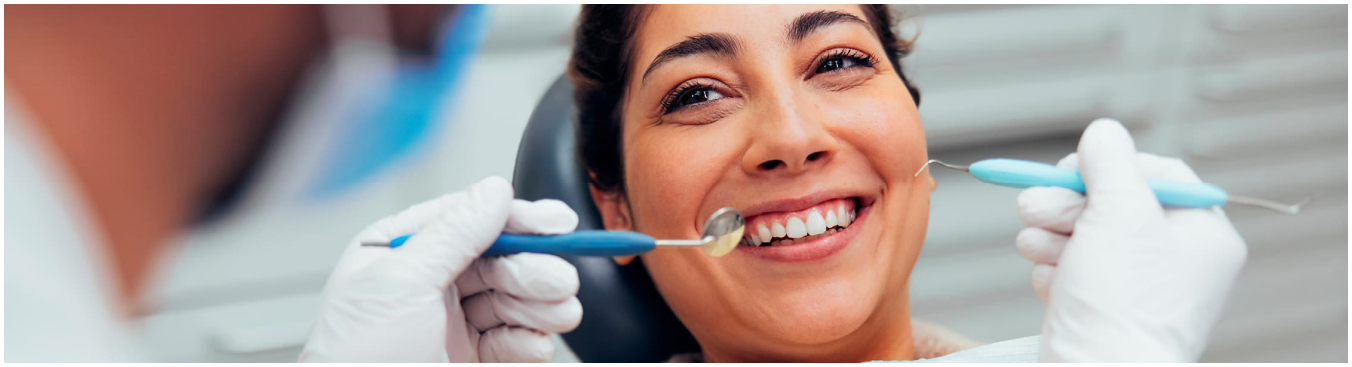
Dental benefits



Dental coverage under Stryker's healthcare plan helps pay dental bills for you and your family. It is designed to encourage good dental care. The plan covers preventive dental services and treatment for a disease, defect or accident that injures your teeth and is not job-related, as long as treatment meets accepted dental standards and is provided by a licensed dentist.

This section of the Stryker Benefits Summary describes Stryker's dental benefits administered by Delta Dental of Michigan. For additional information about the plan, see the Delta Dental PPO certificate available at **https://totalrewards.stryker.com/spd/michigan-ppo-certificate-aso.pdf**.

While the definition of dependent child has been voluntarily amended to align with the medical and prescription benefit pursuant to the Patient Protection and Affordable Care Act (PPACA), the dental benefit is not otherwise subject to the insurance market reforms of PPACA.

How dental benefits work

Delta Dental of Michigan administers Stryker's dental benefits. Under the Delta Dental program, you may choose any licensed dentist. If you choose a dentist who participates in Delta Dental Premier or Delta Dental PPO networks, you will pay only your copayment for covered services. Participating dentists agree to accept Delta Dental's payment and your copayment as payment in full for covered services.

If you choose a dentist who does not participate in a Delta Dental program, you will still be covered. However, you may have to pay more than just the copayment amount. You will also be responsible for the difference, if any, between Delta Dental's allowed fee and the dentist's submitted fee.

Your deductible

A deductible is money you must spend on your own for covered services before the dental plan pays benefits. Your deductible is $50 per person per year, not to exceed $150 per family per year.

The deductible does not apply to Class I Benefits or to Class IV Benefits (see "Schedule of benefits" on page 116).

Before you have treatment

When you or a covered dependent expects to have any dental treatment that may cost more than $200, it is recommended that your dental provider submit a Pre-Treatment Estimate from Delta Dental. This lets you and the treating dentist know in advance what benefits are covered, how much the plan will pay and how much you will have to pay.

To file for Pre-Treatment Estimate, ask your dentist to complete a claim form describing the planned services and charges, and submit the form to Delta Dental before treatment begins.

Optional treatment

If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination

regarding optional treatment and any available allowance.

While you are responsible for the difference in cost for any optional treatment, having a Pre-Treatment Estimate can help determine the amount you will have to pay toward the service before it is completed. Examples of services for which Delta Dental will provide an allowance for optional treatment include:

- Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

If you lose coverage during treatment

If you or a covered dependent lose your dental coverage under Stryker's healthcare plan while receiving dental treatment, payment will be made only for those covered services actually received while coverage was in effect. However, crowns, jackets, bridges and dentures (full or partial) begun before the loss of eligibility will be covered if the work is completed within 60 days from the date coverage ends.

Schedule of benefits

Benefits under the plan are divided into four classes:

- **Class I Benefits** cover 100% of diagnostic and preventive services including X-rays.
- **Class II Benefits** cover basic dental services such as oral surgery, minor restorative services, periodontics and endodontics. Class II Benefits are paid at 80% after deductible.
- **Class III Benefits** cover prosthodontics and major restorative services. Benefits are paid at 50% after deductible.
- **Class IV Benefits** cover orthodontics for dependents under age 19. Orthodontics for plan participants age 19 and older may be covered if there is a medical necessity for the orthodontic treatment. Benefits are paid at 50%.

Benefit maximums

For Class I, Class II and Class III Benefits, the dental plan pays a combined maximum of $2,000 per person per year. For Class IV Benefits, the maximum is $2,000 per person per lifetime.

Covered dental expenses

The amounts you pay for covered services are shown in the chart below:

Covered service	Your share of cost
Class I Benefits: Diagnostic and Preventive Services (no deductible applies)	
Oral exams Limited to two in any calendar year.	$0
X-rays, full mouth (including bitewing) Limited to one set in any five-year period.	$0
X-rays, bitewing only Limited to once in any calendar year.	$0
Prophylaxis (cleaning, scaling and polishing) Limited to two in any calendar year, including periodontal prophylaxes. May be performed by a licensed dental hygienist.	$0
Fluoride treatments Limited to children under age 19. Limited to two in any consecutive 12-month period. May be performed by a licensed dental hygienist.	$0
Sealants Limited to occlusal (top biting) surface of first permanent molars for children under age 9 and second permanent molars for children under age 14. Covered once per tooth per lifetime.	$0
Emergency palliative treatment (to temporarily relieve pain)	$0

Covered service	Your share of cost
Class II Benefits: Basic Services (subject to deductible)	
Oral surgery	20%
Minor restorative services, including fillings, relines and repairs to bridges, dentures and partials Amalgam and resin restorations are payable once within a 24-month period regardless of the number or combination of restorations placed on a tooth surface. Benefits for reline or complete replacement of denture base material are payable once in any three-year period.	20%
Periodontics (treatment of the gums and supporting structures of the teeth) Benefits for root planing are payable once in any two-year period. Periodontal surgery, including subgingival curettage, is payable once in any three-year period.	$0 for cleaning; 20% for all other services
Endodontics (root canal therapy)	20%
Class III Benefits: Major Restorative Services (subject to deductible)	
Prosthodontics (treatment to replace missing natural teeth or other dental structures)	50%
Complete dentures Limit of one complete upper and one complete lower denture per person in any five-year period.	50%
Partial dentures, fixed bridges or removable partials Limit of one per person in any five-year period except where the loss of additional teeth requires the construction of a new appliance. Fixed bridges and removable cast partials are not covered for children under age 16.	50%
Major restorative services, including crowns, jackets and onlays Treatment per tooth is limited to once in any five-year period. Full porcelain, porcelain/resin processed to metal, full cast or 3/4 cast crowns are not covered for children under age 12.	50%
Endosteal implants An implant for any person can be covered once in any five-year period, per tooth.	50%
Class IV Benefits: Orthodontics (no deductible applies)	
Limited to children under age 19. If orthodontia treatment began before coverage under Stryker's healthcare plan became effective, benefits will be calculated based on the remaining months of treatment. If orthodontia treatment is terminated prior to completion, for any reason, benefit payment will end as of the date treatment is terminated. Orthodontics for individuals age 19 and older may be covered if the treatment is determined to be medically necessary.	50%
Benefit Maximums	
Class I, Class II and Class III combined	$2,000 per person per calendar year
Class IV	$2,000 per person lifetime maximum

Expenses not covered

The plan does not pay for the following expenses:

- Services that are not necessary as determined by the standards of generally accepted dental practice
- Treatment by other than a licensed dentist, except for prophylaxis (cleaning and scaling of teeth) and topical application of fluoride performed by a licensed dental hygienist under the supervision and direction of a licensed dentist
- Cosmetic dentistry or dentistry to correct congenital malformations
- Services or appliances, including crowns and bridges, for which treatment began prior to the date the person became covered under the plan
- Prescription drugs, laboratory tests and/or exams, premedications and local anesthesia (These services may be covered under the medical plan.)
- Hospitalization
- General anesthesia and intravenous sedation for restorative dentistry or surgical procedures, unless a specific need is shown (e.g., on account of a child's age)
- Preventive control programs, including home care items
- Charges for completion of claim forms
- Missed dental appointments
- Appliances, surgical procedures or restorations whose primary purpose is to alter vertical dimension, restore occlusion or replace tooth structure loss resulting from attrition, abrasion or erosion
- Inlays
- Replacement, repair, relines or adjustments of occlusal guards (Occlusal guards are limited to one per lifetime.)
- Lost, missing or stolen appliances of any type, and replacement or repair of orthodontic appliances
- Services that are experimental in nature
- Services and supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage
- Services to treat a dental disease, defect or injury due to an act of war, declared or undeclared
- Services that are covered under the medical or prescription drug benefits provided under the Stryker Corporation Welfare Benefits Plan
- Services or appliances for the treatment of temporomandibular joint (TMJ) disorder (Note: These services are covered under the medical plan.)
- Services for injuries or conditions covered under Workers' Compensation or employers' liability laws
- Services that are available from any government agency, political subdivision, community agency, foundation or similar entity
- Services that are excluded by Delta Dental's processing policies

How to obtain dental benefits

If you use participating dentists

If you use a dentist who participates in Delta Dental Premier or Delta Dental PPO, the dentist will submit your claim and receive payment directly from Delta Dental. You will receive an explanation of benefits (EOB) showing the portion of the charges paid by Delta Dental and the amount you owe.

If you have other dental coverage

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

For participating dentists, claim payment is based on the Maximum Approved Fee for a covered service as determined by Delta Dental. Payment is based on the lesser of the fee charged or the Maximum Approved Fee. Participating dentists agree not to charge you for any difference between their actual fee and the Maximum Approved Fee.

If you use non-participating dentists

In most cases, when you use a non-participating dentist, you are responsible for paying the dentist directly and filing a claim for reimbursement. You will receive payment from Delta Dental along with an explanation of benefits (EOB) form.

For non-participating dentists, benefits are based on Delta Dental's non-participating dentist fee for

a covered service. Payment is based on the lesser of the dentist's submitted fee or Delta Dental's non-participating dentist fee. You are responsible for the difference between the claim payment amount and actual charges.

Coordination of benefits

Coordination of Benefits (COB) is used to pay healthcare expenses when you are covered by more than one plan. See "If You Have Other Coverage" in the *Participating in Healthcare Benefits* section of this Benefits Summary for more information about COB provisions for the dental plan.

How payment is made

If the dentist is a PPO dentist and a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The PPO dentist schedule
- The Maximum Approved Fee

Delta Dental will send payment to the PPO dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the PPO dentist schedule or the Maximum Approved Fee for covered services. The subscriber will be responsible for the lesser of the PPO schedule amount, the Maximum Approved Fee, or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist is a PPO dentist but is not a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The PPO dentist schedule.

Delta Dental will send payment to the PPO dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the PPO dentist schedule for covered services. The subscriber will be responsible for the lesser of the PPO schedule amount or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist is not a PPO dentist but is a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The Maximum Approved Fee

Delta Dental will send payment to the Premier dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for covered services. The subscriber will be responsible for the lesser of the Maximum Approved Fee or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist does not participate in Delta Dental PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of:

- The submitted amount
- The non-participating dentist Fee

Delta Dental will usually send payment to the subscriber, who will be responsible for making payment to the dentist. The subscriber will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount.

For dental services rendered by an out-of-country dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The out-of-country dentist fee

Delta Dental will usually send payment to the subscriber, who will be responsible for making payment to the dentist. The subscriber will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount.

Claims determinations

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or

service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, **800 524 0149**, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Claims appeal procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the claims appeal procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, the Dental Director will assess the information, including any additional information that you have provided, as if the Dental Director were deciding the claim for the first time.

The Dental Director will make a decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of the adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no

charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required claims appeal procedure or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

How to reach Delta Dental

Delta Dental Plan of Michigan

Stryker Group #: 5480
P.O. Box 9085
Farmington Hills, MI 48333-9085
800 524 0149
www.deltadentalmi.com

If you are using the dentist directory, select "Delta Dental Premier" or "Delta Dental PPO" for the product type.

Dental Plan definitions

Dentist

A person licensed to practice dentistry in the state or country in which the dental services are provided.

Diagnostic and preventive services

Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Such services include examinations, prophylaxis (cleaning) and topical application of fluoride solution.

Maximum Approved Fee

A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental participating dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The submitted amount
- The lowest fee regularly charged, offered, or received by an individual dentist for a dental service, irrespective of the dentist's contractual agreement with another dental benefits organization
- The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty, under normal circumstances

Delta Dental may also approve a fee under unusual circumstances. Participating dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the covered service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the covered service.

Non-participating dentist

A licensed dentist who has not signed an agreement with Delta Dental. Delta Dental's payment is sent to the employee, who is responsible for making full payment to the non-participating dentist.

Orthodontics

Services and treatment required for the correction of malpositioned teeth.

Participating dentist

A licensed dentist who has signed an agreement to participate in Delta Dental Premier or Delta Dental PPO. A participating dentist agrees to accept Delta Dental's payment and the patient's payment, if any, as payment in full. Delta Dental's payment is sent directly to the participating dentist.

Pre-Treatment Estimate

A procedure in which the dentist submits a treatment plan and expected charges to Delta Dental before rendering services. Delta Dental reviews the treatment plan and notifies the patient and dentist of its determination regarding covered services and the amount of benefits payable. Payment for predetermined services is contingent on continued eligibility of the patient. Generally, a pre-treatment estimate is recommended for procedures that are expected to cost $200 or more, but Delta Dental will predetermine benefits for less expensive procedures.

Restorative services

Services to rebuild and repair natural tooth structure damaged by disease or injury. Minor restorative services include amalgam and resin fillings. Major restorative services include crowns, jackets and gold-related services when the teeth cannot be restored with another filling material.