and lodging assistance is available for you or your eligible family member when you meet certain qualifications related to treatment for cancer, congenital heart disease or an organ transplant services. To qualify, you must receive care at a Designated Provider and require traveling a designated distance from your home address to the facility for cancer, congenital heart disease or an organ transplant services. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion.
- If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The claims administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient (when not in the hospital) or the caregiver.
- Per diem is limited to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries
- Alcoholic beverages
- Personal or cleaning supplies
- Meals
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separate from the rent payment
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider
- Taxi fares (not including limos or car services)
- Economy or coach airfare
- Parking
- Trains
- Boat
- Bus
- Tolls.

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.

Important to Remember…

UnitedHealthcare 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.

Benefits for Covered Medical Expenses -- UHC PPO Plans and Out-of-Area Plan

The following table highlights the amount you pay for covered services (your share of the cost):

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	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	20%	40%	20%	40%	20%
Intensive care unit	20%	40%	20%	40%	20%
Services and supplies, including diagnostic testing, laboratory services and X-rays	20%	40%	20%	40%	20%
Surgery	20%	40%	20%	40%	20%
Emergency Treatment					
Emergency room for medical emergencies and accidental injuries	$125 copayment	$125 copayment	$125 copayment	$125 copayment	$125 copayment
Emergency room for non-emergency conditions	Not covered	Not covered	Not covered	Not covered	
Urgent care/walk-in facility	$40 copayment	40%	$40 copayment	40%	20%
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 38 for more information about your share of the cost for preventive care office visits.)					
Routine physical exam	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible	40%; not subject to deductible	$0; 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.	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
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	$25 copayment	40%	$25 copayment (no copayment after first visit for prenatal care)	40%	20%
Office visit – specialist	$40 copayment	40%	$40 copayment (no copayment after first visit for prenatal care)	40%	20%
Physician Lab and X-ray services Prior authorization is required for out-of-network before Genetic Testing – BRCA is performed. Otherwise, benefits will be subject to a $400 penalty.	20%	40%	20%	40%	20%
Medical care	20%	40%	20%	40%	20%
Surgery* (including Congenital Heart Disease surgery)	20%	40%	20%	40%	20%
Allergy testing and treatment	$40 office visit copayment for allergy treatment Injections/Allergy testing: 20%	40%	$40 office visit copayment for allergy treatment Injections/Allergy testing: 20%	40%	20%
Physical therapy *provided in all settings*	20%	40%	20%	40%	20%
Occupational therapy	20%	40%	20%	40%	20%
Speech therapy	20%	40%	20%	40%	20%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Chiropractic treatment Medical necessity documentation required after 30 visits per calendar year. If visits exceed 30 in any calendar year, UnitedHealthcare must review and approve additional benefits for chiropractic treatment.	$40 copayment	40%	$40 copayment	40%	20%
Private duty nursing by an RN or LPN	20%	40%	20%	40%	20%
Podiatric treatment Covered only if for systematic disease or diabetes.	$40 copayment	40%	$40 copayment	40%	20%
Other Services—After Deductible Unless Noted					
Ambulance*	20%	20%	20%	20%	20%
Anesthetics and their administration	20%	40%	20%	40%	20%
Durable medical equipment (DME)*	20%	40%	20%	40%	20%
Gender Dysphoria Treatment*	20%	40%	20%	40%	20%
Infertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $10,000 lifetime maximum. Participants must work with a nurse consultant through the UHC Fertility Solutions (FS) program to identify the best treatment options and facilitate care through one of UHC's Centers of Excellence network clinics.	20%, up to lifetime maximums	Not covered	20%, up to lifetime maximums	Not covered	20%, up to lifetime maximums
Prosthetic and orthotic devices*	20%	40%	20%	40%	20%
Injectable drugs not intended for self administration	20%	40%	20%	40%	20%

	UHC Choice PPO Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*	***Out-of-Area Plan*** *(R&C guidelines apply)*
Mental Health and Substance-Related and Addictive Disorder Treatment—After Deductible Unless Noted					
Inpatient*	20%	40%	20%	40%	20%
Residential day care*	20%	40%	20%	40%	20%
Outpatient* (outpatient professional services will be subject to the deductible and coinsurance; office visits are covered with no deductible)	$25 copayment	40%	$25 copayment	40%	20%
Special Facilities					
Birthing centers	20%	40%	20%	40%	20%
Home healthcare*	20%	40%	20%	40%	20%
Hospice care—inpatient and outpatient*	20%	40%	20%	40%	20%
Skilled nursing facility*	20%	40%	20%	40%	20%
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**.					

* In general, your network provider must obtain prior authorization from the claims administrator, as described in this SPD before you receive certain covered health services. There are some network benefits, however, for which you are responsible for obtaining prior authorization from the claims administrator.

Plan Benefits for Covered Medical Expenses – UHC Premium and Basic HSA Plans

The following table highlights the amount you pay for covered services (your share of the cost):

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Hospital Charges: Inpatient and Outpatient Services*—After Deductible				
Room and board charges up to the semi-private room rate	20%	40%	30%	50%
Intensive care unit	20%	40%	30%	50%
Services and supplies, including diagnostic testing, laboratory services and X-rays*	20%	40%	30%	50%
Surgery	20%	40%	30%	50%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Emergency Treatment—After Deductible				
Emergency room for medical emergencies and accidental injuries	20%	20%	30%	30%
Emergency room for non-emergency conditions	Not covered	Not covered	Not covered	Not covered
Urgent care/walk-in facility	20%	40%	30%	50%
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 38 for more information about your share of the cost for preventive care office visits.)				
Routine physical exam	$0; not subject to deductible	40%;after deductible	$0; not subject to deductible	50%; after 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.	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible	50%; not subject to deductible
Doctors and Healthcare Professionals—After Deductible (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	20%	40%	30%	50%
Office visit – specialist	20%	40%	30%	50%
Physician Lab and X-ray services Prior authorization is required before out-of-network Genetic Testing – BRCA is performed. Otherwise, benefits will be subject to a $400 penalty.	20%	40%	30%	50%
Medical care	20%	40%	30%	50%
Surgery*	20%	40%	30%	50%
Allergy testing and treatment	20%	40%	30%	50%
Physical and occupational therapy	20%	40%	30%	50%
Speech therapy	20%	40%	30%	50%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Chiropractaic treatment Medical necessity documentation required after 30 visits per calendar year. If visits exceed 30 in any calendar year, UnitedHealthcare must review and approve additional benefits for chiropractic treatment.	20%	40%	30%	50%
Private duty nursing by an RN or LPN	20%	40%	30%	50%
Podiatric treatment Covered only if for systematic disease or diabetes.	20%	40%	30%	50%
Other Services—After Deductible				
Ambulance*	20%	20%	30%	30%
Anesthetics and their administration	20%	40%	30%	50%
Durable medical equipment (DME)*	20%	40%	30%	50%
Gender Dysphoria Treatment*	20%	40%	30%	50%
Infertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $10,000 lifetime maximum. Participants must work with a nurse consultant through the UHC Fertility Solutions (FS) program to identify the best treatment options and facilitate care through one of UHC's Centers of Excellence network clinics.	20%, up to lifetime maximums	Not covered	30%, up to lifetime maximums	Not covered
Prosthetic and orthotic devices*	20%	40%	30%	50%
Injectable drugs not intended for self administration	20%	40%	30%	50%
Mental Health and Substance-Related and Addictive Disorder Services—After Deductible				
Inpatient*	20%	40%	30%	50%
Residential day care*	20%	40%	30%	50%
Outpatient	20%	40%	30%	50%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	***Out-of-Network*** *(MNRP guidelines apply)*	***In-Network***	***Out-of-Network*** *(MNRP guidelines apply)*
Special Facilities—After Deductible				
Birthing centers	20%	40%	30%	50%
Home healthcare*	20%	40%	30%	50%
Hospice care—inpatient and outpatient*	20%	40%	30%	50%
Skilled nursing facility*	20%	40%	30%	50%

* In general, your network provider must obtain prior authorization from the claims administrator, as described in this SPD before you receive certain covered health services. There are some network benefits, however, for which you are responsible for obtaining prior authorization from the claims administrator.

Maternity Benefits

Stryker's medical 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.

Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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 Benefits Enrollment Site at **http://enroll.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 30 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.

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

It is important that you notify us regarding your pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Benefits for Outpatient Rehabilitation Services

Stryker's medical plan covers short term outpatient rehabilitation services (including habilitative 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

For all rehabilitation services, a licensed therapy provider, under the direction of a physician (when required by state law), must perform the services. Benefits include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility. Rehabilitative services provided in a covered member's home by a home health agency are covered as home health care. Rehabilitative services provided in a covered member's home other than by a home health agency are provided as described in this section.

Benefits can be denied or shortened for covered member who is not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, the Plan will pay benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorder or developmental delay.

Habilitative Services

For the purpose of this benefit, "habilitative services" means covered health services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a covered member's current condition or to prevent or slow further decline.
- It is ordered by a physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

The claims administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for covered members with a disabling condition when both of the following conditions are met:

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

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

Limitations

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

Benefits for durable medical equipment and prosthetic devices, when used as a component of habilitative services, are described under "Durable Medical Equipment (DME)" on page 63 and under "Prosthetic Devices" on page 67 .

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 benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, 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; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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 (including three-dimensional (3-D) breast cancer mammography)
- 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
  - Pre-eclampsia screening (included in prenatal visit)
- Routine PSA
- Routine lab tests and X-rays related to covered preventive testing (facility and professional charges)
- Breast pumps:

  Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

  If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. UnitedHealthcare will determine the following:
  - Which pump is the most cost effective;
  - Whether the pump should be purchased or rented;
  - Duration of a rental;
  - Timing of an acquisition.

  Benefits are only available if breast pumps are obtained from a DME provider or physician.
- Immunizations:
  - Covered childhood immunizations generally include: Diptheria-tetanuspertussis (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.
- Statins for prevention of cardiovascular disease for adults ages 40 - 75
- Adult latent tuberculosis screening
- Colorectal cancer fecal DNA test for adults ages 50 to 75

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 or dental exams

To confirm whether a service is covered as a preventive care benefit, contact UnitedHealthcare at **800 387 7508**.

Cancer Resource Center (CRS)

The Plan pays benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated providers are defined in the "Medical Plan Definitions" on page 72.

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 the UHC Health Advantage Program;
- 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 Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays benefits as described for:

- 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: Services described for travel and lodging are covered health services only in connection with cancer-related services received at a Designated Provider.

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 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**.

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

Prior Authorization Requirement

You must obtain prior authorization from the claims administrator as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, eligible benefits will be subject to a $400 penalty.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered as outpatient prescription drugs

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining any durable medical equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

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

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

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator five business days before receiving services including nutritional foods and private duty nursing or as soon as is reasonably possible. If you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

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 covered as defined by the Plan.

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 members 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 72.
- Any combination of network benefits and out-of-network benefits is limited to 120 days per calendar year.

Prior Authorization Requirement

Please remember for out-of-network benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a $400 penalty.

Mental Health, Substance-Related and Addictive Disorder and Neurobiological Disorder Services

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

Covered neurobiological disorder services include behavioral services for Autism Spectrum Disorder, including intensive behavioral therapies, such as applied behavior analysis (ABA) that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;

- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

Note: The benefits described here are for the behavioral 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.

Mental health, substance-related and addictive disorder and neurobiological disorder benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

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

The Mental Health or Substance-Related and Addictive Disorder Administrator provides administrative services for all levels of care.

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

Prior Authorization Requirement

Please remember for out-of-network benefits for:

- A scheduled admission (including partial hospitalization/day treatment and admission for services at a residential treatment facility) you must obtain authorization from the claims administrator five business days before admission.
- A non-scheduled admission (including emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for out-of-network benefits you must obtain prior authorization from the claims administrator before the following services are received. Services requiring prior authorization: Intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

If you fail to obtain prior authorization from or provide notification to the claims administrator as required, benefits will be subject to a $400 penalty.

Exclusions for Mental Health/Substance-Related and Addictive Disorders

In addition to any exclusions or limits that may be described in “Expenses Not Covered” on page 68, 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.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Transitional Living 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 Provider 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 Provider 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 as described in "Travel and Lodging Assistance Program" under "Clinical Programs and Resources" on page 44

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.

Prior Authorization Requirement

For in-network benefits you must obtain prior authorization from the claims administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed by a Designated Provider, in-network benefits will not be paid. Out-of-network benefits will apply.

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Ambulance Services

The Plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers emergency health services. Ambulance service by air is covered in an emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, the claims administrator may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.

The Plan also covers non-emergency transportation provided by a licensed professional ambulance (either ground or air ambulance as the claims administrator determines appropriate) between facilities when the transport is:

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

Prior Authorization Requirement

In most cases, the claims administrator will initiate and direct non-emergency ambulance transportation. If you are requesting non-emergency ambulance services, you must obtain prior authorization as soon as possible before transport.

If you fail to obtain prior authorization from the claims administrator, benefits will be subject to a $400 penalty.

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
- Standard 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 67.

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

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 member’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 any time 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.

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining any durable medical equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a $400 penalty.

Gender Dysphoria

Benefits for the treatment of gender dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses;
- Cross-sex hormone therapy:
- Cross-sex hormone therapy administered by a medical provider (for example during an office visit);
- Cross-sex hormone therapy dispensed from a pharmacy;
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting;
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy;
- Surgery for the treatment for gender dysphoria, including the surgeries listed below:
  - Male to Female:
    - Clitoroplasty (creation of clitoris)
    - Labiaplasty (creation of labia)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Urethroplasty (reconstruction of female urethra)
    - Vaginoplasty (creation of vagina)
  - Female to Male:
    - Bilateral mastectomy or breast reduction
    - Hysterectomy (removal of uterus)
    - Metoidioplasty (creation of penis, using clitoris)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vulvectomy (removal of vulva)]

Genital surgery and bilateral mastectomy or breast reduction surgery documentation requirements:

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

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating gender dysphoria. The assessment must document that the covered member meets all of the following criteria:
  - Persistent, well-documented gender dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The covered member must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria, who have independently assessed the covered member. The assessment must document that the covered member meets all of the following criteria.
  - Persistent, well-documented gender dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).]

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment

You must obtain prior authorization as soon as the possibility of surgery arises.

If you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

Prior Authorization Requirement for Non-Surgical Treatment

Depending upon where the covered health service is provided, any applicable prior authorization requirements will be the same as those stated under each covered health service category in this section.

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 members 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.

Infertility Services and Fertility Solutions (FS) Program

Therapeutic services for the treatment of infertility when provided by or under the direction of a physician. The Plan pays benefits for infertility when provided by Designated Providers participating in the Fertility Solutions (FS) program.

Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation.
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo’s (storage is limited to 12 months).

  Note. Long-term storage costs (anything longer than 12 months) are not covered under the Plan.
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.

- Embryo transportation related network disruption.
- Donor coverage –associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm.

  Note. The Plan does not cover donor charges associated with compensation or administrative services.
- Fertility Preservation - when planned cancer or other medical treatment is likely to produce infertility/sterility, the Plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Pre-implantation Genetic Screening (PGS)

- The Plan also covers pre-implantation genetic screening (PGS) when used in conjunction with elective single embryo transfer. These technologies include, but are not limited to, array comparative genomic hybridization, quantitative polymerase chain reaction and single nucleotide polymorphism array testing.

Infertility Services for Surrogate Coverage

- Artificial insemination of a surrogate female partner in the case of a male covered member without a female partner is a covered benefit. If the female does not conceive following six cycles of insemination, no further coverage is provided unless a different surrogate is used, and then only for an additional six months of inseminations with the male covered member's sperm. The cost of any surrogate fees, as well as the costs associated with pregnancy, delivery and any complications, is not covered under the Plan.

To be eligible for benefits, you must:

- Have failed to achieve a pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Have failed to achieve pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination.
- Have failed to achieve pregnancy due to impotence/sexual dysfunction.
- Have infertility that is not related to voluntary sterilization.
- Be under age 44, if female and using own oocytes (eggs).
- Be under age 50, if female and using donor oocytes (eggs).

  Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.
- Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- Child dependents are eligible for infertility benefit if above eligibility criteria is met.

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

Any combination of in-network benefits and out-of-network benefits are limited to $25,000 per covered member during the entire period you are covered under the Plan. There is also a separate prescription drug lifetime maximum benefit.

Fertility Solutions

The Plan pays benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions (FS) program. The Fertility Solutions (FS) provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics.

Covered members who do not live within a 60 mile radius of a FS Designated Provider will need to contact an FS case manager to determine a network facility prior to starting treatment. For infertility services and supplies to be considered covered health services, contact FS and enroll with a nurse consultant prior to receiving services.

You or a covered dependent may:

- Be referred to FS by the claims administrator.
- Call the telephone number on your ID card.
- Call FS directly at 1-866-774-4626.

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

Prosthetic Devices

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the covered member's medical condition occurs sooner than the three 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.

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, benefits will be subject to a $400 penalty.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided all of the following is true:

- You have a minimum Body Mass Index (BMI) of 40 or 35 in conjunction with any other co-morbidity (i.e. coronary heart disease, type 2 diabetes, etc.);
- You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five years;
- Patient has completed growth;
- You have completed a six-month physician-supervised weight loss program.

Benefits for obesity surgery services are covered only if they meet the definition of a covered health service (see "Medical Plan Definitions" on page 72) and are not considered experimental, investigational or unproven.

Prior Authorization Requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as the possibility of obesity surgery arises.

If you fail to obtain prior authorization from the claims administrator as required, benefits will be subject to a $400 penalty.

It is important that you provide notification regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Hyperhidrosis Treatment

The Plan provides coverage for the following medical and surgical treatments for hyperhidrosis (excessive sweating) under the direction of a physician:

Medical treatments:

- Botulinum (botox) injections

Surgical treatments:

- Sympathectomy (scopic or open procedure) for the sympathetic nerve or sympathetic ganglion;
- Liposuction for the removal of axillary sweat glands; and
- Excision of axillary sweat glands.

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 days. Specialty pharmacies guarantee round-the-clock access to a pharmacist for any medication or administration-related questions.

Please note that there is a Coupon Adjustment Benefit Plan Protection program for prescriptions filled through UHC's specialty pharmacy, BriovaRx. Through this program, if a manufacturer drug coupon or manufacturer copay card is used, the drug manufacturer drug coupon or copay card dollar amount will not apply to your deductible and/ or out-of-pocket maximum amounts. Only your actual payment amount (after the coupon is applied) will apply to the deductible and out-of-pocket maximum amounts.

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 72.) Covered health services are those health services including services, supplies or pharmaceutical products, which the Claims administrator determines to be all of the following:
    - Medically necessary.
    - Described as a covered health service in this SPD under "Covered Medical Expenses" on page 48.
    - Not otherwise excluded in this SPD "Expenses Not Covered" on page 68.
- Health services related to a non-covered health service: When a service is not a covered health service, all services related to that non-covered health service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service.

  For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization.
- Services and supplies that are not necessary for the diagnosis, care or treatment of the disease or injury involved
- Experimental or investigational services or unproven services, unless the Plan has agreed to cover them as defined in "Medical Plan Definitions" on page 72. This exclusion applies even if experimental or investigational services or unproven services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.
- 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 covered member 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 member'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
  - To 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
  - For breast reduction surgery in which UHC determines is requested to treat a physiologic functional impairment or for coverage required by the Women's Health and Cancer Rights Act of 1998
- Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- Charges for cosmetic procedures for gender dysphoria including:
  - Abdominoplasty
  - Blepharoplasty
  - Breast enlargement, including augmentation mammoplasty and breast implants
  - Body contouring, such as lipoplasty
  - Brow lift
  - Calf implants

  - Cheek, chin, and nose implants
  - Injection of fillers or neurotoxins
  - Face lift, forehead lift, or neck tightening
  - Facial bone remodeling for facial feminizations
  - Hair removal
  - Hair transplantation
  - Lip augmentation
  - Lip reduction
  - Liposuction
  - Mastopexy
  - Pectoral implants for chest masculinization
  - Rhinoplasty
  - Skin resurfacing
  - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple)
  - Voice modification surgery, including voice lessons and voice therapy.
- Charges for infertility treatment-related services, including:
  - Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue
  - Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees)
  - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes
  - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma
  - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier
  - Ovulation predictor kits
- Charges for surrogate parenting, donor oocytes (eggs), donor sperm and host uterus
- Charges for artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes
- Charges for the reversal of voluntary sterilization
- Charges for food of any kind, including enteral feedings and other nutritional and electrolyte formulas, infant formula, infant formula available over the counter and donor breast milk. Note: This exclusion will not apply if the food is the only source of nutrition as determined by a physician or to treat inborn errors of metabolism, such as phenylketonuria (PKU), or if it is over the counter formula administered through enteral feedings (Gastric Tube) for children up to the age of 18.
- 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 "Travel and Lodging Assistance Program" on page 47.
- 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 Surgery" on page 67.
- Charges for insulin syringes, lancets, insulin pen injectors and diabetic test strips (These expenses are covered under the prescription drug plan.)
- 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
- Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
  - Commode chairs for the shower;
  - Non-standard wheelchairs.

- 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 member

  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 62, 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 for snoring, except when provided as part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- 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,
- Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under “Obesity Surgery” on page 67
- 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.

Assisted Reproductive Technology (ART)

The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism spectrum disorders

A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

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. Reshaping a nose with a prominent bump is a good example of a cosmetic procedure because appearance would be improved, but there would be no improvement in physiological function, for example breathing.

Covered health services

Those health services, including services, supplies or pharmaceutical products, which the claims administrator determines to be:

- Medically necessary.
- Described as a covered health service in this SPD under "Covered Medical Expenses" on page 48.
- Provided to a covered person who meets the Plan's eligibility requirements, as described in the "Healthcare Participation" section of this SPD.
- Not otherwise excluded in this SPD as described under "Expenses Not Covered" on page 68.

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 Provider

A provider and/or facility that:

- Has entered into an agreement with the claims administrator, or with an organization contracting on the claims administrator's behalf, to provide covered health services for the treatment of specific diseases or conditions; or
- The claims administrator has identified through the claims administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all in-network hospitals or physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the claims administrator at www.myuhc.com or the telephone number on your ID card.

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

For covered health services, incurred while the Plan is in effect, eligible expenses are determined by UnitedHealthcare as stated below and as detailed in "Eligible Expenses" on page 33.

Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in their discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services

With respect to an emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Experimental or investigational services

Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time 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.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are available as described under the definition of "Clinical Trials" above.
- If you are not a participant in a qualifying clinical trial as described above, and have a sickness or condition that is likely to cause death within one year of the request for 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, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Fertility Solutions (FS)

A program administered by UnitedHealthcare or its affiliates. The FS program provides:

- Specialized clinical consulting services to covered employees and enrolled dependents to educate on infertility treatment options.
- Access to specialized network facilities and physicians for infertility services.

Gender Dysphoria

A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

Diagnostic criteria for adults and adolescents:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.

  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

UHC Health Advantage

Programs provided by the claims administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents.

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.

Intensive Behavioral Therapy (IBT)

Outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavioral Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

Intensive Outpatient Treatment

Astructured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or hospital-based and provides services for at least three hours per day, two or more days per week.

Maximum Out-of-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.

Medically Necessary

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the claims administrator or its designee, within the claims administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The claims administrator reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the claims administrator's sole discretion.

The claims administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the claims administrator and revised from time to time), are available to covered persons on www.myuhc.com or by calling the number on your ID card, and to physicians and other health care professionals on UnitedHealthcareOnline.

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.

Neonatal Resource Services (NRS)

A program administered by UnitedHealthcare or its affiliates made available to you by Stryker. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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 members. 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 out-of-network benefits)

Benefits for covered health services that are provided by a out-of-network physician or other out-of-network provider.

Personal Health Nurse

The primary nurse that the claims administrator may assign to you if you have a chronic or complex health condition. If a Personal Health Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products

U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a covered health service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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.

Shared Savings Program

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

Sickness

Physical illness, disease or pregnancy. The term sickness as used in this SPD includes mental illness, or substance-related and addictive disorders, regardless of the cause or origin of the mental illness, or substance-related and addictive disorder.

Skilled nursing facility

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

Substance-related and addictive disorder services

Covered health services for the diagnosis and treatment of alcoholism and substance-related and addictive 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 a covered health service.

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

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

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

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

Please note:

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

The decision about whether such a service can be deemed a covered health service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care

Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center

A facility that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.