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Zimmer Biomet Medical Coverage

(For non-bargaining Team Members in the United States)

January 2021

ZIMMER BIOMET
Your progress. Our promise.™

Table of Contents

INTRODUCTION 1
SPANISH LANGUAGE NOTICE 1
Aviso en el Idioma Español 1
ABOUT YOUR PARTICIPATION 2
Who Is Eligible 2
Full-Time Team Members 2
Part-Time Team Members 2
Affordable Care Act Determination of Eligibility 2
If You Take a Leave of Absence or Reduce Your Work Hours 2
Who Is Not Eligible 2
Eligible Dependents 3
If Two Family Members Work for Zimmer Biomet 3
When Other Coverage Is Available 4
Qualified Medical Child Support Orders 4
Keeping Dependent Information Up to Date 4
When Coverage Begins 5
What Happens If You Don't Enroll 5
Coverage Choices 5
Paying for Coverage 6
Spousal/Domestic Partner Surcharge 6
Tobacco Surcharge 6
Making Changes During the Year 7
Special Enrollment Rights 7
When Coverage Ends 7
ABOUT THE MEDICAL PLAN 8
YOUR CHOICES FOR MEDICAL COVERAGE 9
Medical Plan Choices 9
COMPARING THE THREE MEDICAL OPTIONS 10

HOW THE HSA MEDICAL OPTIONS WORK..13
Contributions to Your HSA..13
Zimmer Biomet's HSA Contributions..13
Your HSA Contributions..14
Your Catch-Up Contributions..14
Maximum HSA Contributions..14
Prorating Contributions for Mid-Year Enrollments..14
Contributions to Your HSA Extra Bucks Account..15
Zimmer Biomet's Incentive Contributions..15
Rollover Contributions..15
How the HSA Options Pay for Benefits..16
For Preventive Care..16
For Other Covered Medical Expenses..16
For Expenses That Are Not Covered by the Medical Plan..19
Setting Up Your Accounts..19
How to Pay Expenses From Your HSA..20
Saving for Future Healthcare Expenses..20
If You Change Medical Options..20
When You Leave Zimmer Biomet..20
HOW THE HRA MEDICAL OPTION WORKS..21
Contributions to Your HRA..21
Zimmer Biomet's HRA Contributions..21
Prorating Contributions for Mid-Year Enrollments..21
Zimmer Biomet's Incentive Contributions..22
Rollover Contributions..22
No Team Member Contributions..22
How the HRA Option Pays Benefits..22
For Preventive Care..22
For Other Covered Medical Expenses..22
If You Change Medical Options..25

If You Leave Zimmer Biomet 25
COVERED EXPENSES 26
What Are Eligible Charges? 26
Provider Choices Affect Your Benefits 27
Finding In-Network Providers 28
Preventive Care 28
Medical Services 30
Surgery 33
Emergency and Urgent Care Services 37
Inpatient Hospital Treatment 38
Alternatives to Inpatient Care 40
Medical Equipment and Supplies 42
Maternity Care and Family Planning 43
Behavioral Health and Substance Abuse Treatment 45
Clinical Trials 47
CHARGES THAT ARE NOT COVERED 48
PRE-ADMISSION REVIEW AND PRE-CERTIFICATION 54
Anthem Medical Management 54
Anthem Behavioral Health 57
Out-of-Network Referrals 57
How to Request Reviews 58
ANTHEM PROGRAMS AND TOOLS 59
24/7 Nurseline 61
Imaging Management Program (AIM Program) 61
Sleep Management Program 61
Find a Doctor 61
WELLNESS PROGRAM 62
Eligibility 62
Your Virgin Pulse Account 62
PRESCRIPTION DRUG COVERAGE 67

How the Medical Plan Pays Benefits 67
Prescription Drug Program Highlights 67
Select Preventive Prescription Drugs 68
Other Prescriptions........ 68
Managing Prescription Costs........ 69
Generic and Brand Formulary Drugs........ 69
Network Pharmacies 69
How to Use the Retail Pharmacy Program........ 69
How to Use the Exclusive Home Delivery Program and the Walgreens Retail Smart90 Program 69
About Generic, Formulary, Non-Formulary and Lifestyle Drugs 70
Charges Covered by the Prescription Drug Program........ 71
Prior Authorization Requirements 71
Quantity Limitations........ 72
Specialty Medications........ 72
Charges Not Covered by the Prescription Drug Program 72
If You Have Questions........ 73
HOW TO FILE A CLAIM 74
Medical Claims 74
If You Use In-Network Providers........ 74
If You Use Out-of-Network Providers 74
Foreign Claims........ 74
If You Are Enrolled in the Healthcare FSA........ 74
Prescription Drug Program Claims 75
Initial Coverage Review........ 75
Work-Life Solutions Claims 75
Claims Administrators........ 76
Medical 76
Prescription Drug Program 76
Work-Life Solutions 76
When Claims Are Processed........ 76

Initial Determination........77
Explanation of Benefits (EOB)........77
YOUR RIGHT TO APPEAL........78
If a Medical or Prescription Drug Claim Is Denied........78
Important Information About the Medical Plan's Appeal Procedures........78
Follow the Steps Below to Appeal a Claim Denial........78
Step 1: You receive written notice from the claims administrator........78
Step 2: Review your notice carefully........79
Step 3: If you disagree with the decision, file a first-level (mandatory) appeal........79
Step 4: You receive notice of first-level appeal decision........80
Step 5: Review your notice carefully........80
Step 6: Independent external review........80
External Review........80
Voluntary second-level appeals........82
Receiving a Decision on Your Voluntary Second-Level Appeal........83
You Must Timely File an Appeal Before Filing a Lawsuit........83
Eligibility Determinations........83
COORDINATION OF BENEFITS........84
Coordination with Other Group Plans........84
How COB Works........84
COB Birthday Rule........85
Right to Recover........85
Coordination with Medicare........85
Medical Coverage for Individuals with End-Stage Renal Disease........86
No Third-Party Beneficiaries; Limitation on Assignment........86
Subrogation/Right of Recovery........86
Misrepresentation........88
Claim Filing Deadline........89
CONTINUATION OF COVERAGE........90
COBRA Continuation........90

Continuation of Coverage for Team Members in the Uniformed Services 90
Continuation of Coverage While on a Family and Medical Leave... 90
YOUR RIGHTS UNDER ERISA 91
Receive Information About Your Plan and Benefits.. 91
Continue Group Health Coverage.. 91
Prudent Actions by Plan Fiduciaries 91
Enforce Your Rights... 91
Assistance with Your Questions 92
CONTACT INFORMATION 93
PLAN ADMINISTRATION.. 95
Plan Sponsor... 95
Plan Administrator... 95
Agent for Service of Legal Process.. 95
Identification Numbers 96
Plan Year... 96
Organizations Providing Administrative Services 96
Plan Funding 96
OTHER PLAN INFORMATION 97
When Coverage Starts and Ends 97
Plan Administration and Your Legal Rights... 97
In Case of Incompetency.. 97
Compliance With Privacy Regulations 97
Your Employment 97
Future of the Plan and Reservation of Rights.. 97
This Summary Plan Description 98
Patient Protection Disclosure 98
TERMS TO KNOW... 99

INTRODUCTION

This summary plan description (SPD) describes the medical coverage available to eligible participants and the types of benefits payable under the Zimmer Biomet medical plan for non-bargaining team members in the United States as of January 1, 2021. This SPD and the Benefits Administration SPD make up your medical plan SPD as required under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the Benefits Administration SPD for important information about:

- Enrollment;
- When coverage begins and ends when you are hired, leave Zimmer Biomet or take a leave of absence;
- The COBRA continuation coverage available when your coverage ends due to certain qualifying events; and
- Information about other Zimmer Biomet benefits, plan operation and administration, and legal requirements.

We encourage you to read both SPDs carefully to understand how your medical benefits work so you can make the best use of them.

Note: This Zimmer Biomet medical plan is part of the Zimmer Biomet Holdings, Inc. Health and Welfare Plan. If there is a conflict between this SPD and the official plan document, the Plan document will control. The "plan document" in this case is the Zimmer Biomet Holdings, Inc. Health and Welfare Plan document and any applicable component plan document, insurance policy, benefit booklet, certificate of coverage or similar that is incorporated therein by reference (each, an Incorporated Document).

SPANISH LANGUAGE NOTICE

This SPD contains a summary in English about the medical plan component of the Zimmer Biomet Holdings, Inc. Health and Welfare Plan. If you have difficulty understanding any part of this summary, contact the Zimmer Biomet Benefits Service Center at 1-877-588-0933. Representatives are available Monday through Friday, from 9 a.m. to 7 p.m. Eastern time, except on U.S. federal holidays.

Aviso en el Idioma Español

Este SPD contiene un resumen en ingles sobre el componente del plan médico del Plan Médico y de Bienestar de Zimmer Biomet Holdings, Inc. Si usted tiene dificultad entendiendo alguna parte de este resumen, comuníquese con el Centro de servicios sobre beneficios de Zimmer Biomet llamando al 1-877-588-0933. Los representantes están disponibles de lunes a viernes, de las 9 a.m. a las 7 p.m. (tiempo del este), excepto durante días feriados de E.E.U.U.

ABOUT YOUR PARTICIPATION

This section includes important information about your participation in the medical plan.

Who Is Eligible

Full-Time Team Members
(expected to work at least 40 hours per week)

You and your dependents are eligible to participate in the medical plan if you are a full-time team member[1]. Full-time means you are reasonably expected to work the paid equivalent of 40 hours per week when your employment begins (or prior to annual benefits enrollment for any subsequent plan year in which your employment status changed). For example, if you are regularly scheduled to work three 12-hour shifts per week for which you receive the paid equivalent of a 40-hour week, you are considered a full-time team member for purposes of eligibility to participate in this medical plan.

To participate in any medical plan or any other plans or programs for which you are otherwise eligible, you must be employed by Zimmer Biomet or a subsidiary that adopts the medical plan and must be paid under Zimmer Biomet's U.S. payroll.

[1] Team member means an individual who is a common law employee of Zimmer Biomet and related employers, unless excluded.

Part-Time Team Members

If you are a part-time team member who is regularly scheduled to work (or averaged during a measurement period) at least 20 hours per week, but fewer than 40 hours per week (other than because of a disability or approved leave) you and your dependents are eligible to participate in the medical plan.

Affordable Care Act Determination of Eligibility

Notwithstanding the foregoing, the plan uses a 12-month look-back measurement method, in accordance with the requirements of the Patient Protection and Affordable Care Act ("ACA") to ensure that coverage is offered to team members who are considered full time employees (i.e., generally those employees that average 30 hour per week) under the ACA. For further details, please see the plan administrator.

If You Take a Leave of Absence or Reduce Your Work Hours

If you take an approved leave of absence, your right to continued coverage under the medical plan is set forth in the Benefits Administration SPD. If you are no longer regularly scheduled to work at least 20 hours per week, you will no longer be eligible for plan coverage, subject to any COBRA rights you may have.

Who Is Not Eligible

You are not eligible to participate if you are:

- A temporary employee or part-time team member working less than 20 hours per week (during the most recent measurement period);
- A student or intern (regardless of the number of hours you work);
- A seasonal employee (regardless of the number of hours you work);
- A leased employee who is not a common law employee of Zimmer Biomet or a related employer;

- An independent contractor;
- Covered by a collective bargaining agreement that does not provide for participation in the medical plan and its programs; or
- Any of the above, even if reclassified as a common law employee by any court, government agency or similar authority.

Eligible Dependents

If you are a full-time team member working 40 hours or a part-time team member working between 20-39 hours you are eligible for coverage and can elect coverage for your eligible dependents. An eligible dependent is:

- Your legal spouse (including same-gender spouse) to whom you are legally married under the law of the state where the marriage occurred, or your common law spouse if recognized under the law of your state of residence.
- Your domestic partner (same or opposite gender). An eligible domestic partner is either:
- A registered domestic partner who is legally recognized under state or local law; or
- An unregistered domestic partner who has satisfied the requirements described in Zimmer Biomet's domestic partner affidavit and for whom you have submitted a notarized domestic partner affidavit to the Zimmer Biomet Benefits Service Center.
- Your child (as defined in section 152(f)(1) of the tax code) who is under the age of 26 (during all or a portion of a calendar month), regardless of whether he/she is a full-time student or married, or whether you claim him/her as a dependent on your income taxes.
- Your unmarried, incapacitated child of any age, if his/her incapacitation existed before age 26, and if he/she was enrolled in the Zimmer Biomet medical plan (or the legacy medical plan sponsored by either Zimmer or Biomet) at the time of his/her incapacity, and if the plan administrator (or its designee) approves him/her as eligible to continue coverage under the Zimmer Biomet Benefits Program.

Other Dependents

Other dependents, including stepchildren, may be eligible for coverage. Contact the Zimmer Biomet Benefits Service Center at 1-877-588-0933 to determine eligibility for your circumstances.

If you enroll an eligible individual (other than your spouse, child or domestic partner and his/her children) in the medical plan, you are certifying to Zimmer Biomet that the individual is your dependent for federal income tax purposes (as defined in section 152 of the tax code). If you enroll an individual, such as a legal ward, who is eligible to participate, but who is not your dependent for federal tax purposes, you must notify the Zimmer Biomet Benefits Service Center no later than December 31 of each plan year that you will not be eligible to claim that person as a dependent on your federal income tax return so Zimmer Biomet can properly report the value of that individual's coverage as taxable income on your W-2.

Note: Zimmer Biomet does not provide tax advice. If you have any questions about whether an individual you enroll in the medical plan is your dependent for federal income tax purposes, you should consult your tax professional.

If Two Family Members Work for Zimmer Biomet

No person may be covered as both a full-time team member and a dependent under the medical plan. If two family members work full-time for Zimmer Biomet, each team member can elect coverage for himself or herself, or one can cover the other Zimmer Biomet-employed family

member as a dependent, but only if he/she has met the eligibility requirements and is not enrolled for coverage as a team member.

In addition, no person may be covered as an eligible dependent under more than one team member. In other words, if you and your spouse/domestic partner both work for Zimmer Biomet, you can cover your child(ren) under either your coverage or your spouse's/domestic partner's coverage, but not both, and your child must meet the dependent eligibility requirements.

When Other Coverage Is Available

You (and your dependents) cannot contribute to a Health Savings Account (HSA) if you are enrolled in another medical plan (for example, as a dependent under your spouse's/domestic partner's employer plan), unless the coverage is a high-deductible health plan.

Once you become enrolled in Medicare, you may not contribute to your HSA.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) may be either a National Medical Child Support Notice issued by a state child support agency or a legal judgment, decree or order under a state domestic relations law resulting from a divorce, legal separation, annulment or change in legal custody. A QMCSO creates or recognizes the rights of a child to healthcare coverage, even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment season restrictions that might otherwise exist for eligible dependent coverage.

Under a QMCSO, you can be required to provide medical coverage to your eligible dependent children. If the order directs you to cover the child, you must enroll the child (and yourself) in the medical plan. Unless the order is updated to direct someone other than you to cover the child, you may not drop coverage for the child.

Federal law provides that a QMCSO must meet certain form and content requirements in order to be valid. If the medical plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, Zimmer Biomet may withhold any contributions from your paycheck that are required for such coverage.

Please call the Zimmer Biomet Benefits Service Center if you know of a QMCSO that will affect your benefit elections or if you want additional information on Zimmer Biomet's policies and procedures for QMCSOs. You also can request, without charge, a copy of the written procedure for determining whether a QMCSO is valid.

Keeping Dependent Information Up to Date

It is important that you keep your dependent information up to date, including enrolling new dependents whom you want to cover when first eligible and removing dependents when they are no longer eligible. As a plan participant, you have an affirmative responsibility to notify the Zimmer Biomet Benefits Service Center whenever any covered dependent you have enrolled becomes ineligible. Failure to timely notify the Service Center is deemed an intentional misrepresentation, and may result in retroactive termination of coverage.

To make a change, timely notify the Zimmer Biomet Benefits Service Center at 1-877-588-0933 and speak with a customer service representative, or go online and declare the Qualified Status Change at **benefits.zimmerbiomet.com**.

No matter which method you use, you must notify the Zimmer Biomet Benefits Service Center and make the changes to your benefit elections:

- **Within 31 calendar days** of the Qualified Status Change (other than birth or adoption), including the day of the event. (Within 60 days if change is due to gaining or losing Medicaid or Children's Health Insurance Program coverage.)
- **Within 90 calendar days** of the Qualified Status Change for birth or adoption of a child, including the day of the event.

Coverage and contributions for any elected benefits will be effective as soon as administratively practical after your election, except in the cases of birth or adoption of a dependent (in which cases coverage and contributions are retroactively effective as of the date of birth or adoption). Contributions will be taken as soon as administratively practical, typically within one or two paychecks after your Qualified Status Change, including any contributions for retroactive coverage in the cases of birth or adoption.

You must submit the required documentation **within 60 calendar days** from the day of notification; otherwise, coverage will terminate retroactively. Respond promptly to any notices provided by the Zimmer Biomet Benefits Service Center. No documentation is required to remove a dependent from coverage.

From time to time, the Company reviews the eligibility of team members and dependents. If you enroll an individual who is ineligible, or if you do not timely notify the plan to remove a person when they are no longer eligible, coverage will terminate, further benefits will be denied and the plan may seek reimbursement (including offset) to reclaim amounts paid after eligibility ended.

When Coverage Begins

If you are a newly eligible team member, you have 31 calendar days to enroll in the medical plan. Coverage for you and your dependents will begin as of your first day of employment, provided you elect benefits in a timely manner. Your initial election will run through December 31 of that year. If you enroll during the annual benefits enrollment period, coverage for you and your dependents will begin on January 1 and remain in effect through December 31 of the following year. According to IRS rules, you may only make changes in your election during the year if you have a Qualified Status Change or if you experience a different event permitting a mid-year election change. See the **Making Changes During the Year** section for details.

What Happens If You Don't Enroll

Ensure you receive the benefits you want by completing your enrollment elections on time. If you don't complete the enrollment process, you will be enrolled in default coverage.

Please refer to the Benefits Enrollment Guide on the Zimmer Biomet intranet or at **benefits.zimmerbiomet.com** for more information regarding enrollment deadlines and default coverage.

Coverage Choices

If you elect a medical option, you also must choose the tier of coverage you want to receive:

- You only
- You + spouse/domestic partner
- You + child(ren)
- You + family

Any elections you choose when you enroll (or the default elections) will remain in effect until December 31 of the plan year, unless you experience a Qualified Status Change or otherwise become ineligible.

For purposes within this document, spouse, children and domestic partners must satisfy the eligibility requirements described in this SPD.

You can choose a different coverage level for medical than you do for your vision or dental coverage.

Paying for Coverage

You and the Company share in the cost of your medical coverage. Your portion of the cost is deducted from your paycheck on a pre-tax basis. Paying on a pre-tax basis means your contributions are made before federal (and, in most cases, state) income taxes and FICA taxes are withheld. Expected costs and contributions are group rates, meaning they are determined by the total cost of providing coverage to all participants in the medical plan.

If you enroll someone who is eligible but who is not your dependent for federal tax purposes, the portion of your coverage paid for by Zimmer Biomet will be included in your gross income and reported to the IRS. This would include your domestic partner or your partner's children if either are not your tax dependent under Internal Revenue Code Section 152.

Spousal/Domestic Partner Surcharge

If your spouse/domestic partner has access to group medical coverage aside from the coverage under the Zimmer Biomet plan, you will pay a surcharge if you choose to enroll your spouse/domestic partner as a covered dependent in the Company's medical plan. When you enroll you must attest that your spouse/domestic partner does not have access to any other available group medical coverage in order to avoid the surcharge. Group medical coverage is considered medical coverage your spouse/domestic partner has through his/her employer's benefits.

Throughout the year, you must promptly inform the Zimmer Biomet Benefits Service Center if your spouse/domestic partner becomes eligible for other group medical coverage.

The Company reserves the right to periodically review whether your spouse/domestic partner is eligible for other group medical coverage; however, you are responsible for promptly notifying the Zimmer Biomet Benefits Service Center of any changes in your spouse's/domestic partner's eligibility. Failure to accurately attest or timely update information about your spouse's/domestic partner's eligibility for other group medical coverage will be deemed an intentional misrepresentation and coverage may terminate retroactively.

Tobacco Surcharge

When you enroll for benefits, you will be asked to declare whether you and/or your spouse/domestic partner currently use or have used tobacco products within the last six months or have enrolled and completed the Virgin Pulse tobacco cessation program. The Tobacco Surcharge does not apply to new hires in their first plan year.

- If you answer that you and/or your spouse/domestic partner do use tobacco products, you will pay the tobacco surcharge.
- If you answer that you and/or your spouse/domestic partner do not use tobacco products or have been tobacco-free within the last six months, you will not pay the tobacco surcharge.
- If you answer that you and/or your spouse/domestic partner have enrolled and completed the Virgin Pulse tobacco cessation program, you will not pay the tobacco surcharge.

Making Changes During the Year

Because you pay for your medical coverage with pre-tax dollars, you may make changes during the year only if you have a change in your family or employment status (referred to as a Qualified Status Change) or if you experience a different event permitting a mid-year election change.

Special Enrollment Rights

You or your dependents may be eligible for Special Enrollment Rights in certain situations. See **Special Enrollment Rights** in the Benefits Administration SPD for more information.

When Coverage Ends

In general, coverage under the Zimmer Biomet medical plan will end on the last day of the month during which your employment ends. Coverage also may end for other reasons, such as:

- Zimmer Biomet terminates this medical plan;
- You are no longer eligible for coverage or benefits;
- You fail to make any required contributions; or
- You die.

Your dependent's coverage will end for the following reasons:

- Zimmer Biomet terminates all dependent coverage under this medical plan;
- Your dependent becomes covered as a team member;
- Your dependent is no longer eligible for benefits;
- You fail to make any required contributions;
- Your coverage terminates; or
- You or your dependent dies.

If you terminate employment and are rehired, you will remain subject to any benefit maximum or frequency limitations for the plan year.

You may be able to continue your Zimmer Biomet medical coverage through the COBRA. See the **COBRA Continuation** section for details. You also may be able to continue coverage if you are on an approved Family and Medical Leave Act (FMLA) leave or are on military leave. See the **Continuation of Coverage While on a Family and Medical Leave** or **Continuation of Coverage for team members in the Uniformed Services** sections for more details.

ABOUT THE MEDICAL PLAN

As an eligible team member, you have an opportunity to participate in Zimmer Biomet's medical plan (including prescription drug coverage). The medical plan offers three medical options to meet the needs of different family and health situations. It also gives you flexibility and control in choosing your providers, the healthcare services you need and how you pay for services. The medical plan helps you and your family take control of your healthcare dollars and decisions.

Zimmer Biomet sponsors the medical plan and pays the majority of the cost. You also share the cost through contributions that are deducted from your paycheck, deductibles and coinsurance. Medical benefits are self-insured, which means claims are paid from Company general assets. Anthem Blue Cross Blue Shield (Anthem) administers the medical options, processes benefit claims and provides other services. Express Scripts administers the prescription drug coverage. Although Anthem and Express Scripts provide administrative services and are claims administrators, they do not insure any benefits under the medical plan.

YOUR CHOICES FOR MEDICAL COVERAGE

Zimmer Biomet's medical plan is an innovative approach to providing healthcare benefits. Unlike plans offered at most organizations, there are five guiding principles around the healthcare benefits that are focused on supporting and protecting you and your family:

- You can choose among three medical options. Each option comes with prescription drug coverage through Express Scripts, and has the same Anthem Blue Cross Blue Shield network providers and discounts (negotiated rates).
- Each option has a special account that you can use to pay medical expenses now or in the future. The accounts allow you to roll over unused balances from year to year.
- Each option pays 100% of preventive care and of select preventive prescription drugs with no deductible.
- For other eligible expenses covered by the medical plan, each option pays a percentage of charges after you meet the applicable annual deductible and 100% once you meet the out-of-pocket maximum during a calendar year.
- You have access to personalized health services and online tools to help you manage your health, make informed health decisions and save healthcare dollars.

The medical plan is designed to give you greater control over your healthcare expenses and to provide choices that are likely to appeal to team members with a range of different family and healthcare situations. The medical plan gives you flexibility to choose the doctors you want, help in deciding on the healthcare services you and your family members receive and control in how costs for services are paid.

Medical Plan Choices

When you enroll for medical coverage, you have three options:

- Premium Health Savings Account (HSA) Medical
- Value Health Savings Account (HSA) Medical
- Health Reimbursement Account (HRA) Medical

Each medical option pairs a health account (HSA or HRA), with medical plan coverage and prescription drug coverage. The options cover the same medical services and supplies, but each has different contributions, deductibles, coinsurance and out-of-pocket maximums.

If you elect either the Premium HSA Medical or Value HSA Medical option, you will need to decide whether to make personal contributions to your HSA and how much you want to contribute. You may not contribute to the HRA under the HRA Medical option.

When you elect a medical option, you also can access online health tools through Anthem's website, **anthem.com**. These tools can help you use your benefits more effectively.

You also can elect to choose no coverage when you initially become eligible or during the plan's annual benefits enrollment period.

COMPARING THE THREE MEDICAL OPTIONS

Each medical option pairs a health account (HSA or HRA) with medical plan coverage that has a deductible, coinsurance and an out-of-pocket maximum. Below is a brief summary of how the three options compare. The pages that follow have details on how each option works. For purposes of determining deductibles, out-of-pocket maximums and Zimmer Biomet HSA or HRA contributions, this chart uses the term "You + family" to mean You + spouse/domestic partner, You + child(ren) or You + family (spouse/domestic partner and child(ren)). Dependents can include same-gender domestic partners and their dependent children, as described in the **Who Is Eligible** section.

Medical Plan Feature		Premium HSA Medical (True Family)	Value HSA Medical (Embedded)	HRA Medical (True Family)
Claims Administrator		Anthem		
Network		Blue Cross Blue Shield		
Type of Option		Medical option with a portable HSA funded by Zimmer Biomet that can include your own tax-free contributions		Medical option with an HRA funded by Zimmer Biomet only
Preventive Care and Select Preventive Prescription Drugs		Covered at 100%		
Zimmer Biomet Contributions (You only/You + family)		Up to $750/up to $1,500[1] (contributions deposited twice a year)		Up to $500/up to $1,000[1]
Personal Contributions		Up to IRS annual limits, tax-free[2]		Not allowed
Wellness Incentives		Zimmer Biomet adds incentives to your HSA Extra Bucks Account when you and/or your covered spouse/domestic partner complete certain healthy activities		Zimmer Biomet adds incentives to your HRA when you and/or your covered spouse/domestic partner complete certain healthy activities
Annual Deductible (You only/You + family)		$1,500/$3,000 (True Family)[3]	$3,000/$6,000 (Embedded)[4]	$1,700/$3,400 (True Family)[3]
Coinsurance after Deductible	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Out-of-Pocket Maximum[5] (You only/ You + family)	In-Network	$3,500/$6,850 (including prescriptions) (True Family)[6]	$4,000/$8,000 (including prescriptions) (Embedded)[7]	$3,200/$6,400 (excluding prescriptions) (True Family)[6]
	Out-of-Network	$7,000/$14,000 (including prescriptions) (True Family)[6]	$7,000/$14,000 (including prescriptions) (Embedded)[7]	$6,400/$12,800 (excluding prescriptions) (True Family)[6]
Copayment (office visits/specialist/ER)		No copayment (deductible and coinsurance only)		
Eligibility for Healthcare FSA		No		Yes[8]
Office Visit (PCP/specialist)	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Urgent Care	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Emergency Room (medical emergency)	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 80% ; you pay 20%		
Emergency Room (non-emergency)	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Inpatient Care	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Outpatient Surgery	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		

Medical Plan Feature		Premium HSA Medical (True Family)	Value HSA Medical (Embedded)	HRA Medical (True Family)
Durable Medical Equipment	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Mental Health/Substance Abuse Inpatient (alternative care limited to non-residential program)	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Outpatient Care	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		
Infertility Coverage[9] (limited to $15,000 medical expenses and $15,000 prescription drug expenses per lifetime)	In-Network	Zimmer Biomet pays 80% ; you pay 20%		
	Out-of-Network	Zimmer Biomet pays 60% ; you pay 40%		

[1] As a newly eligible team member, your Zimmer Biomet HSA or HRA contribution is prorated (based on eligibility date) for the number of months remaining in the year, including the month of your start date (unless you are hired and enroll in the HSA Plan after December 1). See the proration charts in this SPD for details.

[2] For 2021, the HSA limits are $3,600 (You only) and $7,200 (You + family), including both your and Zimmer Biomet's contributions, and may increase for future years as provided by the IRS.

[3] True Family deductible requires all or one individual to meet the family deductible before the medical plan pays coinsurance.

[4] Embedded deductible limits each individual in a family to the individual deductible (until the family deductible is satisfied) before the medical plan pays coinsurance. This means that no individual family member will pay more than the individual deductible before the medical plan pays coinsurance.

[5] Any eligible medical or prescription drug expenses paid from your HSA, HSA Extra Bucks Account or HRA and any deductible or coinsurance you pay will all apply toward the applicable out-of-pocket maximum.

[6] True Family out-of-pocket maximum – requires all or one individual to meet the out-of-pocket maximum before the medical plan pays 100%. (No covered individual will be subject to an out-of-pocket maximum greater than the annual limit established by the U.S. Department of Health & Human Services (HHS), which is $7,000 in 2021.)

[7] Embedded out-of-pocket maximum – limits each individual in a family to the individual out-of-pocket maximum (until the family out-of-pocket maximum is satisfied) before the medical plan pays 100%.

[8] Healthcare FSA available for eligible out-of-pocket healthcare expenses not covered by your HRA or any qualified dental and vision expenses. For a complete list of eligible expenses, go to **wageworks.com**.

[9] Infertility coverage is provided for the initial evaluation, treatment and correction of the underlying condition. Additionally, infertility treatment or assisted reproductive technologies are covered under the medical plan, if treatments that foster natural conception are not successful.

HOW THE HSA MEDICAL OPTIONS WORK

When you enroll in the HSA Premium Medical option or the HSA Value Medical option, you have two accounts:

- **An HSA** with HealthEquity, Anthem's partner for HSA services, for Zimmer Biomet's HSA contributions and your personal contributions. You establish this account and can use it to help pay current qualified healthcare expenses or to save for future healthcare costs.
- **An HSA Extra Bucks Account** administered by Anthem under the medical plan for Zimmer Biomet wellness incentives and any prior-year rollovers from the HRA. This account is established for you and can be used to help pay your portion of coinsurance under the medical plan.

  Note: The HSA Extra Bucks Account is used automatically by Anthem and/or Express Scripts for tax-free coverage of your portion due for coinsurance after you meet the deductible. You cannot make team member contributions to this account or invest these account funds. You also can't control the utilizing of these dollars. Anthem and/or Express Scripts will automatically utilize these to pay coinsurance.

HSA Tax Advantages

Your HSA is a special account that you can use for tax-free reimbursement of qualified medical expenses and for tax-preferred savings for healthcare needs in the future (including retirement). When you contribute to your HSA, you get triple tax advantages:

- The money you contribute to your HSA is not taxed when it is deposited into your account because it is exempt from federal income tax, FICA (Social Security and Medicare) taxes and state income tax (for most states).
- Money in the HSA accumulates interest, tax-free.
- Withdrawals are not taxed if used to pay for qualified healthcare expenses.

Because the HSA is an individual account, you are responsible for ensuring you are eligible to contribute to an HSA (whether for your contributions or company contributions).

Contributions to Your HSA

Zimmer Biomet's HSA Contributions

Each year, Zimmer Biomet contributes a set amount to your HSA, based on your tier of coverage:

- You only coverage
- Family coverage — includes You + spouse/domestic partner, You + child(ren) or You + family (spouse/domestic partner and child(ren))

Zimmer Biomet deposits half of the annual HSA contribution into your account in mid-January and the other half in mid-July. If you switch between You only coverage and You + family coverage between January and July due to a Qualified Status Change, Zimmer Biomet's HSA contribution will change accordingly. If you enroll in the HSA mid-year or have a change in your coverage level, Zimmer Biomet's contributions will be prorated as described below.

Zimmer Biomet contributions are made through the Section 125 plan. All contributions to your HSA are yours to keep once they are deposited in the HSA. You won't forfeit deposited HSA funds if you leave the Company.

HSA Contribution Limits

The Internal Revenue Service (IRS) limits the amount you and Zimmer Biomet can contribute to your HSA each year.

For 2021, HSA maximum contribution limits are:

- You only: $3,600
- You + family: $7,200

These limits include both your and Zimmer Biomet's contributions.

For 2021, Zimmer Biomet HSA contributions:

- You only: up to $750
- You + Family: up to $1,500

All team member contributions are the difference between Zimmer Biomet's contribution to your HSA and the annual limit set by the IRS.

Team members age 55 or above can make an additional “catch-up contribution” of $1,000 each year, as long as you are not enrolled in Medicare.

Your HSA Contributions

You can make personal contributions to your HSA, up to the IRS maximum, by:

- Authorizing voluntary pre-tax contributions by payroll deduction; or
- Making after-tax contributions to HealthEquity.

You cannot make HSA contributions after you are enrolled in Medicare.

Your Catch-Up Contributions

If you are age 55 or above and are not enrolled in Medicare, you may make additional catch-up HSA contributions up to $1,000 per year.

Maximum HSA Contributions

By law, there are annual HSA contribution maximums, which are a combination of Zimmer Biomet's HSA contributions plus your personal HSA contributions. If you are eligible for catch-up contributions, the HSA maximum can be increased by $1,000. (**Note:** Any rollovers do not count toward the HSA maximum contribution.)

Prorating Contributions for Mid-Year Enrollments

Mid-year enrollment is any enrollment to the HSA Premium Medical option or the HSA Value Medical option effective after January 1. Examples are new hire enrollments or becoming newly eligible for enrollment.

Zimmer Biomet's HSA contributions are prorated (reduced) for mid-year enrollments to account for the fewer number of months that you will participate in the HSA for that calendar year. When counting months, the month you are hired or become newly eligible for enrollment counts as the first month for purposes of prorating Zimmer Biomet's contribution. However, if you enroll after December 1, tax law does not allow you to make an HSA contribution or receive a Zimmer Biomet

HSA contribution for that year. For details on prorating contributions, see the following chart:

HSA Contribution Proration Chart

	Hired before 7/1		Hired on or after 7/1 (and before 12/2)	
Month	**You only**	**You + family**	**You only**	**You + family**
January	$375.00	$750.00		
February	$312.50	$625.00		
March	$250.00	$500.00		
April	$187.50	$375.00		
May	$125.00	$250.00		
June	$62.50	$125.00		
July			$375.00	$750.00
August			$312.50	$625.00
September			$250.00	$500.00
October			$187.50	$375.00
November			$125.00	$250.00
December[1]			$62.50	$125.00

[1] Only team members eligible as of December 1 are eligible for the Company HSA contribution.

You can still make personal HSA contributions up to the annual HSA maximum (see **HSA Contribution Limits**), if you enroll in the HSA after January 1 but before December 1. If you do this, special rules in the tax code require that you remain enrolled in the HSA Premium Medical option or the HSA Value Medical option until December 31 of the following year. If you stop participating in the HSA option before that date, any contributions that you make over the maximum HSA contribution based on the number of full calendar months for which you were covered by either HSA medical option are reduced for the year of your mid-year enrollment, and any excess contributions made to your HSA will be subject to taxes and penalties. The HSA deductible is not prorated due to IRS regulations.

Remember, you cannot use your HSA to pay any otherwise eligible medical expenses incurred before you open your HSA. If you fail to open your HSA by December 31, or the HSA provider's last business day before December 31, any of your HSA contributions and any Company HSA contributions for that plan year will be forfeited.

You should consult with a tax advisor if you have questions about the annual maximum for HSA contributions permitted by law in your situation.

Contributions to Your HSA Extra Bucks Account

Zimmer Biomet's Incentive Contributions

You also can earn incentives from Zimmer Biomet if you or your eligible covered spouse/domestic partner complete certain Virgin Pulse healthy activities. Up to $400 each per covered team member and/or covered spouse/domestic partner may be earned. Incentives are credited to your HSA Extra Bucks Account after completion of the healthy activities. The wellness program and its incentives are described later in this SPD.

Rollover Contributions

If you change your medical option during the annual benefits enrollment window and elect the HSA Premium Medical or the HSA Value Medical, any unused amounts from your HRA will roll over to your HSA Extra Bucks Account.

How the HSA Options Pay for Benefits

For Preventive Care

During the year, when you and your family have preventive care expenses (such as routine exams and tests), the medical plan pays the full cost with no deductible required. It also pays the full cost for certain preventive care prescription drugs, such as those to help control chronic health conditions. See **Prescription Drug Coverage**, or for a complete list of select preventive prescription drugs, visit the Team Member Center on the Zimmer Biomet intranet.

For Other Covered Medical Expenses

For other covered medical services and supplies that are not preventive services, the medical plan pays benefits as described below.

Deductibles
You must meet the deductible each calendar year before the medical plan starts to pay benefits. You can choose to pay covered expenses until your annual deductible is met from your HSA or from your personal funds, but you cannot use your HSA Extra Bucks Account before the applicable deductible is met.

More About the Annual Deductible

The annual deductible is the amount you or a covered family member pays for covered medical and/or prescription drug expenses during the year before coinsurance starts. The amount of your deductible is based upon your medical option and tier of coverage.

Premium HSA Medical:

- You only: $1,500
- You + family: $3,000

With the Premium HSA Medical option, the family deductible is met when one family member or a combination of family members meets the family deductible amount. (This is called a “True Family” deductible.)

For example, you would meet the family deductible if:

- Two family members each have $1,500 in deductible expenses;
- One family member has $1,500 in deductible expenses and two or more other family members have combined deductible expenses that total an additional $1,500; or
- Three or more family members have combined deductible expenses that total $3,000.

  Note: Coinsurance will not apply for any family member until the True Family deductible has been met.

Value HSA Medical:

- You only: $3,000
- You + family: $6,000

With the Value HSA Medical option, each individual in a family is limited to the individual deductible (until the family deductible is satisfied) before the medical plan pays coinsurance. This applies to each family member until the family deductible is satisfied. (This is called an “Embedded” deductible.)

For example, you would meet deductible if:

- One family member has $3,000 in deductible expenses, that family member's deductible is met (any subsequent medical bills that family member receives will be subject to coinsurance even though the family deductible of $6,000 has not been met yet).
- One family member has $3,000 in deductible expenses and two or more other family members have combined deductible expenses that total an additional $3,000 (any subsequent medical bills any family member receives will be subject to coinsurance because the family deductible of $6,000 has been met).
- Three family members each have $2,000 in deductible expense totaling $6,000 (any subsequent medical bills any family member receives will be subject to coinsurance because the family deductible of $6,000 has been met.)

  Note: Coinsurance will not apply for any family member until his/her individual deductible has been met or the family deductible has been met.

Eligible Expenses:

Any amounts paid from your HSA or from your personal funds for covered medical and prescription drug program expenses count toward meeting the deductible (either True Family or Embedded). The following expenses do not count toward the deductible:

- Expenses that do not qualify as covered charges or as medically necessary charges under the medical plan (see **Covered Expenses**).
- Expenses that exceed maximum allowed amounts, benefit limits or treatment limits.
- Charges that are covered by Work-Life Solutions or the dental or vision plans.

Coinsurance

Once you meet the applicable annual deductible, the medical option begins to pay a percentage of the cost of your eligible healthcare expenses (called coinsurance) and you pay the remainder. The percentage is based on whether you use in-network providers. In-network providers have agreed to charge discounted fees for services, so the option pays a higher coinsurance rate (80%) for in-network providers and you pay a lower rate (20%). If you use out-of-network providers, the option pays a lower coinsurance rate (60%), and benefits are based on the maximum allowed amount. As a result, the amount you pay can be significantly more. See **Provider Choices Affect Your Benefits** for more information and an example.

When the medical plan processes payments after you meet the deductible, the claims administrator automatically draws funds from the available balance in your HSA Extra Bucks Account to help pay your portion of coinsurance. You do not access funds or pay bills from this account yourself. Once your HSA Extra Bucks Account is depleted, you decide whether to pay any additional coinsurance out of pocket or from your personal HSA.

Coinsurance Exceptions

Please note there are some coinsurance exceptions:

- Some non-essential health benefits and supplies have annual or lifetime benefits or treatment limits, including, without limitation: treatment of infertility, artificial insemination and prescriptions to treat infertility; bone marrow donor searches and travel for transplants[1]; physical, speech and occupational therapy; chiropractic care; home health care; nutritional counseling; care in a rehabilitation facility; and skilled nursing facility care.

- Emergency room treatment for true emergencies (medical emergencies as defined under the medical plan) is covered at in-network rates for both in-network and out-of-network providers.
- Ambulance services are covered at 100% for both in-network and out-of-network providers, but you are responsible for out-of-network charges that exceed the maximum allowed amount. See **Provider Choices Affect Your Benefits** for additional information.

[1] Travel and Lodging has a $10,000 per transplant maximum. Covered expenses include: hotel, motel, apartment rental, air/train/bus fares, car rental, gas, parking (excluding valet), tolls, personal car mileage (only if the individual does not fly; covered to and from facility), car rental car mileage (only if charged by car rental agency), and taxes on covered expenses. Lodging allowance is $50 per day for double occupancy. Travel includes transportation for two companions if the patient is a minor child. Non-Covered Expenses include: convenience items (e.g., telephone and fax), entertainment items (e.g., movies, books and video rentals), valet parking, personal car mileage except as stated above, furnishing for apartments (including cooking utensils), appliances and furniture, groceries including alcohol, tobacco products, paper products, toiletries, personal hygiene products, meals, laundry service, dry cleaning, gratuities, and moving trucks.

Out-of-Pocket Maximums

The out-of-pocket maximum gives you additional protection against high medical costs. If the portion of covered in-network medical and prescription drug expenses that you pay (for example, your deductibles and coinsurance) reaches the out-of-pocket maximum during a calendar year, the medical plan pays 100% of your covered in-network expenses for the rest of that calendar year.

More About the Annual Out-of-Pocket Maximum

In addition to separate team member and family out-of-pocket maximums, there also are separate maximums for in-network and out-of-network charges. The annual in-network out-of-pocket maximum is based upon your medical option and tier of coverage.

Premium HSA Medical:

Annual in-network out-of-pocket maximum

- You only: $3,500
- You + family: $6,850

Annual out-of-network out-of-pocket maximum

- You only: $7,000
- You + family: $14,000

The Premium HSA Medical option has a True Family out-of-pocket maximum, which requires one family member or a combination of family members to meet the family out-of-pocket maximum before the medical plan pays 100%.

Value HSA Medical:

Annual in-network out-of-pocket maximum

- You only: $4,000
- You + family: $8,000

Annual out-of-network out-of-pocket maximum

- You only: $7,000
- You + family: $14,000

The Value HSA Medical option has an Embedded out-of-pocket maximum, which limits each individual in a family to the individual out-of-pocket maximum (until the family out-of-pocket is

satisfied) before the medical plan pays 100%.

Note: In-network charges count toward both the in-network and out-of-network out-of-pocket maximums, but out-of-network charges count only toward the out-of-network out-of-pocket maximum.

Eligible Expenses:

Any amounts paid from your HSA, HSA Extra Bucks Account or your personal funds for your portion of covered medical and prescription drug program expenses except out-of-network charges that exceed the maximum allowed amount (e.g., deductibles and coinsurance) count toward meeting the out-of-pocket maximums.

The following expenses do not count toward the out-of-pocket maximum:

- Expenses that do not qualify as covered charges or as medically necessary charges under the medical plan (see the **Covered Expenses** section).
- Expenses that exceed the maximum allowed amount, benefit limits or treatment limits.
- Charges that are covered by the Work-Life Solutions, dental, or vision plans.
- Any excluded charges or claims.

For Expenses That Are Not Covered by the Medical Plan

You also can use your HSA to pay:

- Deductibles and coinsurance for covered services under the dental and vision plans.
- Other eligible healthcare expenses under the federal income tax code that are not covered by Zimmer Biomet's medical plan or other insurance.

Save Your Receipts
When you pay expenses through the HSA, it is important to keep copies of your bills and receipts. This documentation is not required by Anthem, but may be required by the IRS.

Setting Up Your Accounts

When you enroll in the Premium HSA Medical option or Value HSA Medical option for the first time, you must establish your HSA in your name with HealthEquity. You'll receive instructions during the enrollment process on how to activate your HSA. Once activated, you will receive a welcome kit and HSA debit card from HealthEquity. You will not be able to use your HSA until you activate your account and funds have been deposited. HealthEquity banking fees will apply for overdraft charges or for the replacement of a debit card and will be deducted from your HSA.

HSAs are team member-owned accounts. This means you are responsible for ensuring you are eligible to contribute to an HSA and the tax consequences of contributing to and taking reimbursements from the HSA. Your HSA Extra Bucks Account is a separate Zimmer Biomet-owned account, established under either HSA medical option.

Please consult a financial/tax advisor for questions related to your personal tax implications.

Reminders About HSA Eligibility

You and your covered dependents cannot contribute to an HSA if:

- You or a covered dependent is covered by Medicare.
- You or a covered dependent is enrolled in any other medical option (including your

spouse/domestic partner's), unless it is a high-deductible option.

- You only have a post office box address and do not have a physical address. The Department of Homeland Security requires bank accounts, including your HSA, to be tied to a physical mailing address (not a P.O. Box).
- You have unused funds remaining in your Healthcare Flexible Spending Account (FSA). Note that the HSA has all of the advantages of a Healthcare FSA (including the ability to contribute pre-tax dollars and pay expenses tax-free) plus the additional advantages of tax-free investment earnings and no "use it or lose it" rules. The IRS does not allow you to participate in both an HSA and an FSA.

To learn more about HSAs, go to **irs.gov**. See IRS Publication 969 for guidelines and more information about contributing to and using the HSA.

How to Pay Expenses From Your HSA

If you decide to pay expenses through your HSA, you can use your HSA debit card to pay for qualified healthcare expenses.

When the medical plan processes payments after you meet the deductible, the claims administrator automatically draws funds from the available balance in your HSA Extra Bucks Account to help pay your portion of coinsurance. Once your HSA Extra Bucks Account is depleted, you decide whether to pay any additional coinsurance out of pocket or from your HSA.

Saving for Future Healthcare Expenses

The HSA is a tax-deferred savings vehicle. It can be used to pay qualified health expenses you incur this year, next year or in retirement. Saving for future healthcare expenses makes sense, and the HSA is one of the most tax-effective and easy ways to save.

Once your account balance reaches the minimum set by HealthEquity (currently $1,000), you can invest Zimmer Biomet's contributions and your contributions with HealthEquity. You have several investment choices. When you are ready to invest, contact HealthEquity at 1-877-713-7712 or visit **myhealthequity.com** for more information on the investment choices and a prospectus.

If You Change Medical Options

If you change your medical option during annual benefits enrollment and elect the HRA Medical option, your personal HSA will remain in your name, and you will be able to use your account to pay for qualified healthcare expenses, but all contributions (yours and Zimmer Biomet's) to your HSA will end. Any contributions to the HSA Extra Bucks Account that are not used to pay eligible expenses while you participate in either HSA medical option will roll over to the HRA for use in the next year. You will be responsible for paying the monthly administrative fee to maintain your HSA with HealthEquity, which will be deducted directly from your HSA.

When You Leave Zimmer Biomet

Your personal HSA belongs to you. If you leave Zimmer Biomet, you will continue to have access to your HSA. You should notify HealthEquity when you leave Zimmer Biomet for information on working directly with them in administering your account. You will be responsible for all bank fees associated with your HSA.

The HSA Extra Bucks Account is Zimmer Biomet-owned. When your coverage ends under either of the Zimmer Biomet HSA medical options, any amount in your HSA Extra Bucks Account will be used to offset expenses incurred while you were employed. Once those eligible expenses are paid, you will forfeit any unused funds that remain in the account.

HOW THE HRA MEDICAL OPTION WORKS

When you enroll in the HRA Medical option, a health reimbursement account (HRA) is established for you. The account is funded by Zimmer Biomet and administered by Anthem under the medical plan. Your HRA is used to help pay your deductible and coinsurance for covered medical expenses.

HRA Tax Advantages

Your HRA is a tax-favored vehicle for paying medical expenses. Zimmer Biomet's contributions are not taxed when they are deposited into your account or when the money is drawn from your account to pay deductibles and coinsurance for covered medical expenses, so you are able to pay expenses with tax-free dollars.

Contributions to Your HRA

Zimmer Biomet's HRA Contributions

Each year, Zimmer Biomet contributes a set amount to your HRA, based on your tier of coverage:

- You only
- You + family — includes You + spouse/domestic partner, You + child(ren) or You + family (spouse/domestic partner and child(ren))

Zimmer Biomet deposits the annual HRA contribution into your HRA account in January or in your first month you are eligible and enrolled in the HRA medical option.

The maximum amounts are shown below.

2021 HRA Contributions

Zimmer Biomet contributes:

- You only: up to $500
- You + family: up to $1,000

Incentive potential up to $400 each per covered team member and covered spouse/domestic partner (depends on completing certain Virgin Pulse healthy activities). The wellness program and its incentives are described in this SPD.

You cannot make personal contributions to the HRA.

Prorating Contributions for Mid-Year Enrollments

Mid-year enrollment is any enrollment to the HRA Medical option effective after January 1. Examples are new hire enrollments or becoming newly eligible for enrollment.

Zimmer Biomet's HRA contributions are prorated (reduced) for mid-year enrollments to account for the fewer number of months that you will participate in the HRA for that calendar year.

When counting months, the month you are hired or become newly eligible for enrollment counts as the first month. For details on prorating contributions, see the chart below:

HRA Contribution Proration Chart

Month	You only	You + family
January	$500.00	$1,000.00
February	$458.33	$ 916.67
March	$416.67	$ 833.33
April	$375.00	$ 750.00
May	$333.33	$ 666.67
June	$291.67	$ 583.33

Month	You only	You + family
July	$250.00	$ 500.00
August	$208.33	$ 416.67
September	$166.67	$ 333.33
October	$125.00	$ 250.00
November	$ 83.33	$ 166.67
December	$ 41.67	$ 83.33

Zimmer Biomet's Incentive Contributions

You also can earn incentives from Zimmer Biomet if you or your eligible covered spouse/domestic partner complete certain Virgin Pulse healthy activities. Up to $400 each per covered team member and/or covered spouse/domestic partner may be earned. Incentives are credited to the HRA after completion of the healthy activities. The wellness program and its incentives are described later in this SPD.

Rollover Contributions

If you change your medical option during annual benefits enrollment and elect the HRA, any contributions to the HSA Extra Bucks Account that are not used to pay eligible expenses for the period when you participate in either HSA medical option will roll over to the HRA for use in the next year. Amounts in your HSA will not roll over; they will remain in your HSA.

No Team Member Contributions

Team member contributions are not allowed into the HRA.

You Can Elect the HRA Medical Option and a Healthcare FSA

Because you don't make pre-tax contributions to your HRA, you are eligible to participate in both the HRA Medical option and the Healthcare Flexible Spending Account (FSA). However, you must use HRA funds for covered expenses before sending claims to the Healthcare FSA, unless the expense is for items not covered by the medical plan. See IRS Publication 969 for guidelines and more information about contributing to and using the Healthcare FSA.

How the HRA Option Pays Benefits

For Preventive Care

During the year, when you and your family have preventive care expenses (such as routine exams and tests), the medical plan pays the full cost with no deductible required. It also pays the full costs for select preventive prescription drugs, such as those to help control chronic health conditions.

For Other Covered Medical Expenses

For other covered medical services and supplies, the medical plan pays benefits as described in the following pages.

Deductibles

You must meet the deductible each calendar year before the medical plan starts to pay benefits. When the medical plan processes claims, it automatically draws funds from your HRA to pay

toward your deductible to the extent funds permit. You do not access funds or pay bills from this account yourself. Once your account is depleted, you pay any remaining deductible amount out of pocket.

Note: If you enroll mid-year, your HRA annual deductible is prorated, based on the number of months that you participate in the medical plan. Please see the chart below:

HRA Deductible Proration Chart (Total Deductible)

Month	You only	You + family
January	$1,700.00	$3,400.00
February	$1,558.33	$3,116.67
March	$1,416.67	$2,833.33
April	$1,275.00	$2,550.00
May	$1,133.33	$2,266.67
June	$991.67	$1,983.33

Month	You only	You + family
July	$850.00	$1,700.00
August	$708.33	$1,416.67
September	$566.67	$1133.33
October	$425.00	$850.00
November	$283.33	$566.367
December	$141.67	$283.33

More About the Annual Deductible

The annual deductible is the amount you or a covered family member pays for covered medical expenses during the year before coinsurance starts. The amount of your deductible is based upon your medical option and tier of coverage.

HRA Medical:

- You only: $1,700
- You + family: $3,400

With the HRA medical option, the family deductible is met when one family member or a combination of family members meets the family deductible amount. (This is called a “True Family” deductible.)

For example, you would meet the family deductible if:

- Two family members each have $1,700 in deductible expenses;
- One family member has $1,700 in deductible expenses and two or more other family members have combined deductible expenses that total an additional $1,700; or
- Three or more family members have combined deductible expenses that total $3,400.

Note: Coinsurance will not apply for any family member until the True Family deductible has been met.

Eligible Expenses:

Any amounts paid from your HRA or from your personal funds for covered medical expenses count toward meeting the deductible.

The following expenses do not count toward the deductible:

- Expenses that do not qualify as covered charges or as medically necessary charges (see **Covered Expenses**).
- Expenses that exceed the maximum allowed amount, benefit limits or treatment limits.
- Charges that are covered by the prescription drug program, Work-Life Solutions, or the dental or vision plans.
- Any excluded charges or claims.

Coinsurance

Once you meet the deductible, the medical plan pays a percentage of charges (called coinsurance) and you pay the remainder. The percentage is based on whether you use in-network providers. In-network providers have agreed to charge discounted fees for services, so the medical plan pays a higher coinsurance rate (80%) and you pay a lower rate (20%). If you use out-of-network providers, the medical plan pays a lower coinsurance rate (60%), and benefits are based on the maximum allowed amount. As a result, the amount you pay can be significantly higher. See the **Provider Choices Affect Your Benefits** section for more information and an example.

If there are any funds remaining in your account after meeting the deductible, the claims administrator automatically draws funds to pay your portion of coinsurance. Once your HRA is depleted, you pay any additional coinsurance out of pocket.

Coinsurance Exceptions

Please note that there are some coinsurance exceptions:

- Some non-essential health benefits and supplies have annual or lifetime benefits, or treatment limits, including, without limitation: treatment of infertility, artificial insemination and prescriptions to treat infertility; bone marrow donor searches and travel for transplants; physical, speech and occupational therapy; chiropractic care; home health care; nutritional counseling; care in a rehabilitation facility; and skilled nursing facility care.
- Emergency room treatment for true emergencies is covered at the in-network level of benefits, up to the maximum allowed amount, for both in-network and out-of-network providers.
- Ambulance services are covered at 100% for both in-network and out-of-network providers, but you are responsible for out-of-network charges that exceed the maximum allowed amount. See the **Provider Choices Affect Your Benefits** section for additional information.

Out-of-Pocket Maximum

The out-of-pocket maximum gives you additional protection against high medical costs. If the portion of covered medical expenses that you pay (for example, your deductibles and coinsurance) reaches the out-of-pocket maximum during a calendar year, the medical plan pays 100% of covered in-network expenses for the rest of that calendar year.

More About the Annual Out-of-Pocket Maximum

In addition to separate team member and family out-of-pocket maximums, there also are separate maximums for in-network and out-of-network charges. The annual in-network out-of-pocket maximum is based upon your medical option and tier of coverage.

There are separate maximums for in-network and out-of-network charges:

HRA Medical:

Annual in-network out-of-pocket maximum:

- You only: $3,200
- You + family: $6,400

Annual out-of-network out-of-pocket maximum:

- You only: $6,400

- You + family: $12,800

The HRA medical option has a True Family out-of-pocket maximum, which requires one family member or a combination of family members to meet the family maximum before the medical plan pays 100%.

Note: In-network charges count toward both the in-network and out-of-network out-of-pocket maximums, but out-of-network charges count only toward the out-of-network out-of-pocket maximum.

Eligible Expenses:

Any amounts paid from your HRA or from your personal funds to pay your portion of covered medical expenses (e.g., deductibles and coinsurance) count toward meeting the out-of-pocket maximum.

The following expenses do not count toward the out-of-pocket maximum:

- Expenses that do not qualify as covered charges or as medically necessary charges (see the **Covered Expenses** section and the **Charges That Are Not Covered** section).
- Expenses that exceed the maximum allowed amount, benefit limits or treatment limits.
- Charges that are covered by the prescription drug program, Work-Life Solutions, or the dental or vision plans. **Note:** The prescription drug program has a separate out-of-pocket maximum, so coinsurance paid under the prescription drug program counts toward the prescription drug out-of-pocket maximum rather than the medical out-of-pocket maximum.

If You Change Medical Options

If you change your medical option during annual benefits enrollment and elect the Premium HSA Medical option or Value HSA Medical option, any amounts from your HRA will roll over to your HSA Extra Bucks Account.

If You Leave Zimmer Biomet

The HRA is Zimmer Biomet-owned. When your coverage ends under the Zimmer Biomet HRA medical option, any amount in your HRA will be used to offset expenses incurred while you were employed. Once those eligible expenses are paid, you will forfeit any unused funds that remain in the account.

COVERED EXPENSES

The medical plan pays benefits for preventive care and for treatment of an injury or disease. Covered charges include professional services, maternity care, behavioral health, substance abuse treatment, hospital and facility services, and certain clinical trials, as well as those Zimmer Biomet Technologies, as defined by the plan. Prescription drugs also are covered through a separate administrative arrangement with Express Scripts.

What Are Eligible Charges?

To be eligible for coverage, a service, supply or treatment must:

- Be a covered expense listed on the following pages for treatment of an injury or disease, or provided for preventive care as specified by the medical plan;
- Be medically necessary, as determined by the claims administrator (see **What It Means to Be Medically Necessary** below);
- Not be for treatment of an occupational condition (the medical plan does not cover medical treatment of conditions that are related to or resulted from your work or employment with Zimmer Biomet or any other employer or your self-employment or are eligible for Workers' Compensation); and
- Be rendered by a licensed provider.

What It Means to Be Medically Necessary

Medically necessary care is defined as:

- Commonly recognized by the appropriate medical specialist, within standards of good practice.
- Appropriate, effective and consistent with the diagnosis or treatment of an illness or injury.
- The appropriate supply or level of service that can be safely administered.
- Provided by a practitioner, hospital or covered provider.
- A drug or supply approved by the U.S. Food & Drug Administration (FDA).

Medically necessary care is not:

- Experimental or investigational in nature.
- Primarily for the convenience of the patient or covered provider.
- Provided primarily for the purpose of medical or other research.
- Care that does not require the technical skills of a medical, mental health or dental professional.
- Care that is more costly than care that could safely and adequately be furnished in an alternative setting.
- Scholastic, educational or developmental in nature, or intended for vocational training.

See **Terms to Know** on the following page for more information about medically necessary services.

Provider Choices Affect Your Benefits

The medical plan pays a percentage of covered charges, called coinsurance, after you meet the applicable annual deductible. The medical plan's coinsurance depends on the type of charge; whether you participate in the HSA or HRA; and whether you use in-network or out-of-network providers. In-network providers have agreed to discounted rates established by the medical plan (the negotiated rate). They will accept this negotiated rate as full payment for covered services provided to plan members.

The medical plan pays benefits for covered charges based on the established negotiated rate. Any charges that exceed the negotiated rate are your responsibility. This can have a significant impact on benefits, so understanding this provision is important. It works like this:

- When you receive care from in-network providers, the provider bills the medical plan at its regular rate. Then the medical plan reduces the bill based on the negotiated rate. The provider has agreed to accept this amount as payment for services. The medical plan then pays the in-network coinsurance (80%) for that service or supply under your medical plan. You pay the remaining 20% under the HSA or HRA.
- When you receive care from out-of-network providers, the provider bills the medical plan at its regular rate. The medical plan calculates the maximum allowed amount, the maximum amount of reimbursement Anthem will allow for services and supplies (see **Terms to Know** in the box below for details). The medical plan's benefit is the out-of-network coinsurance (60%) times the maximum allowed amount. Since the providers have not agreed to accept the maximum allowed amount as payment, you are responsible for paying the entire remaining bill.

Terms to Know

The ***negotiated rate*** or fee is the charge that in-network providers have agreed to accept under Anthem plans as full payment (the maximum allowed amount) for a service or supply.

The ***maximum allowed amount*** also is the maximum amount on which benefits for out-of-network providers are based. It is usually determined by the local Anthem Blue Cross Blue Shield plan in the geographic area in which you receive services. It may be the negotiated rate, another discounted amount based on the average charges for similar providers and services in your area, or an amount based on Medicare allowances. (Out-of-network providers may bill you for charges in excess of the maximum allowed amount.)

See the **Terms to Know** section for more details about the maximum allowed amount for covered services performed by in-network and out-of-network providers.

An Example

Suppose you meet the deductible and have surgery and you are covered under the HRA Plan with 80% coinsurance for in-network providers and 60% coinsurance for out-of-network providers. Also assume the surgeon’s regular charges are $5,000, and the negotiated rate and maximum allowed amount is $3,500. Assuming you have met any deductible requirements, in- and out-of-network payments would be calculated as follows:

In-Network Providers		Out-of-Network Providers	
Regular charge	$5,000	Regular charge	$5,000
Negotiated Rate	$3,500	Maximum allowed amount	$3,500
Plan pays 80% of the negotiated rate	80% of $3,500 = $2,800	Plan pays 60% of the maximum allowed amount	60% of $3,500 = $2,100
You pay remaining 20% of the negotiated rate	20% of $3,500 = $700	You pay the remaining bill (up to regular charge)	$5,000 - $2,100 = $2,900

In this example, you pay $700 if you receive services from in-network providers, or you pay $2,900 if you receive services from out-of-network providers. Please note that this is a very simple example to show how the concept works. The actual negotiated rate and the maximum allowed amount may vary depending on the type of expense, the physician's billing practices and the geographic area.

Finding In-Network Providers

Generally, in-network providers are those providers who participate in the Anthem Blue Cross Blue Shield network or other providers who will agree to the negotiated rate. You can find providers by using the Find a Doctor tool on **anthem.com** or by calling Anthem Customer Service at 1-800-693-5406. It's a good idea to check with your providers to be sure they are in-network.

Finding Specialty Care in Your Area

If you need care from a specialist provider, and one is not available in your area, call Anthem. They will try to negotiate with a provider to provide care at network-negotiated rates.

Finding Out-of-Area Providers

If you are traveling or if a dependent lives out of area, call Anthem for help finding out-of-area providers who will provide discounted services.

If Your Provider Is Out-of-Network

If your doctor or other provider is not in the network, Anthem may be able to qualify and enroll the provider in the network. Call Anthem for assistance, but be aware that expenses will be paid at out-of-network rates until the provider joins the network.

If you visit an out-of-network provider, you may have to pay their full fees at the time of service, then file a claim for reimbursement. You will be responsible for coinsurance, as well as the difference between the charge for the service and the maximum allowed amount.

Preventive Care

Preventive[1]

- Baby/Child screening tests —unlimited, unless otherwise indicated
- Hearing screenings — annually
- Lead level tests
- Oral/dental health — annual fluoride varnish and fluoride prescription
- Preventive care visits — unlimited
- Routine pelvic exam, Pap test and contraceptive management
- Vision screenings — annually

Immunizations[2]

- Diphtheria, Tetanus, Pertussis (DTaP)
- H. Influenza Type B
- Hepatitis A: Recommended for high-risk groups, such as international travelers or workers in food service or healthcare industry
- Hepatitis B and Varicella: Recommended for high-risk individuals

- Human Papilloma Virus (HPV) Vaccine
- Influenza — flu shot
- Measles, Mumps, Rubella (MMR)
- Meningococcal: Considered for college students who live in dormitories and have a slightly increased risk of getting meningococcal disease
- Pneumococcal Conjugate (pneumonia)
- Polio
- Rotavirus
- Tuberculosis (TB) Vaccine
- Varicella (chicken pox)

Preventive[1]
- Alcohol and drug screening
- Breastfeeding support, supplies and counseling
- Cardiovascular disease prevention counseling
- Clinical breast exam and mammogram
- Colorectal cancer screenings: Fecal occult blood testing or flexible sigmoidoscopy
- Coronary artery disease: Periodic cholesterol and lipid screening
- Diabetes (Type II) screening: Periodic blood glucose testing for high-risk individuals (e.g., hypertension, hyperlipidemia)
- Domestic violence screening and counseling
- Fall prevention for older adults
- FDA-approved contraception methods and contraceptive counseling
- Gestational diabetes screening
- Hearing tests — annually
- HIV screening and counseling
- HPV DNA testing
- Lung cancer screening for 30-pack-per-year smokers (or those who stopped smoking within 15 years)
- Obesity screening and counseling
- Osteoporosis screening: Periodic bone density screening for women age 35 and older with increased risk for osteoporotic fractures
- Preventive care visits — unlimited
- Prostate cancer screenings: Digital rectal examination (DRE) and Prostate Specific Antigen (PSA)
- Routine pelvic exam, Pap test and contraceptive management
- Sexually transmitted infection counseling
- Tobacco product counseling for children and adults
- Vision screening — annually
- Well-woman visits

Immunizations[2]
- Hepatitis A: Recommended for high-risk groups, such as international travelers or workers in food service or healthcare industry
- Hepatitis B and Varicella: Recommended for high-risk individuals
- Human Papilloma Virus (HPV) Vaccine
- Influenza — flu shot
- Measles, Mumps, Rubella (MMR)
- Meningococcal: Considered for college students who live in dormitories and have a slightly increased risk of getting meningococcal disease
- Pneumococcal Conjugate (pneumonia)
- Tetanus, Diphtheria (DTaP)
- Herpes Zoster/Varicell Zoster (Shingles Vaccine)

[1] *The HSA and HRA Medical options cover services recommended with A or B ratings by the U.S. Preventive Services Task Force (USPSTF) as preventive services. Preventive care is updated based on changes in the USPSTF ratings.*

[2] *Actual dosing regimen.*

Medical Services

Medical Services	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Doctor and Other Provider Visits	80%	60%	80%	60%	80%	60%

The medical plan covers professional services billed by a provider's office (rather than by a facility). Covered professional services are:

- Home visits – visits by a provider to your home for diagnosis, treatment and follow-up
- Inpatient consultation – visits by a provider for observation, care, diagnosis or treatment while you are admitted to a health facility that provides room and board
- Office visits – patient visits to your doctor's or other health service provider's office for diagnosis, treatment and follow-up

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Diagnostic Test and X-Rays (Non-Routine)	80%	60%	80%	60%	80%	60%

Coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:

- Diagnostic laboratory and pathology tests
- Diagnostic medical procedures consisting of EKG, EEG and other electronic diagnostic medical procedures
- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging
- Pre-admission, pre-surgical tests that are done before inpatient or outpatient surgery

Pre-admission and/or post-release testing only when your doctor specifies the required tests and approves the facility for testing. In most cases, the tests can be performed in the outpatient department of a hospital, at an independent medical testing laboratory or in your doctor's office.

Pre-admission tests are covered even if hospitalization is delayed, postponed or cancelled.

Not Covered

Lab and X-ray services received in the absence of a diagnosis, except those specifically listed the Preventive Care section

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Physical, Speech and Occupational Therapy	80%	60%	80%	60%	80%	60%
Annual maximum (each therapy)	30 visits		30 visits		30 visits	

You have coverage for up to 30 physical therapy, 30 speech therapy and 30 occupational therapy visits each calendar year when needed to treat a congenital defect, a sickness or an injury, or to promote recovery from a sickness or injury. The medical plan also covers treatment needed due to developmental delays and learning disabilities. Therapy services are covered only when provided according to a physician's written treatment plan.

- Occupational therapy – treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of abilities that are lost or impaired and to satisfactorily accomplish the ordinary tasks of daily living
- Physical therapy – treatment by physical means, hydrotherapy, heat or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, to restore maximum function that is lost or impaired, or to prevent disability
- Speech therapy – speech therapy is covered to restore speech loss or correct impairment

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Clinics	80%	60%	80%	60%	80%	60%

The medical plan covers medical services and supplies provided during a visit to a medical clinic.

Medical Services	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Chemotherapy, Dialysis Treatment, Radiation Therapy and Respiratory Therapy	80%	60%	80%	60%	80%	60%

The plan covers these therapy services as described below:

- Chemotherapy – the treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included
- Hemodialysis treatment – the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, including hemodialysis or peritoneal dialysis
- Radiation therapy – the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes
- Respiratory therapy – the introduction of dry or moist gases into the lungs for treatment purposes

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Allergy Care – Injections and Tests	80%	60%	80%	60%	80%	60%

The medical plan covers allergy care by a physician, allergist or specialist, including:

- Allergy Injections – immunotherapy (including allergy shots, injections and sublingual drops) to increase your tolerance and reduce sensitivity to the substances that provoke allergy symptoms (allergens), but not to cure allergies
- Allergy tests, including skin or scratch tests to identify the substances that are causing allergy symptoms and RAST (radioallegrosorbent test) blood tests to identify substances causing symptoms and to estimate your relative sensitivity
- Serum when administered in the provider's office

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Chiropractic Services	80%	60%	80%	60%	80%	60%
Maximum visits	25 per calendar year		25 per calendar year		25 per calendar year	

The medical plan covers chiropractic services to detect and correct nerve interference related to misalignment or partial dislocation of the vertebral column. Coverage includes an initial consultation and up to 25 chiropractic treatments (in-network and out-of-network combined) during a calendar year.

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Cardiac Rehabilitation Therapy	80%	60%	80%	60%	80%	60%

Coverage for cardiac rehabilitation therapy is provided in two phases:

- Phase I begins during or after an acute event (for example, by-pass surgery, myocardial infarction, angioplasty). It includes nursing services, physical therapy and teaching you how to deal with your condition
- Phase II is a hospital-based outpatient program after inpatient hospital discharge. It is a physician-directed program of 3 therapy sessions a week over a 12-week period. The sessions include active treatment and EKG monitoring

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Acupuncture	80%	60%	80%	60%	80%	60%

The medical plan covers acupuncture services by a licensed provider:

- In lieu of traditional anesthesia
- To relieve chronic pain associated with arthritis, menstruation and irregularity, back pain, migraine, lumbago, pinched nerve, sciatica, post laminectomy, slipped disc, rheumatism, Bell's palsy, spastic colon, bursitis, stroke, dysmenorrhea, tennis elbow, headaches, tendonitis, herpes zoster and trigeminal neuralgia
- To relieve nausea related to chemotherapy or pregnancy

Medical Services	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Nutritional Counseling	80%	60%	80%	60%	80%	60%
Maximum visits	6 per year (maximum does not apply to diabetes)					

If you or a dependent has diabetes or another medical condition that requires a special diet, the medical plan covers nutrition counseling with a registered dietician or other licensed provider. Benefits for nutrition counseling are limited to six visits during a calendar year for conditions other than diabetes (for example, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias).

Medical Services	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Blood Transfusions	80%	60%	80%	60%	80%	60%

You have coverage for blood transfusions when needed to:

- Covered charges include those for blood and blood products, administration, and autologous and direct donations
- Exchange blood that has been removed in the treatment of Rh incompatibility in a newborn, liver failure in which toxins accumulate in the blood or certain other types of toxemia
- Maintain or replace blood volume, provide deficient blood elements and improve coagulation
- Maintain or improve transport of oxygen

Podiatry	80%	60%	80%	60%	80%	60%

The medical plan covers the services of a podiatrist, acting within the scope of his or her license, for certain surgical podiatry services, including:

- Incision and drainage of infected foot tissue
- Removal or debridement of infected toenails
- Removal of foot lesions
- Treatment of fractures and dislocations of bones of the foot
- Treatment required as part of diabetes treatment of impaired circulation to the lower extremities

Not Covered

- Procedures considered to be routine foot care or for cosmetic purposes, such as treatment of corns and calluses, non-surgical care of toenails, fallen arches and other symptomatic foot complaints of the feet
- Services outside the scope of a podiatrist's license

Eye and Ear Treatment	80%	60%	80%	60%	80%	60%

If you have an injury or disease of the eyes or ears, the medical plan covers doctor visits, diagnosis and treatment in the same way as any other illness or injury. In addition, the medical plan covers orthoptic training when medically necessary, the first pair of eyeglasses and contact lenses following cataract surgery, the initial prosthetic lenses or sclera shells following intraocular surgery, and soft contact lenses needed because of a medical condition such as diabetes.

The medical plan covers one pair of hearing aids every 36 rolling calendar months up to $2,000 per pair for dependents up to the age of 19.

Note that routine vision and hearing screenings and exams are covered only as described under Preventive Care. Eyeglasses and contact lenses to correct visual acuity are covered by the vision plan, which is described in a separate SPD.

Surgery

Surgery	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Surgical Procedures	80%	60%	80%	60%	80%	60%

The medical plan covers inpatient and outpatient surgery for treatment of a disease or injury. Surgery can be performed in a doctor's office, hospital or ambulatory surgical center.

*You must receive pre-authorization for certain surgeries – including transplants, weight loss, cardiac, and complex and rare cancer surgeries – as described under the **Pre-Admission Review and Pre-Certification** section before scheduling the procedure. As part of the pre-certification process, you may be referred to a Center of Excellence.* The medical plan pays 100% of covered medical expenses and covered travel expenses, up to the medical plan's maximums, for the surgery when you are referred to and use a Center of Excellence.

Not Covered

Separate billings made for pre-operative or post-operative care normally provided by the surgeon as part of the surgical procedure.

Anesthesia	80%	175% of Medicare maximum allowed	80%	175% of Medicare maximum allowed	80%	175% of Medicare maximum allowed

The medical plan covers administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure. To qualify for coverage, the anesthesia must be administered and billed by a physician other than the operating surgeon or his assistant.

Second Opinions	80%	60%	80%	60%	80%	60%

If your doctor recommends surgery but you want to get a second opinion whether surgery or alternative treatments are preferred for your conditions, the medical plan covers the outpatient costs for obtaining the second opinion.

Assistant Surgeon	80%	175% of Medicare maximum allowed	80%	175% of Medicare maximum allowed	80%	175% of Medicare maximum allowed

The medical plan covers the services of an assistant surgeon when the primary surgeon determines that assistance is required due to the patient's condition or the type of surgery.

The benefit is 20% of the primary surgeon's benefit payable or an amount set by the provider contract. If you use out-of-network providers and charges exceed these amounts, you are responsible for the difference in charges as well as your coinsurance.

Special Circumstances	80%	60%	80%	60%	80%	60%

Co-Surgeon

Co-surgeons are covered when two surgeons are needed in the operating room for multiple, complicated or lengthy surgeries. The co-surgeon's benefit is 50% of the primary surgeon's fee, or an amount set by the provider contract. If you use out-of-network providers, you are responsible for any costs that exceed this amount.

Bilateral Surgical Procedures

Bilateral surgical procedures refer to multiple procedures performed at the same time. The bilateral procedure benefit is 50% of the benefit for the primary procedure, or an amount set by the provider contract. If you use out-of-network providers and charges exceed these amounts, you are responsible for the difference in charges as well as your coinsurance.

Multiple Surgical Procedures

For multiple surgeries (related operations or procedures performed through the same incision or in the same operative field, or during the same operative session), the medical plan covers 100% of the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for the second highest paying procedure and 50% of the surgical allowance for each additional procedure, or an amount set by the provider contract. For example, if the medical plan normally pays 90%, the primary surgical procedure is paid at 90%; the remaining surgical procedures are paid at 50% of the 90% benefit. If you use out-of-network providers and charges exceed these amounts, you are responsible for the difference in charges as well as your coinsurance.

Surgery	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Dental Services and Oral Surgery	80%	60%	80%	60%	80%	60%

The medical plan covers charges for:

- Oral surgery by a physician or dentist to treat a disease, injury, fracture or dislocation of the jaw
- Removal of impacted teeth
- Supplies or appliances needed to promptly repair accidental injury to sound natural teeth
- Treatment by a physician or dentist of accidental injury to the jaws, sound natural teeth, mouth or face. Treatment must be completed within one year of the accident. Examples of covered accidental injuries include fractures of facial bones, the jaw and other internal mouth structures

Not Covered

- Injury as a result of chewing or biting (not considered an accidental injury)
- Normal extraction and care of teeth and structures directly supporting the teeth

Surgery	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Gender Reassignment Surgery	80%	60%	80%	60%	80%	60%

The medical plan covers: surgical and non-surgical medical treatment and study related to the modification of sex (transexualism) and related services, or the reversal thereof; and services or supplies related to treatment of gender identity disorders or sex change surgery in accordance with the administrator’s medical policy.

Surgery	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
TMJ Surgery	80%	60%	80%	60%	80%	60%

The medical plan covers surgical and non-surgical treatment of temporomandibular joint dysfunction if due to accident, congenital defect or developmental defect.

No Coverage

The medical plan does not cover appliances to treat TMJ.

Surgery	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Weight Reduction Surgery	80% *	Not Covered	80% *	Not Covered	80% *	Not Covered

The medical plan covers gastric restrictive procedures and gastric bypass surgeries when approved by Anthem Medical Management. *You must receive pre-authorization for all weight reduction surgeries as described under the **Pre-Admission Review and Pre-Certification** section before scheduling the procedure. As part of the pre-certification process, you may be referred to a Center of Excellence.*

* **Note:** For your benefit to apply, you must have surgery at a Blue Distinction Center (BDC) or BDC+. If you have surgery at a non-BDC, even if it is in-network, your benefit will not apply. See **Terms to Know** to learn more about what a BDC is, and visit **anthem.com** to find a BDC or BDC+ location near you.

Surgery	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Breast Reconstruction	80%	60%	80%	60%	80%	60%

In accordance with the Women’s Health and Cancer Right Act, the medical plan covers breast reconstruction charges for patients who have a mastectomy as long as the reconstruction is performed in a manner determined through consultation between the patient and physician. Benefits include:

- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

Surgery	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Organ, Tissue, Bone Marrow and Stem Cell Transplants	80%	60%	80%	60%	80%	60%

Covered Transplants

The medical plan covers expenses for human-to-human organ, tissue, bone marrow and stem cell transplants including those listed below. *You must receive pre-authorization for transplant surgery as described under the **Pre-Admission Review and Pre-Certification** section before scheduling the procedure. As part of the pre-certification process, you may be referred to a Center of Excellence.* The medical plan pays 100% of covered medical expenses and covered travel expenses, up to the medical plan's maximums, for the surgery when you are referred to and use a Center of Excellence.

- Bone marrow/Stem cell (includes myeloablative therapy)
- Cornea

Surgery	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

- Heart
- Heart/lung
- Kidney/pancreas
- Liver
- Liver/small bowel
- Lung
- Pancreas
- Multi-visceral
- Small bowel

Covered Expenses

Covered expenses include:

- Bone marrow donor search (up to $30,000 per search)
- Donor expenses:
  - When the donor and recipient are covered by the medical plan – the donor's expenses are covered in the same way as any other sickness
  - When the donor is covered by the medical plan but the recipient is not covered by the medical plan – the medical plan covers donor expenses only to the extent they are not covered under the recipient's plan and under any other group or individual policy
  - When the donor is not covered but the recipient is covered by the medical plan – after payment of the covered recipient's expenses, the donor's expenses are covered to the extent any benefits remain and to the extent the donor's expenses are not covered under any other group or individual insurance policy or benefit plan and are charged to the recipient
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue
- Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part
- Services and supplies furnished by a facility provider
- Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a member's covered transplant. (Benefits are paid even if a covered procedure is cancelled due to the intended recipient's medical condition or death.)
- Treatment and surgery by a professional provider

Not Covered

Any procurement costs for an organ or tissue that is sold rather than donated

Travel Expenses

If the transplant recipient lives more than 75 miles from the designated transplant facility, the medical plan covers transportation, lodging and meal expenses for the patient, and one companion (two companions if the patient is a dependent child), up to a maximum of $10,000 for all transportation, lodging and meal expenses related to the transplant:

- Lodging – reasonable and necessary expenses for the patient (while not hospitalized) and companion(s), up to a maximum of $50 per day
- Transportation – for the patient and companion(s) traveling on the same day(s) to and/or from the transplant site for the evaluation, transplant procedure and necessary post-discharge follow-up

Not Covered

Charges for entertainment, personal, convenience or comfort items, including such things as books, movie rentals, valet parking, phone or fax charges, laundry or dry cleaning services or supplies, groceries, toiletries, cooking utensils, furnishings, U-Haul rental or gratuities other than meals

Centers of Excellence

If you need certain surgeries, you may be referred to a Center of Excellence. Centers of Excellence are facilities that have a proven record of effectively providing the type of surgery needed. When you call Anthem Medical Management for pre-certification or pre-admission review, the representative will refer you to a Center of Excellence for these procedures:

- Certain cardiac surgeries

Surgery	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

- Certain complex and rare cancer surgeries
- Organ, tissue, bone marrow, and stem cell transplants
- Weight reduction surgeries

Anthem Medical Management will coordinate all surgeries and specialized care that is provided through a Center of Excellence. The program also pays travel expenses when care is directed to a medical facility more than 75 miles from your home.

Emergency and Urgent Care Services

Emergency and Urgent Care	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Emergency Room Care	80%	80%	80%	80%	80%	80%

The medical plan covers emergency room facility charges and professional provider services and supplies for the initial treatment of traumatic bodily injuries resulting from an accident. The medical plan also covers emergency care for medical emergencies.

What Are Medical Emergencies?

A medical emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Causing other serious medical consequences
- Causing serious and permanent dysfunction of any bodily organ or part
- Causing serious impairment to bodily functions
- Permanently placing the covered person's health in jeopardy

If an emergency room visit results in a hospital admission, you should notify the medical plan within 48 hours of the admission.

Emergency and Urgent Care	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Emergency Room Care for Non-Emergencies	80%	60%	80%	60%	80%	60%

Emergency room care for non-emergencies covered at regular rates. Care for non-emergencies is defined as care received in an emergency room for a service or condition that does not meet the definition of medical emergency as described above.

Emergency and Urgent Care	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Ambulance Service	100%	100%	100%	100%	100%	100%

Professional **ground ambulance** transportation services are covered in the following circumstances:

- To transport a patient from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient
- To transport a patient from hospital to home, skilled nursing facility or nursing home when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available
- To transport a patient from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the patient
- To transport a patient upon medical stabilization from a non-discounted facility to a discounted facility when they were admitted due to a medical emergency to a non-discounted facility
- When used to transport the patient from the place of accidental injury or serious medical incident to the nearest facility where treatment can be given

The medical plan also covers air ambulance transportation for medical emergencies in the following circumstances:

- Patient has an unstable condition requiring medical supervision and rapid transport
- Patient requires transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient; and ground transportation is not medically appropriate because of the distance involved

Notification is required except in a life-threatening circumstance.

Emergency and Urgent Care	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Urgent Care Facilities	80%	60%	80%	60%	80%	60%

The medical plan covers treatment provided at an emergency medical service center, which is separate from any other hospital or medical facility.

Inpatient Hospital Treatment

Inpatient Hospital Treatment	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Hospitals and Inpatient Medical Facilities	80%	60%	80%	60%	80%	60%

If you need to be admitted to a hospital or other inpatient medical facility, you have coverage for room, board, services and supplies during the hospital stay. *You must pre-certify any inpatient facility stay for medical necessity before you schedule the admission. See the* ***Pre-Admission Review and Pre-Certification*** *section for more information.*

Room and Board

The medical plan covers room and board up to the hospital's semi-private room rate.

Private rooms and special care units such as intensive care or coronary care are covered only when medically necessary to treat your condition. If you decide on a private room when it is not considered medically necessary, the medical plan pay benefits based on the semi-private rate.

Inpatient Ancillary Charges

The medical plan also covers necessary services and supplies while you are in the hospital, including:

- Admission fees
- Anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility
- Diagnostic services
- Medical and surgical dressings, supplies, casts and splints
- Prescribed drugs
- Therapy services
- Use of operating, delivery and treatment rooms
- Whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced)

Not covered

- Drugs or supplies that are not consumed or used at the facility
- Services of a physician are covered as described under **Professional Services**

Inpatient Hospital Treatment	Premium HSA Medical In-Network	Premium HSA Medical Out-of-Network	Value HSA Medical In-Network	Value HSA Medical Out-of-Network	HRA Medical In-Network	HRA Medical Out-of-Network
Rehabilitation Facility	80%	60%	80%	60%	80%	60%
Maximum per calendar year	30 days		30 days		30 days	

You also have inpatient coverage for rehabilitation facilities, in the event admission is needed for recovery from a severe injury or illness. *You must pre-certify any rehabilitation facility stay for medical necessity before you schedule the admission. See the* ***Pre-Admission Review and Pre-Certification*** *section.*

Generally, rehabilitation facilities treat patients who are recovering from severe impairments due to strokes, spinal cord or traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions. Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT), physical therapy (PT), and speech and language therapy
- Onsite orthotic and prosthetic services
- Psychology and social work
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Vocational and community re-entry services

Behavioral health and substance abuse rehabilitation is not covered under this benefit, but is covered as described in the **Behavioral Health and Substance Abuse** section.

Inpatient Hospital Treatment	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing Facility	80%	60%	80%	60%	80%	60%
Maximum per calendar year	120 days		120 days		120 days	

Skilled nursing facilities provide a residential care setting with a protective, therapeutic environment for persons who:

- Can no longer live independently because of a chronic physical or mental condition requiring round-the-clock skilled nursing care
- Need rehabilitative care

Skilled nursing facilities must be licensed by the state and are subject to certain state and federal regulations.

Covered services and supplies include semi-private room and board, medical services and supplies, and physician's services.

*You must pre-certify any skilled nursing facility stay for medical necessity before you schedule the admission. See the **Pre-Admission Review and Pre-Certification** section for more information.*

Alternatives to Inpatient Care

Alternatives to Inpatient Care	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Home Healthcare	80%	60%	80%	60%	80%	60%
Maximum visits	120 per calendar year		120 per calendar year		120 per calendar year	

The medical plan covers home healthcare expenses if the services are provided by a licensed home healthcare agency, and:

- The care is given according to a home healthcare agency treatment plan
- The care is given to a person in his or her home
- The charge is made by a home healthcare agency

Home health covers the following charges:

- The following to the extent they would have been covered under this medical plan if the person had been confined in a hospital or convalescent facility:
  - Drugs and medicines provided by a physician
  - Home infusion therapy (visits for infusion therapy do not count toward the 120-visit maximum)
  - Lab services provided by a home healthcare agency
  - Medical supplies
- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care
- Physical, occupational and speech therapy

If you receive private-duty nursing care through the home healthcare agency, private-duty services are subject to the 120-day maximum.

Not Covered

- Services of a person who usually lives with the patient or who is a member of the patient's family
- Services of a social worker
- Services or supplies that are not part of the home healthcare treatment plan
- Transportation

Hospice Care	80%	60%	80%	60%	80%	60%

Hospice is a healthcare program providing a coordinated set of services rendered at home, in an outpatient setting or in an institutional setting for those suffering from a condition that has a terminal prognosis. To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under this provision of the medical plan.

Services and supplies typically provided and billed by a hospice are:

- Bereavement counseling for immediate family members during the six-month period following the death of covered person — limited to a combined maximum of $500 per episode. (Immediate family members include the patient's spouse, domestic partner and children)
- Homemaker services
- Inpatient care
- Nutrition counseling and special meals
- Part-time nursing
- Physical and chemical therapy
- Respite care – limited to 5 days during a six-month hospice period

Alternatives to Inpatient Care	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Private Duty Nursing	80%	60%	80%	60%	80%	60%

The medical plan covers outpatient private-duty nursing services in your home when the attending physician certifies that your condition requires care that can be provided only by an RN or LPN. Private-duty nursing counts toward the 120-day home healthcare maximum.

Not Covered

- Private-duty nursing services while you are an inpatient
- Services that are part of a home health agency's plan of treatment
- Services provided by a person who lives in the patient's home or is an immediate family member

	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Outpatient Facilities	80%	60%	80%	60%	80%	60%

When you need the medical services, but do not need overnight inpatient care, the medical plan covers outpatient facility charges. Outpatient facility services covered are similar to the ancillary services and supplies that you would receive as an inpatient, but without the inpatient room and board charges.

Medical Equipment and Supplies

Medical Equipment and Supplies	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment	80%	60%	80%	60%	80%	60%

Coverage is provided for rental or, at the discretion of the medical plan, purchase of durable medical equipment, when it is prescribed by a professional provider and required for therapeutic use.

If purchased, charges for repair or medically necessary replacement of durable medical equipment will be considered a covered expense (for example, when replacement is needed due to growth of the patient). Examples of durable medical equipment include crutches, commodes, hospital beds, nebulizers, monitoring equipment, wheelchairs, glucometers and blood pressure monitors with a provider's prescription and an applicable diagnosis.

Services are covered at the in-network level based on the maximum allowed amount for both discounted and non-discounted providers.

Not Covered

- Consumable supplies, except when medically necessary for the function of authorized DME
- Equipment that is not prescribed by a professional provider, is not for therapeutic use or does not have an applicable diagnosis
- Exercise equipment, equipment that is not solely for the use of the patient, comfort items, routine maintenance or DME for the convenience of the patient

Orthotics	80%	60%	80%	60%	80%	60%

The medical plan covers orthotic devices (rigid or semi-rigid supportive device that restrict or eliminate motion for a weak or diseased body part). Examples include:

- Back braces
- Halos
- Molded foot inserts and orthopedic shoes when prescribed by a physician and medically necessary for a condition, disease or systemic disease that affects the foot (such as diabetes). There is no limit
- Slings

Prosthetics	80%	60%	80%	60%	80%	60%

The medical plan covers the purchase and fitting of external prosthetic appliances that are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury or congenital defect.

Replacement or repair, as appropriate, of external prosthetic appliances is covered if needed because of normal anatomical growth, physical changes that make the device ineffective, or excessive wear. Coverage for internal prosthetic appliances includes the purchase, maintenance or repair of permanent or temporary internal aids and supports for defective body parts. The medical plan covers intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints and other surgical materials such as screw nails, sutures and wire mesh.

Wigs and Toupees	80%	60%	80%	60%	80%	60%

The medical plan covers one wig or toupee each calendar year when baldness is a result of hair loss due to a cancer diagnosis. Wigs and toupees are not covered for any other condition.

Other Medical Supplies	80%	60%	80%	60%	80%	60%

The medical plan covers medical supplies when they are prescribed by a licensed provider for a medical condition or diagnosis. Examples of medical supplies are injectables, glucomoters and blood pressure monitors with a provider's prescription and an applicable diagnosis.

Not Covered

Over-the-counter supplies. The medical plan does not cover supplies that can be purchased without a prescription, except as listed above.

Maternity Care and Family Planning

Maternity Care and Family Planning	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Pregnancy Expenses	80%	60%	80%	60%	80%	60%

Benefits are payable for pregnancy-related expenses of female team members and female dependents on the same basis as a covered illness. The expenses must be incurred while the person is covered under the medical plan. Covered services include prenatal obstetrician office visits, hospital and professional fees for delivery, and follow-up care following delivery.

Birthing Facilities

The medical plan covers services rendered in a birthing facility, provided that:

- The birthing facility meets all legal requirements
- The physician in charge is acting within the scope of his license

Midwife Delivery Services

The medical plan also covers midwife delivery services provided that:

- The midwife is licensed at the time delivery is performed
- The service is provided within an eligible location
- The state in which such services are performed has legally recognized midwife delivery

Home births are not covered, even if attended by a midwife.

Length of Hospital Stays for Childbirth

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

You must pre-certify any length of hospital stay that exceeds the timeframes noted above or any newborn stay after the mother is released from the hospital. Be sure the extra length of stay is pre-certified before these timeframes have passed. See the ***Pre-Admission Review and Pre-Certification*** *section for more information.*

Nursery Coverage for Baby

The medical plan covers the baby's stay in the nursery under the enrolled mother's benefits, so a separate deductible is not required for well-baby care.

However, only charges for nursery care are included in this benefit. If your baby needs a more intensive level of care, or if the mother is discharged before the baby, no additional benefits are payable until you enroll your baby for medical plan coverage. After you have enrolled your baby, the medical plan can consider coverage of other necessary services such as pediatrician's and other doctor's treatment, laboratory services, drugs, surgery and other facility fees, etc.

Enrolling Your Newborn

If you want to cover your newborn, you should enroll for coverage immediately after birth. You must enroll your newborn within 90 days and provide documentation within 60 days following birth to have coverage of newborn expenses beyond nursery facility charges. To enroll, call the Zimmer Biomet Benefits Service Center at the number shown under **Contact Information**.

Family Planning Services	80%	60%	80%	60%	80%	60%

The medical plan provides coverage for family planning services including:

- Contraceptives administered in a doctor's office, such as implantable or injectable contraceptives (for example, Depo-Provera)
- Diaphragms and their fitting
- Intrauterine devices (IUDs), including insertion and removal
- Sterilization procedures, such as vasectomy or tubal ligation
- Therapeutic abortion

Not Covered

- Birth control drugs (covered under the prescription drug program)
- Reversal of sterilization

Maternity Care and Family Planning	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Infertility Treatment	80%	60%	80%	60%	80%	60%

The medical plan covers the treatment of medical conditions causing infertility in the same way as any other illness or injury, including an initial evaluation, and the correction of underlying conditions causing infertility.

The medical plan also pays benefits for certain treatments to produce pregnancy. These benefits cover the following procedures and are limited to a $15,000 lifetime maximum (all Zimmer Biomet plans combined). In addition, there is an $15,000 lifetime maximum benefit under the prescription drug program for drugs to treat infertility.

- Artificial Insemination
- Drug therapy
- Drugs related to the inducement of pregnancy
- In-vitro fertilization
- Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures

Note: Treatment of underlying causes of infertility do not count toward the lifetime maximum.

Behavioral Health and Substance Abuse Treatment

Behavioral Health and Substance Abuse Treatment	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

The medical plan provides coverage for both behavioral health and substance abuse care services, including outpatient treatment, inpatient treatment and alternative levels of care (residential, partial hospitalization, intensive outpatient).

Behavioral Health and Substance Abuse Treatment	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Work-Life Solutions	100%	N/A	100%	N/A	100%	N/A
Maximum sessions per issue	6	N/A	6	N/A	6	N/A

Work-Life Solutions offers six free counseling sessions with a behavior health professional for issues such as balancing work and family, family crisis or illness, elder care, child care and many others. Anthem is the administrator of Work-Life Solutions.

The program is available to you and members of your household. You do not need to be enrolled in the Zimmer Biomet medical plan to access the Work-Life Solutions.

You can call Work-Life Solutions anytime, day or night, to speak to a specially trained representative. See **Contact Information** for contact information. There are no limitations on how often you can call. When you access Work-Life Solutions, you can receive:

- Access to an assisted search and self-search for child and elder care. Through the assisted search, a specialist will find and verify openings that fit your specific needs
- Access to the website, **anthem.com** (from the Members section > Login > zimmerbiomet), which includes helpful articles and interactive tools that can help you with life situations
- Legal and financial services. You will receive a referral to a free or discounted legal or financial services group
- Six free face-to-face visits with a network licensed behavioral health counselor per issue, and if you are in need of further counseling, your Work-Life Solutions counselor will coordinate appropriate and affordable resources in your community

Behavioral Health and Substance Abuse Treatment	Premium HSA In-Network	Premium HSA Out-of-Network	Value HSA In-Network	Value HSA Out-of-Network	HRA In-Network	HRA Out-of-Network
Outpatient Behavior Health and Substance Abuse Treatment	80%	60%	80%	60%	80%	60%

The medical plan covers outpatient treatment of mental health disorders and substance abuse. It also covers development delays and learning disabilities.

Care must be provided by a physician or licensed mental health or substance abuse provider. Covered services include but are not limited to:

- Applied behavior analysis
- Assessment
- Crisis intervention
- Diagnosis
- Electroconvulsive treatment (ECT)
- Individual, group, family or conjoint psychotherapy
- Medication management
- Psychological testing and assessment
- Rehabilitation (drug and alcohol related)

A mental health disorder or substance abuse is defined as a mental disease, disorder or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder or condition is physical, chemical or mental in nature or origin. It also includes developmental delays and learning disabilities.

Behavioral Health and Substance Abuse Treatment	Premium HSA Medical		Value HSA Medical		HRA Medical	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Treatment	80%	60%	80%	60%	80%	60%

The medical plan provides coverage for acute inpatient hospitalization in a hospital or residential treatment center for mental health disorders and substance abuse, including detoxification treatment. Covered charges include inpatient facility and professional providers services, including:

- Applied behavior analysis
- Electro-convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider. (This does not count toward benefit limit; rather it is a medical service that may be rendered in conjunction with a mental health diagnosis.)
- Facility charges for semi-private room, board and ancillary services and supplies
- Family counseling (counseling with family members to assist in the covered person's diagnosis and treatment)
- Group psychotherapy
- Individual psychotherapy
- Psychological testing

A residential treatment center is medically supervised, psychiatric residential treatment – a level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting.

Acute inpatient hospitalization is defined as treatment that includes 24-hour nursing and daily, active treatment under the direction of a psychiatrist, or for children and adolescents, a board certified/eligible child and adolescent psychiatrist.

Alternative Levels of Care

The medical plan also covers partial hospitalization and intensive outpatient treatment of mental health disorders and substance abuse. Alternative levels of care are covered as follows:

- Acute Partial Hospitalization: This treatment includes daily nursing and active treatment in a structured treatment program lasting 5 – 7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend
- Intensive Outpatient Treatment (IOP): IOP is a structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least four hours of treatment per week

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are otherwise covered services under this medical plan. An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that studies the prevention, detection or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a. The National Institutes of Health
   b. The Centers for Disease Control and Prevention
   c. The Agency for Health Care Research and Quality
   d. The Centers for Medicare & Medicaid Services
   e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   g. Any of the following in i - iii below if the study or investigation has been reviewed and approved through a system of peer review that the secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs
      ii. The Department of Defense
      iii. The Department of Energy
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration; and
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The medical plan may require you to use an in-network provider to maximize your benefits.

Routine patient care costs include items, services and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this medical plan. All other requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to our clinical coverage guidelines, related policies and procedures.

The medical plan is not required to provide benefits for the following:

1. Experimental/investigative items, devices or services;
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

CHARGES THAT ARE NOT COVERED

Although the medical plan covers many medical expenses, it doesn't cover everything. Certain services and supplies are not covered, as described below. (See the **Prescription Drug Coverage** section for a separate list of drugs that are not covered.)

- Administrative Charges – Any administrative charges including, but not limited to:
  - Failure to keep a scheduled visit
  - Completion of claim forms or medical records or reports unless otherwise required by law
  - For physician or hospital's stand-by services
  - For holiday or overtime rates
  - Membership, administrative or access fees charged by physicians or other providers, such as fees charged for educational brochures or calling a patient to provide their test results
  - Specific medical reports including those not directly related to your treatment, employment or insurance physicals, and reports prepared in connection with litigation
- Allergy Services – Specific non-standard allergy services and supplies including, but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity and urine autoinjections.
- Alternative Therapies – Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
- Before Coverage Begins / After Coverage Ends – Services rendered or supplies provided before coverage begins, i.e., before your effective date or after coverage ends.
- Behavioral Rehabilitation – Services provided in a halfway house for substance abuse rehabilitation.
- Biomicroscopy – Biomicroscopy, field charting or aniseikonic investigation.
- Comfort and Convenience Items – Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses and take-home supplies.
- Contraceptives – Contraceptive drugs, products or devices except those considered **Preventive Care** or specifically described in the **Family Planning** and the **Prescription Drug Program** sections.
- Cosmetic Services – Cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification or treatment relating to the consequences of, or as a result of, cosmetic surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be medically necessary by the claims administrator is not covered. This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes. It also does not apply to surgery to correct the results of injuries that caused the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate. In

addition, this exclusion does not apply to breast reconstructive surgery.

- Counseling – Any treatment or services that are considered or that are related to religious counseling, marital or marital relationship counseling, or sex therapy or counseling.
- Court-Ordered Care – Any court-ordered services, or those required by court order as a condition of parole or probation.
- Crime and Incarceration – Injuries received during the commission of a crime, regardless whether a misdemeanor, felony or other unlawful act and regardless whether you are arrested, charged or convicted for your involvement in the act (unless your involvement resulted solely from your medical or mental condition or you were the victim of a crime, including domestic violence). Any care required while you are incarcerated in any federal, state or local institution or while you are in the custody of any federal, state or local law enforcement authorities.
- Custodial Care – Any services provided during confinement for custodial or convalescent care, rest cures or long-term custodial hospital care.
- Daily Room Charges – Daily room charges while the medical plan is paying for an intensive care, cardiac care or other special care unit.
- Dental Care – Any dental care, treatment or oral surgery (by physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related services except otherwise specified as a covered charge.
- Diagnosis Investigations – Investigations for your diagnosis, or that are not generally accepted medical practice for the prevention, diagnosis or treatment of an illness or injury.
- Donor Searches – Any donor search/compatibility fees (except bone marrow searches).
- Educational Services – Services and supplies primarily for educational, vocational or training purposes, including structured teaching and educational interventions.
- Excess Charges – Any portion of a charge that exceeds the maximum allowed amount determined by the claims administrator.
- Experimental or Investigational Treatments – Treatments, procedures, equipment, drugs, devices or supplies which are, in the claims administrator's judgment, experimental or investigative for the diagnosis for which you are being treated. An experimental or investigative service is not made eligible for coverage by the fact that other treatment is considered by your physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- Family Members – Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
- Foot Care – Any care that is provided only to improve comfort or appearance; that is considered routine care of corns, bunions, calluses, toenails (except surgical removal of an ingrown toenail) or that is provided to treat flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints related to the feet.
- Government Provided Care – Services that can be provided through a government program for which you, as a member of the community, are eligible (for example, school, speech and reading programs). Services provided by a local, state or federal government agency, or by a public school system or school district, except when the medical plan's benefits must be provided by law.
- Hair Care – Hair transplants, prescriptions, medications or treatments related to hair growth. Hair pieces, wigs (except wigs and toupees covered as described in this SPD) or wig

maintenance.

- Health Spa – Expenses incurred at a health spa or similar facility.
- Hearing Devices – Hearing aids, hearing devices or examinations for prescribing or fitting them.
- Hospital Confinement – Services for hospital confinement primarily for diagnostic testing.
- Ineligible Hospital – Any services rendered or supplies provided while you are confined in an ineligible hospital.
- Ineligible Provider – Any services rendered or supplies provided while you are a patient or receive services at or from an ineligible provider.
- Inpatient Rehabilitation Programs – Inpatient rehabilitation in the hospital or hospital-based rehabilitation facility, when you are medically stable and do not require skilled nursing care or the constant availability of a physician or:
  - The treatment is for maintenance therapy
  - You have no restorative potential
  - The treatment is for congenital learning or neurological disability/disorder
  - The treatment is for communication training, educational training or vocational training.
- Maintenance Care – Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Medicare Benefits – Services paid under Medicare or which would have been paid if you applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease, Medicare shall be treated as the primary payor whether or not you have enrolled in Medicare Part B. For services provided pursuant to a private contract between you and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
- Military Benefits – Any treatment, services or supplies related to or connected with military service and provided or available from the Veterans' Administration or military facilities as required by law.
- Never Events – The medical plan will not pay for errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a healthcare facility. The provider will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure or operating on the wrong patient.
- Non-Chargeable Care – Charges you are not required to pay or services provided for free (or would be provided free if you had no health insurance coverage).
- Non-Covered Services – Any item, service, supply or care not specifically listed as a covered service in this SPD.
- Non-Eligibility Care – Charges for treatment received before coverage under this medical plan began or after eligibility for medical plan coverage or benefits that have terminated.
- Non-Licensed Care – Charges from a provider who is not licensed, charges for a provider's supervision of a non-licensed person, charges for services or supplies that can legally be provided by a non-licensed person, or charges for services that are outside of the scope of a provider's license.
- Not Medically Necessary Services – Care, supplies or equipment not medically necessary, as determined by the claims administrator, for the treatment of an injury or illness. This includes, but is not limited to, care which does not meet the claims administrator’s medical policy, clinical coverage guidelines or benefit policy guidelines.

- Nutritional Supplements – Any services, supplies, including nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
- Obesity Services – Any services or supplies for the treatment of obesity including, but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling). Services for inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs including, but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig and LA Weight Loss), nutritional supplements, appetite suppressants and supplies of a similar nature. This exclusion does not apply to morbid obesity surgery when approved by the medical plan.
- Outpatient Care – Outpatient therapy or rehabilitation other than the therapies specifically described in this SPD. Examples of excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging and bioenergetic therapy.
- Over-the-Counter Drug Equivalents – Any drugs, devices, products or supplies with over-the-counter (OTC) equivalents and any drugs, devices, products or supplies that are therapeutically comparable to an OTC drug, device, product or supply. This exclusion does not apply to OTC products that the medical plan must cover under federal law with a prescription.
- Prescription Drugs – Any prescription or non-prescription medications unless provided by a hospital in conjunction with admission or covered under the prescription drug program.
- Private Duty Nursing – For private duty nursing services except when provided through the “Home Care” benefit.
- Private Rooms – Private room, except as specified as covered services.
- Religious Care – Christian Science Practitioner charges.
- Research Screenings – For examinations related to research screenings, unless required by law.
- Routine Examinations – Routine physical examinations, screening procedures and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or injury except those which may be specifically listed as covered expenses.
- Safe Surroundings – Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Sclerotherapy – Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- Separate Charges – Any separate charges by interns, residents, house physicians or other healthcare professionals whose services are available through their employment by a covered facility.
- Services Not Specified as Covered – No benefits are available for services that are not specifically described as covered services in this SPD. This exclusion applies even if your physician orders the service.
- Sexual Dysfunction – Medical/surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs and

all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

- Skin Care – Salabrasion, chemosurgery or similar skin abrasion procedures for removal of scars, tattoos, actinic changes or treatment for acne.
- Spider Veins – Treatment of telangiectatic dermal veins (spider veins) by any method.
- Supplies or Equipment (including Durable Medical Equipment) Not Medically Necessary – Supplies or equipment not medically necessary for the treatment of an injury or illness. Non-covered supplies are inclusive of, but not limited to:
  - Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
  - Household supplies including, but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
  - The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
  - Water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
  - Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to your house or place of business and adjustments made to vehicles;
  - Air conditioners, humidifiers, dehumidifiers or purifiers;
  - Rental or purchase of equipment if you are in a facility which provides such equipment;
  - Other items of equipment that the claims administrator determines do not meet the listed criteria.
- Telecommunication Care – Charges for any form of telecommunication.
- Therapy Services – Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this SPD. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
- Transplant Services – The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
  - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
  - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
  - Any transplant not specifically listed as covered.
- Transportation – Transportation provided by other than a state licensed professional ambulance service, and ambulance services that are not medically necessary. Transportation to another area for medical care is also excluded except as stated as covered under the **Ambulance Service** section. Ambulance transportation from the hospital to the home is not covered.
- Travel Costs and Mileage – For mileage costs or other travel expenses, except as authorized by the claims administrator, on behalf of the employer.
- Thermograms – Thermograms and thermography.
- Vasectomy Reversal – Reversal of vasectomy or tubal ligation.

- Vision Care – Eyeglasses, contact lenses and routine vision examinations and services, including eye refractions, analysis of vision, visual acuity testing or other vision care services and supplies, except those described under **Preventive Care** and **Eye and Ear Treatments**.
- Vision Surgery – Surgery and related services and supplies to correct vision, refractive problems, near-sightedness, astigmatism or other vision correction, including radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy.
- Vitamins – Any vitamins, minerals, food supplements and vitamin injections that are not considered to be medically necessary for treatment of a specific illness.
- War Injuries – Any disease or injury resulting from a declared or undeclared war, military duty or any release of nuclear energy.
- Workers' Compensation Care – Services covered under Workers' Compensation, no-fault automobile insurance or similar statutory programs.

PRE-ADMISSION REVIEW AND PRE-CERTIFICATION

To help assure that your treatment is medically necessary under the terms of your medical option, the medical plan requires pre-admission review and requires pre-certification of certain admissions and procedures. If these claims are not pre-certified, they will not be covered. You should call before receiving services or no later than two business days after emergency admission to satisfy these authorization requirements.

Pre-certification does not guarantee coverage for, or payment of, the service or procedure reviewed. For benefit to be paid by the medical plan, on the date you receive service:

1. You must be eligible for benefits;
2. The service or surgery must be a covered service under the medical plan that is not excluded from coverage under the medical plan; and
3. You must not have exceeded any applicable limits under the medical plan.

Note: This list is not all-inclusive and is subject to change. Please call the claims administrator at the telephone number on your identification card to confirm the most current list and requirements for the medical plan.

Anthem Medical Management

Anthem Medical Management provides medical pre-admission and concurrent reviews and certain treatment requires pre-certifications for:

- Inpatient admissions:
  - Inclusive of all acute inpatient, skilled nursing facility, long-term acute rehab and OB delivery stays beyond the federal mandate minimum LOS (including newborn stays beyond the mother's stay).
  - Emergency admissions (requires medical plan notification no later than 2 business days after admission).
  - For all solid organ and bone marrow/stem cell transplants (including kidney only transplants).
- Outpatient services:
  - Ablative techniques as a treatment for Barrett's Esophagus
  - Air ambulance (excludes 911 initiated emergency transport)
  - Artificial intervertebral discs
  - Balloon sinuplasty
  - Bariatric surgery
  - Bone-anchored hearing aids
  - Breast procedures; including reconstructive surgery, implants, reduction, mastectomy for gynecomastia and other breast procedures
  - Canaloplasty
  - Cardiac Resynchronization Therapy (CRT) with or without an implantable cardioverter defibrillator (CRT/ICD) for the treatment of heart failure
  - Carotid, vertebral and intracranial artery angioplasty with or without stent placement
  - Cochlear implants and auditory brainstem implants
  - Computer-assisted musculoskeletal surgical navigational orthopedic procedures
  - Cryoablation for plantar fasciitis and plantar fibroma

- Cryopreservation of oocytes or ovarian tissue
- Cryosurgical ablation of solid tumors outside the liver
- Deep brain stimulation
- Diagnostic testing
  - Diagnosis of sleep disorders
  - Gene expression profiling for managing breast cancer treatment
  - Genetic testing for cancer susceptibility
- DME/Prosthetics
  - Bone growth stimulator: electrical or ultrasound
  - Communication assisting/speech generating devices
  - External (portable) continuous insulin infusion pump
  - Functional electrical stimulation (FES); threshold electrical stimulation (TES)
  - Microprocessor controlled lower limb prosthesis
  - Oscillatory devices for airway clearance including high frequency chest compression and intrapulmonary percussive ventilation (IPV)
  - Pneumatic pressure device with calibrated pressure
  - Power wheeled mobility devices
  - Prosthetics: electronic or externally powered and select other prosthetics
  - Standing frame
- Electrothermal shrinkage of joint capsules, ligaments, and tendons
- Extracorporeal shock wave therapy for orthopedic conditions
- Functional endoscopic sinus surgery
- Gastric electrical stimulation
- Gender reassignment surgery
- Implantable or wearable cardioverter-defibrillator
- Implantable infusion pumps
- Implantable middle ear hearing aids
- Implanted devices for spinal stenosis
- Implanted spinal cord stimulators
- Intraocular anterior segment aqueous drainage devices (without extraocular reservoir)
- Locally ablative techniques for treating primary and metastatic liver malignancies
- Lumbar spinal surgeries
- Lung volume reduction surgery
- Lysis of epidural adhesions
- Manipulation under anesthesia of the spine and joints other than the knee
- Maze procedure
- MRI guided high intensity focused ultrasound ablation of uterine fibroids
- Oral, pharyngeal & maxillofacial surgical treatment for obstructive sleep apnea
- Surgical treatment of migraine headaches
- Occiptal nerve stimulation
- Orthognathic surgery
- Ovarian and internal iliac vein embolization as a treatment of pelvic congestion syndrome

- Partial left ventriculectomy
- Penile prosthesis implantation
- Percutaneous neurolysis for chronic back pain
- Photocoagulation of macular drusen
- Physician attendance and supervision of hyperbaric oxygen therapy
- Plastic/Reconstructive surgeries:
  - Abdominoplasty, panniculectomy, diastasis recti repair
  - Blepharoplasty
  - Brachioplasty
  - Buttock/thigh lift
  - Chin implant, mentoplasty, osteoplasty mandible
  - Insertion/Injection of prosthetic material collagen implants
  - Liposuction/lipectomy
  - Procedures performed on male or female genitalia
  - Procedures performed on the face, jaw or neck (including facial dermabrasion, scar revision)
  - Procedures performed on the trunk and groin
  - Repair of pectus excavatum/carinatum
  - Rhinoplasty
  - Skin-related procedures
- Percutaneous spinal procedures
- Private duty nursing
- Presbyopia and astigmatism-correcting intraocular lenses
- Radiation therapy
  - Intensity modulated radiation therapy (IMRT)
  - Proton beam therapy
- Radiofrequency ablation to treat tumors outside the liver
- Real-time remote heart monitors
- Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Septoplasty
- Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT)
- Subtalar arthroereisis
- Suprachoroidal injection of a pharmacologic agent
- Surgical and minimally invasive treatments for benign prostatic hyperplasia (BPH) and other GU conditions
- Thoracoscopy for treatment of hyperhidrosis
- Tonsillectomy in children
- Total ankle replacement
- Transcatheter closure of cardiac defects
- Transcatheter uterine artery embolization
- Transmyocardial preventicular device

- Transplant or transplant related procedures including, but not limited to:
  - Stem cell/bone marrow transplant (with or without myeloablative therapy)
  - Donor leukocyte infusion
- Transtympanic micropressure for the treatment of ménière's disease
- Treatment of obstructive sleep apnea, UPPP
- Treatment of osteochondral defects of the knee and ankle
- Treatment of temporomandibular disorders
- Vagus nerve stimulation
- Varicose vein treatment

When Pre-certification Is Not Required

You do not have to pre-certify treatment for a patient who has primary coverage under Medicare or another group plan, if Zimmer Biomet's medical plan is secondary. See **Coordination of Benefits** for information on primary and secondary coverage.

Pre-Admission Review for Childbirth

Under the federal Newborns' and Mothers' Health Protection Act, benefits for any hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:

- 48 hours – following a normal vaginal delivery
- 96 hours – following a cesarean section

Although you are encouraged to call, neither you nor your physician needs to notify the medical plan for any length of stay less than these periods for childbirth. However, the physician, after consulting with the mother, may discharge the mother or newborn before the 48- or 96-hour timeframe noted above.

Anthem Behavioral Health

Anthem Behavioral Health performs behavioral health and substance abuse pre-admission reviews and pre-certifications, including:

- Acute inpatient admissions
- Transcranial magnetic stimulation (TMS)
- Employer group custom coverage decision (Check with an Anthem customer service representative)
  - Intensive outpatient therapy
  - Partial hospitalization
- Residential care

Out-of-Network Referrals

Out-of-network care for consideration of payment at the in-network benefit level may be authorized, based on network availability and/or medical necessity, but pre-certification is required.

How to Request Reviews

You are responsible for getting any required pre-certification or pre-admission reviews, although you, your doctor or the hospital may request the review. To start the process, notify Anthem Medical Management or Anthem Behavioral Health at the number listed on the back of your medical ID card. Elective admissions or procedures should be pre-certified before the admission is scheduled. In the case of an emergency admission when there is not time to pre-certify, you, your doctor or the hospital must call Anthem Medical Management or Anthem Behavioral Health no later than two business days after the admission.

If you do not obtain pre-admission or pre-certification reviews when required, benefits may be denied or reduced if the medical plan determines that services are not medically necessary or charges are not reasonable. You are responsible for any portion of expenses that the medical plan does not cover.

This notification process assists us in helping you manage your healthcare.

Reviews for Certain Tests

The medical plan has specific rules regarding the types of diagnostic testing covered in different situations. Because of these rules and potential costs, we recommend that you pre-certify the medical plan's coverage for certain tests, even though pre-certification is not required, including nuclear cardiac studies, CT scans, magnetic resonance imaging (MRI, MRA and MRS) and PET scans.

ANTHEM PROGRAMS AND TOOLS

Through Anthem, the medical plan offers a number of programs and tools. These resources can help you stay healthy, deal with an illness or injury, prepare for a medical procedure and make the best use of your healthcare dollars.

- Anthem Health Guide
- Engage
- Integrated Health Model
- LiveHealth Online
- 24/7 Nurseline
- Imaging Management Program (AIM Program)
- Sleep Management Program
- Find a Doctor

Accessing the Programs

You can get additional information on these programs by contacting Anthem Customer Service. See **Contact Information** for web addresses and phone numbers.

Anthem Health Guide

With Anthem Health Guide, our goal is to help you stay involved with your health and navigate the healthcare system so you can make the most of your Zimmer Biomet benefits at no additional cost to you. And, it's easy to connect with a Health Guide by phone, email or web chat. You can also schedule a convenient time for a Health Guide to call you.

The Health Guides:
• Can provide support to find an in-network doctor, save money on prescription drugs, estimate your cost for a procedure or help set up an appointment with a provider.
• Connect you with the right programs and resources to help you feel your best.
• Help you understand when, where and how to get the care you need.
• Work with a team of nurses, health coaches, educators and social workers to provide you with guided decision support to ensure you get the right care at the right time — and the right cost.
• Alert you about preventive and medical gaps in care, so the Health Guide can address these gaps during conversations and transfer you to nurse coaches, as needed.

Engage

Engage is a tool that provides a one-stop shop for a seamless healthcare experience.

Engage allows you to:
• Manage your benefits
• Find a doctor
• Estimate your costs for services
• Check the price of a prescription drug
• Receive personalized reminders
• Get support managing your health conditions
• Track your health goals
• View your health account balance and claims
• Get your ID card

To learn more about Engage, register at engage-wellbeing.com or download the Engage mobile app.

Integrated Health Model

If you (or a family member) are dealing with a complex health condition or hospital care, the last thing you need is to feel overwhelmed. Wouldn't it be great if someone could help you figure out which specialists to talk to and help you navigate your treatment and medication options?

If you are enrolled in one of the Zimmer Biomet medical options, you and your covered family members will have access to a personal health consultant — at no cost to you — through the Anthem's Health Guide enhanced service, Integrated Health Model (IHM).

With IHM, you have access to a personal health consultant who can recommend you to the full range of Zimmer Biomet programs and resources. The personal health consultant can help identify at-risk members or assist with everyday health issues and questions, concerns about an upcoming surgery or hospital stay, or things like managing a chronic or complex medical condition.

When you call the Anthem Health Guide, you may be connected to a personal health consultant in the IHM area that can help:
• Find the most appropriate resource based on your medical concern.
• Explain a diagnosis and treatment options, and help you obtain referrals.
• Put you in contact with a trained professional who can answer any additional questions.
• Navigate the healthcare system on clinical issues to save you money and improve your health.
You may receive a call from an IHM personal health consultant if you or your covered family member:
• Plan to be hospitalized in the near future.
• Were recently diagnosed with a complex medical condition, such as a heart condition or cancer.
• Are managing a chronic health condition such as diabetes or asthma.
• Has a high-risk pregnancy.

To support your health goals, you also will have access to a team of personal health consultants that work side by side with professionals such as nurses, registered dietitians, behavioral health resources, pharmacists and more. Your personal health consultant will be your single point of contact for you and your covered family members, working with a support team of other professionals as needed.

LiveHealth Online

Anthem's LiveHealth Online makes it more convenient to get the care you need — no waiting at an urgent care center or in your doctor's office. You are able to video chat with a doctor through your mobile device or a webcam-enabled computer. Doctors are available 24/7, 365 days a year for non-emergency healthcare needs, such as flu, fevers, infections, allergies and more. Most visits are just $59, with the exception of a psychology therapist which is $80 or a psychologist which is $95 per visit. The cost of these visits counts toward your deductible. And the cost is the same regardless of when you see the doctor. If you enroll in either HAS Medical option, you can pay out of pocket and reimburse yourself from your HSA. If you have met your HSA deductible and have funds available in your Extra Bucks Account, those funds will automatically pay the claim. If you enroll in the HRA Medical option and have funds available, your HRA will automatically pay the claim.

In all states, doctors can send prescriptions to the local pharmacy of your choice after your visit. To access LiveHealth Online, go to livehealthonline.com or download the LiveHealth Online app on your mobile device. You will need to register and establish an account in your name prior to you connecting with a doctor. For dependents under age 18, you can add them as your dependents when you register. For dependents over age 18 and spouse/domestic partner, they must establish their own account.

24/7 Nurseline

Nurseline is available 24 hours a day, seven days a week to provide support for your everyday health issues and questions. The service is available at no charge to you and your covered family members. Call to be connected with a registered nurse who can provide accurate, confidential health information about a multitude of health conditions. If you have questions about your symptoms or the care you need, Nurseline offers free advice about your care options. Speaking with a nurse first can help you determine the appropriate level of care for your situation, and whether you need to go to an urgent care facility, your primary care physician or the Emergency Room.

Imaging Management Program (AIM Program)

When it comes to important imaging services such as CT scans and MRIs, higher cost doesn't necessarily mean higher quality. The AIM Program gathers information from imaging providers about their staff, equipment, accreditations and quality-control measures to ensure you're getting high-quality imaging without the high cost.

After your doctor refers you to an imaging provider and calls for pre-authorization, Anthem reviews the referral to see if the provider offers the best quality of care and price in your area. If it doesn't, you'll get a call to let you know of alternative providers. You may choose to follow your doctor's referral or go to one of the recommended providers through the program.

Sleep Management Program

Experts agree that good health starts with a good night's sleep. If you suffer from Obstructive Sleep Apnea, the sleep management program can help you find high quality providers and the right type of care to help you get a better night's sleep.

Find a Doctor

Find a Doctor is a directory that will help you locate and find information about doctors and other healthcare services in your area. Whether you need a specialist, a pharmacy, a hospital, vision care, a chiropractor or a nutritionist, you will find it in one place. In addition, this directory will help you:

- Find in-network providers
- Find an estimate on how much you'll typically be charged for certain services
- Get background information about physicians in your area
- View provider recommendations from other consumers
- Get directions and a map

You can access the online tool by logging onto **anthem.com** and entering your user name and password.

WELLNESS PROGRAM

Through Virgin Pulse, you receive access to expert wellness guidance and support at no cost. The Virgin Pulse wellness program offers a number of activities, coaching programs and resources to help guide and inspire you. Program and activity topics include: weight loss, quitting tobacco, stress reduction, financial wellness and much more.

Eligibility

All active team members have the opportunity to participate in the Virgin Pulse wellness program; however, team members enrolled in the Zimmer Biomet medical plan also can earn wellness incentive dollars in the HSA Extra Bucks Account or HRA for completing certain wellness-related activities.

Spouses or domestic partners who are enrolled in the Zimmer Biomet medical plan also can participate and earn incentives.

Incentives for participating in the healthy activities are available to all team members enrolled in a medical option. If you feel you are unable to meet a standard for an incentive, you might qualify for an opportunity to earn the same reward by a different means. Contact Virgin Pulse and they can work with you (and, if you wish, your doctor) to find a healthy activity with the same reward that is right for you.

Your Virgin Pulse Account

You will need to register as a participant with Virgin Pulse by accessing the web site at join.virginpulse.com/zimmerbiomet to set up your login and password. When registering, you will enter your last name and team member ID (SAP number). Your covered spouse/domestic partner will need to register for their own account. Your spouse/domestic partner will enter their last name and team member ID but will need to add an “S” at the end of ID number (i.e., 123456S). Once an account has been created, team members can access the account with no login or password through the Zimmer Biomet network — go to The Circle and search for Virgin Pulse.

How the Program Works

The Wellness Program allows team members and spouse/domestic partners to complete activities and earn points. As the points accumulate, you work your way through four levels. Each level has a total point value and once that value is met you will earn incentives. The structure promotes daily engagement as you complete activities consistently, which help build long-lasting healthy habits throughout the year. If you are enrolled in an HSA or HRA medical option, you and your spouse/domestic partner can each earn up to $400 per year in incentives in your HSA Extra Bucks Account or HRA by completing any combination of healthy activities. If you are not enrolled in one of the medical options, you are eligible to participate in the wellness programs but will not receive incentives.

Level	Achieve this Point Level*	Incentive
One	5,000	$100
Two	15,000	$100
Three	30,000	$100
Four	45,000	$100

*Point level values are cumulative

Healthy Activity	Description	Points Earned for team member, covered spouse/domestic partner
Health Screening	Complete a health screening at your doctor's office, a Community Access Partner or an on-site health screening event (if available)	7,500 points/year
Health assessment	An interactive questionnaire that will give you an in-depth snapshot of your current health along with personalized recommendations for ways you can improve it	7,500 points/year
Flu shot	Receive a flu shot at an on-site clinic (if available) or at your doctor's office.	1,000 points/year
Tobacco-Free	If you're tobacco-free, log on to your Virgin Pulse account and complete the Nicotine-Free Agreement	1,000 points/year
Next-Steps Consult®[1]	Complete a Next-Steps Consult call	2,500 points/year
Track your Healthy Habits	Achieve points by tracking nutrition, sleep or other healthy habits	10 – 1,000 points/day (depending on activity completed)
Journeys®[1]	Complete a Journey Step	20 points/day (per Journey step)
Health coaching	Complete a call with a health coach	1,000 points/month
Healthy factors (based on health screening results)	You can earn points for achieving one or all of the healthy factors that falls within the healthy ranges or those that have improved from the prior year.	150 points/year (per healthy factor)

Note: Team members who are not enrolled in a medical option are eligible to participate in the Wellness Programs but are not eligible to receive incentives.
[1] *Journeys and Next-Steps Consult are registered trademarks of Virgin Pulse, Inc.*

Health Screening
A health screening is a blood test and key measurements that will summarize your basic health numbers including Body Mass Index (BMI), blood pressure, cholesterol, blood sugar, triglycerides and several other important health indicators. The results can reveal health risks early when they are easier to treat. By completing a screening, you are taking steps that help your chances of living a longer, healthier life.

Complete a health screening at your doctor's office, a Community Access Partner or an on-site health screening event (if available). Download the health screening form for use at your doctor's office from the Health Screening page after logging in to your Virgin Pulse account.

Health Assessment
The health assessment asks questions about your current health status and wellbeing habits. Once completed, your responses will be analyzed to generate a health score, show your health risks, and provide practical tips to help you improve. Log into your Virgin Pulse account to complete your health assessment. The health assessment can also be completed manually, request a paper version by contacting Virgin Pulse.

Tobacco Free
Log into your Virgin Pulse account and complete the Nicotine-Free Agreement.

Next-Steps Consult®
During this one-time, 15-minute call, a certified expert will help you understand your health screening and health assessment results and help you choose which Virgin Pulse programs will be the best fit for you.

Track your Healthy Habits
Log into your Virgin Pulse account to track your activity such as nutrition, sleep, steps in a day and many more. You may also sync approved devices to your Virgin Pulse account in order to automatically track your physical activity.

Journeys®
Make simple changes to improve your health, one step at a time when you participate in Journeys by logging into your Virgin Pulse account.

- Alcohol Use
- Blood Pressure
- Cholesterol
- COVID-19
- Depression
- Diabetes
- Eating Healthy
- Getting Active
- Managing My Finances
- Pregnancy
- Reducing Stress
- Sleep Well
- Tobacco Cessation

Health Coaching
Talk to a professional health coach over the phone to get one-on-one support, expert guidance and help navigating your health care questions. Key focus areas include:

Lifestyle Management

- Eat Healthy
- Be Tobacco Free
- Manage Weight
- Sleep Well
- Reduce Stress
- Get Active
- Manage My Finances

Condition Management (and the conditions associated)

- Anxiety & Depression
  - Anxiety

- — Depression
- Chronic Pain
  - — Arthritis (osteoand rheumatoid)
  - — Chronic (low) back pain
  - — Migraine
- Diabetes
  - — Diabetes, Type I
  - — Diabetes, Type II
- Digestive Health
  - — Gastroesophageal Reflux Disorder (GERD)
  - — Irritable Bowel Syndrome (IBS)
- Heart Health
  - — Coronary Artery Disease (CAD)
  - — Heart Failure (a.k.a. Congestive Heart Failure or CHF)
  - — Hyperlipidemia
  - — Hypertension
- Insomnia & Sleep
  - — Insomnia
- Infertility
  - — Infertility
- Lung Health
  - — Asthma
  - — Chronic Obstructive Pulmonary Disorder (COPD)
- Pregnancy
  - — Pregnancy
- Substance Support
  - — Alcohol Misuse
  - — Opioid Misuse
- Weight Management
  - — Obesity
- Hypothyroidism

Healthy Factors

Once you have completed your health screening, you can earn points for achieving one or all of the Healthy factors that falls within the healthy ranges below or those that have improved from the prior year.

- Target blood pressure < 140/90
- Target BMI < 30
- Target fasting glucose < 126
- Target non-fasting glucose < 200
- Target A1C < 5.7
- Target total cholesterol < 240
- Target cholesterol (HDL) (female) > 50
- Target cholesterol (HDL) (male) > 40
- Target cholesterol (LDL) < 130
- Target body fat levels (female 18-34) < 35
- Target body fat levels (female 35+) < 38
- Target body fat levels (male 18-34) < 22
- Target body fat levels (male 35+) < 25
- Target triglycerides < 200
- Target waist circumference (female) < 35.1
- Target waist circumference (male) < 40.1
- 5% improved blood pressure

- 5% improved body mass index
- 5% improved fasting glucose
- 5% improved non-fasting glucose
- 5% improved A1C
- 5% improved total cholesterol
- 5% improved cholesterol (HDL)
- 5% improved cholesterol (LDL)
- 5% improved body fat levels
- 5% improved triglycerides
- 5% improved waist circumference

Tobacco Cessation Program
To enroll in the Program, log into your Virgin Pulse account and go to the Programs page and select the Tobacco Cessation Program tile. The program is self-paced and consists of completing one Journey and four calls with a health coach. A Virgin Pulse coach will work with you to help you quit, your way, on your terms. After you and/or your spouse/domestic partner have completed the tobacco cessation program, Virgin Pulse will work with the Zimmer Biomet Benefits Service Center to remove and/or return the tobacco surcharge for that plan year.

Parenting Wellness Leave Program
The Parenting Wellness Leave Program involves the team member or the team member's covered spouse/domestic partner enrolling in the Parenting Wellness Leave program and completing one Journey and three phone calls with a health coach. To enroll in the Program, log into your Virgin Pulse account and go to the Programs page and select the Parenting Wellness Leave Program tile. Once you complete your activities they will appear on the Rewards page. The program may be started any time before the birth/adoption, but must be completed within 90 days after the birth of a biological child or filing with the court of a petition for legal adoption of a child.

PRESCRIPTION DRUG COVERAGE

When you enroll in one of the options available under the Zimmer Biomet medical plan, you also receive prescription drug coverage. Prescription drug coverage is not available if you choose to elect no coverage when you make your medical plan election.

The prescription drug program is administered by Express Scripts.

How the Medical Plan Pays Benefits

Generally, the program covers drugs and medicines that require a prescription and can be obtained only through a licensed pharmacy. The medical plan has two parts – a retail pharmacy program for short-term prescriptions and an exclusive home delivery program or Walgreens Smart90 program for maintenance medications. The chart below highlights the main features of the medical plan.

Prescription Drug Program Highlights

Plan Element	**Premium HSA Medical and Value HSA Medical**		**HRA Medical**	
Select Preventive Prescription Drugs	Covered at 100%			
Retail (30-day supply)	**After Deductible, You Pay**	**After Deductible, Zimmer Biomet Pays**	**You Pay**	**Zimmer Biomet Pays**
Generic[1]	20% ($7 minimum, $30 maximum)	80% and/or any amount over the maximum	20% ($7 minimum, $30 maximum)	80% and/or any amount over the maximum
Brand Formulary[2]	30% ($25 minimum, $60 maximum)	70% and/or any amount over the maximum	30% ($25 minimum, $60 maximum)	70% and/or any amount over the maximum
Brand Non-Formulary[3]	40% ($50 minimum, $120 maximum)	60% and/or any amount over the maximum	40% ($50 minimum, $120 maximum)	60% and/or any amount over the maximum
Brand Lifestyle Drugs[4]	50% ($50 minimum, no maximum)	50% and/or any amount over the maximum	50% ($50 minimum, no maximum)	50% and/or any amount over the maximum
Exclusive Home Delivery Program or Walgreens Retail Smart90 Program (90-day supply)	**After Deductible, You Pay**	**After Deductible, Zimmer Biomet Pays**	**You Pay**	**Zimmer Biomet Pays**
Generic[1]	20% ($14 minimum, $50 maximum)	80% and/or any amount over the maximum	20% ($14 minimum, $50 maximum)	80% and/or any amount over the maximum
Brand Formulary[2]	30% ($50 minimum, $100 maximum)	70% and/or any amount over the maximum	30% ($50 minimum, $100 maximum)	70% and/or any amount over the maximum
Brand Non-Formulary[3]	40% ($100 minimum, $175 maximum)	60% and/or any amount over the maximum	40% ($100 minimum, $175 maximum)	60% and/or any amount over the maximum
Brand Lifestyle Drugs[4]	50% ($100 minimum, no maximum)	50% and/or any amount over the maximum	50% ($100 minimum, no maximum)	50% and/or any amount over the maximum
Plan Element	**Premium HSA Medical**	**Value HSA Medical**	**HRA Medical**	

Annual Out-of-Pocket Maximum[5] (You only/You + family)	$3,500/$6,850 (Includes covered medical and prescription drug costs)	$4,000/$8,000 (Includes covered medical and prescription drug costs)	$1,500/$3,000 (Includes prescription drug costs only)

[1] An FDA-approved prescription drug containing the same active ingredients as its brand-name counterpart. It must be available in the same strength and dosage forms as the equivalent brand-name drug, but may be a different shape or color.

[2] Prescription medications that are included on the Express Scripts preferred prescription drug list selected by a panel of healthcare professionals. The list includes a select group of brand-name drugs that are evaluated on their usefulness, safety and cost-effectiveness.

[3] Prescription medications that are not on Express Scripts' preferred prescription drug list.

[4] Brand lifestyle drugs refer to brand-name prescription drugs used for conditions such as erectile dysfunction and infertility.

[5] Annual out-of-pocket maximum for Premium HSA family coverage has a True Family out-of-pocket maximum that requires all or one individual to meet the family out-of-pocket maximum before the medical plan pays 100%. For example, the annual out-of-pocket maximum is an aggregate amount that includes both medical and prescription drug costs. The Value HSA family coverage has an Embedded out-of-pocket maximum that limits each individual in a family to the individual out-of-pocket maximum (until the family out-of-pocket maximum is satisfied) before the medical plan pays 100%. For example, the annual out-of-pocket maximum is an individual amount that includes both medical and prescription drug costs. The HRA family coverage level is an aggregate amount and only includes prescription drug costs; how ever no individual w ill be subject to a combined medical and RX out-of-pocket maximum greater than $6,850 as increased by IRS for future years.

Select Preventive Prescription Drugs

The medical plan pays 100% of select preventive prescription drugs with no deductible required. Examples include medications to lower blood pressure and cholesterol levels; treat osteoporosis; thin blood; prevent nausea and vomiting; prevent malaria and reoccurrence of breast cancer; certain vitamins, contraceptives, stop-smoking and weight loss agents. For a complete list of select preventive prescription drugs, visit the Team Member Center on the Zimmer Biomet intranet or **express-scripts.com**.

Other Prescriptions

Benefits for other prescription drugs vary, depending on your medical option and the type of prescription.

- **Premium or Value HSA Medical.** As with other medical expenses, the prescription drug program pays benefits only after you meet the medical plan's combined medical and prescription drug annual deductible. If you have prescription expenses (that are not for select preventive prescription drugs) before you meet the deductible, you pay the full negotiated rate. You can pay these expenses out-of-pocket from your own funds or from your HSA, using your HSA debit card. In either case, the payments count toward meeting the medical deductible. Depending on your medical option, either a True Family or Embedded deductible will apply. After you meet the deductible, you pay coinsurance (dollar minimums and maximums may apply) based on the type of prescription until you reach the out-of-pocket maximum. Your coinsurance is drawn automatically from your HSA Extra Bucks Account if funds allow; otherwise, you can use out-of-pocket or HSA funds to pay coinsurance. Prescription coinsurance payments will combine with your other medical payments for purposes of meeting the combined medical and prescription drug out-of-pocket maximum, depending on your medical option. If you reach the HSA plan out-of-pocket maximum, then the medical plan pays 100% of covered medical and prescription drug expenses. Depending on your medical option, either a True Family or Embedded out-of-pocket maximum will apply.
- **HRA Medical.** There are no deductible requirements for any prescription expenses under the HRA Medical option. You pay coinsurance (dollar minimums and maximums may apply) based on the type of prescription until you reach the out-of-pocket maximum. The HRA has a prescription out-of-pocket maximum that is separate from the medical out-of-pocket maximum.

Your prescription drug coinsurance counts toward the prescription out-of-pocket maximum, but does not count toward the medical out-of-pocket maximum. If you reach the medical plan's prescription drug out-of-pocket maximum, then the medical plan pays 100% of covered prescription drugs. To meet the family prescription drug out-of-pocket maximum, a combination of family members must meet the family out-of-pocket maximum in order for the medical plan to pay 100% of covered prescription drugs for all eligible family members for the rest of the calendar year; however, no individual will be subject to a combined medical and prescription drug out-of-pocket maximum greater than $6,850 as increased by the U.S. Department of Health & Human Services (HHS) for future years.

Managing Prescription Costs

The prescription drug program has several features to help you manage your prescription costs.

Generic and Brand Formulary Drugs

You can achieve the greatest cost savings by choosing generics. You also can achieve significant cost savings by using brand formulary when a brand-name medication must be prescribed (where group buying power helps the plan administrator negotiate for lower prices). By taking a tiered approach and paying different coinsurance rates for these types of prescriptions in each of the medical plan options, the medical plan lets you take advantage of these discounts, and keep the flexibility to make your own choices under the medical plan. Go to **express-scripts.com** or use the Express Scripts mobile application to obtain a medication's formulary status.

Network Pharmacies

Similar to the medical plan's coverage for eligible medical services, the prescription drug program contracts with network pharmacies to fill team members' prescriptions at lower rates. You can save money by using network pharmacies. Although the medical plan pays the same coinsurance percentages for in-network and out-of-network charges, the network pharmacy's costs are significantly reduced in most cases. As a result, the amount you pay also is reduced. Remember, when you use out-of-network, you are responsible for paying the full amount of any charges that exceed the medical plan's allowed amount.

For a list of network pharmacies, log in to Express Scripts' website or call Express Scripts Customer Service. See **Contact Information** for more information.

How to Use the Retail Pharmacy Program

You can purchase up to a 30-day supply of medication at retail pharmacies. To make a purchase:

- When you use the pharmacy for the first time, present your Express Scripts ID card. The card identifies you as a Zimmer Biomet member and will provide the pharmacist information needed to bill you the correct amount, based on whether you participate in either HSA Medical option or the HRA Medical option, the type of medication, and whether you have met the applicable deductible or out-of-pocket maximum.
- You pay your portion of costs when you pick up your prescription. (If you participate in the Premium or Value HSA Medical option, you can use your HSA debit card or pay out of pocket for expenses.)
- The pharmacy then bills the medical plan for the remaining charges.

How to Use the Exclusive Home Delivery Program and the Walgreens Retail Smart90 Program

You can purchase up to a 90-day supply of medication through the Exclusive Home Delivery

Program. This mail order program is especially convenient and cost-effective if you take maintenance medication for ongoing conditions like diabetes or high blood pressure. To fill your maintenance medication through Exclusive Home Delivery:

- Ask your prescribing doctor to submit your prescription to Express Scripts (see **Contact Information**).
- Complete the mail order form (Home Delivery) found on **express-scripts.com**.
- Mail your prescription, the mail order form and your payment information to the mail order pharmacy. The address also is listed on the order form.
- Include a check, debit/credit card information, or your HSA or FSA debit card information for your payment. The amount you pay is based on whether you purchase a generic, formulary, non-formulary or lifestyle drug. If you have questions about your payment, call Express Scripts (see **Contact Information**).
- Your prescription will be mailed to your home. (It usually takes about eight days to receive your prescription, but allow up to 14 days for the first fill of a medication.)

You also can purchase up to a 90-day supply of medication at any Walgreens retail pharmacy through the Walgreens Retail Smart90 Program. This option is not available at a non-Walgreens retail pharmacy. Follow the steps outlined in the **How to Use the Retail Pharmacy Program** section on the previous page.

Planning Ahead

Plan ahead to make sure you don't run out of your medicine before your refills arrive. Send in your order for maintenance refills at least two weeks before your supply runs out, or enroll in the auto refill feature available under your medical plan.

About Generic, Formulary, Non-Formulary and Lifestyle Drugs

Your prescription drug coverage includes special coverage for generic, formulary, non-formulary and lifestyle drugs for both the retail and 90-supply programs.

- Preventing a medical condition is always better than having to treat it after it starts. A ***select preventive prescription*** drug is used to prevent certain health conditions, rather than to treat symptoms or conditions. For example, prenatal vitamins are considered preventive because they have been shown to be effective in preventing certain birth defects. However, antibiotics are not considered preventive because they treat a specific condition.
- A ***generic drug*** is a chemical copy of a brand-name prescription drug. It must contain the same active ingredients and is equivalent in strength and dosage to its brand-name counterpart. It is subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as its brand-name counterpart. Generally, generic drugs cost 30% to 60% less than their brand-name counterparts because manufacturers of generic drugs do not have to pay for research and development or marketing and advertising.
- A ***formulary*** is a list of frequently prescribed brand-name medications for which the program has negotiated reduced pricing. As a result, prescriptions for formulary medications are more cost-effective for you and the program. Physicians and pharmacists develop and evaluate the formulary list. You can get a current formulary list on Express Scripts' website (see **Contact Information**). Be sure to give the formulary list to your doctors so they can use it when selecting drug therapy for you.
- A ***non-formulary drug*** is a covered brand-name medication that is not on the formulary and is not a lifestyle drug.

- A ***lifestyle drug*** is a prescribed brand-name drug that is used for certain conditions that the medical plan ordinarily would not consider medically necessary, such as erectile dysfunction and infertility.

For a list of formulary, non-formulary or lifestyle drugs, log onto Express Scripts' website or call Express Scripts Customer Service. See **Contact Information** for more information.

A national panel of physicians and pharmacists continually reviews and compares prescription drugs to ensure your drug list includes proven medications to treat every condition. Some drugs may no longer be included when other safe and effective alternatives are available. Additionally, if over-the-counter versions of a medication are available, prescription forms may no longer be covered under your prescription benefit.

Charges Covered by the Prescription Drug Program

The prescription drug program covers the following drugs and medications that are medically necessary and prescribed by a physician. All medical plan choices cover the same medications.

- Legend drugs (those that require a prescription), with the exception of those that are specifically excluded from coverage.
- Compounded medications (those that consist of two or more ingredients that are weighted, measured, prepared or mixed according to prescription order) of which at least one ingredient is a legend drug.
- Any other drug that, under state law, may be dispensed only with a written prescription from a physician or other lawful prescriber.
- Emergency allergy kits, bee-sting kits, such as Epi-Pen.
- Injectable migraine medications.
- Other self-injectable medications or medications that your physician injects after you purchase through the pharmacy.
- Insulin, over-the-counter diabetic supplies (including alcohol swabs, lancets, test strips, glucose testing monitors, syringes and needles), and Glucagon emergency kits.
- Devices to help children and adults use inhalers efficiently.
- Specialty vitamins, such as prenatal vitamins to support a healthy pregnancy, pediatric fluoride, hematinics, folic acid. Prescription vitamins and supplements are covered only when used to treat certain anemias, renal failure and certain other diseases. Most vitamins can be purchased over the counter and are not covered by the prescription drug program.
- Hemophilia factors when needed to treat a blood clotting disorder.
- Drugs for substance abuse treatment, such as Antabuse and Campral.
- Legend oral contraceptives, transdermal contraceptives, intravaginal contraceptives, contraceptive emergency kits and injectable contraceptives (if purchased through the pharmacy).
- Yocon® (yohimbine).
- Specialty medications.

Prior Authorization Requirements

You or your doctor may need to call Express Scripts to receive prior authorization before you fill a prescription for certain medications:

- Anti-obesity agents.
- Anti-narcoleptic agents (for example, Nuvigil and Provigil).
- Cosmetics (for example, Botox and Myobloc).

- Miscellaneous dermatologics (for example, Solodyn).
- CNS stimulants and amphetamines outside the ages of 5-18 (for example, dextroamphetamine, Adderall XR, Focalin, Daytrana, Strattera, Vyvanse, Desoxyn and methylphenidate).
- Narcotic analgesics (Actiq and Fentora).
- COX II inhibitors (Celebrex).
- Topical vitamins and derivatives (for example, Retin A, Altinac and Avita) for persons over age 35.
- Injectable androgens and anabolic steroids.
- Specialty medications.

Quantity Limitations

In addition, certain medications have quantity limits. For example:

- Smoking deterrents (such as Zyban and Chantix) – limited to 12 weeks per year.
- Migraine medications (for example, Relpax, sumatriptan and zolmitriptan) – limited to 18 tablets within a rolling 21 day period or 54 tablets within a rolling 63 day period; program provides additional quantities through prior authorization process.
- Sleeping aids (such as zolpidem, Lunesta, zalephon, ramelteon, flurazepam, estazolam, quazepam, temazepam and triazolam) – limited to 15 units within a rolling 23 day period or 45 units within a rolling 68 day period.
- Oral medications for erectile dysfunction (e.g., Viagra) – limited to 8 units within a rolling 30 day period under retail program or 24 units within a rolling 90 day period under mail program.
- Fertility medications, oral, injectable and intravaginal (includes injectable progesterone) – limited to lifetime maximum of $12,000.

Specialty Medications

Accredo is Express Scripts' specialty pharmacy used to provide specialty medications to patients with chronic or life-threatening diseases. Accredo focuses on providing infused, injectable and oral drugs that:

- Are expensive.
- Are difficult to administer.
- May cause adverse reactions.
- Require temperature control or other specialized handling.
- May have restrictions as determined by the FDA.

Charges Not Covered by the Prescription Drug Program

Although prescription drug benefits can help you pay many of your prescription drug expenses, certain types of expenses are not covered. Here are some examples of specific expenses and drugs that the medical plan's prescription drug program does not cover:

- Fertility medications, oral, injectable and intravaginal (includes injectable progesterone) – exceeding the medical plan's lifetime maximum of $15,000.
- Drugs and medicines that you receive during an inpatient admission to a hospital or any other inpatient medical facility.
- Prescriptions that an eligible person is entitled to receive without charge, including those paid under workers' compensation. If you have a job-related medical condition, your prescriptions

should be considered for coverage under workers' compensation instead of the prescription drug program.

- GlucoWatch products and insulin pumps (may be covered under the medical plan).
- Over-the counter contraceptives, such as foams or condoms, and other contraceptive devices (**Note:** Prescribed oral contraceptives are covered by the prescription program and contraceptive devices such as diaphragms and implantable contraceptives are covered by the medical program).
- Any products indicated for cosmetic use, such as hair growth products.
- Blood, plasma and other blood products (except Hemophilia factors covered under federal legend drugs).
- Nutritional supplements (except when used for PKU), infant formulas and other supplements unless coverage is needed to treat certain medical conditions.
- Over-the-counter vitamins, except as specifically described.
- Medical supplies and over-the-counter medications, such as aspirin, cough syrup or cold remedies, even if your doctor prescribes them.
- Dental fluoride products.
- Allergy serums (may be covered by the medical plan).
- Non-legend (non-prescription) drugs other than insulin.
- Therapeutic devices or appliances, support garments and other nonmedicinal substances, regardless of their intended use.
- Charges for the administration or injection of any drug.
- A drug labeled "Caution – limited by federal law to investigational use" or an experimental drug, even though a charge is made to the individual.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Any prescription that has an over-the-counter product available under the prescription benefit.

If You Have Questions

Contact Express Scripts if you need to find a participating retail pharmacy, if you need a claim form, you lose your ID card, you want to confirm the type of coverage for a prescription (i.e., generic, formulary, non-formulary or lifestyle), the amount you will pay or you have any other questions about the prescription drug program. For contact information, see **Contact Information**.

HOW TO FILE A CLAIM

To request payment of a claim for medical or prescription drug benefits, follow the procedures for filing claims and appealing claims. A claim for benefits means a request for benefits under the medical plan for purposes of the medical plan's claims and appeals procedures.

Medical Claims

If You Use In-Network Providers

One of the advantages of using in-network providers is you don't have to file claims. When you use in-network providers, the provider will submit claims for you automatically.

If you use an out-of-network provider, the provider should submit the claim directly to Anthem Blue Cross Blue Shield, the claims administrator for the medical plan. (You should not pay these provider bills until claims have been processed by the medical plan.)

If You Use Out-of-Network Providers

Even if you use out-of-network providers, the provider may choose to file claims on your behalf. If your provider does not file the claim for you, you will need to file it yourself. Just follow these steps.

1. You can get claim forms from Anthem (see **Contact Information** for information on accessing or requesting forms).
2. Complete the appropriate forms and mail them with all required documentation to the claims administrator at:

   Anthem Blue Cross Blue Shield
   P.O. Box 105187
   Atlanta, GA 30348-5187

3. Submit claims as soon as possible. Claims submitted more than 12 months from the date of service are not covered by the medical plan. Claims from previous plan years are applied against your previous year's funds and never against your current plan year funds. However, current year claims can be applied against previous year funds but only after you have used all your current year funds.

Foreign Claims

Claims for services rendered while you are out of the country are reimbursed at the in-network level up to the maximum allowed amount. You are responsible for paying any amount that exceeds the maximum allowed amount.

All monetary conversions and rate of exchange are calculated based on the date of service.

If You Are Enrolled in the Healthcare FSA

If you are covered under the HRA Medical option and also are enrolled in the Healthcare FSA, claims for expenses covered both by the medical plan and the Healthcare FSA must be sent to the medical plan first (and to any other medical plans that cover the patient). Charges not covered by the medical plan such as deductibles and coinsurance can be submitted under the Healthcare FSA, but only after all medical plans have paid benefits and any draws have been made from your HRA. Once you receive the Explanation of Benefits (EOB) from the applicable claims administrator for the medical plan, you can file claims under the Healthcare FSA.

Prescription Drug Program Claims

Generally, you pay your coinsurance when you pick up your prescription at the pharmacy or when you send a prescription for mail order processing, so paper claims under the prescription drug program are rare. However, you may need to file a claim if you go to an out-of-network pharmacy or do not use your prescription ID card, or if you think an amount you have been charged is not correct.

1. To file a claim, get a claim form from Express Scripts (see **Contact Information**).
2. Complete the appropriate form and mail it with documentation to Express Scripts at:

   Express Scripts
   Attn: Commercial Claims
   P.O. Box 14711
   Lexington, KY 40512

3. Submit claims as soon as possible. Claims submitted more than 12 months from the date of service are not covered by the medical plan. Remember that you must have claims processed through the medical plan's prescription program before you can use your HSA or your Healthcare FSA to pay any remaining eligible medical expenses not payable under the medical plan.

Initial Coverage Review

In addition to claims, you may request that a medication be covered or covered at a high benefit level by submitting an initial coverage review. Express Scripts provides two types of initial coverage reviews:

1. Clinical coverage review – A request for coverage of a medication based on clinical conditions established under the medical plan (for example, medications requiring prior-authorization); and
2. Administrative coverage review – A request for coverage of a medication you believe is (or should be) covered under the medical plan.

You, the doctor who prescribed your medication or your pharmacist may request an initial coverage review by contacting Express Scripts at 1-800-753-2851, or by faxing or mailing the request to:

Express Scripts
Attn: Benefit Coverage Review Dept.
P.O. Box 66587
St. Louis, MO 63166-6587
Fax: 1-877-329-3760

Please call Express Scripts if you are unsure whether, and what type, of initial coverage review may apply in your circumstances.

Work-Life Solutions Claims

You don't need to file claims for Work-Life Solutions services. Work-Life Solutions services are provided free of charge up to six visits per issue with an in-network licensed behavioral health counselor and with no claim forms to complete.

Claims Administrators

Zimmer Biomet has delegated its claims administration authority to the medical plan's claims administrators, each of which is authorized to review and interpret the medical plan and determine whether a claim is payable under the medical plan.

Medical

Anthem is the claims administrator for medical claims and is responsible for reviewing and processing medical claims and appeals and coordinating external reviews by an independent review organization (IRO), if available for your claim, as follows:

- Initial benefit determinations
- First-level (mandatory) appeals
- Second-level (voluntary) appeals
- All appeals involving urgent care
- Requests for independent external review

Note: The plan administrator retains the discretionary authority to determine eligibility and any appeals related to claim denials for eligibility reasons, which are handled differently. See the Benefits Administration SPD for more information.

Prescription Drug Program

Express Scripts is the claims administrator for the prescription drug program. Express Scripts is responsible for reviewing and processing prescription drug claims, and first-level (mandatory) and second-level (voluntary) appeals for prescription drug claims.

Work-Life Solutions

Anthem is the administrator for Work-Life Solutions.

Claims Must Be Filed Within 12 months

Whether you file claims yourself or your provider files them, they should be filed with the appropriate claims administrator promptly. Claims filed more than 12 months after you receive services are excluded from the medical plan's coverage and are not payable by the medical plan.

When Claims Are Processed

Medical claims are processed according to the type of healthcare claim.

Pre-Service Claim – A claim for healthcare where prior approval for any part of the care is a condition for receiving the care (for example, pre-admission review before a hospital stay, pre-certification of a surgical procedure or prior authorization for purchase of certain prescriptions).

Concurrent Care Claim – A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments (for example, a request by you or your doctor to extend a hospital stay or a determination by Anthem that therapy is no longer medically necessary).

Post-Service Claim – A benefit claim for care that has already been received and any claim for which the medical plan does not require pre-authorization.

Urgent Care Claim – A pre-service or concurrent care claim becomes an urgent care claim when the normal timeframe for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the medical plan who

possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition), or

- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

Benefits are paid directly to the provider if the provider files claims for you. They are paid to you if you file the claim, unless you request that payments be made to the provider.

Initial Determination

There are special rules and timeframes for the administrators who process your claims, depending on the type of claim. In some situations, the claims administrator can ask for additional time to make an initial determination. There also are timeframes if the claims administrator needs additional information from you to process a claim. See the chart below for more details.

Initial Determination Timeframes

Types of Healthcare Claims	You will be notified of decision as soon as possible under the circumstances but no later than:	Decision may be extended for circumstances beyond administrator's control or, for example, to obtain more information:	You must provide any additional information needed within:
Pre-service	15 days from receipt of claim	One extension of 15 days	45 days after date of extension notice
Pre-service – urgent	72 hours (the claims administrator will notify you within 24 hours if they need you to provide additional information)	You will be allowed up to 48 hours to provide requested information	At least 48 hours. Claims administrator will notify you of decision within 24 hours after receiving information from you or by end of the 48-hour period, whichever is earlier
Concurrent care – to end or reduce treatment early	Claims administrator will notify you of decision to reduce or terminate sufficiently in advance of the end date to allow you to appeal	None. Decision to reduce or terminate benefit has already been made. The next step is to appeal	None
Concurrent care – for request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim
Concurrent care – urgent	24 hours, if your request is made at least 24 hours before the date treatment is scheduled to end. Otherwise, request is treated as "pre-service – urgent" claim	None	N/A
Post-service	30 days from receipt of claim	One extension of 15 days	45 days after date of extension notice

Note: Concurrent care claims generally do not apply to prescription drug benefits.

Explanation of Benefits (EOB)

Once the claim is processed, you will receive an EOB describing the benefits that were paid, any discounts that have been applied, any reimbursements that have been made from your accounts to pay deductibles or coinsurance, and any amounts that you are responsible for paying to the provider. If a claim is denied, the EOB will explain the reason for the denial.

YOUR RIGHT TO APPEAL

If a Medical or Prescription Drug Claim Is Denied

The denial of a claim is an adverse benefit determination. An adverse benefit determination includes the denial, reduction or termination of a benefit, or failure to provide or pay for a benefit (in whole or in part). An adverse determination can also include a denial of participation in the medical plan or the rescission (retroactive termination) of coverage under the medical plan. Your coverage will be rescinded if you commit fraud or intentionally misrepresent information to obtain benefits from the medical plan. If your coverage is rescinded, you will receive advance notice and have an opportunity to appeal the rescission.

However, failure to pay premiums or notify the medical plan that you or any dependents are no longer eligible for coverage under the medical plan is not a rescission. As a result, you may not appeal the termination of coverage in those cases even though coverage terminates as of the date you or your dependent failed to satisfy the medical plan's requirements, which may be before you receive notice.

If a claim for benefits is denied, if you have questions about a claim or if you have not received a response, you can contact the claims administrator (Anthem or Express Scripts) for information (see **Contact Information**). In some cases, the medical plan's timeframe may need to be extended, or the claims administrator may need additional information to approve or process the claim. Usually, issues regarding a claim can be resolved quickly and easily over the phone. If the issue is not resolved to your satisfaction, you are entitled to appeal the decision and receive a full and fair review of your claim based on the claims administrator's procedures in accordance with applicable federal regulations.

Your request for an internal or external appeal must be in writing. If you believe your circumstances warrant an expedited internal or external review, call the claims administrator to discuss whether an expedited or simultaneous review is available and the procedure for you or your authorized representative to submit the appeal information under those circumstances.

Important Information About the Medical Plan's Appeal Procedures

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- If an appeal involves medical judgment, then the claims administrator will consult with an independent healthcare professional who has expertise in the specific area involving medical judgment during the mandatory first-level appeal and any voluntary second-level appeal; and
- While it is your option to appeal, you cannot file a lawsuit in federal court or seek a remedy in court until you have exhausted these appeals procedures.

Follow the Steps Below to Appeal a Claim Denial

Step 1: You receive written notice from the claims administrator

If your claim is denied, you will receive written notice from the claims administrator of the medical plan's initial adverse benefit determination (in the case of urgent claims, notice may be oral). The timeframe in which you will receive this notice is described in this SPD and will vary depending on the type of claim. In addition, the claims administrator may obtain an extension of time in which to review your claim by notifying you of any reasons beyond its control. Or, if the reason for the

extension is that you need to provide additional information, you will have a certain amount of time to obtain the requested information (which will vary depending on the type of claim). The time period for the claims administrator to decide your claim will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period.

Step 2: Review your notice carefully

Review the initial notice you receive from the claims administrator carefully. The notice will contain:

- The reason(s) for the denial and the plan provisions on which the denial is based;
- If applicable, a description of any additional information necessary to perfect your claim, why the information is necessary and the time limit for you to submit that information;
- A description of the medical plan's appeal procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under ERISA section 502(a) following an adverse determination resulting from the review of your appeal;
- A statement indicating whether an internal rule, guideline or protocol was relied upon in making the adverse determination and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
- For adverse determinations based on medical necessity, experimental or investigative treatment or a similar exclusion or limit: either an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited appeal process for such claims. The notice may be provided orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.

The notice will also explain your entitlement to receive, upon request and without charge, reasonable access to, or copies of, any documents, records or other information relevant to the determination, including any new or additional evidence considered, relied upon or generated in connection with the claim, and any new or additional reason for the adverse determination. If the medical plan provides new or additional evidence for its decision, you will have an opportunity to respond to the new information.

Step 3: If you disagree with the decision, file a first-level (mandatory) appeal

If you disagree with the claims administrator's decision, you may file a written appeal with the claims administrator within 180 days of receipt of the claims administrator's letter notifying of the adverse determination (or oral notice for an urgent care claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally.

In addition, you should submit any information the claims administrator identified as necessary to perfect your claim (referenced in the notice described in Step 2) with your appeal. You should also provide any other information you believe will support your claim. Your written request for appeal must include:

- Patient's name, date of birth, member identification number and, for prescription drug claims, your Team Member ID and phone number
- Date you received the medical service or purchased prescription drugs or other supplies
- For prescription drug claims, the drug name for which benefit coverage has been denied
- Provider's name
- Reason you believe the claim should be paid

- Any documentation or other written information supporting your request for claim payment

Send appeals to the applicable address below for processing as described on the following pages.

Medical	Prescription Drug
Anthem Blue Cross Blue Shield Attn: Appeals P.O. Box 105568 Atlanta, GA 30348	Express Scripts Attn: Clinical Appeals Dept. P.O. Box 66588 St. Louis, MO 63166-6588 FAX: 1-877-852-4070 Express Scripts Attn: Administrative Appeals Dept. P.O. Box 66587 St. Louis, MO 63166-6587 FAX: 1-877-328-9660

Step 4: You receive notice of first-level appeal decision

If the claim is again denied, the claims administrator will notify you of its decision within the time period described in the following chart depending on the type of claim.

First-Level Appeal Timeframes

Types of Healthcare Claims	You must file an appeal within:	You will be notified of decision no later than:
Pre-service	180 days of receipt of adverse benefit determination	30 days of receipt of appeal (no extensions)
Pre-service – urgent	180 days upon receipt of adverse benefit determination	72 hours of receipt of appeal
Concurrent care – to end or reduce treatment early	The determination letter will identify the applicable time period	15 days of receipt of appeal (no extensions)
Concurrent care – for request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim
Concurrent care – urgent	180 days upon receipt of adverse benefit determination	72 hours of receipt of appeal
Post-service	180 days upon receipt of adverse benefit determination	30 days of receipt of appeal (no extensions)

Note: Concurrent care claims generally do not apply to prescription drug benefits.

Step 5: Review your notice carefully

You should take the same action that you take in Step 2. The notice will contain the same type of information that is provided in the first notice of denial provided by the claims administrator.

Step 6: Independent external review

If you disagree with the first-level decision, you may request an independent external review of certain types of eligible claims OR you may (but are not required to) file a voluntary second-level appeal.

External Review

If you disagree with the claims administrator's final adverse benefit determination of the first-level appeal under the medical plan's internal appeal process and your claim involves the exercise of

medical judgment or a rescission of coverage, you may be eligible to request an external review of the decision by an independent review organization (IRO). An external review is available if the medical plan's adverse determination was based on medical necessity, appropriateness, health care setting, level of care of the effectiveness of a covered benefit, or a determination that a particular treatment is experimental or investigative.

Decisions about your ineligibility for coverage under the medical plan are not eligible for external review. Decisions that interpret the plan's terms or determine the legal requirements applicable to the plan, but do not involve the exercise of medical judgment related to your particular claim, are also not eligible for external review.

If your claim qualifies for external review, the claims administrator will inform you about the external review process. **You must request an external review within four months after you receive a final adverse benefit determination.** If you request an external review, the claims administrator will conduct a preliminary review within five business days to determine whether your claim is eligible for external review. The preliminary review will consider whether you were covered under the medical plan, whether you have provided all of the information needed to process your requested external review and whether you have exhausted the plan's internal appeal process.

The claims administrator will notify you whether your claim is eligible for external review within one business day after completing its preliminary review. If your request is complete but ineligible for external review, the notice will explain the reasons why. If your request is incomplete, the notice will describe the additional information you must provide and you will have 48 hours (or until the end of the four-month period after the medical plan's final adverse benefit determination, whichever is later) to provide the required information.

If your appeal is eligible for external review, one of three IROs will be randomly assigned to review the medical plan's final adverse benefit determination. The IRO is not bound by the medical plan's decision and the selection of the IRO will not be based on the anticipation it will agree with the medical plan's internal decision of your claim.

Once an IRO is assigned it will notify you when it receives your request for an external review. You may submit additional written information for the IRO's consideration when it reviews your claim within 10 business days after you receive notice of the IRO's assignment to review your claim.

The IRO will consider the following information during its external review:

- Any information you timely provided
- Your medical records
- Your healthcare provider's recommendations
- Reports and other documents submitted by you, your provider and the medical plan
- The medical plan's terms and any clinical review criteria the medical plan considered
- Appropriate medical guidelines, including applicable evidence-based standards and other recognized practice guidelines
- The opinion of the IRO's clinical reviewers who have evaluated your claim based on their relevant medical expertise

When You Will Be Notified of External Review Decision (Pre-Service or Post-Service Claims)

For a pre-service or post-service claim, the IRO will notify you and the medical plan of its decision for your external review within 45 days after receiving your request. If the IRO reverses the

medical plan's decision regarding your claim, the medical plan will provide coverage for the requested service or pay the disputed claim.

Expedited External Review

Generally, the first-level (mandatory) appeal must be complete before you request and external review. However, if the time necessary to complete the first-level (mandatory) internal medical plan appeal would seriously jeopardize your life, health or ability to regain maximum function, you may request an expedited external review. You may also request an expedited external review if you received a final adverse decision of your internal appeal and either: (1) the time required to complete the standard external review would seriously jeopardize your life, health or ability to regain maximum function; or (2) if the decision concerns an admission, the availability of care or a continued stay for which you received emergency services and you have not already been discharged from the treatment facility.

When You Will Be Notified of External Review Decision (Expedited Review Claims)

For an expedited external review, the claims administrator will immediately conduct a preliminary review and notify you whether your appeal is eligible for external review. If the appeal is eligible for external review, the claims administrator will promptly assign an IRO and the IRO will make its determination within 72 hours after receiving your request for expedited external review or as soon as possible if your medical condition or circumstances warrant a more expeditious determination.

Medical	Prescription Drug
Anthem Blue Cross Blue Shield Attn: Appeals P.O. Box 105568 Atlanta, GA 30348	Express Scripts Attn: External Appeals Dept. P.O. Box 66588 St. Louis, MO 63166-6588 Phone: 1-800-753-2851 FAX: 1-877-852-4070

Voluntary second-level appeals

If you still do not agree with the claims administrator's decision, you may file a written appeal to the claims fiduciary within 60 days after receiving the first-level appeal denial notice from the claims administrator. You are not required to complete a voluntary second-level appeal before submitting a request for an independent external review. You should gather any additional information identified in the notice as necessary to perfect your claim and any other information that you believe supports your claim. The appeal should be sent to:

Medical	Prescription Drug
Anthem Blue Cross Blue Shield Attn: Appeals P.O. Box 105568 Atlanta, GA 30348	Express Scripts Attn: Clinical Appeals Dept. P.O. Box 66588 St. Louis, MO 63166-6588 FAX: 1-877-852-4070 Express Scripts Attn: Administrative Appeals Dept. P.O. Box 66587 St. Louis, MO 63166-6587 FAX: 1-877-328-9660

Receiving a Decision on Your Voluntary Second-Level Appeal

If the claims fiduciary denies your second-level (voluntary) appeal, you will receive a notice within the time period described in the chart below, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 1.

Second-Level (Voluntary) Appeal Timeframes

Types of Healthcare Claims	You must file an appeal within:	You will be notified of decision no later than:
Pre-service	60 days after receipt of determination letter	15 days of receipt of appeal (no extensions)
Pre-service – urgent	Urgent care claims limited to one level of appeal	N/A
Concurrent care – to end or reduce treatment early	The determination letter will identify the applicable time period	15 days of receipt of appeal (no extensions)
Concurrent care – for request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim
Concurrent care – urgent	Urgent care claims limited to one level of appeal	N/A
Post-service	60 days after receipt of determination letter	30 days of receipt of appeal (no extensions)

Note: Concurrent care claims generally do not apply to prescription drug benefits.

You Must Timely File an Appeal Before Filing a Lawsuit

If your appeal results in an adverse benefit determination, as described above, you will have a right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). You must exhaust the medical plan's internal appeals procedure (but not the voluntary second-level appeal) before filing a lawsuit or taking other legal action of any kind against the plan. Further, ***no lawsuit or legal action related to a benefit decision may be filed in any court of law or any other forum unless it is commenced within two years of the plan's final decision on the claim***. If the plan determines an appeal is untimely, the plan's latest decision on the claim is the final decision date.

The plan administrator and/or the claims administrator reserves the right to modify the policies, procedures and timeframes in this section as necessary under ERISA, as updated by the ACA, upon further guidance or regulatory updates from the Department of Labor.

Eligibility Determinations

The Zimmer Biomet Holdings, Inc. Administrative Committee and Benefits Committee have the discretionary authority to interpret the medical plan to determine eligibility to participate in the medical plan. Any eligibility decision by these committees is final, binding and conclusive. Please see the Benefits Administration SPD for more details.

COORDINATION OF BENEFITS

In certain situations, your benefits are coordinated with other benefits you are eligible to receive from other healthcare plans, Medicare or third parties.

Coordination with Other Group Plans

If you are eligible for benefits under another group healthcare plan, such as your spouse's/domestic partner's plan or another employer's plan, the two plans will coordinate their benefit payments so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB). The medical plan uses a COB method called non-duplication of benefits.

How COB Works

Under COB provisions, one group plan has primary responsibility and pays first. The other group plan has secondary responsibility and considers whether any amounts not paid by the primary carrier are eligible for payment under the secondary plan. When the Zimmer Biomet medical plan is:

- Primary – it pays expenses as if no other insurance coverage is available.
- Secondary – it pays benefits only if you have not already received the full amount the plan would pay if it were primary. For example, if the primary plan pays 80% of charges and Zimmer Biomet's plan pays 80% of charges, no benefits would be paid by Zimmer Biomet's plan. But if the primary plan pays 70% of charges and Zimmer Biomet's plan pays 80%, the 10% that was not covered is considered under Zimmer Biomet's plan.

Group plans use these rules to determine the plan that is primary and secondary:

If the Benefit Is for:	Then:
You as a Team Member	The plan is primary for you
You as a COBRA participant continuing benefits under another plan	COBRA coverage will be primary for limits and exclusions under the other plan
Your spouse/domestic partner	The plan is always the secondary payer if he or she is covered through another employer's plan
Your dependent children	The primary plan for your dependent child is determined by the COB birthday rule (described below) unless your child is covered as a team member under another employer plan. In that case, the plan covering the dependent as a team member will be primary (without regard to the birthday rule).

If the other group benefit plan does not have a COB provision, these rules will not apply. In that case, the other group plan is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

COB Birthday Rule

Under this rule, the plan of the parent whose birthday occurs first in the calendar year is the primary coverage for your dependent children. For example, if your spouse's/domestic partner's birthday is in March and your birthday is in October, your spouse's/domestic partner's plan will provide primary coverage for your children. If a decision cannot be made based on the birthday rule, the plan that has covered the parent the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced is determined in the following order, without regard to the birthday rule:

1. The plan of the parent with custody of the child.
2. The plan of the stepparent whose spouse/domestic partner has custody of the child – if the parent with custody has remarried.
3. The plan of the parent not having custody of the child.

If a court decree declares one parent responsible for a child's healthcare expenses, payment will be made first under that parent's plan.

Right to Recover

If the medical plan makes larger payments than are necessary under this COB provision or under any other provision, the plan administrator has the right to recover the excess payments from any insurance company, any organization and/or any persons to or for whom those payments were made.

The claims administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the medical plan.

The medical plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in the medical plan, you agree to furnish any information that the plan administrator requires to enforce these provisions.

Coordination with Medicare

As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the medical plan pays benefits first, or whether Medicare is primary.

If you are an active team member covered by the medical plan, the medical plan is primary for you and your covered dependent who is entitled to Medicare (for example, due to a disability or being age 65 or older). If you are disabled and not actively working, the medical plan is primary for you and any covered dependents who may be entitled to Medicare for the first six calendar months of your disability period. After the six-month period, if you are not actively working at the company, Medicare pays benefits first for you and any covered dependents (if they are also eligible for Medicare).

During the time the medical plan pays benefits first, you should submit a claim for any remaining expenses not covered by the medical plan to Medicare. (Incidentally, you should apply for Social Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

Medical Coverage for Individuals with End-Stage Renal Disease

In all situations involving end-stage renal disease (ESRD) – regardless of age or Medicare status – the medical plan is primary during the first 30 months the individual is eligible for Medicare benefits as a result of End-Stage Renal Disease. Thereafter, Medicare is primary for that individual and the medical plan is secondary payer.

No Third-Party Beneficiaries; Limitation on Assignment

The plan is not intended to benefit any person other than covered individuals. Your benefits under the plan, and any benefit or right provided by ERISA related to any component benefit under the plan (including the right to file claims or appeals and the right to bring a lawsuit seeking benefits, penalties, damages or equitable relief) may not be sold, transferred, pledged or assigned to your creditors or anyone else. Benefits under the plan will not be subject to attachment, garnishment, execution or levy of any kind. Any such attempted disposition will be void unless expressly permitted under the applicable Incorporated Document and recognized as valid by the insurer for the coverage provided under that Incorporated Document. In no event shall any assignment of benefits be construed to confer status as a participant or a beneficiary, or to confer standing to sue whether in a direct or representative capacity.

In certain situations, a court order called a Qualified Medical Child Support Order (QMCSO) may require that group health benefits be provided for a certain individual or individuals, typically an associate's family member. Additionally, in some situations, for the convenience of the plan, participant or claims administrator, benefits may be paid directly to third parties, such as the provider(s) who provided health care services or supplies for which the benefits are payable under the plan. The Plan Administrator, and any applicable claims administrator, retain the discretionary authority to determine the validity of any arrangement attempting to direct the payment of benefits to a third party. Neither the Plan Administrator, nor any claims administrator, guarantees that any arrangement will be valid under the Plan in every situation. To the extent a purported assignment is possible under the terms of the applicable Incorporated Document (for example, the group life insurance policy), the insurer for the coverage provided under that Incorporated Document retains the discretionary authority to determine the validity of any purported assignment.

The Plan Administrator further reserves the discretionary authority to pay a participant's benefits to his or her legal guardian, if the participant is a minor or is otherwise incompetent; to a member of the participant's family; or to his or her estate, if the participant dies before benefits are paid.

Any benefits payable under the Company's plans are subject to set-off to repay any debt you owe the Company or any affiliate to the extent permitted by law.

Subrogation/Right of Recovery

The plan has a right to reimbursement of expenses that are paid on behalf of you or your covered dependents, if the expenses are related to or result from the acts of a third party (for example, if you are involved in an automobile accident). The plan administrator may seek reimbursement of these expenses on behalf of the plan from any recovery you may receive from any third party or any other source. Recovery, includes, but is not limited to, monies received from any person or party, any party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, or any other insurance proceeds, settlement amounts or amounts recovered, whether recovered in a lawsuit, settlement or otherwise. Regardless how you or your representative or any agreement with any third party or any court document characterizes the recovery, it will be subject to the plan's subrogation and reimbursement provisions.

The plan's subrogation and reimbursement rights are described further below.

If you or a dependent incurs any healthcare expenses otherwise covered by the medical plan as a result of the act of a third party (whether a person or entity) (third party claims), you may only receive benefits under to the terms of the plan if you execute a subrogation and reimbursement agreement and provide a promissory note securing the plan's right to full reimbursement from any settlement you (or the plan) receives. If, as determined by the plan administrator, you or any of your dependents, other family members, agents or representatives does not fully cooperate or fails to preserve and protect the plan's right to full reimbursement of any past or future healthcare expenses the plan has paid or may pay related to or resulting from a third party claim, any further claims will be excluded from coverage. The plan may also reduce or offset its payments for any claims other than the third party claims and your (and any your dependents') eligibility to participate may terminate.

This means you and/or your dependent are required to refund the plan for all benefits paid if there is any recovery, regardless of the amount, from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). As a condition of the payment of any claims the plan administrator or claims administrator determines are third party claims, you and/or your dependent, on behalf of yourself and any of your successors, agents and representatives, must:

- Execute any agreement requested by the plan administrator or claims administrator acknowledging the plan's right of recovery, agreeing to repay any claims paid by the plan, pledging amounts recovered from the third party as security for repayment of any claims paid by the plan (even recovered amounts that subsequently become commingled with your general assets), and to the extent provided below, assigning your or your dependent's cause of action or other right of recovery to the plan. Even before the plan has identified your claims as third party claims and before you have completed any agreement requested by the plan, you or your dependent is deemed to have agreed to the terms of these reimbursement provisions by filing a claim or by assigning payment of claims to have claims filed on your behalf; therefore, you must cooperate with the plan administrator by executing any agreement and providing any information necessary for the plan to enforce its right of recovery. Because third party claims are excluded from coverage under the plan, refusal to cooperate will result in the denial of claims the plan determines are third party claims;
- Provide any information the plan administrator and/or the claims administrator may request;
- Do whatever is necessary for the plan to exercise its rights and do nothing to prejudice the plan's rights;
- Notify the plan administrator or claims administrator in writing of the commencement of any action to recover damages from a third party and provide a copy of the complaint and other pleadings or notify the plan if you and/or your dependent has decided not to commence action to recover damages for a third party claim;
- Notify the plan administrator and claims administrator at least 30 days prior to settling any claim; and
- Agree to notify the plan administrator or claims administrator of any recovery.

The plan's right of recovery applies to the entire proceeds of any recovery. This includes any recovery by judgment, settlement, arbitration award or otherwise. The plan's right to recover is not limited by application of any statutory or common law "make whole" doctrine. This means the plan has the right of first reimbursement from the first dollar of any recovery, even if you or your dependent is not fully compensated. The plan's right to recover will not be limited or reduced in any way based upon the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. Further, the plan's rights will not be reduced due to your negligence.

The plan's right to repayment is not limited by any statutory or common law "common fund" doctrine. The plan and Zimmer Biomet are not responsible for any attorney fees, other expenses or costs without prior written consent. The common fund doctrine does not apply to any funds recovered by any attorney you hire regardless of whether any funds recovered are subject to the plan's right to reimbursement or are used to repay benefits paid by the plan.

The plan will automatically have a lien against the proceeds of any recovery and against future benefits due under the plan in the amount of any claims paid. The lien will attach as soon as any person or entity agrees to pay any amount that may be subject to the plan's right of recovery. You and your representative must hold the gross proceeds from any recovery (the total amount of the recovery before any attorney fees, other expenses or costs are paid) in trust for the plan and pay the plan immediately upon receipt of the recovery. If you or your dependent fails to repay the plan from the proceeds of any recovery, the plan administrator may satisfy the lien by deducting the amount from any future claims otherwise payable under the plan for you or any of your dependents, even if those claims are not third party claims.

If you or a dependent fail to take action against a responsible third party to recover damages within one year or within 30 days after the plan requests that you take action, the plan is deemed to have acquired, by assignment or subrogation, a portion of the claim equal to the amounts the plan has paid on the covered individual's behalf. The plan may begin proceedings directly against any responsible third party. The plan does not waive its right to commence action against a third party if it fails to act after the expiration of one year, and the plan's failure to act will not constitute a waiver or discharge of the lien described above.

You or your dependent must cooperate fully with the plan in asserting claims against a responsible third party and such cooperation will include, where requested, the filing of suit against a responsible third party and giving of testimony in any action filed by the plan. If you or your dependent (including any of your agents or representatives) fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, any further third party claims will be excluded from the plan's coverage and the plan administrator will deny payment of claims and may treat prior claims paid as overpayments recoverable by offset against future plan benefits or by other action of the plan. If you or your covered dependent (or any agent or representative acting for either of you) refuses to cooperate or to reimburse the plan for any third party claims subject to the plan's right to subrogation or reimbursement, the plan may demand additional security for the repayment of its lien and your participation (and that of any of your covered dependents) may terminate prospectively, an event which will not be a COBRA qualifying event.

In addition, the plan has a right to recover benefits that were paid in error (for example, benefits paid to an ineligible person) or benefits that were obtained in a fraudulent manner, as determined by the plan administrator. Benefits may be recovered by either direct payment to the plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of any future benefits equal to the amount of the overpayment.

Misrepresentation

If a plan participant or a person eligible for coverage under the plan makes any intentional misrepresentations or uses fraudulent means in applying for coverage, making a change in their existing coverage election, or filing a claim for benefits, his or her coverage may be subject to immediate termination of coverage, recoupment by the plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity, including retroactive rescission of coverage. For purposes of this section, a

participant's failure to inform the Plan Administrator of status changes which would affect coverage (such as participant's divorce) will be considered an intentional misrepresentation.

Claim Filing Deadline

Except as otherwise provided by the applicable Incorporated Document or as otherwise provided by the plan document, the plan excludes coverage for any benefits for which a claim is not submitted to the plan within two years of the date of service or the date of the event for which the participant or beneficiary would otherwise be eligible for payment under the plan.

CONTINUATION OF COVERAGE

You may be able to continue coverage under the medical plan under certain conditions as outlined in the following pages.

COBRA Continuation

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your spouse and dependent children may elect to temporarily continue coverage under this plan in certain instances where coverage otherwise would be reduced or terminated. See **Continuation Coverage Rights Under COBRA** in the Benefits Administration SPD for more information.

Continuation of Coverage for Team Members in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible team members who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

You may continue your medical coverage by paying the same amount charged to active team members for the same coverage for your military leave of up to 24 months. See the **Continuation of Coverage for Team Members in the Uniformed Services** section in the Benefits Administration SPD for more information.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act, eligible team members are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations, or up to 26 weeks for military caregiver leave or a qualifying (military) exigency leave, and continue their elected medical coverage during this time. You will need to make payments to cover the cost. Contact the Zimmer Biomet Benefits Service Center at 1-877-588-0933 for details.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child or parent who has a serious health condition
- For your own serious health condition

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements. Please refer to Zimmer Biomet's FMLA policy found in the Team Member Center on the Zimmer Biomet intranet for more information.

YOUR RIGHTS UNDER ERISA

As a participant in this plan which is a component plan within the Zimmer Biomet Holdings Inc., Health and Welfare Plan (Zimmer Biomet Health and Welfare Plan), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to the following:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all plan documents and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.
- Obtain copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue group health coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the medical plan as a result of a Qualified Status Change. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the medical plan for the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the plan's claims and appeals procedure as described in the **Your Right to Appeal** section. In addition, if you disagree with the plan's decision, or lack thereof, concerning the status of a Qualified Medical Child Support Order (QMCSO), you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, Frances Perkins Building, 200 Constitution Avenue N.W., Washington, DC 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or by visiting its website at **dol.gov/ebsa** or contacting the EBSA filed office nearest you.

CONTACT INFORMATION

For information about:	Contact:
General plan operation ▪ How to enroll in the plans ▪ How the plan works, choices and benefits ▪ Issues regarding eligibility or enrollment ▪ Report Qualified Status Change ▪ Continuation of coverage during absences ▪ Privacy rights ▪ COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation after coverage ends	Zimmer Biomet Benefits Service Center 1-877-588-0933 Monday through Friday, 9 a.m. to 7 p.m. ET Zimmer Biomet Benefits Service Center P.O. Box 785090 Orlando, FL 32878-5090 **benefits.zimmerbiomet.com** Dependent Verification Service 1-877-588-0933 Fax: 1-877-965-9555 Dependent Verification Center P.O. Box 1401 Lincolnshire, IL 60069-1401
Medical program information ▪ Integrated Health Model (Assistance with any health questions) ▪ Questions about medical benefits and behavioral health and substance abuse benefits ▪ Request provider directory or find out if a certain provider is in-network ▪ Covered charges ▪ Filing claims, benefit payments and claim denials ▪ Request information about travel and lodging expenses during travel for qualifying procedures performed at Centers of Excellence ▪ Request additional ID cards ▪ Obtain a claim form ▪ Anthem Programs ▪ Imaging Management Program (AIM Program) ▪ Sleep Management Program ▪ Find a Doctor	Anthem (Anthem Health Guide) 1-800-693-5406 Monday through Friday, 8 a.m. to 8 p.m. ET Customer Service P.O. Box 105187 Atlanta, GA 30348-5187 **anthem.com** Group Number: 3329200
LiveHealth Online	Anthem 1-888-548-3432 livehealthonline.com
Engage	Anthem 1-800-693-5406 engage-wellbeing.com
Pre-certification and pre-admission review ▪ Medical, behavioral health and substance abuse	Anthem Medical Management 1-866-776-4793 Monday through Friday, 8 a.m. to 8 p.m. ET

Health Savings Account	HealthEquity 1-877-713-7712 24 hours a day, 7 days per week **myhealthequity.com**
Obtain additional information about HSAs	**IRS.gov**
24/7 Nurseline	1-800-700-9184 24 hours a day, 7 days per week
Prescription drug benefits ▪ Covered medications ▪ Finding in-network retail pharmacies ▪ Using the mail service ▪ Request additional ID cards ▪ Filing claims ▪ Specialty Pharmacy	Express Scripts 1-866-544-6884 24 hours a day, 7 days per week P.O. Box 66587 St. Louis, MO 63166-6577 **express-scripts.com** Express Scripts mobile application
Work-Life Solutions ▪ Accessing Work-Life Solutions ▪ Finding in-network providers ▪ Covered service and benefit maximums	1-833-600-4759 24 hours a day, 7 days per week **anthem.com**
Flexible Spending Accounts (FSA) ▪ Obtain a complete list of eligible FSA expenses	HealthEquity (WageWorks) 1-877-924-3967 Monday through Friday, 8 a.m. to 8 p.m. ET Claims Administrator P.O. Box 14053 Lexington, KY 40512 **healthequity.com/wageworks**
Wellness	Virgin Pulse 1-855-479-7626 join.virginpulse.com/ Zimmerbiomet

PLAN ADMINISTRATION

The following information about the administration of the plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your plan.

Plan Sponsor

The name and address of the plan sponsor are:

Zimmer Biomet Holdings, Inc.
345 East Main Street
P.O. Box 708
Warsaw, IN 46581-0708

This plan is a group health plan providing medical benefits, and is a component plan of the Zimmer Biomet Holdings, Inc. Health and Welfare Plan.

Plan Administrator

The name, address and telephone number of the plan administrator are:

Administrative Committee
Zimmer Biomet Holdings, Inc.
345 East Main Street
P.O. Box 708
Warsaw, IN 46581-0708
1-574-267-6131 (request Benefits Department)

The administration of the plan will be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator, the Administrative and Benefits Committees, their delegates, and the service provider, insurer and/or claims administrator, as applicable, will have the discretionary authority to determine all matters relating to eligibility, coverage and benefits under the applicable plan. Benefits under the plan will be paid only if the plan administrator, claims administrator or the applicable delegate decides, in its discretion, that the applicant is entitled to them. The plan administrator, the Administrative and Benefits Committees, their delegates, and the service provider, insurer and/or claims administrator, as applicable, also have the discretionary authority to determine all matters relating to interpretation and operation of the plan. Any determination by the plan administrator, including the committees, claims administrator, insurer or any authorized delegate, shall be final and binding.

Agent for Service of Legal Process

The name and address of the agent for service of legal process are:

Corporate Secretary
Zimmer Biomet Holdings, Inc.
345 East Main Street
P.O. Box 708
Warsaw, IN 46581-0708

Legal process also can be served on the plan administrator.

Identification Numbers

The Zimmer Biomet Holdings, Inc. Employer Identification Number is 13-4151777. The Zimmer Biomet Holdings, Inc. Health and Welfare Plan number is 501.

Plan Year

The plan year is January 1 through December 31.

Organizations Providing Administrative Services

Listed below are the name, address and telephone number of the organization that provides administrative services. These services include administering claims and providing customer assistance.

Anthem Blue Cross Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187
1-800-693-5406
anthem.com

Plan Funding

The medical plan is self-funded by Zimmer Biomet and eligible benefits are paid from the Company's general assets. Any check that remains uncashed after 12 months from date of issuance will be cancelled and any benefit related to the uncashed check will be deemed denied.

OTHER PLAN INFORMATION

When Coverage Starts and Ends

For further information about eligibility rules for yourself and your dependents, enrollment, plan costs, when coverage starts, how coverage is affected when you are absent for disability or take a leave of absence, and when coverage ends when you leave Zimmer Biomet (including COBRA continuation), see the Benefits Administration SPD. You can access the Benefits Administration SPD in the Team Member Center on the Zimmer Biomet intranet, or you can request a paper copy from your local HR representative.

Plan Administration and Your Legal Rights

Information about plan operation, plan administration and your legal rights, including your rights under ERISA or your privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or your rights to have a denied claim reviewed by the plan are described in the Benefits Administration SPD. You can access the Benefits Administration SPD in the Team Member Center on the Zimmer Biomet intranet, or you can request a paper copy from your local HR representative.

In Case of Incompetency

If a person entitled to receive benefits under the plan is legally, physically or mentally incapable of receiving benefits, the plan administrator may make payment to a person or institution that is determined to have custody of the individual.

Compliance With Privacy Regulations

The plan and its service providers or insurers, as applicable, have certain obligations regarding the privacy of your healthcare information according to the provisions of the Health Insurance Portability and Accountability Act of 1996. For details see the **Compliance with Privacy Regulations** section in the Benefits Administration SPD.

Your Employment

Participation in Zimmer Biomet’s medical plan does not guarantee continued employment. The Company’s employment decisions are made without regard to the benefits to which you are entitled upon employment.

This SPD provides detailed information about the plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.

Future of the Plan and Reservation of Rights

Zimmer Biomet expects and intends to continue to offer medical coverage to eligible team members, but reserves the right, by action of Zimmer Biomet or its duly authorized officers, to amend, withdraw or modify, suspend or terminate all or any part of the medical plan at any time, and for any group of participants, without prior notice. No individual, other than the Board of Directors or its delegates, has the authority to change the terms of the medical plan or promise benefits that are not otherwise provided.

Zimmer Biomet may make all such amendments by executing a written document incorporating the changes. The medical plan is part of the Zimmer Biomet Holdings, Inc. Health and Welfare Plan, which is periodically reviewed in an effort to offer competitive benefits. Rates and other plan features are subject to change. When the medical plan is amended, you will be notified. If the

plan should terminate, no benefits would be paid for charges incurred on or after the date of plan termination.

Zimmer Biomet also reserves in the plan administrator, the Administrative and Benefits Committees, and service providers or insurers, as applicable, the discretionary authority and responsibility to interpret and construe the provisions of the plan.

This Summary Plan Description

This SPD, together with the Benefits Administration SPD, is intended to help you understand the main features of the Zimmer Biomet Holdings, Inc. Health and Welfare Plan and the medical plan component plan thereof. It should not be considered as a substitute for the plan document, as defined above, which governs the operation of the Health and Welfare Plan and this medical plan. That document sets forth all of the details and provisions concerning the Health and Welfare Plan and is subject to amendment. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official plan document, the text of the official plan document will determine how questions will be resolved.

Patient Protection Disclosure

This plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, a list of participating primary providers and/or a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem.

TERMS TO KNOW

Definitions included here will help you understand your Anthem medical benefits.

Ambulance Services

Medically necessary ambulance services are a covered service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped and used only to transport the sick and injured and staffed by emergency medical technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when the claims administrator requires you to move from an out-of-network hospital to an in-network hospital; or
  - Between a hospital and a skilled nursing facility or other approved facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when the claims administrator requires you to move from an out-of-network hospital to an in-network hospital;
  - Between a hospital and an approved facility.

Ambulance services are subject to medical necessity reviews by the claims administrator. Emergency ambulance services do not require precertification and are allowed regardless of whether the provider is an in-network or out-of-network provider.

Non-emergency ambulance services are subject to medical necessity reviews by the claims administrator. When using an air ambulance, for non-emergency transportation, the claims administrator reserves the right to select the air ambulance provider. If you do not use the air ambulance provider the claims administrator selects, the out-of-network provider may bill you for any charges that exceed the plan’s maximum allowed amount.

You must be taken to the nearest facility that can give care for your condition. In certain cases the claims administrator may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include medically necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if you are not taken to a facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or physician are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A physician’s office or clinic; or
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a hospital that is not an acute care hospital (such as a skilled nursing facility), or if you are taken to a physician's office or your home.

Hospital to Hospital Transport

If you are moving from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care and critical care are only available at certain hospitals. To be covered, you must be taken to the closest hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family or your provider prefers a specific hospital or physician.

Applied Behavior Analysis

A method of treatment that targets the symptoms of autism spectrum disorder and other psychological disorders by working to improve socially significant behavior (including social skills, communication, reading, and academics, as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence) through the systematic application of the principles of behavior analysis.

Blue Distinction Center

Facilities that have met or exceeded national quality standards for care delivery. To find a center near you, visit **anthem.com**.

Blue Distinction Centers+

Facilities that have met or exceed national quality standards for care delivery and have demonstrated they operate more efficiently. To find a center near you, visit **anthem.com**.

Claims Administrator

An organization that is contracted by the Company to provide administrative services for specific Company benefit plans offered to team members and their dependents.

Clinical Trials

See the **Covered Expenses** section for information about the medical plan's coverage and limitations on coverage of certain approved clinical trials.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

A federal law that enables you or your enrolled dependents to continue medical and dental coverage in the event that you or they lose coverage as the result of certain qualifying events.

Covered Providers

Covered providers are:

- Medical doctors
- Certified acupuncturists
- Osteopaths
- Podiatrists

- Physical and occupational therapists
- Midwives
- Speech therapists
- Licensed clinical psychologists

In addition, to qualify for coverage, providers must:

- Practice within the scope of their license
- Practice within the scope of generally accepted medical practices
- Be recognized by the state in which they practice

Licensed clinical social workers and licensed marriage, family and/or child counselors also are covered if they are:

- Licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service; or
- A member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where the provider renders service.

Providers who are professionally registered in their state, but do not meet these criteria will not be covered.

Custodial Care
Custodial care consists of services and supplies used to assist an individual in the activities of daily living, whether or not the person is disabled. These services and supplies are considered custodial care, regardless of who prescribes, recommends or performs them. However, when room and board and skilled nursing services must be combined with other therapeutic methods to establish a program of medical treatment, they are not considered custodial if:

- They are provided in an institution covered by the plan
- This care can be reasonably expected to substantially improve the patient's medical condition

Deductible
Your annual deductible is an amount you pay each calendar year before benefits from the plan begin.

- True Family deductible – requires all or one individual to meet the family deductible before the plan pays coinsurance.
- Embedded deductible – limits each individual in a family to the individual deductible before the plan pays coinsurance; the embedded individual deductible applies to each family member until the family deductible is satisfied.

Domiciliary Care
Care that is provided or taking place in the home.

Durable Medical Equipment (DME)
Coverage is provided for rental or, at the discretion of the plan, purchase of durable medical equipment, which is prescribed by a professional provider and required for therapeutic use.

If purchased, charges for repair or medically necessary replacement of durable medical equipment will be considered a covered expense. Covered items include, but are not limited to: crutches, commodes, hospital beds, nebulizers, monitoring equipment and wheelchairs.

Emergency Services
The plan covers medical, surgical, hospital and related healthcare services and testing including ambulance service, required for serious accidents, sudden illness or any condition that, if not treated immediately, may result in serious long-term medical complications, loss of life or permanent impairment to bodily functions.

Employee Retirement Income Security Act of 1974 (ERISA)
A federal law that provides certain rights and protections to which participants to the Company's team member benefit plans are entitled. The act imposes duties upon the people who operate team member benefit plans, to do so prudently and in the best interest of team members and other plan participants and beneficiaries.

Family Medical Leave Act (FMLA)
Provides unpaid leaves of absence with job protection for as long as 12 weeks for birth of a child, newborn care, adoption or foster care placement, or the serious health condition of a team member, or a team member's spouse/domestic partner, child or parent or up to 26 weeks for military caregiver leave or a qualifying (military) exigency leave.

Free-Standing Surgical Facility
An institution that meets all of the following requirements:

- Medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room;
- Has immediate access to diagnostic laboratory and X-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis; and
- Is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Healthcare Agency and/or Services
A hospital or a nonprofit or public agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse;
- Is run according to rules established by a group of medical professionals;
- Maintains clinical records on all patients;
- Does not primarily provide custodial care or care and treatment of the mentally ill; and
- Is licensed and runs according to the laws.

Hospice
Hospice is a healthcare program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for covered persons suffering from a condition that has a terminal prognosis.

To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the plan.

Hospital
A legally constituted hospital that offers 24-hour resident service for patients. Hospitals have

professional staff, nursing services and physical equipment that satisfy the legal requirements of the state, province, county, city or community in which they are established.

Inpatient Rehabilitation Facility

Coverage is provided for inpatient rehabilitation facilities. Most people who are admitted to an inpatient rehabilitation facility are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)
- Onsite orthotic and prosthetic services
- Physical therapy (PT)
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

Maximum Allowed Amount

The maximum allowed amount is the amount the plan will reimburse for services and supplies that are covered services, not excluded under the plan, which are medically necessary and provided in accordance with the terms of the plan.

The claims administrator determines the amount of reimbursement for covered services. Reimbursement for services provided by in-network and out-of-network providers is based on the plan's maximum allowed amount for the covered services you receive.

The maximum allowed amount for the plan is the maximum amount of reimbursement the claims administrator will allow for services and supplies:

- That meet the claim's administrator's definition of covered services, to the extent such services and supplies are covered under the plan and are not excluded;
- That are medically necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the plan.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your deductible or have a copayment or coinsurance. In addition, when you receive covered services from an out-of-network provider, you may be responsible for paying any difference between the maximum allowed amount and the provider's actual charges. This amount can be significant.

When you receive covered services from a provider, the claims administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the claims administrator's determination of the maximum allowed amount. The claims administrator's application of these rules does not mean that the covered services you received were not medically necessary. It means the claims administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, the plan may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100% of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status
The maximum allowed amount may vary depending upon whether the provider is an in-network provider or an out-of-network provider.

An in-network provider is a provider who is in the managed network for this specific product or in a special center of excellence or other closely managed specialty network, or who has a participation contract with the claims administrator. For covered services performed by an in-network provider, the maximum allowed amount for this plan is the rate the provider has agreed with the claims administrator to accept as reimbursement for the covered services. Because in-network providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your deductible or have a copayment or coinsurance. Contact Anthem's customer service or visit **anthem.com** to find an in-network provider.

Providers who have not signed any contract with the claims administrator and are not in any of the claims administrator's networks are out-of-network providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For covered services you receive from an out-of-network provider, the maximum allowed amount for this plan will be one of the following as determined by the claims administrator:

1. An amount based on the claims administrator's out-of-network provider fee schedule/rate, which the claims administrator has established at its' discretion, and which the claims administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the claims administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (CMS). When basing the maximum allowed amount upon the level or method of reimbursement used by CMS, the administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by the claims administrator or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the out-of-network provider.

Providers who are not contracted for this product, but contracted for other products with the claims administrator are also considered out-of-network. For this Plan, the maximum allowed amount for services from these providers will be one of the five methods shown above unless the contract between the claims administrator and that provider specifies a different amount.

Unlike in-network providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds the plan's maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the amount the provider charges. This amount can be significant. Choosing an in-network provider will likely result in lower out-of-pocket costs to you. Contact Anthem's customer service or visit **anthem.com** to find an in-network provider.

Customer service also is available to assist you in determining this plan's maximum allowed amount for a particular service from an out-of-network provider. In order for the claims administrator to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You also will need to know the provider's charges to calculate your out-of-pocket responsibility. Although customer service can assist you with this pre-service information, the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

Member Cost Share
Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an in-network or out-of-network provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using out-of-network providers. Contact Anthem's customer service to learn how the plan's benefits or cost share amounts may vary by the type of provider you use.

Medically Necessary
Medically necessary care is defined as:

- Commonly recognized by the appropriate medical specialist, within standards of good practice.
- Appropriate, effective and consistent with the diagnosis or treatment of an illness or injury.
- The appropriate supply or level of service that can be safely administered.
- Provided by a practitioner, hospital or covered provider.
- A drug or supply approved by the U.S. Food & Drug Administration (FDA).

Medically necessary care is not:

- Experimental or investigational in nature.
- Primarily for the convenience of the patient or covered provider.
- Provided primarily for the purpose of medical or other research.
- Care that does not require the technical skills of a medical, mental health or dental professional.

- Care that is more costly than care that could safely and adequately be furnished in an alternative setting.
- Scholastic, educational or developmental in nature, or intended for vocational training.

Non-Occupational
For non-occupational illness or accidents, any sickness or accident not related to work, you (or your covered dependents) are not entitled to Workers' Compensation benefits.

Out-of-Pocket Maximum
Your annual out-of-pocket maximum is the maximum amount you pay each calendar year before the plan pays 100% of covered expenses for the rest of the calendar year.

- True Family out-of-pocket maximum – requires all or one individual to meet the out-of-pocket maximum before the plan pays 100%.
- Embedded out-of-pocket maximum – limits each individual in a family to the individual out-of-pocket maximum before the plan pays 100%. The embedded individual out-of-pocket maximum applies to each family member until the family out-of-pocket maximum is satisfied.

Qualified Medical Child Support Order (QMCSO)
A QMCSO is a court order that requires the plan to provide healthcare coverage to the dependent child named in the order. It is not the equivalent of a divorce settlement requiring a named parent to provide healthcare insurance

Qualified Status Change
An event that permits changing insurance coverage.

Semi-Private Room Rate
Means the room and board rate of any institution for semi-private rooms. Semi-private rooms are accommodations with two or more beds that are classified by the institution as semi-private. If the institution does not have semi-private rooms, then that institution's semi-private room rate will be deemed to be the most common daily room and board rate for semi-private rooms in similar institutions in the area. The term area means a city, county or any greater area necessary to obtain a representative cross-section of similar institutions.

Skilled Nursing Facility
A facility that provides convalescent or long-term illness care, or treatment of a terminal condition, according to standards set by the American Hospital Association.

Skilled Nursing Services
Professional services rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse.

Team Member
Means you are a common law employee of Zimmer Biomet and not a contractor or employee of any other employer that is not Zimmer Biomet or one of its affiliates. To participate in the plan, you must be employed by Zimmer Biomet or a subsidiary that adopts the plan and must be paid under the Zimmer Biomet U.S. payroll.

Transplant Services
The medical, surgical and hospital services, and immuno-suppressive medications required to perform any of the following human-to-human organ or tissue transplants: kidney, cornea, bone marrow, lung, liver or pancreas.

Urgent Care
Conditions that need immediate attention from a doctor or nurse, but are not critical or life threatening.

Zimmer Biomet Technologies
Certain Zimmer Biomet devices and related technologies approved by the company (as plan sponsor) are covered by the plan. The Zimmer Biomet technologies covered by the plan are:

- DeNovo® NT Natural Tissue Graft, a juvenile cartilage allograft tissue available to surgeons as an early-intervention option for the repair of articular cartilage for certain anatomic focal cartilage defects.
- Computer-assisted musculoskeletal surgical (CAS) navigation.
- Dynesys® intervertebral stabilization device used as an adjunct to spinal fusion procedures to provide immobilization and stabilization of spinal segments.
- Patello-femoral joint (PFJ) bicompartmental knee arthroplasty for individuals with osteoarthritis that is limited to the medial and patellofemoral compartments of the knee.
- UniSpacer® Knee System unicondylar interpositional spacer used to treat unicompartmental arthritis of the knee.
- Gel-One® Cross-linked Hyaluronate (hydrogel), synovial fluid supplement as an early intervention treatment to relieve pain related to osteoarthritis of the knee.
- Mobi-C (one and two levels) for cervical disc arthroplasty.
- Aspen, Alpine and Timberline spinal ISP devices.
- Cellentra biologics.
- Perfuse biologics.
- Chondrofix.
- BioCue and GPS III for platelet Rich Plasma (PRP) treatments.
- Pectus Bar for pectus excavatum repair.

If your doctor determines any of the Zimmer Biomet Technologies products are appropriate treatment for your particular medical situation, it will not be excluded from coverage under the plan as experimental or investigative; however, each of the approved Zimmer Biomet Technologies remain subject to the plan's remaining terms and conditions, including, without limitation, the requirement for the treatment to be medically necessary, pre-authorized by the plan and subject to your payment of the applicable deductible, coinsurance and any other amounts required under the plan for the treatment.