Medical and Rx Claims Procedures

This section of the Stryker Benefits Summary describes the procedures for filing a claim for medical and prescription drug benefits and how to appeal denied claims.

Medical and Rx Benefits

In-Network Providers

UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates is the claim administrator for medical and prescription drug benefits and pays **in-network providers** directly for your covered medications and health services. If an in-network provider bills you for any covered health service, contact UnitedHealthcare.

However, you are responsible for paying copayments, your remaining deductible and your coinsurance share to an in-network provider at the time of service or when you receive a bill from the provider.

Out-of-Network Providers

When you receive covered health services from an **out-of-network provider**, you are responsible for filing a claim in order to obtain reimbursement for the cost of these services. You must file the claim in a format that contains all of the information required, as described in "Required Information" on page 72.

- If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and you believe that the plan should have paid for it, you may submit a claim for reimbursement following the procedures for filing a post-service claim (see "Submitting Medical or Rx Benefit Claims" on page 72). If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement, again following the procedures outlined for filing a post-service claim.
- If a retail or mail order pharmacy fails to fill a prescription that you have presented because they believe it is not covered under the plan, you may contact UnitedHealthcare to determine if it is a covered health service. In such a case, you can submit a claim for coverage following the procedures described for filing a pre-service claim (see "Submitting Medical or Rx Benefit Claims" on page 72).

You must submit a request for payment of benefits within one year of the date of service. If you don't provide this information to UnitedHealthcare within one year of the date of service, benefits for that health service or medication will be denied or reduced at UnitedHealthcare's discretion. This time limit does not apply if you are legally incapacitated.

An individual is considered "legally incapacitated" for plan purposes if they are determined by a court of law to be lacking the capacity to make or communicate responsible personal decisions. A person may also be considered "legally incapacitated" if they exhibit an inability to meet their own personal needs for medical care, nutrition, clothing, shelter or safety. In such a case, a general guardian will be appointed.

If your claim relates to an inpatient hospital stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider; all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to you. UnitedHealthcare will not reimburse third parties who have purchased or been assigned benefits by physicians or other providers. See the section entitled "Assignment of Benefits" on page 79.

Required Information

When you request payment of benefits, you must provide UnitedHealthcare with all of the following information:

- The employee's name and address
- The patient's name and age
- The group number stated on your ID card
- The name and address of the provider of the service(s)
- A diagnosis from the physician
- An itemized bill from your provider that includes the current procedural terminology (CPT) codes or a description of each charge
- The date the injury or sickness began
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program (If you are enrolled for other coverage, you must include the name of the other carrier(s).)

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

For medical benefits claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient prescription drug benefits, your claims should be submitted to:

OptumRx
ATTN: Claims Department
P.O. Box 29077
Hot Springs, AR 71903

Payment of Benefits

UnitedHealthcare will make a benefit determination as set forth in "Initial Claim Determinations" on page 73. Benefits will be paid to you unless either of the following is true:

- The provider notifies UnitedHealthcare that your signature is on file, assigning benefits directly to that provider.
- You make a written request to be paid directly at the time you submit your claim.

UnitedHealthcare will notify you if additional information is needed to process the claim. Your claim will be pended until all information is received.

Submitting Medical or Rx Benefit Claims

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the plan's procedures for filing claims. There are three types of claims for medical benefits, each of which is subject to different rules.

If You Have Other Healthcare Coverage

If you have other healthcare coverage, see *Participating in Healthcare Benefits* for information on how that coverage may impact your claims.

- An **urgent care claim** is a type of pre-service claim that, if the regular time periods for handling pre-service claims were followed:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment that is subject to the claim.
- A **pre-service claim** is a claim for a benefit that requires prior approval or notification under the terms of the plan, such as inpatient admission notification.
- A **post-service claim** is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care, medications or supplies that have already been received.

A pre-service claim is considered submitted when UnitedHealthcare receives a request for prior approval. See the "Notification Requirement" section of *Medical Benefits* or "Prior Authorization" in the *Prescription Drug Benefits* section of this Benefits Summary for the procedures for notification or approval.

If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension, not longer than 15 days, and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this

information. If all of the needed information is received within the 45-day time frame, UnitedHealthcare will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based and provide the claim appeal procedures.

In-network providers will generally submit their claims for payment directly to UnitedHealthcare. If you obtain services from an out-of-network provider, or if you are enrolled in the Out-of-Area plan, you must pay for the services and submit a claim for reimbursement.

A claim is considered submitted when UnitedHealthcare receives it.

Initial Claim Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

Urgent Care Claims

The table below describes the timeframes, which you and the claims administrator are required as follows:

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

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

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for benefits as defined above, your request will be decided within 24 hours. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Pre-Service Claims

You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information.

The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within 15 days after the information is received. If you do not provide the requested information within the specified timeframe, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based and provide the claim appeal procedures.

Previously Approved Medical Treatments

If UnitedHealthcare previously approved an ongoing course of medical treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension.

If the claim involves urgent care, you will be notified whether the extension of treatment has been approved or denied no more than 24 hours after your request for the extension of treatment is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims.

If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Post-Service Claims

If your post-service claim is denied, you will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. This time period may be extended for an additional 15 days if additional information is needed to process the claim. You will be advised in writing of the need for a one-time extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information.

The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based and provide the claim appeal procedures.

If Your Claim Is Denied

If your claim for a benefit is denied in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request
- If the basis for the denial was a determination of experimental or investigational treatment or similar exclusion or limit, either:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances
  - A statement that such an explanation will be provided free of charge upon request
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim

Review of Denied Claims: What to Do First

If your question or concern is about a benefit determination, you may informally contact UnitedHealthcare customer service before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "Initial Claim Determinations" on page 73, you may appeal it as described below, without first informally contacting customer service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address for UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to "Urgent Claim Appeals that Require Immediate Action" on page 75 and contact customer service immediately. The customer service telephone number is **800 387 7508**. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

If you still disagree with a claim determination after contacting customer service, you can contact UnitedHealthcare in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of medical service(s)
- The provider's name
- The reason you disagree with the denial (that is, why you believe the claim should be paid)
- Any documentation or other written information to support your request for claim payment

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.

Submit your appeal to UnitedHealthcare at the following address:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Except in the case of urgent care claims, your claim appeal must be made in writing.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

For urgent claim appeals, Stryker has delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the plan. UnitedHealthcare's decisions regarding these matters are conclusive and binding.

The table below describes the timeframes, which you and UnitedHealthcare are required to follow.

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

Urgent Request for Benefits*	
Type of Request for Benefits or Appeal	***Timing***
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

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

Denials of Claims Based on Ineligibility to Participate

If your claim is denied based on a determination that an individual is not eligible for benefits, you have 180 calendar days after receiving the denial notice in which to appeal the determination to the plan administrator. Your appeal must be in writing. If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination. Submit your appeal to the following address:

Health Plan Administrator
Stryker
2825 Airview Boulevard
Kalamazoo, MI 49002

Your appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. UnitedHealthcare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Determinations on Appeal

Urgent Care Claims

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" on page 75.

Denials of Claims Based on Ineligibility to Participate

The plan administrator will review and decide your appeal within a reasonable period of time but no longer than 60 days after it is submitted. The review will take into account all comments, documents, records and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The decision of the plan administrator is final and binding on all individuals claiming benefits under the plan.

Pre-Service Claims

For appeals of pre-service claims, you will be notified of the determination on first level appeal within a reasonable period of time but no longer than 15 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the decision, you have the right to file a second level appeal. Your second level appeal request must be submitted within 60 days of receipt of the first level appeal decision. UnitedHealthcare will make a determination on your appeal no more than 15 days from receipt of a request for review of the first level appeal decision.

The table below describes the timeframes, which you and UnitedHealthcare are required to follow.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	***Timing***
If your request for benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	***Timing***
You must then provide completed request for benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
▪ if the initial request for benefits is complete, within:	**15 days**
▪ after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims

UnitedHealthcare will review and decide your appeal within a reasonable period of time but no longer than 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the decision, you have the right to file a second level appeal. Your second level appeal request must be submitted within 60 days of receipt of the first level appeal decision. UnitedHealthcare will make a determination on your appeal no more than 30 days from receipt of a request for review of the first level appeal decision. For pre-service and post-service claim appeals, Stryker has delegated to UnitedHealthcare the exclusive right to interpret and administer the provisions of the plan. UnitedHealthcare's claim appeal decisions are conclusive and binding. UnitedHealthcare's decision is based only on whether or not benefits are available for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

The table below describes the timeframes, which you and UnitedHealthcare are required to follow.

Post-Service Claims	
Type of Claim or Appeal	***Timing***
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Notification of the Determination on Appeal

Except in instances in which notice is provided under the expedited procedures for urgent care claims, you will be notified in writing of the decision at each level of appeal.

If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
- If the denial was based on a determination of experimental or investigational treatment or similar exclusion or limit, either:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances
  - A statement that such an explanation will be provided free of charge upon request
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request
- A statement of your right to bring a civil action under Section 502 of ERISA

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if UnitedHealthcare fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four months of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by calling **800 387 7508** (the toll-free number on your ID card) or by sending a written request to the address on your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the plan. The independent review organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or Stryker. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

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

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

You may contact UnitedHealthcare at **800 387 7508** for more information regarding your external appeal rights and the independent review process.

Designation of an Authorized Representative

Under provisions of the plan, plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void. However, ERISA provides that in the case of persons with coverage under a state Medicaid program, automatic assignment of benefits to state Medicaid agencies is enforceable against the plan. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a state Medicaid agency), such direct payments are provided at the discretion of the Trustees as a convenience to plan participants and do not imply an enforceable assignment of plan benefits or the right to receive such benefits.

An assignment to a healthcare provider for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other healthcare professional who is licensed, accredited or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claim procedures to "you" is intended to include your authorized representative. An assignment to a healthcare provider for purposes of payment does not constitute appointment of an authorized representative under these claim procedures. Notwithstanding this provision, plan benefits are not subject to assignment by participant, beneficiary or any other person except the Trustees as outlined in the section entitled "Assignment of Benefits" on page 79.

Assignment of Benefits

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you to reimburse the non-network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your benefits be made directly to the non-network provider. Under no circumstances will UnitedHealthcare pay benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-network provider, you remain the sole beneficiary of the payment, and the non-network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the benefits to the non-network provider as well. If payment to a non-network provider is made, the plan reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes the plan, pursuant to the plan's refund of overpayment policies.

Employee Incentive Program

Because of the large volume of activity in hospitals' and doctors' billing offices, oversights and duplicate charges do occur. As an incentive to carefully review your bills, Stryker will pay you 50% of any overcharges that are recovered from a hospital or doctor up to a maximum of $2,000. Bills eligible for this program must be for you or your dependents for which Stryker's plan is primary.

Follow these procedures when reviewing your hospital or doctor bill:

- Before you leave the hospital or doctor's office, make sure you receive or will be sent an itemized bill, including the date and type of service performed and the corresponding charges.
- Check that each listed service was performed, and contact the doctor's or hospital's billing office if you have any questions.
- Ask for an explanation of any charges you don't understand.
- If you find any errors, it is your responsibility to contact the hospital's or doctor's billing department to report the error and obtain a corrected bill within 90 days of discharge or the date of service. Have the hospital or doctor send the corrected bill, with the corrected items circled, to UnitedHealthcare. Upon review of the corrected bill, UnitedHealthcare will issue a corrected Explanation of Benefits (EOB) form.
- Present the original bills and the original and corrected EOBs to your Benefits Representative for review. You and the payroll department will then be notified of the incentive amount for which you are eligible. Please note that reimbursements under this program are considered income for tax purposes.