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 **https://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 Account** 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

Other medical options

If you reside in an area offering an alternative medical option, see the **Location-based provisions** section for more information.

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).

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 an out-of-network benefit level.

How the UnitedHealthcare plans work

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 82 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.

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 costs 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 costs, deductibles, co-insurance and out-of-pocket maximums. In addition there are no co-pays with the HSA plans.

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 handle in-network 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.

Emergency services provided by an out-of-network provider will be reimbursed as eligible expenses under the plan.

Covered services provided at certain in-network facilities by an out-of-network physician, when not emergency services, will be reimbursed as eligible expenses under the plan. For these covered services, "certain network facility" is limited to:

- a hospital (as defined in 1861(e) of the Social Security Act),
- a hospital outpatient department,
- a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act),
- an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and
- any other facility specified by the Secretary.

Air ambulance transport provided by an out-of-network provider will be reimbursed as described under “Eligible expenses” on page 32.

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.

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.

If you receive a covered service from an out-of-network provider and were informed incorrectly prior to receipt that the provider was an in-network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for in-network benefits.

It is possible that you might not be able to obtain services from a particular in-network provider. The network of providers is subject to change. Or you might find that a particular in-network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another in-network provider to get in-network benefits. However, if you are currently receiving treatment for covered services from a provider whose network status changes from in-network to out-of-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the in-network benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing an out-of-network physician or health care facility, you may be eligible to receive transition of care benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care benefits, please contact UHC at the telephone number on your ID card.

Do not assume that an in-network provider's agreement includes all covered services. Some in-network providers contract with UHC to provide only certain covered services, but not others. Some in-network providers choose to be an in-network provider for only some of UHC's products. Refer to your provider directory or contact UHC for assistance.

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 82. 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 expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits.

- For designated in-network benefits and in-network benefits for covered health services provided by an in-network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.
- For out-of-network benefits, except as described below, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for eligible expenses.
  - For covered health services that are **ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.
  - For covered health services that are **non-ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.
  - For covered health services that are **emergency health services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.
  - For covered health services that are **Air Ambulance services provided by an**

out-of-network provider, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated in-network benefits and in-network benefits

Eligible expenses are based on the following:

- When covered health services are received from a designated in-network and in-network provider, Eligible expenses are the UHC contracted fee(s) with that provider.
- When covered health services are received from an out-of-network provider as arranged by UnitedHealthcare, including when there is no in-network provider who is reasonably accessible or available to provide covered services, 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.

Out-of-network benefits

When covered health services are received from an out-of-network provider as described below, Eligible expenses are determined as follows:

- **For non-emergency covered health services received at certain in-network facilities from out-of-network physicians** when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section **2799B-2(d) of the Public Service Act** with respect to a visit as defined by the Secretary, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state **All Payer Model Agreement**.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UnitedHealthcare.
  - The amount determined by **Independent Dispute Resolution (IDR)**.

  For the purpose of this provision, "certain in-network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Important note

For ancillary services, non-ancillary services provided without notice and consent, and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-network physician, may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible.

- **For emergency health services provided by an out-of-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state **All Payer Model Agreement**.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UnitedHealthcare.
  - The amount determined by **Independent Dispute Resolution (IDR)**.

Important note

You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.

- **For air ambulance transportation provided by an out-of-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state **All Payer Model Agreement**.
- The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UnitedHealthcare.
- The amount determined by **Independent Dispute Resolution (IDR)**.

Important note

You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

When covered health services are received from an out-of-network provider, except as described above, eligible expenses are determined as follows:

- An amount negotiated by UnitedHealthcare,
- A specific amount required by law (when required by law), or
- An amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service.

The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-network provider, the applicable coinsurance, copayment or any deductible. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible to access the Advocacy Services as described below.

Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the eligible expense (which includes your coinsurance, copayment, and deductible) is yours.

Advocacy services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment.

In addition, if UnitedHealthcare, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and UnitedHealthcare, or its designee, determines that it would serve the best interests of the Plan and its employees (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare or its designee, may use its sole discretion to increase the eligible expense for that particular claim.

Important note

Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the Public Health Service Act.

With the out-of-area plan

Eligible expenses

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits. For covered health services from out-of-network providers, except as described below, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount the Plan will pay.

- For covered health services that are **ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.
- For covered health services that are **non-ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians** who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is

based on the recognized amount as defined in the SPD.

- For covered health services that are **emergency health services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.
- For covered health services that are **air ambulance services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Eligible expenses are determined in accordance with the UnitedHealthcare's reimbursement policy guidelines or as required by law.

When covered health services are received from an out-of-network provider, eligible expenses are determined as follows:

- **For non-emergency covered health services received at certain in-network facilities from out-of-network physicians** when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section **2799B-2(d) of the Public Service Act** with respect to a visit as defined by the Secretary, the eligible expenses is based on:
  - The reimbursement rate as determined by applicable law or by an applicable state **All Payer Model Agreement**.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Important notice

For ancillary services, and for non-ancillary services provided without notice and consent, you are not responsible, and an out-of-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.

- **For emergency health services provided by an out-of-network provider**, the eligible expense is based on:
  - The reimbursement rate as determined by applicable state law or by an applicable state **All Payer Model Agreement**.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

Important notice

You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.

- **For air ambulance transportation provided by an out-0f-network provider**, the eligible expense is based on:
  - The reimbursement rate as determined by applicable state law or by an applicable **All Payer Model Agreement**.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

Important notice

You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Except as described above, eligible expenses are based on either of the following:

- When covered health services are received from an in-network provider, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered health services are received from an out-of-network provider 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.
- 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 their vendors, affiliates or subcontractors, at UHC's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - For covered health services other than pharmaceutical products, eligible expenses are determined based on available data resources of competitive fees in that geographic area.
    - When covered health services are pharmaceutical products, eligible expenses are determined based on 110% of the published rates allowed by the **Centers for Medicare and Medicaid Services (CMS) for Medicare** for the same or similar service within the geographic market.

When a rate is not published by **CMS** for the service, UnitedHealthcare uses a gap methodology established by **OptumInsight** and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, 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.

Important notice

Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section **2799B-2(d) of the Public Health Service Act**.

Your deductible

A deductible is money you must spend out-of-pocket for covered expenses or the recognized amount when applicable 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 under "Your medical benefits" on page 39 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 eligible expenses guidelines or the recognized amount, 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
- Except when required by law, 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 or the recognized amount when applicable (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 under “Your medical benefits” on page 39 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 PPO plans, 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.

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 under "Your medical benefits" on page 39 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 that exceed eligible expenses, or the recognized amount when applicable, as defined in "Medical plan definitions" on page 82.
- 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.

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific covered health services as described in the definition of "Recognized Amount" on page 90 in "Medical plan definitions."

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)
Emergency room visits-after deductible unless noted					
Facility and physician charges	$150; not subject to deductible	$150; not subject to deductible	$150; not subject to deductible	$150; not subject to deductible	$150; not subject to deductible
Inpatient hospital care	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)
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	$1,600	$3,200	$2,500	$5,000
Employee + 1	$3,200	$6,400	$5,000	$10,000
Family	$3,200	$6,400	$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
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	20% after deductible	20% after deductible	30% after deductible	30% 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)
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
2024 HSA contribution from Stryker*				
Employee	$600		$300	
Employee + 1	$1,200		$600	
Family	$1,200		$600	

* Refer to the **Health Savings Account** 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 PPO plans, when you need emergency care and use an emergency room, you pay a $150 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.

Eligible expenses for emergency health services provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 32.

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

Eligible expenses for emergency health services provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 32

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.

Important note

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

It is recommended that you confirm with the UnitedHealthcare 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 UnitedHealthcare 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 UnitedHealthcare by calling the number on 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 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-network providers are responsible for obtaining prior authorization from UnitedHealthcare before they provide these services to you. There are some benefits, however, for which you are responsible for obtaining prior authorization from UnitedHealthcare 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 air 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 including genetic testing and sleep studies (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 71;
  - For out-of-network benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions.
  - In addition, for out-of-network benefits you must obtain prior authorization before the following services are received:
    - Partial Hospitalization/Day Treatment;
    - Intensive Outpatient Treatment programs;
    - outpatient electro-convulsive treatment;
    - psychological testing;
    - transcranial magnetic stimulation;
    - extended outpatient treatment visits, with or without medication management;
    - Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

- Obesity surgery;
- Inpatient stay for the mother and/or newborn following delivery that will be more than 48 hours following a normal vaginal delivery, or more than 96 hours following a cesarean section delivery;
- Prosthetic devices that exceed $1,000 per device;
- Reconstructive procedures (as described below);
- Skilled nursing facility/inpatient rehabilitation facility services;
- Outpatient surgery for sleep apnea surgeries;
- Therapeutic treatments (outpatient), such as dialysis, IV infusion, 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 you must provide notification as soon as is reasonably possible.

In addition, you must contact UnitedHealthcare 24 hours before admission for a scheduled admission or as soon as reasonably possible for a non-scheduled admission.

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 UnitedHealthcare 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 UnitedHealthcare five business days before a scheduled reconstructive procedure is performed.
- A non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible.

In addition, you must contact UnitedHealthcare 24 hours before admission for a scheduled admission or as soon as reasonably possible for a non-scheduled admission.

If authorization is not obtained from UnitedHealthcare 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.

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 plans 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 UnitedHealthcare 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

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 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;
- 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 or print all of your Explanation of Benefits (EOBs) online; and
- Order a new or replacement ID card or print a temporary ID card.

Expert medical opinion

Whether you need help finding the best physician in your area, information about a new diagnosis or treatment or support deciding if surgery is right for you, Included Health will give you expert medical advice, including second opinions from top doctors, for your individual medical needs. Included Health provides you and your family members with expert medical advice and support to help ensure that you receive the best care possible — at no cost to you. Use Included Health any time, but especially when:

- You need a checkup and don't have a regular doctor. Included Health finds the best physician in your area.
- You need an expert. Included Health can provide you with information about a new diagnosis, help you make tough decisions, or get a second opinion from world-leading expert.

This service is available to all employees and their dependents enrolled in any of Stryker's U.S.-based medical plans. To access this benefit call 1-855-431-5551 or activate your account at **includedhealth.com/stryker** or by downloading the Included Health app on your mobile device.

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, Chronic Obstructive Pulmonary Disease (COPD) and asthma programs are designed to support you. This means that you will receive free educational information, 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 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 your ID card.

Cancer Resource Services (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 “Medical plan definitions” on page 82.

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
- 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. 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 your ID card, or call the program directly at 866 936 6002.

For information regarding specific Benefits for cancer treatment within the Plan, see Section [5][6], **Additional Coverage Details** under the heading **Cancer Resource Services (CRS)**.

Congenital Heart Disease (CHD) resource services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on

CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888 936 7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Kidney Resource Services (KRS)

Comprehensive Kidney Solution (CKS) Program

For Participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) Stage 4/5 through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 866 561 7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the **Travel and Lodging Assistance Program**, refer to the provision below.

Musculoskeletal digital therapy with Kaia Health

UnitedHealthcare has partnered with Kaia Health to provide a mobile app for on-demand, personalized musculoskeletal support to help relieve pain and live healthier. This program offers tailored exercises, bite-sized lessons, one-on-one health coaching and strengthening exercises, all included as part of your health plan. For more information, please download the Kaia app, or visit **startkaia.com/uhc.**

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 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 for complex medical conditions

Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the requisite distance from your home address to the facility is at least 50 miles. 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 **number on your ID card**.

Travel and lodging expenses

The Plan covers expenses for travel and lodging for the covered member and a travel companion, provided he or she is not covered by Medicare 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 care related to one of the programs listed below.
- 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 at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, 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.

UnitedHealthcare 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 or the caregiver if the covered person is in the hospital.
- 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.

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.

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.

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):

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific covered health services as described in the definition of "Recognized Amount" on page 90 in "Medical plan definitions."

	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%

	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 treatment					
Emergency room	$150 copayment	$150 copayment	$150 copayment	$150 copayment	$150 copayment
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 under "Your medical benefits" on page 39 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
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%

	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)**
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 and sleep studies 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%
Acupuncture services Limited to 30 visits per calendar year.	$40 copayment	40%	$40 copayment	40%	20%
Allergy testing and treatment	20%	40%	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					
Ground Ambulance* Eligible expenses for emergency and non-emergency ground ambulance transport provided by an out-of-network provider will be determined as described under “Eligible expenses”	20%	20%	20%	20%	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)**
Air Ambulance* **Eligible expenses for emergency and non-emergency air ambulance transport provided by an out-of-network provider will be determined as described under "Eligible expenses"**	20%	20%	20%	20%	20%
Anesthetics and their administration	20%	40%	20%	40%	20%
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Out-of-Network Benefits are not available	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Out-of-Network Benefits are not available	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Durable medical equipment (DME)*	20%	40%	20%	40%	20%
Gender Dysphoria Treatment*	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)**
Fertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $15,000 lifetime maximum. Participants must work with a nurse consultant through the 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%
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%

	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)**
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.					

* Your network provider must obtain prior authorization from UnitedHealthcare, 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 UnitedHealthcare.

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):

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific Covered Health Services as described in the definition of "Recognized Amount" on page 90 in "Medical plan definitions."

	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	20%	20%	30%	30%
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 under "Your medical benefits" on page 39 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 Includes 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

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network (MNRP guidelines apply)**	**In-Network**	**Out-of-Network (MNRP guidelines apply)**
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 and sleep studies 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%
Acupuncture services **Limited to 30 visits per calendar year.**	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)**
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.	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* Eligible expenses for emergency and non-emergency ground and air ambulance transport provided by an out-of-network provider will be determined as described in "Eligible expenses."	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%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network (MNRP guidelines apply)**	**In-Network**	**Out-of-Network (MNRP guidelines apply)**
Fertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $15,000 lifetime maximum. Participants must work with a nurse consultant through the 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%
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%

* Your network provider must obtain prior authorization from UnitedHealthcare, 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 UnitedHealthcare.

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 are covered for the first four days after the birth. These expenses will be covered separate from the mother. See below for more information regarding how to add your child to the health plan.

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 healthcare benefits** section for more information.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from UnitedHealthcare 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 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.

UnitedHealthcare 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, educational/vocational training and residential treatment are not habilitative services. A service or treatment plan that does not help the covered member to meet functional goals is not a habilitative service.

Limitations

The Plan may require that the following be provided: medical records, or other necessary data to allow the Plan to prove medical treatment is needed. When the treating provider expects that continued treatment is or will be required to allow the covered member to achieve progress, UHC may request additional medical records.

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 65.

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 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 45 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.

Acupuncture services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Covered health services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Related to surgery.

Any combination of in-network Benefits and out-of-network benefits is limited to 30 treatments per calendar year.

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, UnitedHealthcare 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 UnitedHealthcare 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, UnitedHealthcare will initiate and direct non-emergency ambulance transportation. For out-of-network benefits, if you are requesting non-emergency ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization as soon as possible before transport.

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

Cellular and gene therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefits for CAR-T therapy for malignancies are provided under Transplantation Services.

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 UnitedHealthcare 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.

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

You must obtain the durable medical equipment or orthotic from a vendor UHC identifies, or from the prescribing in-network physician.

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 74.

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 dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to sickness or Injury. Benefits for the purchase of these 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 UnitedHealthcare 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.

Enteral nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a physician.

Fertility services and fertility solutions (FS) program

Therapeutic services for the fertility treatment when provided by or under the direction of a physician. Benefits are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, and ovarian cystoplasty.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo."
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in Vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as described in the SPD. Benefits for diagnostic tests are covered as under Scopic Procedures - Outpatient Diagnostic and Therapeutic, Physician's Office Services – Sickness and Injury.

Enhanced benefit coverage

Embryo biopsy for Pre-implantation Genetic Screening (PGS) used to select embryos for transfer in order to increase the chance for conception.

Donor coverage — The plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.

Fertility preservation for medical reasons — when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Fertility preservation for non-medical reasons — when you would like to delay pregnancy for non-medical reasons. Coverage is

limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

To be eligible for the fertility services benefit:

You do not need to have a diagnosis of infertility in order to be eligible to receive services described above.

- You are a female:
  - under age 44 and using own oocytes (eggs), or
  - under age 55 and using donor oocytes (eggs).

Note. For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for Infertility benefit. Child Dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical or non-medical reasons.

Any combination of in-network benefits and out-of-network benefits are limited to $25,000 for medical services and $15,000 for prescription drugs per covered person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include physician office visits for the treatment of infertility.

There are separate limits under the Plan for medical services and prescription drugs.

Charges for the following apply toward the fertility lifetime maximum:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

Fertility Solutions

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by Stryker. The Fertility Solutions program provides:

- Specialized clinical consulting services to you and your enrolled dependents to educate on fertility treatment options.
- Access to specialized in-network facilities and physicians for fertility services.
- Provides education, specialized clinical counseling, treatment options and access to a national network of premier fertility treatment clinics.

The Plan pays benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions program.

Covered persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine an in-network provider prior to starting treatment.

For fertility services and supplies to be considered covered health services, you must contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered dependent may:

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

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

Gender dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a physician.

For the purpose of this benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the **Diagnostic and Statistical Manual of the American Psychiatric Association**.

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses;

- Continuous hormone therapy administered by a medical provider (for example during an office visit);
- Continuous hormone therapy dispensed from a pharmacy (covered as per pharmacy benefits);
- 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;
- Voice modification therapy;
- Surgery for the treatment for gender dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Breast augmentation with implants or fat transfer
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria
  - Metoidioplasty (creation of penis, using clitoris)
  - Nipple/areola reconstruction
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Revision of a reconstructed breast
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Tissue expander placements
  - Tracheal shave/reduction
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Voice modification surgery
  - Vulvectomy (removal of vulva)

Surgical treatment for Gender Dysphoria may be indicated for individuals who provide the following documentation:

- For breast surgery (mastectomy, breast reduction or breast augmentation), a written clinical assessment from at least one **Qualified Healthcare Professional** experienced in treating Gender Dysphoria is required. The assessment must document that an individual 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 at least 18 years of age for breast augmentation
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges
  - For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required
- For thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords), a written clinical assessment from at least one **Qualified Healthcare Professional** experienced in treating Gender Dysphoria is required. The assessment must document that an individual 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 at least 18 years of age
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges
  - Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization

  - For voice modification surgery, documentation of presurgical voice lessons and/or therapy

- For genital surgery, a written clinical assessment from at least two **Qualified Healthcare Professional** experienced in treating Gender Dysphoria, who have independently assessed the individual, is required. The assessment must document that an individual 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 at least 18 years of age
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges
  - Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender
  - Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender)
  - Treatment plan that includes ongoing follow-up and care by a **Qualified Healthcare Professional** experienced in treating Gender Dysphoria

Prior authorization requirement for surgical treatment

For out-of-network benefits, you must obtain prior authorization as soon as the possibility of surgery arises and within 24 hours before admission for an inpatient stay.

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 through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by an audiologist.
- A written prescription.

If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a covered health service for which benefits are available under the applicable medical/surgical covered health services categories in this **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.

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 UnitedHealthcare 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.

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.

Lab, X-ray and diagnostic - outpatient

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists
- Presumptive drug tests and definitive drug tests.
- Any combination of in-network benefits and out-of-network benefits is limited to 18 presumptive drug tests per calendar year.
- Any combination of in-network benefits and out-of-network benefits is limited to 18 definitive drug tests per calendar year.

Genetic testing is covered when it is ordered by a physician, authorized in advance by UnitedHealthcare, follows genetic counseling and results in available medical treatment options.

Benefits for other physician services, such as physician fees for surgical and medical services. Lab, X-ray and diagnostic services for preventive care are covered as described in the appropriate sections of this SPD. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are also covered as described as outpatient services in this SPD.

Nutritional counseling

The Plan will pay for covered health services for medical or behavioral/mental health related education services provided in a physician's office by an appropriately licensed or healthcare professional when:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease
- Congestive heart failure
- Severe obstructive airway disease
- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Note: Benefits for nutritional counseling services are limited to three individual sessions per covered person's lifetime for each medical condition.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under "Preventive care benefits" on page 62.

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 or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their license; 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.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention
- Partial hospitalization/day treatment
- Inpatient treatment and residential treatment including room and board in a semi-private room (a room with two or more beds)
- 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 assistance in locating a provider and for coordination of care.

Prior authorization requirement

For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions.

In addition, for Out-of-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

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

Additional benefits available through the EAP

In addition to benefits available through the EAP program with Lyra, if your counseling or coaching sessions go beyond the annual limit and you participate in a UHC plan sponsored by Stryker, you can continue using the same Lyra provider using your medical plan's mental health benefits. Keep in mind that each medical plan has its own deductibles, coinsurance, copayments, annual maximum and limits on inpatient and outpatient care, including number of visits/days of coverage. You will be responsible for the member cost share of these visits.

In addition, UHC plan participants have access to medication management services through Lyra. This includes a 90-minute consultation with a physician to discuss current medication or get insight into medications recommended by other providers. These visits are billed through the health plan and are subject to member cost share (deductibles, coinsurance and/or co-pays based on which plan you participate in).

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 77, the Plan does **not** pay benefits for the following:

- Services performed in connection with conditions not classified in the current edition of the **International Classification of Diseases section on Mental and Behavioral Disorders** or **Diagnostic and Statistical Manual of the American Psychiatric Association.**
- 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, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- 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.
- Following the American Society of Addiction Medicine (ASAM) criteria, non-medical 24-hour withdrawal management.
- High intensity residential care, including American Society of Addiction Medicine (ASAM) criteria, for covered persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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 irrespective of comorbities, or greater than 35 with at least one comorbity directly related to, or exacerbated by morbid obesity:
  - Type 2 diabetes or pre-diabetes
  - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood

pressure 90 mm Hg or greater, despite pharmacotherapy)

- History of coronary artery disease with a surgical intervention such as cardiopulmonary bypass or percutaneous transluminal coronary angioplasty
- Cardiopulmonary problems (e.g., documented obstructive sleep apnea (OSA) confirmed on polysomnography with an AHI or RDI of >= 30 (as defined by AASM Task Force. Sleep.1999;22:667-89)
- History of cardiomyopathy
- High Cholesterol or Hyperlipidemia
- Polycystic Ovarian Syndrome (PCOS)

- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.
- You have a 3-month physician supervised diet documented within the last 2 years.

Benefits for obesity surgery services are covered only if they meet the definition of a covered health service (see “Medical plan definitions” on page 82) and are not considered experimental, investigational or unproven. Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

Prior authorization requirement

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

If you fail to obtain prior authorization from UnitedHealthcare 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.

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, including CAR-T cell therapy for malignancies when ordered by a physician. 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.

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

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/small bowel
- Pancreas
- Small bowel
- Cornea
- Bone marrow (either from you or from a compatible donor) including CAR-T cell therapy for malignancies, 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 for complex medical conditions" on page 49.

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

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 UnitedHealthcare 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.

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 82.
- 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.

Specialty pharmacy

Specialty drugs are managed differently than everyday 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, OptumRx Specialty Services. 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.

Travel and lodging

(For Travel and Lodging for complex medical conditions see “Travel and lodging assistance program for complex medical conditions” on page 49)

The Plan provides a covered member with a travel and lodging allowance related to all covered health services, including Mental Health Care and Substance-Related and Addictive Disorders Services when such covered services are not available within 50 miles of your address, as reflected in UHC’s records.

Travel and Lodging provides support for the covered person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a covered member and travel companion when the covered member must travel at least 50 miles from their address, as reflected in UHC’s records, to receive the covered services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the covered person. An allowance of up to $4,000 per covered person per year, and is further limited to a maximum allowance of $10,000 per covered person per lifetime, will be provided for travel and lodging expenses incurred as a part of the covered service. Lodging expenses are further limited to $50 per night for the covered person, or $100 per night for the covered person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding Travel and Lodging, you may contact UnitedHealthcare at [www.myuhc.com] or the telephone number on your ID card.

Urinary catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual care services

Virtual care services for covered health services that include the diagnosis and treatment of less serious medical conditions. Virtual care services provide communication of medical information in real-time between the patient and a distant physician or health care specialist outside of a

medical facility (for example, from home or from work).

In-network benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (**CMS** defined originating facilities).

Wigs

The Plan pays benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Any combination of in-network benefits and out-of-network benefits is limited to $500 per lifetime.

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 82.) Covered health services are those health services including services, supplies or pharmaceutical products, which UnitedHealthcare determines to be all of the following:
  - Medically necessary.
  - Described as a covered health service in this SPD under "Covered medical expenses” on page 50.
  - Not otherwise excluded in this SPD "Expenses not covered” on page 77.
- 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.
- Health services provided in a foreign country, unless required as emergency health services.
- 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 82. 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, UnitedHealthcare 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 (except liposuction for lipedema paid as reconstructive procedure) 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
  - For medically necessary treatments for gender dysphoria
- 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
  - Body contouring, such as lipoplasty. Removal of excessive skin and subcutaneous tissue, etc.
  - Brow reduction, augmentation and lift
  - Cheek implants and lipofilling
  - Chin reshaping
  - Injection of fillers or neurotoxins
  - Face lift, forehead lift, or neck tightening
  - Facial bone remodeling
  - Hair removal, except as part of a genital reconstruction procedure by the physician for the treatment of Gender Dysphoria
  - Hairline advancement and transplantation
  - Jaw reconstruction
  - Lip augmentation
  - Lip reduction

- Lipofilling and Liposuction
- Mastopexy
- Penile transplants
- Rhinoplasty
- Skin resurfacing
- Uterine transplants.

- The following fertility treatment-related services:
  - Cryo-preservation and other forms of preservation of reproductive materials except as described under fertility Services. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which benefits are provided as described "Additional Coverage Details".
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
  - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- The following services related to a gestational carrier or surrogate:
  - Fees for the use of a gestational carrier or surrogate.
  - Insemination or InVitro fertilization procedures for surrogate or transfer of an embryo to gestational carrier.
  - Pregnancy services for a gestational carrier or surrogate who is not a covered person.
- Donor, gestational carrier or surrogate administration, agency fees or compensation.
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
  - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen.
  - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
- The reversal of voluntary sterilization.
- Fertility services not received from a Designated Provider (except for covered persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider as determined by the Plan) .
- Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Infertility treatment following unsuccessful reversal of voluntary sterilization.
- Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).
- Nutritional counseling for the following: obesity/weight loss, conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.
- Charges for food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under **Enteral Nutrition**
- Charges for marriage, family, child, career, social adjustment, pastoral or financial counseling without a medical diagnosis
- Charges for 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 or transportation expenses, even if ordered by a physician, 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 for complex medical conditions" on page 49.

- Health services for transplants involving animal organs or animal-assisted therapies.
- 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 72.
- Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under "Obesity surgery" on page 72.
- 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.

  This exclusion does not apply to:

  - Medical foods for which benefits are provide (including medical foods to support enteral nutrition).
  - Diabetic supplies for which benefits are provided.
  - Ostomy supplies for which benefits are provided.
  - Urinary catheters for which benefits are provided.
  - Compression stockings.
  - Ace bandages.
  - Gauze and dressings.
- 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.)
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers contracted that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to covered individuals for self-administration.
- Routine foot care

  - Orthotic appliances and devices that straighten or re-shape a body part, except as covered under durable medical equipment (DME). This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.

  Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a covered person with diabetic foot disease.
- Non-powered exoskeleton devices are excluded. Intracellular micronutrient testing is excluded.
- Cranial molding helmets and cranial banding are excluded except when used to avoid the

need for surgery, and/or to facilitate a successful surgical outcome.

- Health services for organ and tissue transplants except as identified under "Organ transplant benefits" on page 73, 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
- 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
- Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to manipulative treatment and non-manipulative osteopathic care for which benefits are provided
- 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 an out-of-network 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, not pursued, or not collected.)
- 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
- 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
- Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which benefits are provided
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition. Any expenses you incur pursuing a claims appeal that you file.
- Certain new pharmaceutical products and/or new dosage forms until the date as determined by UnitedHealthcare or their designee, but no later than December 31st of the following calendar year.

  This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, benefits may be available for the new pharmaceutical product to the extent provided under the Plan.

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

Air Ambulance

Medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in 42 CFR 414.605.

Ancillary Services

Items and services provided by out-of-network physicians at an in-network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-network physician when no other in-network physician is available.

Annual deductible

The amount you must pay or the recognized amount when applicable, 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.

Cellular Therapy

Administration of living whole cells into a patient for the treatment of disease.

Claims administrator

UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan (e.g., UnitedHealthcare 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 or the recognized amount when applicable, 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 charge, stated as a set dollar amount, that you are required to pay for certain covered health services.

Please note that for covered health services, you are responsible for paying the lesser of the following:

- The applicable copayment.
- The eligible expense or the recognized amount when applicable.

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 UHC determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, Injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Described under "Covered medical expenses" on page 50
- Provided to a covered person who meets the Plan's eligibility requirements, as described in the SPD
- Not otherwise excluded in this SPD under "Expenses not covered" on page 77

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

Definitive Drug Test

Test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Designated Dispensing Entity

A pharmacy, provider, or facility that has entered into an agreement with UHC, or with an organization contracting on UHC's behalf, to provide pharmaceutical products for the treatment of specified diseases or conditions. Not all in-network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Network Benefits

The description of how benefits are paid for the covered health services provided by a physician or other provider that has been identified as a Designated Provider.

Designated Provider

A provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide covered health services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare'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 UnitedHealthcare 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 32.

Eligible expenses are determined 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:

- An appropriate medical screening examination (as required under section **1867 of the Social Security Act, 42 U.S.C. 1395dd** or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, 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 or an Independent Freestanding Emergency Department, as applicable, as are required under section **1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))**, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section **1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).**
- Emergency Health Services include items and services otherwise covered under the Plan when provided by an out-of-network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as

part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

- The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
- The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
- The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

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 as appropriate for the proposed use in any of the following:
  - AHFS Drug Information (AHFS DI) under therapeutic uses section;
  - Elsevier Gold Standard's Clinical Pharmacology under the indications section;
  - DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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 as described 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 fertility treatment options.
- Access to specialized network facilities and physicians for fertility services.

Gender Dysphoria

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

Genetic Counseling

Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for Genetic Testing require Genetic Counseling.

Genetic Testing

Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gene Therapy

Delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gestational Carrier

A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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

Independent Freestanding Emergency Department

A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable law; and
- Provides emergency health services.

Infertility

A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

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

A structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

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 that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

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

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

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare 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 UnitedHealthcare's sole discretion.

UnitedHealthcare 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 UnitedHealthcare and revised from time to time), are available to covered persons on **www.myuhc.com** or by calling the number on your ID card, and to physicians and other health care professionals on **www.UHCprovider.com**.

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

Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the **International Classification of Diseases section on Mental and Behavioral Disorders** or the **Diagnostic and Statistical Manual of the American Psychiatric Association**. The fact that a condition is listed in the current edition of **the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association** does not mean that treatment for the condition is a covered health service.

Mental illness

Those mental health or psychiatric diagnostic categories listed in the current edition of the **International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association**. The fact that a condition is listed in the current edition of the **International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association** does not mean that treatment for the condition is a covered health service.

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.

Non-Medical 24-Hour Withdrawal Management

An organized residential service, including those defined in **American Society of Addiction Medicine (ASAM)**, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care

Out-of-network benefits

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

Personal Health Nurse

The primary nurse that UnitedHealthcare 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 Product(s)

U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Pharmaceutical Products (New)

A pharmaceutical product or new dosage form of a previously approved pharmaceutical product for the period of time starting on the date the pharmaceutical product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

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

Presumptive Drug Test

Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing

Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to covered person by an independent nurse who is hired directly by the covered person or his/her family. This includes nursing services provided on an inpatient or

home-care basis, whether the service is skilled or non-skilled independent nursing.

- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

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.

Recognized Amount

The amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers:

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network. Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following:

- Applicable state law
- An All Payer Model Agreement if adopted, or
- The qualifying payment amount as determined under applicable law.

Note: Covered health services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these covered health services were determined based upon an eligible expense.

Residential Treatment

Treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a physician.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secretary

As that term is applied in the **No Surprises Act** of the **Consolidated Appropriations Act (P.L. 116-260)**.

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.

Specialty Pharmaceutical Product

Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Substance-related and addictive disorder services

Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the **International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association**. The fact that a disorder is listed in the edition of the **International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association** does not mean that treatment of the disorder is a covered health service.

Surrogate

A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine

Live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a covered person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI)

Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living

Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in **American Society of Addiction Medicine (ASAM)** criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.

UHC Health Advantage

Programs provided by the UnitedHealthcare 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.

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.