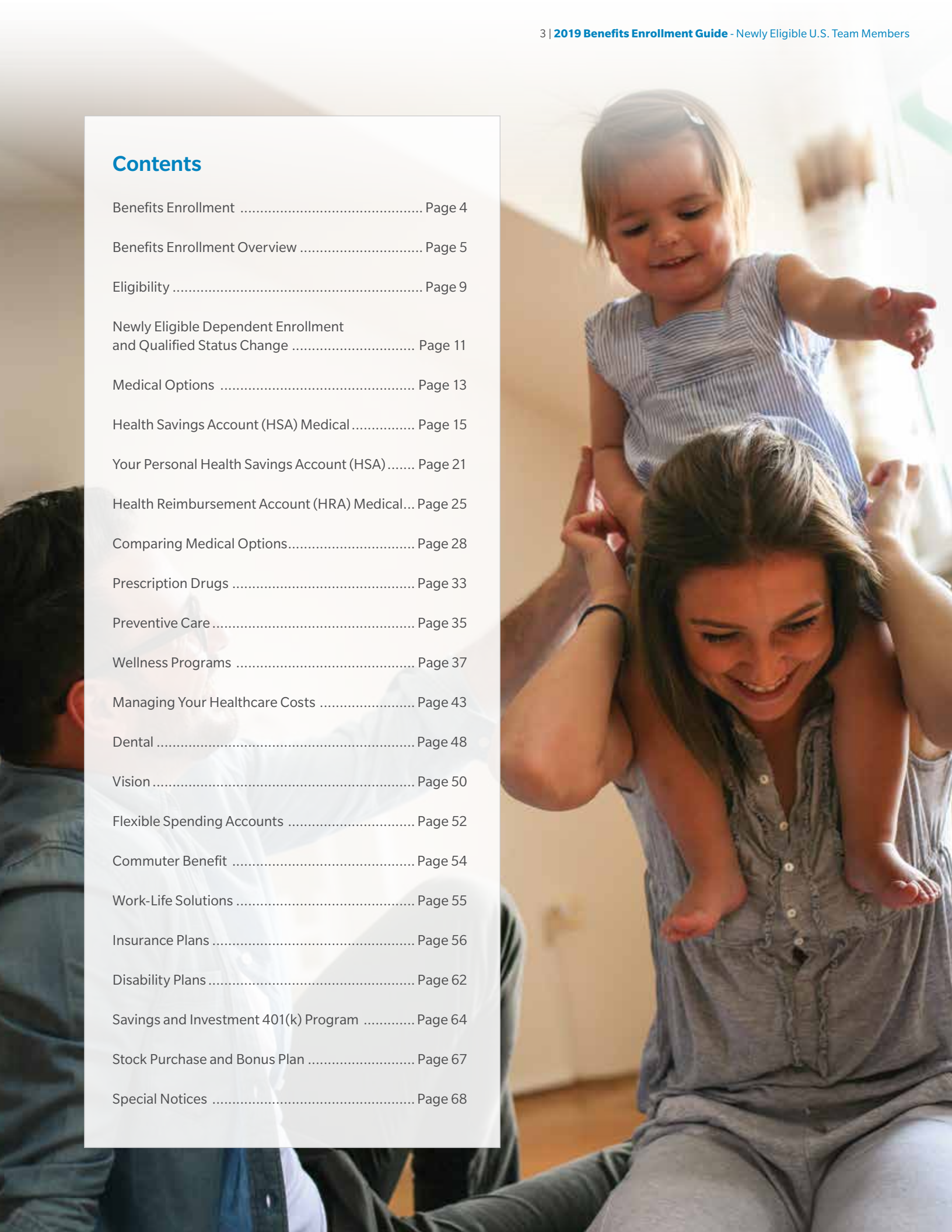
My Rewards: My Benefits

2019 Benefits Enrollment Guide

Newly Eligible U.S. Team Members


THE
POWER
OF
US.

Contents



Benefits Enrollment

Enroll on Time

Newly eligible Team Members must enroll within 31 days of initial eligibility date, which is generally your date of hire or the date you first become eligible under the Plan's terms.

Enroll — in English or Spanish — online at **benefits.zimmerbiomet.com** using a computer, smartphone, iPad or other tablet or via phone at Zimmer Biomet Benefits Service Center at **1-877-588-0933**.

Dependent Verification

When you add a new dependent for coverage under the health and welfare plan, you will be required to provide documentation to verify their eligibility. You must submit the required documentation within 60 calendar days from the date you elect coverage; otherwise, coverage will be terminated retroactively. For further details, please see page 11 regarding the process to submit documentation.

Important — Additional Plan Information

To make updated information more accessible and reduce the environmental impact of printing larger documents, the Company provides additional information about the plans, including the summary plan descriptions (SPDs), on the Zimmer Biomet intranet and the Zimmer Biomet Benefits Service Center website at **benefits.zimmerbiomet.com**, or you may contact the Zimmer Biomet Benefits Service Center at **1-877-588-0933** anytime during its operating hours if you would prefer a paper copy of the SPDs.

Your 2019 Benefits Enrollment Guide provides an overview of the benefits offered by Zimmer Biomet, effective through December 31, 2019. This Enrollment Guide also serves as the summary of material modifications that describes the material changes to the plan document and Summary Plan Description (SPD). If you need specific plan information that isn't detailed in this guide, please refer to the appropriate SPD. All benefits are subject to the terms and conditions of the plan document or insurance policy, as amended from time to time. If there is any discrepancy between this guide and the plan document or policy, the plan document or policy will govern. While the Company intends to continue these benefits, we reserve the right to change or discontinue them at any time for any reason.

Coverage period

Any elections you choose when you enroll (or the default elections) remain in effect through December 31, 2019 (as long as you continue to remain eligible).

Have questions about your benefit options?

Contact the Zimmer Biomet Benefits Service Center at:
Customer Care Center
P.O. Box 785090
Orlando, FL 32878-5090

Phone
1-877-588-0933

Fax
1-800-363-7571

Monday through Friday, from 9 a.m. to 7 p.m. ET

Confidentiality:
The Zimmer Biomet group health plan is covered by the Privacy and Security Rules under the federal law HIPAA. These rules protect the confidentiality of your medical services, including medical, dental, vision and prescription drugs.

Benefits Enrollment Overview

At Zimmer Biomet, you are part of a Company creating and delivering innovative products that are changing the world. As a global leader in musculoskeletal healthcare, we strive to deliver innovative health and wellness programs to you and your family, including high-quality care, comprehensive coverage, and easy access to doctors, care or healthcare facilities of your choice.

For most plans, coverage for you and your covered dependents begins on your first day of eligibility as a full-time or part-time Team Member working at least 30 hours. You must enroll in the benefit options within 31 days of the date you are first eligible for coverage. If you timely enroll (or are deemed to enroll under the default medical option), any elected benefits (or the default medical option) will be retroactive back to your first day of eligibility (typically your date of hire). Retroactive contributions will be taken as soon as administratively practical, typically on the first paycheck after your date of election.

Electronic Distribution of Information

By accessing enrollment online, you are deemed to consent to the electronic distribution of any information unless you opt out.

Active Enrollment

An active benefits election is required if you want to enroll in or choose no coverage in the Company's medical option. Elections must be made within 31 days of your initial eligibility date, which is generally your date of hire or the date you first become eligible under the Plan's terms. If you do not make elections, you will receive default coverage as outlined on page 8.

2019 Benefits Confirmation Statement

The benefits confirmation statement, which will be sent by email and/or mailed to your home address, summarizes the medical, dental, vision, Health Savings Account, flexible spending account and life insurance benefit elections you made for 2019 during your enrollment period.

You must review your statement carefully and report any errors and/or changes to the Zimmer Biomet Benefits Service Center within 15 days from the date on the confirmation.

If you do not receive a benefits confirmation statement within 15 days of completing your enrollment, please contact the Zimmer Biomet Benefits Service Center.

Get the benefits you need

You must enroll or waive coverage during your new hire enrollment. If you do not complete the enrollment process or actively waive coverage during your new hire enrollment, you will automatically receive the following default coverage as outlined on page 8.

You will not be able to make changes to your coverage in 2019 unless you experience a Qualified Status Change, such as a marriage or the birth of a child.

Choosing your beneficiaries

Designating beneficiaries (and keeping your choices up to date) allows you to ensure your assets get distributed to your loved ones in a way you desire. See pages 22, 60 and 64 regarding designation of beneficiaries.

Disability Plans Protect Your Finances

A disabling injury or illness could have a devastating impact on your family. Our Short-Term Disability (STD) and Long-Term Disability (LTD) plans, administered through Unum, are here to help you and your family. Disability claims must be filed within 30 days after your disability begins. Team Members must call Unum at **1-866-779-1037** in order to file a claim. See page 62 for more information.

Tobacco-Free Policy

Having tobacco-free facilities demonstrates Zimmer Biomet's commitment to encouraging all of us to make healthy lifestyle choices every day.

Tobacco use is prohibited at all Zimmer Biomet facilities and locations (e.g., property, buildings, leased buildings, Company vehicles, Company-sponsored meetings, during breaks and lunch periods when on Company property) and applies to Team Members, visitors, vendors, contractors, surgeons, consultants, distributors, temporary agency employees or others on Zimmer Biomet property.

Healthcare Reform

Under the Affordable Care Act (ACA), you are generally required to have healthcare coverage for you and your dependents, if applicable, that meets basic minimum standards, or pay a penalty.

Zimmer Biomet offers comprehensive, affordable healthcare plans that meet these requirements. If you are eligible for healthcare coverage through Zimmer Biomet, this coverage is likely your best option unless you are covered through another employer-sponsored plan.

You may only enroll in the Healthcare FSA if you are also enrolled in the HRA Medical option.

Summary of Benefits and Coverage

The ACA requires group health plans to make available a Summary of Benefits and Coverage (SBC) that describes the key features of each medical and prescription drug coverage option available to you under the Zimmer Biomet Holdings, Inc. Health and Welfare Plan (the "Plan").

The SBCs are available for review on the Zimmer Biomet enrollment website (also known as Upoint™) and the Zimmer Biomet intranet.

Termination of Benefit Coverages

Group medical, dental and/or vision coverage ends as of 11:59 p.m. ET on the last calendar day of the month during which your employment terminates.

Flexible Spending Account (FSA) expenses incurred after your last day of employment are not reimbursable from your FSA.

Life/Accidental Death and Dismemberment (AD&D) Insurance and Survivor Income Plan coverage will terminate as of 11:59 p.m. ET on your last day of employment.

Any applicable bi-weekly contributions will be deducted from your last paycheck for any benefit coverages that were in effect through the termination periods as stated above.

Choose Your 2019 Benefits

The following chart summarizes the benefit programs and options available to you. For most benefits, you may elect a specific option and a level of coverage, or choose no coverage for that benefit.

When electing your medical, dental and/or vision benefits, your contributions each pay period will depend on the type of option and coverage level you elect and whether the spousal surcharge applies.

Levels of Coverage

- You only
- You + spouse/domestic partner
- You + child(ren)
- You + family
- No coverage

Benefit Election Options

Medical

- Premium HSA Medical
- Value HSA Medical
- HRA Medical[1]
- No medical coverage

Dental

- Premium Dental
- Value Dental
- No dental coverage[1]

Vision

- Vision
- No vision coverage[1]

Health Savings Account (HSA)

- Personal contribution up to maximum (less any Zimmer Biomet contribution) IRS limit
- No personal HSA contributions[1]

Note: the amount you elect for your personal HSA contribution can be changed throughout the year.

Flexible Spending Accounts (FSAs)

- Healthcare FSA (requires enrollment in the HRA Medical option; not available if you enroll in Premium or Value HSA Medical option or choose no coverage)
- Dependent Care FSA
- No FSA[1]

Commuter Benefit

- Commuter Benefit
- No Commuter Benefit[1]

Life Insurance and/or Accidental Death and Dismemberment (AD&D) Insurance

- Supplemental Team Member Life and/or AD&D Insurance
  - 1x to 8x annual benefits salary
- No Supplemental Team Member Life and/or AD&D Insurance[1]
- Dependent Life and/or AD&D Insurance
  - Spouse/Domestic Partner Coverage
    - » Denominations between $10,000 and $500,000
  - Child Coverage
    - » $5,000 or $10,000
- No Dependent Life and/or AD&D Insurance[1]

Survivor Income Plan

- Survivor Income Plan
- No Survivor Income Plan[1]

(Please remember to update your beneficiary designations. Only surviving spouse/domestic partner and/or surviving dependent children are eligible to be a beneficiary for the Survivor Income Plan benefit.)

Supplemental Long-Term Disability (LTD) Insurance

- 10% Supplemental Long-Term Disability Insurance
- No Supplemental LTD Insurance[1]

[1] This is the default option for which you will receive if you do not complete the active enrollment process. Refer to page 8 regarding default options.

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 default to the coverage listed below.

Any elections you choose when you enroll (or the default elections) will remain in effect until December 31, 2019, unless you experience a Qualified Status Change.

Default Coverage

Medical
HRA Medical, you only coverage.
Dental
No dental coverage.
Vision
No vision coverage.
Health Savings Account (HSA) Contribution
No personal HSA contributions.
Flexible Spending Accounts
No participation.
Commuter Benefit
No participation.
Life and Accidental Death & Dismemberment (AD&D) Insurance
You will automatically be enrolled in Basic Life and Basic AD&D Insurance at 2x your eligible benefits salary. This is provided at no cost. You will not have any supplemental or dependent coverages.
Survivor Income Plan
No coverage.
Short-Term and Long-Term Disability
You will automatically be enrolled in Basic Short-Term and Long-Term Disability. This is provided at no cost.

Eligibility

Full-Time Team Members[1]

You are eligible to participate in all the Zimmer Biomet benefit programs if you are a full-time Team Member (regularly scheduled to work 40 hours per week) who is paid under the Zimmer Biomet U.S. payroll.

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 30 hours per week, but fewer than 40 hours per week (other than because of a disability or approved leave), you may be eligible for these coverages:

- Medical Option — you and any eligible dependent(s)
- Dental and Vision Options — you only coverage
- Healthcare and Dependent Care Flexible Spending Accounts
- Commuter Benefit
- Work-Life Solutions

If you are a part-time Team Member scheduled to work fewer than 30 hours per week, you are only eligible for Work-Life Solutions. No other benefits will be provided.

To participate in any of the Zimmer Biomet benefits, you must be employed by Zimmer Biomet or a subsidiary that adopts the Plan or program and must be paid under the Zimmer Biomet U.S. payroll.

Team Members and Others Ineligible for Coverage

Team Members covered by a collective bargaining agreement, temporary or seasonal employees, student interns, co-ops, contractors and leased employees are not eligible to participate in the benefit programs.

Dependent Eligibility

Full-time and part-time eligible Team Members may enroll eligible dependents in a medical option. An eligible dependent is:

- **For medical:**
  - Your 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 eligible domestic partner (same or opposite gender). See box below for eligibility requirements.
  - 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, and continuously covered by the Zimmer Biomet plan at and since the time of his/her incapacity, and if the plan administrator (or its designee) approved him/her as eligible to continue coverage under the Plan.

Your domestic partner (same or opposite gender) is eligible if he/she meets the following requirements:

- Be exclusively committed to you for at least 12 months and intend such relationship to continue indefinitely
- Reside in the same household and be jointly responsible for each other's welfare and financial obligations
- Not be legally married to another person or part of another domestic partner relationship
- Not be related by blood closer than would bar marriage under applicable state law in effect where you reside

[1] Team Member refers to a common law employee of Zimmer Biomet and does not include individuals who are contractors or employees of any other employer that is not Zimmer Biomet or one of its affiliates.

Full-time Team Members may enroll eligible dependents in dental, vision, life and AD&D insurance. An eligible dependent is:

- **For Dental and Vision:**
  - Your 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 eligible domestic partner (same or opposite gender). See page 9 for eligibility requirements.
  - Your unmarried dependent child under age 19 (under age 23 if he/she is a full-time student[1]).
  - Your unmarried, incapacitated child of any age, if his/her incapacitation existed before age 19 (or age 23 if he/she is a full-time student), and if he/she was enrolled in the Zimmer Biomet plan at and since the time of his/her incapacity, and if the insurer, or the plan administrator (or its designee), whichever is applicable, approves him/her as eligible to continue coverage under the Plan.
- **For Life and AD&D insurance:**
  - Your 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 eligible domestic partner (same or opposite gender). See page 9 for eligibility requirements.
  - Your unmarried dependent child under age 19 (under age 23 if he/she is a full-time student[1]).
  - Your unmarried, incapacitated child age 19 or over, provided he/she became disabled while covered as an eligible dependent by the Zimmer Biomet plan, remains incapable of self-support because of physical or mental disability, and is approved by the insurer as eligible to continue coverage under the Plan. In addition, the Team Member must be the main source of support and maintenance.

Eligibility as Either Team Member or Dependent

If you and your spouse/domestic partner both work at Zimmer Biomet, you may not be covered as both a Team Member and a dependent (the same applies for your Zimmer Biomet spouse/domestic partner under any plan). Also in this situation, your dependent child(ren) can only be covered by one of you.

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[2].

[1] Schools may have their own definition of a full-time student, but the Plan generally requires being enrolled in at least 12 credits per term at an accredited post-secondary institution.

[2] By enrolling an eligible individual (other than your spouse, child or domestic partner and his/her children) in the 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 in the Plan, but who is not your dependent for federal tax purposes, you must notify the Zimmer Biomet Benefits Service Center no later than December 31 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 Plan is your dependent for federal income tax purposes, you should consult your tax professional.

Newly Eligible Dependent Enrollment and Qualified Status Change

Newly Eligible Dependent Enrollment

When you add a new dependent for coverage under the health and welfare plan, you will be required to provide documentation to verify their eligibility. Documentation will not be required at the time of your enrollment but you must submit the required documentation within 60 calendar days from the date you elect coverage; otherwise, coverage will be terminated retroactively.

You will receive notification via email and home mailings regarding the request for dependent verification.

Qualified Status Change

In accordance with the Internal Revenue Code (the "Code") a Qualified Status Change is a change in work or family status that allows limited mid-year changes to benefit elections. When you add a new dependent through a Qualified Status Change, you may be required to provide documentation.

No documentation is required to remove a dependent from coverage.

Below is a list of Qualified Status Change examples. For a complete list, go to **benefits.zimmerbiomet.com**.

Marriage or Divorce
Non-Registered Domestic Partner Relationship: A non-registered domestic partner is any person recognized as a Team Member's domestic partner based on completion of the Zimmer Biomet domestic partner affidavit. This affidavit will be mailed to your home.
Registered Domestic Partner Relationship: A registered domestic partner is any person recognized as a Team Member's domestic partner under applicable state or municipal law for which the Team Member received proof of the domestic partner relationship.
You, Your Spouse/Domestic Partner or Another Covered Dependent Loses or Gains Benefits Coverage
Birth or Adoption of a Child
New Guardianship
Change in Full-Time Student Status for Your Child (excluding medical coverage)

You must complete the following steps to properly report a Qualified Status Change:

- **Timely notify the Zimmer Biomet Benefits Service Center.** Contact 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 (CHIP) coverage). See page 68 for additional information about Medicaid and CHIP.
  - **Within 90 calendar days** of the birth or adoption of a child, including the day of the event.

- After reporting the Qualified Status Change, updates will be sent to the carriers, and your payroll deductions will be adjusted. However, your dependent will not be eligible for coverage under any plan unless you also timely provide the required documentation.
  - You must submit the required documentation within 60 calendar days from the day of notification; otherwise, coverage will be terminated retroactively.

Note: If you do not timely enroll an eligible dependent, you will need to wait until the next annual benefits enrollment period.

Each Team Member is responsible for timely notifying the Zimmer Biomet Benefits Service Center if his/her dependent becomes ineligible for coverage.

Newly Eligible Dependent Enrollment and Qualified Status Change Documents

After you add any dependent to coverage, you will be sent a request from the Zimmer Biomet Benefits Service Center to provide documentation to verify their eligibility.

Respond promptly to any notices provided by the Zimmer Biomet Benefits Service Center to ensure changes are applied.

Documents can be sent to the Zimmer Biomet Benefits Service Center within 60 calendar days from the date you elect coverage or the date of the Qualified Status Change notification:

Uploading documents:
benefits.zimmerbiomet.com

Mailing:
Dependent Verification Center
P. O. Box 1401
Lincolnshire, IL 60069-1401

Faxing:
1-877-965-9555

Following this process will enable you to update your benefits coverage as permitted based on enrolling newly eligible dependents as a newly eligible Team Member or due to a Qualified Status Change.

Failure to Provide Documentation

Failure to timely notify and provide proper documentation to the Zimmer Biomet Benefits Service Center after enrolling your newly eligible dependent as a newly eligible Team Member or based on a Qualified Status Change event will be deemed an intentional misrepresentation of your dependent's eligibility for coverage, and coverage will terminate retroactively.

Reporting a newly eligible enrollment or Qualified Status Change to anyone other than the Zimmer Biomet Benefits Service Center is not a valid notification under any circumstances.

Failure to follow this process means your benefits election related to your newly eligible enrollment or the Qualified Status Change cannot be adjusted until the next annual benefits enrollment period and will not be effective until the next plan year. In the interim period, you will not have the benefit coverage for which you or your dependent would otherwise be eligible.

Respond promptly to any notices provided by the Zimmer Biomet Benefits Service Center to ensure changes are applied.

If you have a Qualified Status Change, any elected benefits will be retroactive back to the day of eligibility. Retroactive contributions will be taken as soon as administratively practical, typically on the first paycheck after your Qualified Status Change.

Medical Options

Zimmer Biomet provides three comprehensive, yet distinct, medical options administered by Anthem (Blue Cross Blue Shield). Each option has features that appeal to different Team Members and family healthcare situations.

The three medical options are:

Premium HSA Medical	Value HSA Medical	HRA Medical
Deductible: $1,500 you only/ $3,000 you + family ▶ True Family deductible requires all or one individual to meet the family deductible before the plan pays coinsurance ▶ The deductible includes both medical and prescription drug expenses	Deductible: $3,000 you only/ $6,000 you + family ▶ 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 ▶ The deductible includes both medical and prescription drug expenses	Deductible: Prorated based on eligibility date (see the proration chart on page 32) ▶ True Family deductible requires all or one individual to meet the family deductible before the plan pays coinsurance ▶ The deductible only includes medical expenses
HSA Company contribution is prorated based on eligibility date (see the proration chart on page 31)	HSA Company contribution is prorated based on eligibility date (see the proration chart on page 31)	HRA Company contribution is prorated based on eligibility date (see the proration chart on page 32)
Out-of-pocket maximum: $3,500 you only/ $6,850 you + family ▶ True Family out-of-pocket maximum requires all or one individual to meet the out-of-pocket maximum before the plan pays 100% ▶ The out-of-pocket maximum includes both medical and prescription drug expenses	Out-of-pocket maximum: $4,000 you only/ $8,000 you + family ▶ Embedded out-of-pocket maximum limits each individual in a family to the individual out-of-pocket maximum before the plan pays 100% ▶ The out-of-pocket maximum includes both medical and prescription drug expenses	Out-of-pocket maximum: $3,200 you only/ $6,400 you + family ▶ True Family out-of-pocket maximum requires all or one individual to meet the out-of-pocket maximum before the plan pays 100% ▶ The out-of-pocket maximum only includes medical expenses

Anthem. National Accounts

Customer service
1-800-693-5406

Monday through Friday,
8 a.m. to 8 p.m. ET

Website
anthem.com

Mobile App
Download the Anthem Anywhere app on your mobile device

No matter which medical option you elect, you receive competitive prescription drug coverage administered by Express Scripts.

What you pay for a prescription drug is based on the medical option you elect, the formulary list or tier, and coinsurance. The price of a drug may vary depending on what pharmacy you use. If you use an in-network pharmacy, you will receive the Express Scripts negotiated discounted price for that prescription drug.

Note: No covered family member will be subject to combined medical and prescription drug expenses that exceed the annual amount established by the Department of Health and Human Services (HHS) each year, as adjusted for inflation ($7,900 for 2019).

Embedded or True Family — What Does it Mean?

The deductible and out-of-pocket maximum work differently depending on which medical option you select.

- When you enroll in Premium HSA Medical or HRA Medical, you are subject to a **True Family deductible** and out-of-pocket maximum. This means that when you enroll in either of these options and cover dependents, the entire family deductible must be met before expenses are covered by coinsurance. The deductible may be met entirely by one family member or by a combination of family members.

  With the **True Family out-of-pocket maximum**, the entire family out-of-pocket maximum must be met before the plan will begin paying 100% of the remaining eligible expenses. The out-of-pocket maximum can be met entirely by one family member, or by a combination of family members.

- When you enroll in Value HSA Medical, you are subject to an **Embedded deductible** and out-of-pocket maximum. If you enroll in this option and cover dependents, when one family member reaches the $3,000 individual deductible, the plan will begin covering that family member's additional expenses through coinsurance. Coinsurance will apply for that family member only — even if the total eligible expenses for all family members have not yet reached the $6,000 deductible for family coverage.

  With the **Embedded out-of-pocket maximum**, once a family member reaches the individual out-of-pocket maximum of $4,000, the plan will begin paying 100% of that family member's eligible expenses, even if the $8,000 family out-of-pocket maximum has not yet been met.

Health Savings Account (HSA) Medical

HSA Medical combines traditional health coverage with a special account that provides a tax-free way to pay for current, or save for future, healthcare expenses. The account is funded by the Company and can include your own tax-free contributions.

Any unused funds roll over to the next year and your HSA is portable if you leave the Company or change medical options.

You have the opportunity to earn additional funding in your Extra Bucks Account by completing healthy activities.

All medical services, including non-preventive prescription drugs, are subject to the deductible and coinsurance. However, preventive care and select preventive prescription drugs are covered 100% and are not subject to the deductible.

Zimmer Biomet offers two HSA medical options — Premium HSA and Value HSA.

How Premium and Value HSA Medical Work (for in-network services)

Zimmer Biomet makes a contribution[1]:	You can make personal contributions[2]:	You pay the deductible (with HSA funds or out-of- pocket):	100% coverage after out-of-pocket maximum:
Each year, Zimmer Biomet will contribute a set amount to your HSA. For 2019, the amount will be up to $750[1] (you only) or $1,500[1] (you + family). Deposits will be made according to the HSA proration chart on page 31[1]. Once this money is deposited into your account, it is yours to keep. It will not be forfeited if you leave the Company.	During the year, you can contribute to your HSA on a pre-tax basis through payroll deductions. For 2019, the IRS limits the total annual contribution — the combination of your personal and Zimmer Biomet's contributions — to $3,500 (you only) or $7,000 (you + family). The maximum you can contribute is based on the number of months you participate in either HSA Medical option[3].	You must satisfy the deductible before the plan's coinsurance begins. During the year, when you incur non-preventive care expenses[4], you choose how you want to pay for those medical services. You can either pay with money from your HSA, or pay out of your pocket for the expense, keeping the money in your HSA to continue to accumulate and earn interest (so you have more available funds to use for future healthcare expenses). After you satisfy your annual deductible, Zimmer Biomet pays 80% of eligible expenses and you pay 20%. The deductible includes both medical and prescription drug expenses.	Once you meet your annual out-of-pocket expenses, the plan pays 100% of eligible medical and prescription drug expenses. The out-of-pocket maximum includes both medical and prescription drug expenses.

[1] For a newly eligible Team Member enrolled in the HSA on or before December 1, the Company HSA contribution is prorated (based on eligibility date) for the number of months remaining in the year, including the month of your eligibility date. See the proration chart on page 31 for details. All Company contributions are made through the Section 125 Plan.

[2] 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. You can start, stop, increase or decrease your personal HSA contributions throughout the year and the change will go into effect as soon as administratively possible. Team Members age 55+ may be eligible to make additional personal contributions up to a maximum of $1,000. Consult your tax advisor about your eligibility to contribute to or receive reimbursements from your HSA.

[3] If you enroll after January 1, a special IRS rule permits HSA contributions up to the full annual contribution limit but only if you are enrolled in an HSA Medical option by December 1 and remain enrolled in an HSA Medical option (or another high-deductible health plan (HDHP)) until December 31 of next year. Otherwise, you may owe income tax and penalties on the portion of your HSA contributions that exceeds the maximum permissible contribution for the number of months that you participated in an HDHP.

[4] You can use your HSA to pay for any qualified healthcare expense, including non-preventive medical care, such as doctor office visits, hospitalizations and prescription drugs. You can also use your HSA to pay for dental and vision expenses. Dental and vision expenses do not count toward HSA Medical out-of-pocket maximums.

HSA Extra Bucks Account

The HSA Extra Bucks Account is a second account administered by Anthem that includes incentives earned from completing healthy activities or any rollover funds from the HRA. Certain restrictions apply to your HSA Extra Bucks Account that do not apply to your personal HSA.

Here is how the HSA Extra Bucks Account works with both Premium and Value HSA Medical Option:

The HSA Extra Bucks Account is only available when you enroll in an HSA Medical option. Because your HSA is a tax-free account, the IRS imposes certain regulations limiting access to other Company-provided funds, such as the contributions to your HSA Extra Bucks Account for participation in healthy activities.

- Your HSA Extra Bucks Account is funded when you complete healthy activities (see page 39 for information on the healthy activities).
- You must first meet the deductible before funds are automatically deducted from your HSA Extra Bucks Account. You cannot use your HSA Extra Bucks Account to help meet the cost of your deductible, but you can use your personal HSA to pay these expenses.
- Once you have met the deductible, the funds will automatically draw from the available balance in your HSA Extra Bucks Account to help cover your coinsurance for medical and prescription drug expenses. If you do not have enough funds in your HSA Extra Bucks Account, you will be responsible for paying the cost of the healthcare expense either out of your pocket or by using funds from your HSA. Expenses paid from your HSA Extra Bucks Account will apply toward your out-of-pocket maximum.
- When your coverage ends, any remaining balance in your HSA Extra Bucks Account will be forfeited.

Because of the rules under the Code, the IRS limits the use of a Healthcare FSA if you want to contribute to an HSA. Therefore, if you enroll in HSA Medical, you cannot enroll in the Healthcare FSA. Your HSA has all the tax advantages of the Healthcare FSA without the use-it-or-lose-it condition.

The following chart highlights the specific features of Premium HSA Medical:

Premium HSA Medical Provisions	In-Network[1]	Out-of-Network
Preventive Care/Wellness	Covered at 100%, no deductible	Covered at 100%, no deductible
Select Preventive Prescription Drugs	Covered at 100%, no deductible	Covered at 100%, no deductible
HSA Contribution from Zimmer Biomet[2]	See proration chart on page 31[3]	
Personal HSA Contributions	Up to $3,500 for you only; $7,000 for you + family (includes Zimmer Biomet contributions)	
Catch-up Contributions	Team Members age 55+ who are not eligible for or enrolled in Medicare can contribute up to an additional $1,000 per year	
Annual Deductible[4]	$1,500[3] you only/$3,000[3] you + family	
HSA Extra Bucks Account[5]	Zimmer Biomet adds incentives to your HSA Extra Bucks Account when you and/or your covered spouse/domestic partner complete healthy activities. See page 16 regarding details about the HSA Extra Bucks Account.	
Coinsurance[6]	Zimmer Biomet pays 80%/You pay 20%	Zimmer Biomet pays 60%/You pay 40%
Out-of-Pocket Maximum[7]	$3,500 you only/$6,850 you + family	$7,000 you only/$14,000 you + family
Prescription Drugs	Subject to Premium HSA Medical deductible and coinsurance	

[1] Network Providers are a group of doctors, hospitals and other healthcare service providers that contract with a medical plan to provide healthcare services at negotiated rates. The Anthem Blue Cross Blue Shield network is used for all three medical options.

[2] If you timely set up your HSA, all Zimmer Biomet contributions are made through the Section 125 Plan (unless you opt out).

[3] You can reduce the amount you pay out of your pocket toward your deductible by using the Zimmer Biomet contribution in your HSA, which will also apply toward your out-of-pocket maximum.

[4] The amount you pay each plan year for covered services before the medical option pays benefits. You can pay from your HSA or out of your pocket. Premium HSA has a True Family deductible that requires all or one individual to meet the family deductible before the plan pays coinsurance. For example, the annual deductible for Premium HSA family coverage is an aggregate amount that includes both medical and prescription drug costs.

[5] Incentives used from your HSA Extra Bucks Account apply toward your coinsurance and out-of-pocket maximum, but not toward your annual deductible.

[6] The percentage the Plan pays for certain covered expenses after you meet your applicable annual deductible. You pay the remaining percentage.

[7] The maximum amount you pay in a plan year for covered services. Once you meet the out-of-pocket maximum, the medical option pays 100% of any eligible expenses covered by the plan for the rest of the plan year. Deductible, coinsurance and any eligible medical or prescription expenses paid from your HSA Extra Bucks Account apply toward the out-of-pocket maximum. Amounts that exceed maximum allowable amount[8] limits do not count toward the out-of-pocket maximum. Premium HSA Medical has a True Family out-of-pocket maximum that requires all or one individual to meet the family out-of-pocket maximum before the plan pays 100%. For example, the annual out-of-pocket maximum for Premium HSA family coverage is an aggregate amount that includes both medical and prescription drug costs.

[8] The maximum allowable amount is the amount the claims administrator will reimburse for services and supplies which meet its definition of covered services, as long as such services and supplies are not excluded under the Plan; are medically necessary; and are provided in accordance with the Plan. Coinsurance/maximums are calculated based upon the maximum allowable amount, not the provider's charge. If an out-of-network provider is used, however, you are responsible for paying the difference between the maximum allowable amount and the amount the out-of-network provider charges.

If you enroll in Premium HSA Medical, you can choose to use the money in your HSA to help pay for prescription drug expenses, or you can pay out of your pocket.

In the HSA Medical option, prescription drugs are treated like any other medical expense and are subject to the deductible. You will be responsible for the drug's actual cost (or the network discounted rate) until you meet your annual deductible.

After you satisfy the deductible, you pay a portion of the prescription drug through coinsurance until you meet your annual out-of-pocket maximum. Once you have met your out-of-pocket maximum, the coverage pays 100% of your costs.

Maintenance medications are the medications you take long-term for chronic conditions like high blood pressure or diabetes. If you take these medications, your costs will be lowered by using either the Exclusive Home Delivery or Walgreens Retail Pharmacy. If after two fills you elect to stay at a retail (non-Walgreens) pharmacy and do not move to either the Home Delivery or Walgreens Retail Pharmacy, you will pay a penalty. That penalty amount will be the full cost of the medication which will not count toward your deductible or annual out-of-pocket maximum (even after meeting your annual out-of-pocket maximum, the penalty will still be an additional cost).

If you choose to receive a brand-name medication when a generic is available, you will pay your brand non-formulary coinsurance plus the difference in cost between the brand-name and the generic price, and the additional amount will not apply towards your annual deductible or out-of-pocket maximum (and will still be an additional cost after meeting your out-of-pocket maximum). Note that you can use your HSA to pay this difference if you have funds available.

In the event that a generic is not available, you will be required to pay the applicable coinsurance for the brand-name medication. You can use any available funds in your HSA to pay for your prescription drug costs.

Type of Prescription	Premium HSA Medical
Select Preventive Prescription Drugs	Covered at 100%
Retail (30-day supply)	**After deductible, you pay:**
Generic[1]	20% ($7 minimum, $30 maximum)
Brand Formulary[2]	30% ($25 minimum, $60 maximum)
Brand Non-Formulary[3]	40% ($50 minimum, $120 maximum)
Brand Lifestyle Drugs[4]	50% ($50 minimum, no maximum)
Exclusive Home Delivery or Walgreens Retail Pharmacy (90-day supply)	**After deductible, you pay:**
Generic[1]	20% ($14 minimum, $50 maximum)
Brand Formulary[2]	30% ($50 minimum, $100 maximum)
Brand Non-Formulary[3]	40% ($100 minimum, $175 maximum)
Brand Lifestyle Drugs[4]	50% ($100 minimum, no maximum)
Annual Out-of-Pocket Maximum[5]	$3,500 you only/$6,850 you + family (Includes covered medical and prescription drug costs)

[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 refers to brand-name prescription drugs used for conditions such as erectile dysfunction and infertility (infertility coverage is up to the lifetime maximum of $15,000).

[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 plan pays 100%. For example, the annual out-of-pocket maximum is an aggregate amount that includes both medical and prescription drug costs.

Note: No covered family member will be subject to combined medical and prescription drug expenses that exceed the annual amount established by the Department of Health and Human Services (HHS) each year, as adjusted for inflation ($7,900 for 2019).

The following chart highlights the specific features of Value HSA Medical:

Value HSA Medical Provisions	In-Network[1]	Out-of-Network
Preventive Care/Wellness	Covered at 100%, no deductible	Covered at 100%, no deductible
Select Preventive Prescription Drugs	Covered at 100%, no deductible	Covered at 100%, no deductible
HSA Contribution from Zimmer Biomet[2]	See proration chart on page 31[3]	
Personal HSA Contributions	Up to $3,500 for you only; $7,000 for you + family (includes Zimmer Biomet contributions)	
Catch-up Contributions	Team Members age 55+ who are not eligible for or enrolled in Medicare can contribute up to an additional $1,000 per year	
Annual Deductible[4]	$3,000[3] you only/$6,000[3] you + family	
HSA Extra Bucks Account[5]	Zimmer Biomet adds incentives to your HSA Extra Bucks Account when you and/or your covered spouse/domestic partner complete healthy activities. See page 16 regarding details about the HSA Extra Bucks Account.	
Coinsurance[6]	Zimmer Biomet pays 80%/You pay 20%	Zimmer Biomet pays 60%/You pay 40%
Out-of-Pocket Maximum[7]	$4,000 you only/$8,000 you + family	$7,000 you only/$14,000 you + family
Prescription Drugs	Subject to Value HSA Medical deductible and coinsurance	

[1] Network Providers are a group of doctors, hospitals and other healthcare service providers that contract with a medical plan to provide healthcare services at negotiated rates. The Anthem Blue Cross Blue Shield network is used for all three medical options.

[2] If you timely set up your HSA, all Zimmer Biomet contributions are made through the Section 125 Plan (unless you opt out).

[3] You can reduce the amount you pay out of your pocket toward your deductible by using the Zimmer Biomet contribution in your HSA, which will also apply toward your out-of-pocket maximum.

[4] The amount you pay each plan year for covered services before the medical option pays benefits. You can pay from your HSA or out of your pocket. Value HSA has an Embedded deductible that limits each individual in a family to the individual deductible before the plan pays coinsurance. For example, the Embedded individual deductible applies until the family deductible is satisfied, which means no individual family member will pay more than the individual deductible before the plan pays coinsurance.

[5] Incentives used from your HSA Extra Bucks Account apply toward your coinsurance and out-of-pocket maximum, but not toward your annual deductible.

[6] The percentage the Plan pays for certain covered expenses after you meet your annual deductible if applicable. You pay the remaining percentage.

[7] The maximum amount you pay in a plan year for covered services. Once you meet the out-of-pocket maximum, the medical option pays 100% of all covered expenses for the rest of the plan year. Deductible, coinsurance and any eligible medical and prescription expenses paid from your HSA Extra Bucks Account apply toward the out-of-pocket maximum. Out-of-network amounts that exceed maximum allowable amount[8] limits do not count toward the out-of-pocket maximum. Value HSA has an Embedded out-of-pocket that limits each individual in a family to the individual out-of-pocket before the plan pays 100%. For example, the Embedded individual out-of-pocket maximum applies to each covered individual until the family out-of-pocket maximum is satisfied.

[8] The maximum allowable amount is the amount the claims administrator will reimburse for services and supplies which meet its definition of covered services, as long as such services and supplies are not excluded under the Plan; are medically necessary; and are provided in accordance with the Plan. Coinsurance/maximums are calculated based upon the maximum allowable amount, not the provider's charge. If an out-of-network provider is used, however, you are responsible for paying the difference between the maximum allowable amount and the amount the out-of-network provider charges.

If you enroll in Value HSA Medical, you can choose to use the money in your HSA to help pay for prescription drug expenses, or you can pay out of your pocket.

In the HSA Medical option, prescription drugs are treated like any other healthcare expense and are subject to the deductible. You will be responsible for the drug's actual cost (or the network discounted rate) until you meet your annual deductible.

After you satisfy the deductible, you pay a portion of the prescription drug through coinsurance until you meet your annual out-of-pocket maximum. Once you have met your out-of-pocket maximum, the coverage pays 100% of your costs.

Maintenance medications are the medications you take long-term for chronic conditions like high blood pressure or diabetes. If you take these medications, your costs will be lowered by using either the Exclusive Home Delivery or Walgreens Retail Pharmacy. If after two fills you elect to stay at a retail (non-Walgreens) pharmacy and do not move to either the Home Delivery or Walgreens Retail Pharmacy, you will pay a penalty. That penalty amount will be the full cost of the medication which will not count toward your deductible or annual out-of-pocket maximum (even after meeting your annual out-of-pocket maximum, the penalty will still be an additional cost).

If you choose to receive a brand-name medication when a generic is available, you will pay your brand non-formulary coinsurance plus the difference in cost between the brand-name and the generic price, and the additional amount will not apply towards your annual deductible or out-of-pocket maximum (and will still be an additional cost after meeting your out-of-pocket maximum). Note that you can use your HSA to pay this difference if you have funds available.

In the event that a generic is not available, you will be required to pay the applicable coinsurance for the brand-name medication. You can use any available funds in your HSA to pay for your prescription drug costs.

Type of Prescription	Value HSA Medical
Select Preventive Prescription Drugs	Covered at 100%
Retail (30-day supply)	**After deductible, you pay:**
Generic[1]	20% ($7 minimum, $30 maximum)
Brand Formulary[2]	30% ($25 minimum, $60 maximum)
Brand Non-Formulary[3]	40% ($50 minimum, $120 maximum)
Brand Lifestyle Drugs[4]	50% ($50 minimum, no maximum)
Exclusive Home Delivery or Walgreens Retail Pharmacy (90-day supply)	**After deductible, you pay:**
Generic[1]	20% ($14 minimum, $50 maximum)
Brand Formulary[2]	30% ($50 minimum, $100 maximum)
Brand Non-Formulary[3]	40% ($100 minimum, $175 maximum)
Brand Lifestyle Drugs[4]	50% ($100 minimum, no maximum)
Annual Out-of-Pocket Maximum[5]	$4,000 you only/$8,000 you + family (Includes covered medical and prescription drug costs)

[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 refers to brand-name prescription drugs used for conditions such as erectile dysfunction and infertility (infertility coverage is up to the lifetime maximum of $15,000).

[5] Annual out-of-pocket maximum for Value HSA family coverage has an Embedded out-of-pocket that limits each individual in a family to the individual out-of-pocket before the plan pays 100%. For example, the annual out-of-pocket maximum is an individual amount that includes both medical and prescription drug costs.

Note: No covered family member will be subject to combined medical and prescription drug expenses that exceed the annual amount established by the HHS each year, as adjusted for inflation ($7,900 for 2019).

Your Personal Health Savings Account (HSA)

When you enroll in the Premium HSA Medical option or the Value HSA Medical option for the first time, an HSA will be opened[1] in your name with HealthEquity, Anthem's partner for HSA services.

No personal or Company contributions will be made to your HSA until your account is confirmed opened.

You cannot use your HSA to pay expenses incurred before you open your HSA. Any personal and Company contributions will be forfeited if you do not open your HSA with HealthEquity by the last business day of 2019.

Activating Your HSA

When you enroll, you will have the opportunity to agree to the terms and conditions as required by federal law to open your HSA. If you enroll online, the website will walk you through this process.

- If you successfully meet the criteria for the terms and conditions, your HSA will be opened.
- If you do not successfully meet the criteria for the terms and conditions, your HSA will not be opened, and you will be notified by mail or email[1].

Once you successfully meet the criteria for the terms and conditions and your HSA has been opened, you will receive welcome materials from HealthEquity that include:

- HealthEquity Visa® debit card
- Instructions for accessing the HealthEquity website
- Contact information for member services
- Tips for maximizing health savings with an HSA

You are automatically set up to receive paper HealthEquity statements and will be charged $1.00 per monthly statement. To avoid this fee, we recommend you switch your account preference settings to electronic statements.

HealthEquity®
Building Health Savings℠

Customer service
1-877-713-7712

24 hours a day, 7 days per week

Website
myhealthequity.com

Mobile App
Download the HealthEquity app on your mobile device

[1] Your HSA will not be opened until your identity is verified by HealthEquity as required by the USA Patriot Act.

Important HSA Information

You cannot contribute to an HSA if you are enrolled in the HRA Medical option or any other medical option, including your spouse's/domestic partner's, unless it is an IRS qualified high-deductible health plan.

If you are age 65 or older (or are otherwise eligible) and have enrolled in Medicare, you can no longer contribute to an HSA or receive any Zimmer Biomet contributions to your HSA. Of course, even after you are no longer eligible to contribute to an HSA, you may still use the funds in your HSA to pay for qualified medical expenses. You must promptly notify the Zimmer Biomet Benefits Service Center as soon as you enroll in Medicare and request to stop any HSA contributions (once you become eligible for Medicare, you may still contribute to an HSA, but only if you have not enrolled in Medicare).

HSA Eligibility for Children and Domestic Partners

If you enroll in HSA Medical and elect coverage for your child, domestic partner and/or their dependent child, you may receive the Zimmer Biomet contribution for you + family coverage. However, generally, you may only use your HSA to pay eligible medical expenses on a tax-preferred basis for: (1) your child if he or she is a qualifying child as defined in tax code section 152; or (2) your domestic partner and/or his or her dependent child, or your legal ward, if the individual qualifies as a qualifying relative as defined in tax code section 152.

HSA is portable

Your HSA is portable and will not be forfeited if you retire or leave Zimmer Biomet.

Beneficiaries

Establishing a beneficiary is one of the first actions you should take when you open your HSA. You can add or change your beneficiaries for your HSA online at **myhealthequity.com** or by calling **1-877-713-7712** and speaking with a customer service representative.

To learn more about qualified healthcare expenses and regulations that apply to HSAs, go to **irs.gov**.

Remember, because the HSA is an individual account, you are responsible for ensuring you are eligible to contribute to an HSA, determining what healthcare expenses are eligible and reporting contributions and disbursements each year to the IRS.

Growing Your HSA

There are several ways you can increase the balance in your HSA:

- Contribute the maximum amount into your account
- Save rather than spend
- Invest your money

For information regarding each of the available investment funds, including management fees and expenses, please consult a current mutual fund prospectus, which is available on the HealthEquity website. Please read it carefully before you invest or send money. Because the HSA is your account, you are solely responsible for investment decisions and any gains and/or losses.

Triple Tax Advantage

Your HSA provides you with a tax-free way to pay for out-of-pocket expenses, similar to a Healthcare FSA, but without the use-it-or-lose-it feature.

Your HSA is a tax-preferred savings vehicle for your healthcare needs now and in the future. When you contribute to your HSA, you get triple tax advantages:

- The money 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).
- It accumulates interest, or investment earnings (or losses), tax-free.
- The money is not taxed when you use it to pay for qualified healthcare expenses. Remember — save your receipts in the event the IRS requests them.

Advantages and Important Considerations of Premium and Value HSA Medical

Advantages	Important Considerations
Premium and Value HSA Medical Options	**Premium and Value HSA Medical Options**
• Lower biweekly medical premiums than HRA Medical. • You have the flexibility to visit any doctor or other healthcare providers you wish — but you pay less with the group discounted rates when you use in-network providers[1].	• By law, you must be enrolled in an IRS qualified high-deductible health plan like the HSA Medical options to contribute to an HSA. You will pay more initially out of pocket for healthcare services, until you meet your deductible. • When you visit an out-of-network provider, you are responsible for paying any amount that exceeds the maximum allowable charge that applies for in-network providers, plus any deductible and/or coinsurance amount.
Your HSA	**Your HSA**
• Zimmer Biomet makes an annual contribution. For newly eligible Team Members, these contributions are prorated (based on eligibility date) for the number of months remaining in the year. See the proration chart on page 31 for details. • You can also contribute your own money, tax-free, up to annual IRS limits. The 2019 HSA limits are $3,500 (you only) or $7,000 (you + family), including both your and Zimmer Biomet's contributions. • Tax advantages, ongoing contributions and account earnings help you save for the future and can help you cover COBRA or retiree medical expenses. • Over the long term, you may benefit from investing your account in a variety of funds available through the HSA administrator. You must have a balance of $1,000 in order to invest. • Team Members who are age 55+ and not eligible for or enrolled in Medicare may make extra catch-up contributions, up to an additional $1,000 per year, to their HSA. • Both interest and investment earnings grow tax-free and can be used tax-free for any qualified medical, prescription drug, dental or vision expense. • Your HSA is portable and will not be forfeited if you retire or leave Zimmer Biomet. • As long as you are enrolled in either HSA Medical option, Zimmer Biomet pays the administrative fee to manage the HSA through HealthEquity.	• You are responsible for retaining healthcare expense receipts to support your tax treatment of your HSA contributions and disbursements. You cannot use or be reimbursed for eligible expenses until your HSA is activated and funds are available in your HSA. • The Department of Homeland Security requires bank accounts — including the HSA — to be tied to a physical mailing address. If you have only a P.O. Box address, you may not enroll in this option. • In order to contribute to your HSA, you cannot be enrolled in any other medical coverage, unless it is also a high-deductible health plan. • Typical banking fees will apply for monthly paper banking statements, overdraft charges or replacement of an HSA debit card. • You and your eligible dependents may not make contributions to your HSA after you enroll in Medicare. • You are not eligible to enroll in a Healthcare FSA if you (or the Company) are contributing to an HSA. • Your HSA Extra Bucks Account will be forfeited once your coverage ends.

[1] Network Providers are a group of doctors, hospitals and other healthcare service providers that contract with a medical plan to provide healthcare services at negotiated rates. The Anthem Blue Cross Blue Shield network is used for all three medical options.

Regarding the HSA

The information contained in this guide does not constitute legal, tax or personal planning advice. Consult with a tax advisor before establishing an HSA. All benefits under Premium and Value HSA Medical options are subject to the terms and conditions of the Plan, as amended from time to time. Your HSA is not a group plan, therefore, you are responsible for ensuring your eligibility and contribution limits, reporting to the IRS and whether distributions from your HSA are tax-exempt.

Health Reimbursement Account (HRA) Medical

HRA Medical provides traditional medical coverage combined with a special Company-funded account called an HRA. The funds in your HRA will automatically be used to help pay for medical services for you and your enrolled dependents. You have the opportunity to earn additional funding by completing healthy activities. If you do not use all the funds in your HRA, the remaining balance will roll over each year. There is no cap on the total funds you can accumulate in your HRA. If you leave Zimmer Biomet, any remaining balance will be forfeited.

How HRA Medical Works (for in-network services)

Zimmer Biomet makes a contribution[1]:	You pay the deductible (with HRA funds or out-of-pocket)[2]:	100% coverage after out-of-pocket maximum[3]:
Your Zimmer Biomet HRA contribution is prorated based on your eligibility date. This contribution will be used to help pay for covered expenses. The contribution amount will be up to $500[1] (you only) or $1,000[1] (you + family) Deposits will be made according to the HRA proration chart on page 32[1].	Zimmer Biomet's annual contribution to your HRA will be used to help satisfy your annual deductible. When you use in-network providers, you pay only the negotiated rate. Prescription drug expenses do not apply toward your annual medical deductible. After you satisfy your annual deductible[2], Zimmer Biomet pays 80% of eligible expenses and you pay 20%. The annual deductible[1] will be prorated based on eligibility date (see the proration chart on page 32).	Once you meet your annual medical out-of-pocket maximum, the plan pays 100% of eligible medical expenses. Prescription drugs are subject to a separate out-of-pocket maximum.

[1] For a newly eligible Team Member enrolled in the HRA, the Company HRA contribution and deductible is prorated (based on eligibility date) for the number of months remaining in the year, including the month of your eligibility date. See the proration chart on page 32 for details. Zimmer Biomet's HRA contribution will be used to help satisfy the deductible and will apply toward your out-of-pocket maximum.

[2] HRA Medical has a True Family deductible, which requires all or one individual to meet the family deductible before the plan pays coinsurance.

[3] The HRA Medical has a True Family out-of-pocket maximum that requires all or one individual to meet the family out-of-pocket maximum before the plan pays 100%. For example, the annual out-of-pocket maximum for HRA family coverage is an aggregate amount and includes medical only.

The following chart highlights the specific features of HRA Medical:

HRA Medical Provisions	In-Network	Out-of-Network
Preventive Care/Wellness	Covered at 100%, no deductible	Covered at 100%, no deductible
Select Preventive Prescription Drugs	Covered at 100%, no deductible	Covered at 100%, no deductible
HRA Contribution from Zimmer Biomet[1,2]	See proration chart on page 32	
Healthy Activities[3]	Zimmer Biomet adds incentives to your HRA when you and/or your covered spouse/domestic partner complete healthy activities. See page 39 for details regarding healthy activities.	
Annual Deductible[4]	See proration chart on page 32	
Coinsurance[5]	Zimmer Biomet pays 80%/You pay 20%	Zimmer Biomet pays 60%/You pay 40%
Out-of-Pocket Maximum[6]	$3,200 you only/$6,400 you + family	$6,400 you only/$12,800 you + family

[1] As a newly eligible Team Member, the Company's HRA contribution and deductible are prorated (based on eligibility date) for the number of months remaining in the year, including the month of your eligibility date. See the proration chart on page 32 for details.

[2] Zimmer Biomet's HRA contribution will be used to help satisfy the deductible and will apply toward your out-of-pocket maximum.

[3] Incentives, as well as rollover funds from prior years, can be used to help meet your annual deductible or pay your coinsurance and they apply toward your out-of-pocket maximum.

[4] The amount you pay each plan year either from your HRA or out of pocket for covered services before the medical option pays benefits. HRA Medical has a True Family deductible that requires all or one individual to meet the family deductible before the plan pays coinsurance. For example, the annual deductible for the HRA family coverage is an aggregate amount.

[5] The percentage the Plan pays for certain covered expenses after you meet your applicable annual deductible. You pay the remaining percentage.

[6] The maximum amount you pay in a plan year for covered services. Once you meet the out-of-pocket maximum, the medical option pays 100% of all covered expenses for the rest of the plan year. The deductible, coinsurance and eligible medical expenses paid from your HRA apply toward the out-of-pocket maximum. Amounts that exceed maximum allowable amount[7] limits for out-of-network expenses do not count toward the out-of-pocket maximum. Separate out-of-pocket maximum applies for prescription drug expenses covered by HRA Medical. HRA Medical has a True Family out-of-pocket maximum that requires all or one individual to meet the family out-of-pocket maximum before the plan pays 100%. For example the annual out-of-pocket maximum for the HRA family coverage is an aggregate amount.

[7] The maximum allowable amount is the amount the claims administrator will reimburse for services and supplies which meet its definition of covered services, as long as such services and supplies are not excluded under the Plan; are medically necessary; and are provided in accordance with the Plan. Coinsurance/maximums are calculated based upon the maximum allowable amount, not the provider's charge. If an out-of-network provider is used, however, you are responsible for paying the difference between the maximum allowable amount and the amount the out-of-network provider charges.

If you enroll in HRA Medical, you will pay coinsurance based on the formulary list or tier until you meet your annual prescription drug out-of-pocket maximum. The prescription drug out-of-pocket maximum is separate from the medical out-of-pocket maximum.

Maintenance medications are the medications you take long-term for chronic conditions like high blood pressure or diabetes. If you take these medications, your costs will be lowered by using either the Exclusive Home Delivery or Walgreens Retail Pharmacy. If after two fills you elect to stay at a retail (non-Walgreens) pharmacy and do not move to either the Home Delivery or Walgreens Retail Pharmacy, you will pay a penalty. That penalty amount will be the full cost of the medication which will not count toward your annual out-of-pocket maximum (even after meeting your annual out-of-pocket maximum, the penalty will still be an additional cost).

If you choose to receive a brand-name medication when a generic is available, you will pay your brand non-formulary coinsurance plus the difference in cost between the brand-name and the generic price, and the additional amount will not apply towards your out-of-pocket maximum (and will still be an additional cost after meeting your out-of-pocket maximum).

In the event that a generic is not available, you will be required to pay the applicable coinsurance for the brand-name medication.

Type of Prescription	HRA Medical
Select Preventive Prescription Drugs	Covered at 100%
Retail (30-day supply)	**You pay:**
Generic[1]	20% ($7 minimum, $30 maximum)
Brand Formulary[2]	30% ($25 minimum, $60 maximum)
Brand Non-Formulary[3]	40% ($50 minimum, $120 maximum)
Brand Lifestyle Drugs[4]	50% ($50 minimum, no maximum)
Exclusive Home Delivery or Walgreens Retail Pharmacy (90-day supply)	**You pay:**
Generic[1]	20% ($14 minimum, $50 maximum)
Brand Formulary[2]	30% ($50 minimum, $100 maximum)
Brand Non-Formulary[3]	40% ($100 minimum, $175 maximum)
Brand Lifestyle Drugs[4]	50% ($100 minimum, no maximum)
Annual Out-of-Pocket Maximum[5]	$1,500 you only/$3,000 you + family (Includes prescription drug costs only) (no covered family member will exceed $1,500 in expenses)

[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 (infertility coverage is up to the lifetime maximum of $15,000).

[5] Annual out-of-pocket maximum for HRA family coverage level is an aggregate amount and only includes prescription drug costs.

Note: No covered family member will be subject to combined medical and prescription drug expenses that exceed the annual amount established by the Department of Health and Human Services (HHS) each year, as adjusted for inflation ($7,900 for 2019).

Comparing Medical Options

	Premium and Value HSA Medical	HRA Medical
Zimmer Biomet contribution	• As a newly eligible Team Member, your Company contributions to the HSA and HRA are prorated (based on eligibility date) for the number of months remaining in the year, including the month of your eligibility date (unless you are eligible and enrolled in an HSA Medical option after December 1). See the proration charts on pages 31 – 32 for details.	
Personal contribution[1]	• The 2019 HSA limits are $3,500 (you only) or $7,000 (you + family), including both your and Zimmer Biomet's contributions[1]. • Team Members age 55+ may be eligible to make additional contributions up to a maximum of $1,000 per year.	• You may not make personal contributions to your HRA.
Incentives for healthy behaviors	• Zimmer Biomet contributes incentives to the HSA Extra Bucks Account when you or your covered spouse/domestic partner participate in and complete healthy activities. • The funds in your HSA Extra Bucks Account will help pay your coinsurance only after you have met the applicable deductible.	• Zimmer Biomet contributes incentives to your HRA when you or your covered spouse/domestic partner participate in and complete healthy activities. • The funds in your HRA will help satisfy your annual deductible or pay for coinsurance.
Choice of when to use your account	• You may choose to use available funds from your HSA to pay for your qualified healthcare expenses, or you may keep the funds in your HSA and pay out of your pocket. • If you incur healthcare expenses (medical or prescription drugs) after you meet your deductible, funds will automatically be drawn from your HSA Extra Bucks Account to help pay for coinsurance.	• When you incur medical expenses, funds will automatically be drawn from your HRA. • If you do not have enough funds in your HRA for medical expenses, you pay the difference out of your pocket toward the deductible and/or coinsurance.
Rolling over unused funds	• Your HSA and/or HSA Extra Bucks Account balance will roll over each year. Your HSA will continue to grow tax-free with interest.	• Your HRA balance will roll over each year as long as you are an active Team Member and are enrolled in one of the Zimmer Biomet medical options.
Portability when you leave Zimmer Biomet	• You own your HSA, so you take it with you to pay for healthcare expenses when you leave Zimmer Biomet or retire. You can build up unused funds in your HSA to use for retiree healthcare expenses. • The HSA Extra Bucks Account is a Zimmer Biomet-owned account. When your coverage ends, any remaining HSA Extra Bucks Account balance will be used to offset healthcare expenses incurred while you have active coverage. Otherwise, the funds in the HSA Extra Bucks Account will be forfeited.	• The HRA is a Zimmer Biomet–owned account. • When your coverage ends, any remaining HRA balance will be used to offset healthcare expenses incurred while you were still covered. Otherwise, any remaining balance in the HRA will be forfeited.
Retirement savings	• Your HSA is a great way to save money, especially for healthcare in retirement. Unused funds in your HSA earn interest and can be invested.	• N/A
Tax benefits	• Triple tax advantage — both Zimmer Biomet's and your contributions are tax-free, your HSA's earnings are tax-free and your withdrawals to pay for qualified healthcare expenses are tax-free.	• You are not taxed on the funds in your HRA when they are deposited or used.

[1] If you enrolled in an HSA Medical option after January 1 and made the maximum contribution to your HSA (including Zimmer Biomet's contribution) based on the annual HSA limit, income taxes and penalties may apply to a portion of your HSA contributions unless you remain enrolled in an HSA Medical option (or another high-deductible plan) until December 31 of next year.

The following chart highlights specific details for both Premium and Value HSA Medical and HRA Medical:

Provision		Provider: Anthem Network: Blue Cross Blue Shield		
		Premium HSA Medical	**Value HSA Medical**	**HRA Medical**
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
Preventive Care and Select Preventive Prescription Drugs		Covered at 100%		
Zimmer Biomet Contributions (you only/you + family)		Company contribution is prorated (based on eligibility date). See the proration charts on pages 31 - 32		
Personal Contributions		Up to IRS annual limits[1]		Not allowed
Incentives		Zimmer Biomet adds incentives to your HSA Extra Bucks Account or HRA when you and/or your covered spouse/domestic partner complete healthy activities		
Annual Deductible (you only/you + family) (includes Zimmer Biomet contribution)		$1,500/$3,000 (True Family)[2]	$3,000/$6,000 (Embedded)[3]	Deductible is prorated (based on eligibility date). See the proration chart on page 32. (True Family)[2]
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 (you only/you + family)	In-Network	$3,500/ $6,850[4]	$4,000/$8,000[4]	$3,200/$6,400[5]
	Out-of-Network	$7,000/$14,000 (including prescriptions)	$7,000/$14,000 (including prescriptions)	$6,400/$12,800 (excluding prescriptions)
Copayment (office visits/specialist/ER)		No copayment (deductible and coinsurance only)		
Use with Healthcare FSA		No	No	Yes[6]
Office Visit (PCP/specialist)	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Urgent Care	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Emergency Room (medical emergency)	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
Emergency Room (non-emergency)	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Inpatient Care	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Outpatient Surgery	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Durable Medical Equipment	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Mental Health/Substance Abuse Inpatient (alternative care limited to non-residential program)	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Outpatient Care	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%
Infertility Coverage (limited to lifetime maximum of $15,000 medical expenses and $15,000 prescription drug expenses)	In-Network	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%	Zimmer Biomet pays 80%
	Out-of-Network	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%	Zimmer Biomet pays 60%

[1] The 2019 HSA limits are $3,500 (you only) and $7,000 (you + family), including both your and Zimmer Biomet's contributions, which are made pre-tax through the section 125 plan (unless you opt out).

[2] True Family deductible requires all or one individual to meet the family deductible before the plan pays coinsurance. Deductible for HRA Medical is prorated based on eligibility date. See the proration chart on page 32.

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

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

[5] Any eligible medical expenses paid from your HRA, and any deductible or coinsurance you pay, will all apply toward the applicable out-of-pocket maximum. Prescription drugs have a separate out-of-pocket maximum.

[6] 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**.

Medical Payroll Contributions

Please take the time to consider the total cost of each medical option, meaning your contributions for coverage, your annual deductible and your other out-of-pocket costs, before selecting the option that is best for you and your family. Use this guide as a resource to help you make this important decision.

Medical Payroll Contributions Cost Per Pay Period			
	Premium HSA Medical	**Value HSA Medical**	**HRA Medical**
You only	$41.45	$35.43	$50.54
You + spouse/domestic partner	$101.95	$87.56	$121.54
You + child(ren)	$97.10	$79.21	$113.66
You + family	$176.04	$142.79	$209.93
Spouse/domestic partner surcharge*	$57.69	$57.69	$57.69

*Spouse/Domestic Partner Surcharge

If your spouse/domestic partner has access to group medical coverage outside of Zimmer Biomet, you will pay a surcharge if you choose to enroll him/her as your covered dependent. When you enroll, you will be asked to attest that your spouse/domestic partner does not have available group medical coverage to avoid the surcharge.

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

Zimmer Biomet reserves the right to periodically review whether your spouse/domestic partner is eligible for other group medical coverage. However, you are responsible for timely notifying the Zimmer Biomet Benefits Service Center of any changes in your spouse's/domestic partner's eligibility. Your 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.

Imputed Income for Domestic Partner's and Non-Dependent Child's Coverage

The federal tax code excludes the value of medical, dental and/or vision (group health) coverage for you (the Team Member) and any of your federal tax dependents from your taxable income, but it is difficult for a domestic partner (and often his or her children) to qualify as your dependents under the federal tax rules. As a result, the fair market value of any group health coverage extended to your domestic partner and his or her children, who are not dependents for federal tax purposes, are treated as your taxable income. This means the value of your domestic partner's and any eligible non-dependent child's coverage is reflected on your pay statement as imputed income and reported as taxable wages on your Form W-2, and Zimmer Biomet must withhold for federal Social Security (FICA), unemployment (FUTA), Medicare and income taxes on the value of these benefits.

Company HSA Contributions

As a newly eligible Team Member, your Company HSA contributions are prorated (based on eligibility date) for the number of months remaining in the year, including the month of your eligibility date. For example, if your eligibility with the Company begins in March and you enroll in Premium or Value HSA Medical, you will receive two thirds of the first half contribution and the entire second half in July. However, because of limits imposed by the tax code, you will not receive the Company HSA contribution if you are eligible and enroll in Premium or Value HSA Medical after December 1.

See the proration chart below to determine the amounts you will receive in your HSA when you enroll.

HSA Proration Chart

	HSA Contribution — Eligible Team Member before 7/1/2019				HSA Contribution — Eligible Team Member on or after 7/1/2019			
Month	**You only**	**You + spouse/ domestic partner**	**You + child(ren)**	**You + family**	**You only**	**You + spouse/ domestic partner**	**You + child(ren)**	**You + family**
January	$375.00	$750.00	$750.00	$750.00				
February	$312.50	$625.00	$625.00	$625.00				
March	$250.00	$500.00	$500.00	$500.00				
April	$187.50	$375.00	$375.00	$375.00				
May	$125.00	$250.00	$250.00	$250.00				
June	$62.50	$125.00	$125.00	$125.00				
July	$375.00	$750.00	$750.00	$750.00	$375.00	$750.00	$750.00	$750.00
August					$312.50	$625.00	$625.00	$625.00
September					$250.00	$500.00	$500.00	$500.00
October					$187.50	$375.00	$375.00	$375.00
November					$125.00	$250.00	$250.00	$250.00
December[1]					$62.50	$125.00	$125.00	$125.00

[1] Only Team Members eligible as of December 1 are eligible for a Company HSA contribution.

HRA Proration Chart

If you are a newly eligible Team Member your HRA contributions and deductible are prorated for the number of months remaining in the year, based on your eligibility date. See the proration chart below to determine the amount you will receive when you enroll.

	HRA Contribution and Deductible — Total Annual Amount for Newly Eligible Team Member			
	HRA Contribution		Total Deductible	
Month	You only	You + family	You only	You + family
January	$500.00	$1,000.00	$1,700.00	$3,400.00
February	$458.33	$916.67	$1,558.33	$3,116.67
March	$416.67	$833.33	$1,416.67	$2,833.33
April	$375.00	$750.00	$1,275.00	$2,550.00
May	$333.33	$666.67	$1,133.33	$2,266.67
June	$291.67	$583.33	$991.67	$1,983.33
July	$250.00	$500.00	$850.00	$1,700.00
August	$208.33	$416.67	$708.33	$1,416.67
September	$166.67	$333.33	$566.67	$1,133.33
October	$125.00	$250.00	$425.00	$850.00
November	$83.33	$166.67	$283.33	$566.67
December	$41.67	$83.33	$141.67	$283.33

Prescription Drugs

Select Preventive Prescription Drugs

Zimmer Biomet wants to remove as many barriers as possible that keep you and your family from getting the care you need, when you need it. In order to encourage Team Members to use their preventive benefits, Zimmer Biomet covers select preventive prescription drugs at 100%.

This program is administered separately from your other prescription drug coverage. The Select Preventive Prescription Drug list will be updated quarterly, and covered prescription drugs are subject to change. For the most recent Select Preventive Prescription Drug List, go to the Zimmer Biomet intranet and select Team Member Center.

Exclusive Home Delivery and Walgreens Retail Pharmacy

Maintenance medications are used to treat chronic conditions such as diabetes, high cholesterol and asthma. To help you save time and money, your maintenance medications will be mailed to your home. Enjoy no longer waiting in line at the pharmacy — your drugs are delivered to your door and you can set up worry-free refills and receive medication-related alerts.

You and your covered dependents will be allowed two fills of maintenance medications at a retail pharmacy at the negotiated cost even if the drug is on the Select Preventive Prescription Drug list. If, after the second fill of a prescription at a retail pharmacy, you don't transfer the prescription to the Exclusive Home Delivery or Walgreens Retail Pharmacy, you will pay the full cost of the prescription at a non-Walgreens retail pharmacy. That penalty amount will not count toward your deductible or annual out-of-pocket maximum (even after meeting your annual out-of-pocket maximum, the penalty will still be an additional cost).

If you are currently taking a maintenance medication, you will need to get a 90-day prescription from your doctor and process it through the Express Scripts Exclusive Home Delivery or Walgreens Retail Pharmacy.

Note: Use the prescription drug cost comparison tool at **express-scripts.com/zimmerbiomet** to find the prescription options with the lowest cost.

Three ways to order your prescriptions through Exclusive Home Delivery:

1. Go to **express-scripts.com**
2. Call Express Scripts at **1-866-544-6884**
3. Use the convenient Home Delivery form

EXPRESS SCRIPTS®

Customer service
1-866-544-6884

24 hours a day, 7 days a week

Website
express-scripts.com

Mobile App
Download the Express Scripts app on your mobile device

To help you save money you can fill a 90-day supply of your maintenance medications through the mail-order pharmacy at Express Scripts or a Walgreens Retail Pharmacy.

Accredo Specialty Pharmacy

Express Scripts has a preferred specialty pharmacy called Accredo, where members are required to fill specialty medications. Specialty medications are drugs that are used to treat complex conditions, such as rheumatoid arthritis, multiple sclerosis and cancer.

Benefits of Accredo include 24/7 phone access to specially trained pharmacists, personalized counseling from registered nurses and pharmacists, and expedited delivery of medications and supplies, such as syringes and needles, at no cost to you.

If you are currently taking specialty medications and are interested in participating, call Express Scripts Member Services at **1-866-544-6884**.

Additional Prescription Plan Information

Certain drugs have quantity limits per prescription or month. For a list of drugs with quantity limits, contact Express Scripts. Other drugs will require prior authorization before coverage will be approved. Contact Express Scripts for a list of these drugs.

Note: Not all prescription drugs are covered. Please contact Express Scripts for a list of excluded drugs.

Express Scripts helps make safe and effective medications available for you.

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.

Preventive Care

Zimmer Biomet provides full coverage for preventive care to help you reduce the risk of serious health issues in the future. All preventive care services — no matter which medical option you elect — are covered at 100% and you do not pay any out-of-pocket expenses for eligible preventive care services.

It is important to remind the doctor or nurse at the time of service that these preventive care services should be coded as preventive when claims are submitted.

What Qualifies as Preventive Care

Preventive care generally will not include any service or benefit intended to treat an existing illness or diagnosed condition. The following services are considered to be preventive:

Well-Baby and Well-Child Care

Preventive[1]:

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

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)

[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 to be determined by physician.

Adult Care

Preventive[1]:

- Preventive visits — unlimited
- Vision screening — annually
- Hearing tests — annually

Adult Screening Tests:

- 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)
- Osteoporosis screening: Periodic bone density screening for women age 35 and older with increased risk for osteoporotic fractures
- Prostate cancer screenings: Digital rectal examination (DRE) and Prostate Specific Antigen (PSA)
- Routine pelvic exam, Pap test and contraceptive management
- Alcohol and drug screening
- Tobacco counseling for children and adults
- Cardiovascular disease prevention counseling
- Obesity screening and counseling
- Lung cancer screening for 30-pack-per-year smokers (or those who stopped smoking within 15 years)
- Fall prevention for older adults

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)

Women's Health Services:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- FDA-approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

[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 to be determined by physician.

Wellness Programs

Your health and wellness are important to Zimmer Biomet; therefore, we partner with RedBrick Health to provide tools, resources and the motivation to help you understand, maintain and improve your health.

In addition to reduced payroll contributions for your medical coverage, you and your covered spouse/domestic partner can earn incentives for participating in healthy activities through RedBrick Health. See how your healthy activities can add up — while you get rewarded for getting healthier.

Healthy Activities Incentives

If you are enrolled in the HSA or HRA medical option, you and your covered spouse/domestic partner can also receive incentives in your HSA Extra Bucks Account or HRA for participating in healthy activities.

If you are not enrolled in one of the medical options, you are eligible to participate in the wellness programs without receiving incentives.

Accessing RedBrick Health

If you are logged on to the Zimmer Biomet network — go to Team Member Center on the Zimmer Biomet intranet. No login or password required.

If you are not logged on to the Zimmer Biomet network — go to **myredbrick.com/ZimmerBiomet**. Register and set up a login and password. Your covered spouse/domestic partner will need to register for their own account to participate in the program. When registering, you will enter your first name, last name, birthdate and Team Member ID (SAP number). Your spouse/domestic partner will use your Team Member ID.

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 RedBrick Health at **1-855-479-7626** 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.

REDBRICK HEALTH®

Customer service
1-855-479-7626

Monday through Friday,
8 a.m. to 11 p.m. ET
Saturday, 8 a.m to 3 p.m. ET

Website
myredbrick.com/ZimmerBiomet

Mobile App
To download your RedBrick Health app:
Step 1: Visit the App Store (iPhone users) or Google Play (Android users)
Step 2: Enter activation code/sponsor: zimmerbiomet
Step 3: Download the app and get started using Track and Journeys

You must have an active RedBrick account in order to access the RedBrick Health app.

Get all of your favorite RedBrick tools in one easily accessible place—your smartphone or mobile device.

- Complete your health assessment at your convenience
- Commit and complete RedBrick Journeys steps
- Update RedBrick Track as you leave the gym
- Apple users, sync your RedBrick account with Apple Health

Complete the health screening and health assessment to receive healthy activity recommendations from RedBrick Health, as well as earn incentives in your HSA Extra Bucks Account or HRA.

Healthy activity	Description	Incentive earned for Team Member	Incentive earned for 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). Download the health screening form for use at your doctor's office from the health screening page after logging into your RedBrick Health account.	$100/year	$100/year
Health assessment	An online, interactive questionnaire that will give you an in-depth snapshot of your current health along with personalized recommendations for ways you can improve it. The health assessment can also be completed by telephone or by requesting a paper version at 1-855-479-7626.	$100/year	$100/year
	Incentives Available	$200 per year	$200 per year
Flu Shot	Receive a flu shot at an on-site clinic (if available) or at your doctor's office	$25/year	$25/year
RedBrick Next-Steps Consult®	Complete a Next-Steps Consult call	$50/year	$50/year
RedBrick Track®	Achieve a daily wellness score of 300 (Get Active, Eat Healthier and Live Well Activities)	$1/day ($3/week maximum)	$1/day ($3/week maximum)
RedBrick Journeys®	Complete a Journey	$25/1 Journey	$25/1 Journey
RedBrick Phone Coaching (including RedBrick Healthy Pregnancy)	Complete a call with a health coach	$10/call	$10/call
RedBrick Healthy Factors (based on health screening results)	Healthy BMI (<30) or reduce by 5% from the prior year	$25/year	$25/year
	Healthy Non-HDL Cholesterol (<100) or improve by 10% from the prior year	$25/year	$25/year
	Healthy Blood Pressure (<140/90 for age <60 or 150/90 for age 60+) or improve by 20mm systolic or 10mm diastolic from the prior year	$25/year	$25/year
	Incentives Available	$200 per year	$200 per year
	Total Incentives Available:	**$400 per year**	**$400 per year**

Note: Team Members that are not enrolled in a medical option are eligible to participate in the Wellness Programs but are not eligible to receive incentives.

Healthy Activities

If you are enrolled in one of the medical options, you and your covered spouse/domestic partner can each earn $200 annually in incentives by completing the programs listed below.

Refer to the healthy activity incentive chart on page 38 for details or call RedBrick Health with questions about any of the programs or to get started.

RedBrick 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 RedBrick programs will be the best fit for you.

RedBrick Track®

The RedBrick Track tool allows you to log your activity in three categories: Eat Healthier, Live Well and Get Active.

You may also sync a number of mobile apps and approved devices to your RedBrick Health portal in order to automatically log your physical activity.

RedBrick Journeys®

Journeys is a refreshing, re-energizing alternative to more traditional online healthy activities that can be accessed online and by text message, email and telephone.

Select a journey focused on one of the health topics and you are presented with bite-sized, fun steps tailored to your interests. Choose steps you'd like to commit to as part of your journey. Steps may incorporate activities, as well as brief videos. You can continue to personalize your experience by giving feedback on the steps you like and the ones you don't.

Choose from the following health topics:

- Amp Up Your Health
- Be Tobacco Free
- Blood Pressure in Check
- Diabetes Life: Type 2
- Eat Healthier
- Financial Fitness
- Find Your Balance
- Get Active
- Health in a Hurry
- Healthier Heart
- Healthy Back
- Healthy Family
- Healthy Pregnancy
- Heart-Healthy Cholesterol
- Live Well with Asthma
- Manage Well
- Manage Your CAD
- Manage Your COPD
- Manage Your Heart Failure
- Power Patient
- Sleep Well
- Stress Less
- Weigh Less

RedBrick Phone Coaching (in-depth, one-on-one guidance)

RedBrick Health coaches are certified experts who will work with you by phone and provide tools and the support you need to help make lifestyle and behavioral changes, provide health education, self-management skill-building and medication compliance.

Key focus areas include:

Lifestyle Management

- Anxiety
- Back, Muscles and Joints
- Depression
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Nutrition Management
- Personalized Pharmacist Support
- Physical Activity
- Stress Wellbeing
- Tobacco Cessation
- Weight Management

Condition Management

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes

Healthy Pregnancy Program

Through RedBrick Health, you have multiple options designed to promote a healthy pregnancy through delivery. Pregnant consumers may elect to enroll and participate in a phone coaching program addressing fitness, nutrition, stress management and/or tobacco cessation.

Your health coach (a registered nurse with obstetrical experience) will complete an assessment, including current health status. Based on the assessment, you and your health coach will identify education needs and focus areas for lifestyle modification such as proper nutrition, stress management and/or physical activity.

If, after the assessment, any factors indicate you may be at high risk, the coach will refer you to a high-risk pregnancy program or case management.

Healthy Factors

Once you have completed your health screening, Zimmer Biomet will deposit $25 into your HSA Extra Bucks Account or HRA for each of your Healthy Factors that falls within the healthy ranges below or has improved from the prior year.

- Healthy Blood Pressure (<140/90 for age <60 or 150/90 for age 60+) or improve by 20mm systolic or 10mm diastolic from the prior year.
  - Healthy: under 120/80
  - Prehypertension: 120-139/80-89 or 120-149/80-89 for adults 60 and older
  - Stage 1 Hypertension: 140-159/90-99 or 150-159/90-99 for adults 60 and older
  - Stage 2 Hypertension: 160/100 or over
- Healthy Non-HDL Cholesterol (<100) or improve by 10% from the prior year.
  - Healthy: Less than 100
  - Moderate Risk: 100-219
  - High Risk: 220 or over
- Healthy BMI (<30) or reduce by 5% from the prior year.

Notice Regarding Wellness Program

The RedBrick Health Wellness Program is a voluntary wellness program available to all Team Members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve Team Member health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, heart disease). You will also be asked to complete a health screening, which will include a blood test to check your general health and measure your total cholesterol, glucose and metabolic function to monitor how well your organs are functioning and identify potential health problems. If you would like more information about the specific tests performed as part of the health screening, you may contact RedBrick Health at **1-855-479-7626**. You are not required to complete the health assessment or to participate in the blood test or other medical examinations. Incentive contributions are only available to individuals who are enrolled in one of Zimmer Biomet's medical options.

If you are enrolled in one of Zimmer Biomet's medical coverage options, additional contributions to your HSA Extra Bucks or HRA described in the Wellness Programs section above may be available for you (and your spouse/domestic partner) if you participate in certain health-related activities, such as receiving a flu shot and completing healthy activities or achieve certain health outcomes for Body Mass Index (BMI), non-HDL cholesterol and blood pressure. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting RedBrick Health at **1-855-479-7626**.

The information from your health screening results and from your health assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as a consultation and recommendation for healthy activities, phone coaching and online healthy activity programs. You also are encouraged to share your results or concerns with your own doctor.

*Note: If you are enrolled in one of Zimmer Biomet's medical options, to participate in the wellness program and be incentive eligible, you must provide authorization as required by the Genetic Information Non-Discrimination Act (GINA). GINA can be authorized by logging into your RedBrick Health account at **MyRedbrick.com/ZimmerBiomet**. You have the option to authorize or refuse the GINA health authorization. However, if you choose not to authorize, you will not be eligible to participate in the wellness program or receive incentive contributions. If you have any questions, please call RedBrick Health at **1-855-479-7626**.*

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Zimmer Biomet may use aggregate information it collects to design a program based on identified health risks in the workplace, RedBrick Health will never disclose any of your personal information either publicly or to the employer (Zimmer Biomet), except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a certified health expert or a personal health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Zimmer Biomet Benefits Service Center at **1-877-588-0933**.

Managing Your Healthcare Costs

Anthem Health Guide

Make the most of your Zimmer Biomet benefits with Anthem Health Guide — at no additional cost to you.

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. 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.

Our 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.

Anthem. National Accounts

Anthem Health Guide
1-800-693-5406

Monday through Friday,
8 a.m. to 8 p.m. ET

Website
anthem.com

Engage

Engage is a new tool that provides a one-stop shop for a seamless health care 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.

Customer service
1-800-693-5406

Monday through Friday,
8 a.m. to 8 p.m. ET

Website
engage-wellbeing.com

Mobile App
Download the Engage app on your mobile device

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.

Anthem. National Accounts

Anthem Health Guide
1-800-693-5406

Monday through Friday,
8 a.m. to 8 p.m. ET

Website
anthem.com

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 $49, 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 HSA 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 HRA Medical 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.

Anthem. National Accounts

LiveHealth Online
1-888-548-3432

24 hours a day, 7 days a week

Website
livehealthonline.com

Mobile App
Download the LiveHealth Online app on your mobile device

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.

Anthem Imaging Management (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.

Anthem. National Accounts

Nurseline
800-700-9184

24 hours a day, 7 days a week

Customer service
1-800-693-5406

Monday through Friday,
8 a.m. to 8 p.m. ET

Dental

The Company provides you with two dental options administered by Aetna. Each option has features that appeal to different Team Members and family healthcare situations.

When you need dental care, you and your covered dependents may visit any dentist you choose. However, if you visit a dentist who is part of the Aetna provider network, you can take advantage of pre-negotiated, discounted rates and pay less for your dental care.

Plan Design Features	Premium Dental	Value Dental
Annual deductible (you only/you + family) for basic and major procedures	$50/$150	$50/$150
Preventive and diagnostic care (e.g., routine exams, cleanings, X-rays, one fluoride treatment every 12 consecutive months for children up to age 19)	100% up to two[1] visits per person per calendar year (does not apply to annual maximum benefit)	100% up to two[1] visits per person per calendar year (does not apply to annual maximum benefit)
Basic restorative care (e.g., oral surgery, extractions, periodontal treatment)	80%	80%
Major restorative care (e.g., dentures, crowns, bridgework, inlays, onlays)	50% (1 every 8 years)	50% (1 every 8 years)
General anesthesia	Covered under major services	Covered under major services
Panoramic and/or full mouth X-rays	1 every 5 years	1 every 5 years
Orthodontia for children and adults	50%	Not covered
Orthodontia lifetime benefit maximum	$2,000 per adult or child	N/A
Dental implants	100% up to annual benefit maximum	100% up to annual benefit maximum
Annual benefit maximum	$2,000 per person	$750 per person

[1] Any individual that is identified as being pregnant, having diabetes or heart disease may request one extra cleaning.

aetna

Customer service
1-800-279-1434

Monday through Friday,
8 a.m. to 6 p.m. ET

Website
aetna.com

Mobile App
Download the Aetna app on your mobile device

Dental Payroll Contributions Cost Per Pay Period		
	Premium Dental	**Value Dental**
You only	$7.14	$5.07
You + spouse/domestic partner	$15.42	$10.95
You + child(ren)	$18.45	$13.21
You + family	$27.53	$19.53

Note: Refer to page 30 regarding imputed income for domestic partner coverage.

Vision

Comprehensive vision coverage is available through Vision Service Plan (VSP). This coverage has features for you and your family for many basic services, such as eye exams, lenses, frames or contact lenses. When you go to a VSP provider, your costs will be significantly lower and you will not need to submit a claim to receive reimbursement.

If you are interested in LASIK surgery, a discount program is available to you when you use an in-network provider.

Plan Design Features	In-Network	Out-of-Network[4]
Eye Exam[1]	$15 copayment, then 100%	$15 copayment, up to $45
Frames[2]	$25 copayment, up to $175	$25 copayment, up to $70
Spectacle Lenses[2,3] **(including Photochromic or tinted)**		
Single Vision	$25 copayment, then 100%	$25 copayment, up to $30[5]
Lined Bifocal	$25 copayment, then 100%	$25 copayment, up to $50[5]
Lined Trifocal	$25 copayment, then 100%	$25 copayment, up to $65[5]
Contact Lens Exam Fitting Evaluation	$60 maximum copayment	Included with contact lens allowance
Contact Lenses[3]	$175 allowance, no copayment	$105 allowance, no copayment

[1] If you are enrolled in a medical option, you can submit expenses related to your eye exam to Anthem for reimbursement of any covered portion of the eye exam expense.

[2] The $25 copay is for a complete pair of glasses, which include the frame and lenses.

[3] The plan covers either glasses or contact lenses (not both) once per calendar year.

[4] Out-of-network providers will be reimbursed by VSP up to the amount listed (which includes your copayment). You will be required to submit a claim form for reimbursement. If you use an out-of- network provider, you will pay the provider for any additional charges over the amount listed (in addition to your copayment).

[5] Up to $5 extra allowance for tinting.

VSP® Vision care for life

Customer service
1-800-877-7195

Monday through Friday,
8 a.m. to 11 p.m. ET
Saturday and Sunday,
10 a.m. to 10 p.m. ET

Website
vsp.com

Extra Discounts and Savings at a VSP Doctor

Glasses and Sunglasses

- Average 20–25% savings on all non-covered lens options.
- 20% off additional glasses and sunglasses from the same VSP doctor on the same day as your preventive exam. Or get 20% off from any VSP doctor within 12 months of your last covered preventive exam.

Contacts

- 15% off the cost of a contact lens exam (fitting and evaluation). Available from any VSP doctor within 12 months of your last covered preventive exam.

Polycarbonate Lenses

- Covered in full for dependent children, up to age 19.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Vision Payroll Contributions Cost Per Pay Period	
You only	$3.25
You + spouse/domestic partner	$6.81
You + child(ren)	$6.49
You + family	$11.36

Note: Refer to page 30 regarding imputed income for domestic partner coverage.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are tax-advantaged accounts that help you save money on eligible out-of-pocket healthcare and dependent care expenses. You may make contributions to the Healthcare FSA and/or Dependent Care FSA before taxes are deducted and then receive reimbursement for eligible expenses as you incur them throughout the year.

- **Healthcare FSA:** For eligible out-of-pocket healthcare expenses, between $120 and $2,700[1] per year, that are not covered by your HRA. You can only use your Healthcare FSA to help cover your medical deductible, coinsurance, eligible prescription drugs or over-the-counter medications once your HRA is exhausted, but can use money in your Healthcare FSA to help cover your eligible dental or vision expenses any time during the year. You need to enroll in the HRA medical option to enroll in a Healthcare FSA. If you enroll in an HSA Medical option or choose no medical coverage, you are not eligible for a Healthcare FSA.
- You can access funds at any time during the year. If needed, you can use the full account value at the beginning of the plan year.
- Claims must be incurred between your eligibility date and March 15, 2020.
- You have until June 30, 2020, to submit Healthcare FSA expenses for 2019.
- **Dependent Care FSA:** For eligible dependent care expenses, between $120 and $5,000[1] per year ($2,500 if married and filing separate federal income tax returns), that are necessary for you and your spouse/domestic partner to work or attend school full-time.

  Eligible dependents include:

  - Your children under age 13
  - Your eligible spouse/domestic partner or other dependent of any age (such as a parent or older child) who is physically or mentally unable to care for himself or herself
- You can only access funds once they are available in the account.
- Claims must be incurred between your eligibility date and December 31, 2019.
- You have until June 30, 2020, to submit Dependent Care expenses for 2019.

[1]Additional limitations may be imposed because of IRS requirements.

WageWorks
everyone benefits

Customer service
1-877-924-3967

Monday through Friday,
8 a.m. to 8 p.m. ET

Fax
1-877-353-9236

Claims administrator
P.O. Box 14053
Lexington, KY 40512

Website
wageworks.com

Mobile App
Download the WageWorks app on your mobile device

Important FSA Rules

There are important rules to keep in mind as you consider enrolling in either the Healthcare and/or Dependent Care FSA. Some rules apply to both types of accounts. Other rules, as described to the right, are specific to either the Healthcare or Dependent Care FSA.

- The FSA is a use-it-or-lose-it account — under the current tax rules, you must use the money you elected to set aside in an FSA for eligible expenses by the applicable deadline (see page 52 for deadlines). IRS regulations do not allow Zimmer Biomet to refund any unused money. Any leftover money in your account(s) after the deadline will be forfeited. For this reason, it is important that you carefully estimate the amount you want to set aside for an FSA.
- You cannot use funds from the Dependent Care FSA to pay expenses eligible under the Healthcare FSA, or vice versa.
- Expenses that are reimbursed through your Healthcare FSA or Dependent Care FSA cannot be claimed as a deduction when you file your income tax return. Participating in the Dependent Care FSA also makes you ineligible for the child care credit on your annual tax filing — check with a tax advisor to see which option is right for you.
- Your elected FSA contributions cannot be changed during the plan year unless you experience a Qualified Status Change (such as marriage, divorce, birth or adoption) or a change in employment status.
- If you leave Zimmer Biomet, your FSA (either Healthcare or Dependent Care) will terminate on your last day of employment. Any expenses incurred after your termination date are not eligible for payment through the FSA, unless you are eligible and elect to continue your Healthcare FSA with COBRA. You will still be allowed to use available FSA funds to pay for expenses incurred before your termination date.
- You may only enroll in the Healthcare FSA if you also enroll in HRA Medical. (You cannot enroll in the Healthcare FSA if you enroll in Premium or Value HSA Medical or choose no coverage.)
- No matter which medical option you choose (even if you choose no medical coverage), you can enroll in the Dependent Care FSA.

Debit card transactions during the grace period (January 1, 2020 – March 15, 2020)

The Company allows a "grace period" that provides more time to incur claims against your 2019 Healthcare FSA balance.

Debit card transactions used between January 1, 2020, and March 15, 2020 (the grace period for the 2019 plan year) will use the previous year's balance before taking funds out of the current year.

For example, if you have a 2019 balance in your Healthcare FSA and you make a debit card purchase during the grace period in 2020, the amount will be deducted from your 2019 funds prior to using your 2020 funds (if applicable).

If you elected the Healthcare FSA this year but plan to enroll in HSA Medical next year and contribute to an HSA during the grace period, you must use all your available Healthcare FSA funds by December 31 of this year.

Integrating your Healthcare FSA with the Medical Options

- **HSA (Premium or Value)**
  Because you can contribute your own pre-tax earnings into your HSA, you cannot participate in both HSA Medical and a Healthcare FSA. Your HSA has all the tax advantages of the Healthcare FSA without the use-it-or-lose-it requirement. Unlike the Healthcare FSA, your HSA grows by earning interest.
- **HRA**
  If you enroll in HRA Medical, your HRA funds for medical expenses will be used first before you can use FSA funds for healthcare expenses. Eligible expenses, such as dental and vision expenses, can be paid for with funds from the Healthcare FSA regardless of your HRA balance.

Commuter Benefit

The Commuter Benefit is administered by WageWorks. It lets you set aside pre-tax dollars through payroll deductions to pay for eligible transit and parking expenses, up to IRS limits. Since your deductions are taken from your paycheck before taxes, you'll reduce your taxable income — which means you'll keep more money in your pocket. The IRS allows you to set aside up to $265 per month for work-related transportation costs and up to $265 per month for work-related parking costs for 2019 (these limits are subject to change).

Eligible expenses include:

- Buses
- Light rail
- Regional rail
- Streetcar
- Trolley
- Subway
- Ferry
- Vanpool
- Parking at or near your work
- Parking at or near public transportation for your commute

Ineligible expenses include:

- Parking and transportation costs that are not work related
- Fuel expenses
- Mileage
- Tolls
- Taxis
- Limousines
- Parking at an airport for air travel

You can sign up for the Commuter Benefit, change your election or stop participating at any time during the year by visiting **wageworks.com**. This is not a once-a-year election as your elections must be made by the tenth of each month and will be effective for the first of the following month.

Transit and Parking options:

- A transit card will be loaded on the 20th of the election month
- Parking cards are loaded on the 1st of the benefit month

The Commuter Benefit is a use-it-or-lose-it account — under the current tax rules, you must use the money you elected to set aside in a Commuter Benefit account for eligible expenses prior to ending employment with the Company. IRS regulations do not allow Zimmer Biomet to refund any unused money. Any leftover money in your account(s) is forfeited after your employment ends. For this reason, it is important that you carefully estimate the amount you want to set aside for the Commuter Benefit.

WageWorks
everyone benefits

Customer service
1-877-924-3967

Monday through Friday,
8 a.m. to 8 p.m. ET

Fax
1-877-353-9236

Claims administrator
P.O. Box 14053
Lexington, KY 40512

Website
wageworks.com

Mobile App
Download the WageWorks app on your mobile device

Work-Life Solutions

Life is always changing, and balancing work and family priorities can be a challenge. Occasionally, situations such as a family crisis, caring for an elderly parent, dealing with a serious family illness or finding dependable child care can become overwhelming.

With the Anthem Work-Life Solutions, you receive six free, in-person visits per issue with a network licensed behavioral health counselor. If you need further counseling, your Work-Life Solutions counselor will coordinate appropriate and affordable resources in your community.

You do not have to be enrolled in a Zimmer Biomet medical option to participate in this Company-provided benefit, available to you and any member of your household.

Here are some of the topics covered by Work-Life Solutions:

- Workplace safety
- Child and elder care
- Tobacco cessation
- Grief and loss
- Family health
- Home improvement
- Addiction and recovery
- Identity theft
- Legal and financial services

Simply visit the website at **anthem.com/wls** or call the toll-free number, day or night, at **1-833-600-4759**. Anthem specialists are available at no cost to you and there are no limitations on how often you can call.

Anthem. National Accounts

Customer service
1-833-600-4759

24 hours a day, 7 days a week

Website
anthem.com/wls

(From the Members section > Login > zimmer biomet)

Insurance Plans

Zimmer Biomet automatically provides you with a basic level of life insurance and accidental death and dismemberment (AD&D) insurance both at no cost to you.

Zimmer Biomet offers different levels of life and AD&D insurance coverage to help protect you and your family. You may purchase supplemental life and AD&D insurance and survivor income plan for yourself, as well as dependent life and AD&D insurance for your spouse/domestic partner and/or children.

The following is a summary of all of the coverage options[1].

Basic Life Insurance

Zimmer Biomet provides basic life insurance coverage (equal to two times your annual earnings[2]) at no cost to you. The maximum for basic life insurance is $1 million. Keep in mind that the tax code requires that you be taxed on the cost of basic life insurance coverage amounts over $50,000, which is called imputed income. This is shown as Group Term Life Imputed on your paycheck statement.

Basic Accidental Death & Dismemberment (AD&D) Insurance

Zimmer Biomet provides basic AD&D insurance coverage (equal to two times your annual earnings[2]) at no cost to you. The maximum for basic AD&D insurance is $1 million.

THE HARTFORD

Customer service

1-877-320-0484

Monday through Friday,
9 a.m. to 7 p.m. ET

[1] Life, AD&D and business travel accident benefits are subject to the terms of the current insurance policy for each plan. Life, AD&D, survivor income and business travel benefits are generally based on your eligible annual earnings, determined by the insurer at the time of a covered loss according to the terms of the policy.

[2] For purposes of your life insurance coverage (as well as AD&D, survivor income and business travel), annual earnings are your eligible earnings, as defined by the insurance policy, immediately prior to a covered loss. Eligible earnings are generally your basic annual wages or salary, including commissions paid to you prior to the date of loss, but excluding bonuses, overtime and any other special pay. (Annual commissions will be based on average commissions paid to you over the 12 months immediately prior to the date of a covered loss, or over your actual period of employment, whichever period is shorter.)

Supplemental Life Insurance

You may elect supplemental life insurance coverage for yourself and purchase up to eight times your annual earnings on an after-tax basis. The maximum basic life and supplemental life insurance coverage combined is $1.5 million.

If you elect supplemental life insurance as a newly eligible Team Member, you do not need to provide evidence of insurability (EOI) for any election up to three times your annual benefits salary or $500,000 of coverage (whichever is less).

Evidence of insurability is required for supplemental coverage above either three times annual earnings or $500,000 during your new hire eligibility period.

The cost of life insurance coverage is calculated before the beginning of each year based on your anticipated annual earnings. Life insurance costs are affected by your tobacco use status and age bracket. Be sure to complete your tobacco use declaration.

If you decide to increase your level of supplemental coverage anytime after your initial enrollment opportunity, you will need to provide EOI for any amount of additional supplemental coverage.

Coverage that is subject to EOI will not become effective until you complete the insurer's EOI application and the insurer approves your EOI application. If premiums are inadvertently deducted for supplemental coverage that has not been approved by The Hartford or was not allowed by the policy, your applicable premiums will be returned (and no life insurance benefit will be due for coverage in excess of limits or terms of the policy). Contact The Hartford if you have any questions about its EOI process and requirements or the status of your application for additional coverage that is subject to EOI.

Supplemental Accidental Death & Dismemberment (AD&D) Insurance

You may elect supplemental AD&D insurance coverage for yourself and purchase up to eight times your annual earnings on an after-tax basis. The maximum basic AD&D and supplemental AD&D insurance coverage combined is $1.5 million.

The cost of AD&D insurance coverage is calculated before the beginning of each year based on your anticipated annual earnings. AD&D insurance costs are affected by your tobacco use status and age bracket. Be sure to complete your tobacco use declaration.

AD&D insurance does not require EOI.

Dependent Life Insurance

You may purchase life insurance for your spouse/domestic partner and/or child(ren) on an after-tax basis.

The coverage amounts for spouse/domestic partner are:

- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000
- $300,000
- $400,000
- $500,000

If you elect spouse/domestic partner life insurance as a newly eligible Team Member, EOI is not required for any election up to $75,000. EOI will be required for any increase in spouse/domestic partner life insurance coverage throughout the year. Any spouse/domestic partner coverage that is subject to EOI will not become effective until your spouse/domestic partner completes the EOI application and the insurer notifies you that the additional coverage has been approved. You are automatically the beneficiary for any life insurance you elect for your eligible dependents. Contact The Hartford if you have any questions about its EOI process and requirements, or the status of the application for additional coverage that is subject to EOI.

If premiums are inadvertently deducted for supplemental coverage that has not been approved by The Hartford or was not allowed by the policy, your applicable premiums will be returned (and no life insurance benefit will be due for coverage in excess of limits or terms of the policy).

Your spouse's/domestic partner's coverage cannot exceed 50% of your combined basic and supplemental life insurance. Contributions for your spouse's/domestic partner's coverage are based on your spouse's/domestic partner's age, the amount of coverage you elect and whether or not your spouse/domestic partner uses tobacco.

You have two coverage options for life insurance for your child(ren) who are up to age 19 (or 23 if a full-time student):

- $5,000
- $10,000

The cost of coverage is the same regardless of how many children you have. There is no evidence of insurability required for child life coverage.

Dependent AD&D Insurance

You may purchase AD&D insurance for your spouse/domestic partner and/or child(ren) on an after-tax basis.

The coverage amounts for spouse/domestic partner are:

- $10,000
- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000
- $300,000
- $400,000
- $500,000

AD&D insurance does not require EOI. You are automatically the beneficiary for any AD&D insurance you elect for your eligible dependents. Spouse/domestic partner coverage cannot exceed 50% of your combined basic and supplemental AD&D insurance.

You have two coverage options for AD&D insurance for your child(ren) who are up to age 19 (or 23 if a full-time student):

- $5,000
- $10,000

The cost of coverage is the same regardless of how many children you have. There is no EOI required for child AD&D coverage.

Life and AD&D Insurance Reduction

The amount of life and AD&D coverage will be reduced based on the Team Member's age. The annual earnings used to calculate coverage is frozen as of the day before the Team Member's 70th birthday. Your and any dependents' coverage will be reduced when you reach age 70 (and further reduced at age 75) to the amounts specified by the insurance policy at that time, as summarized below.

On your 70th birthday, up through the day before your 75th birthday, coverage will be reduced to:

65% of:

- Company-provided basic life insurance (2x), on the day before your 70th birthday
- Company-provided AD&D insurance (2x), on the day before your 70th birthday
- Any supplemental life insurance option level that was in force the day before your 70th birthday
- Any supplemental AD&D insurance option level that was in force the day before your 70th birthday
- Any spouse/domestic partner life insurance option level that was in force the day before your 70th birthday
- Any spouse/domestic partner AD&D insurance option level that was in force the day before your 70th birthday

On your 75th birthday, coverage will be further reduced to:

50% of:

- Company-provided basic life insurance (2x) on the day before your 70th birthday
- Company-provided AD&D insurance (2x) on the day before your 70th birthday
- Any supplemental life insurance option level that was in force the day before your 70th birthday
- Any supplemental AD&D insurance option level that was in force the day before your 70th birthday
- Any spouse/domestic partner life insurance option level that was in force the day before your 70th birthday
- Any spouse/domestic partner AD&D insurance option level you elected that was in force the day before your 70th birthday

Survivor Income Plan

The Survivor Income Plan pays your surviving spouse/domestic partner or surviving dependent children 25% of your eligible annual earnings each year for ten years following your death. You pay for this coverage with after-tax dollars. EOI is required at time of enrollment and no coverage will be effective until your EOI is approved by the insurer.

Business Travel Accident Insurance Plan

The Business Travel Accident Insurance Plan is administered by AIG. In the event of an accidental death or permanent total disability while you are traveling on Company business, the Business Travel Accident Insurance Plan provides your beneficiary with an amount equal to five times your annual earnings, up to $2 million[1]. If you are eligible for business travel coverage, you automatically receive this coverage and do not need to enroll or make any payroll contributions for this benefit.

The Business Travel Accident Insurance Plan also provides Team Members traveling internationally additional services in the areas of Travel Assistance, Concierge Services, Identify Theft Assistance and Security Assistance. Contact AIG at **1-877-244-6871** if you need any assistance.

Choosing your beneficiary

Your beneficiary(ies) is the person(s) who will receive benefits from your life insurance, AD&D insurance and survivor income plan in the event of your death. When you enroll in your benefits, you need to designate your beneficiary online at **benefits.zimmerbiomet.com** or by calling **1-877-588-0933** and speaking with a customer service representative.

If your beneficiary is a Zimmer Biomet Team Member, you must call and speak with a customer service representative at the Zimmer Biomet Benefits Service Center to add him/her as your beneficiary.

If you do not designate your beneficiary(ies) during enrollment, any benefits will be paid to the recipient(s) described in the policy.

Note: Only surviving spouse/domestic partner and/or surviving dependent children are eligible to be a beneficiary for the Survivor Income Plan benefit.

Portability and Conversion

If your eligibility for life, AD&D or Survivor Income insurance ends for any reason except failure to pay the required premium (for example, you are no longer actively working as a full-time Team Member or you have been on Short-Term Disability or any leave of absence for six months), you may qualify to port or convert your life insurance coverage if you apply to The Hartford and pay the required premium within 31 days after coverage ends according to the insurance policy. No port or convert option is available for AD&D or Survivor Income.

Please contact the Zimmer Biomet Benefits Service Center for information about your option to port or convert to continue any coverage available under its policy.

[1]Benefit amount may be reduced for certain events/accidents described in the insurance policy.

Take advantage of additional services that come with your insurance plan

Your life insurance from The Hartford can help you protect the financial future of your loved ones. They provide valuable services to you and your family when you need them most. Below is an overview of the services offered.

Funeral Planning and Concierge Services

The Hartford offers a funeral planning and concierge service provided by Everest. It provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiations of funeral prices with local providers, often resulting in significant financial savings. For more information, contact Everest at **1-866-854-5429** or visit **www.everestfuneral.com/hartford** and use code HFEVLC.

Beneficiary Assist® Counseling Services

The Hartford offers you beneficiary assist counseling services provided by ComPsych®. Compassionate professionals can help you or your beneficiaries (named in your policy) cope with emotional, financial, and legal issues that arise after a loss. This includes unlimited phone contact with a counselor, attorney, or financial planner for up to a year and five face-to-face sessions. For more information, contact Beneficiary Assist at **1-800-411-7239.**

EstateGuidance® Will Service

Whether your assets are few or many, it's important to have a will. Through The Hartford, you have access to EstateGuidance® Will Services, provided by ComPsych. It helps you protect your family's future by creating a will online, backed by online support from licensed attorneys. Your will is customized and legally binding. Visit **www.estateguidance.com/wills** and use the code WILLHLF.

Travel Assistance Services with ID Theft Protection and Assistance

Travel assistance services with ID theft protection and assistance include pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel. For more information on travel assistance services or ID theft services, call **1-800-243-6108** or email **idtheft@europassistance-usa.com**. Please provide your employer's name, a phone number where you can be reached, nature of the problem, travel assistance identification number GLD-09012, and your company policy number 402887.

Disability Plans

Zimmer Biomet provides you with both Short-Term Disability (STD) pay continuation and basic Long-Term Disability (LTD) insurance coverage, both at no cost to you.

You are automatically enrolled in both plans following 90 days of continuous employment from the later of your hire date or the date you become eligible for benefits, if you are actively employed on that date.

To be eligible for the Family Medical Leave Act (FMLA), you must have worked for Zimmer Biomet as of the date the requested leave is to begin:

- For at least 12 months; and
- For at least 1,250 hours during the previous 12 months.

Requesting Family Medical Leave and/or Filing Disability Claims

To request leave under the FMLA, or file a STD or LTD claim, call Unum. **FMLA claims must be filed within two business days of the requested family or medical leave. Disability claims must be filed within 30 days after your disability begins.** You must timely submit a disability claim and have it approved before payments begin.

Customer service
1-866-779-1037

Monday through Friday,
8 a.m. to 8 p.m. ET

Website
unum.com

Mobile App
Download the Unum Customer app on your mobile device

Short-Term Disability (STD)

If Unum determines you became disabled after 90 days of continuous full-time employment and you have satisfied the seven-day elimination period under Zimmer Biomet's STD pay continuation plan, you may receive continuation pay for up to 26 weeks, subject to the terms of the applicable STD plan as described below.

- The STD benefit for non-exempt/hourly Team Members is up to 60% of eligible pay.
- The STD benefit for exempt/salaried Team Members is up to 100% of eligible pay for first 13 weeks, then up to 80% of eligible pay for remaining 13 weeks.

Weekly pay is your eligible earnings, as defined by the Plan, immediately prior to your disability. Eligible earnings are generally your basic weekly wages or salary, including commissions paid to you prior to disability, but excluding bonuses, overtime and any other special pay. Weekly commissions will be based on average commissions paid to you over the 12 months immediately prior to your disability, or over your actual period of employment, whichever period is shorter.

Once your STD has been exhausted and you fail to return to active work, your employment may terminate and your (and any of your dependents') eligibility to participate in Zimmer Biomet benefit plans will end. Unum will determine if you qualify to receive pay continuation under Zimmer Biomet's STD plan and whether you qualify for any further disability benefit payments under the terms of its LTD insurance policy.

Long-Term Disability (LTD)

If Unum determines you are still disabled after receiving any applicable STD pay continuation benefits for 26 weeks, you may qualify to receive LTD benefits. The insurer will determine your basic LTD benefit based on 60% of your monthly pay, less any income you receive from certain other sources.

Monthly pay is your eligible earnings, as defined by the insurance policy, immediately prior to your disability.

Eligible earnings are generally your basic monthly wages or salary, including commissions paid to you prior to disability, but excluding bonuses, overtime and any other special pay. Monthly commissions will be based on average commissions paid to you over the 12 months immediately prior to your disability, or over your actual period of employment, whichever period is shorter.

You may also elect supplemental LTD coverage, which is an additional 10% of your eligible pay (for a total of 70%). You pay for the 10% Supplemental LTD Plan with after-tax dollars. There is a monthly cap of $15,000 on both the basic and supplemental coverage. Your disability must be approved by Unum before you can receive any LTD benefits. You will receive notification to make elections for supplemental LTD 31 days prior to eligibility.

Savings and Investment 401(k) Program

The Zimmer Biomet Savings and Investment 401(k) Program (the 401(k) Program) offers a convenient, tax-deferred way to save for retirement. Your investment decisions and strategies today will help you prepare for a secure financial future.

Who is Eligible

You are eligible to make contributions to, and receive the Company match for, the 401(k) Program as soon as you become a regular full-time or part-time Team Member (including temporary and interns) who is expected to work at least 1,000 hours in an eligibility computation period (explained below), and:

- You are a non-union Team Member in the United States (excluding Puerto Rico); or
- You are a U.S. citizen or resident on a foreign payroll of a company that participates in this 401(k) Program.

In your first year of service, the 12-month eligibility computation period begins on your date of hire. Future years begin on January 1 after your date of hire, and run from January 1 to December 31.

Leased employees and independent contractors are not eligible to participate.

Default coverage

Team Members who do not make an election within 31 days after becoming newly hired or eligible are automatically enrolled and deemed to have elected to contribute 3% of their eligible pay as a pre-tax contribution each pay period. Automatic contributions will also default to the appropriate target date retirement fund based on your retirement at age 65, until you provide investment instructions. If you were automatically enrolled, you may call Fidelity or register at **netbenefits.com** to manage your account.

Choosing your beneficiary

Your beneficiary(ies) is the person(s) who will receive your benefits from the 401(k) Program in the event of your death. When you enroll in the 401(k) Program, you need to designate your beneficiary online at **netbenefits.com** or by calling **1-800-835-5095** and speaking with a customer service representative.

If you do not designate your beneficiary(ies), any benefits will be paid to the recipient(s) described in the plan document for the 401(k) Program.

Fidelity INVESTMENTS

Customer service

1-800-835-5095 - English
1-800-587-5282 - Spanish

Monday through Friday,
8:30 a.m. to 8 p.m. ET

Website

netbenefits.com

Mobile App

Download the Fidelity app on your mobile device

Give your retirement savings a raise

One of the steps to help boost your retirement savings is to increase your deferral percentage when you receive a raise. By raising the amount you contribute to the 401(k) Program by a small percentage, you will improve your chances of reaching your retirement goals.

Log on to Fidelity at **netbenefits.com** or call **1-800-835-5095** to enroll in the annual increase program.

How the Program Works

- Contributions can be made through automatic payroll deductions.
- You can defer between 2% and 60% of your eligible earnings[1].
  - A separate deferral is allowed for annual performance or sales bonus earnings.
- You can contribute on a pre-tax, after-tax or Roth basis.
  - In 2019, the IRS contribution limit for pre-tax and Roth combined is $19,000. If you are over age 50, you can make catch-up contributions up to $6,000. The combined IRS limit is $25,000.
  - The annual compensation limit for 2019 is $280,000, so any deferrals you elect and any employer contributions will be taxed only on the portion of your eligible pay up to that limit.

When you enroll, you choose how to invest your account in one or more of the investment funds available under the 401(k) Plan. If you do not make an investment election, at the direction of the plan administrator, your contributions will default to the appropriate target retirement date fund that is based on your retirement at age 65.

Roth contributions

A Roth contribution to your retirement savings plan allows you to make after-tax contributions and take any associated earnings completely tax-free at retirement, as long as the distribution is a qualified one. A qualified distribution is one taken at least five years after your first Roth 401(k) contribution and after you reach age 59½, become disabled or pass away.

The Company Match

- You must contribute each pay period to maximize your employer matching contribution. The company will match on pre-tax, after-tax or Roth contributions.
- No Company match is provided for catch up contributions.
- You are immediately eligible for the Company contributions:
  - For each dollar you contribute each pay period up to 6% of your eligible earnings, Zimmer Biomet will match $1.00.

To enroll or change your contribution or investment elections, log on to Fidelity at **netbenefits.com** or call the Fidelity Retirement Benefits line at **1-800-835-5095**.

Vesting

Vesting means you have a right to the amount credited to your account in the 401(k) Program[2]. You are always 100% vested in the value of your own contributions to the 401(k). You become vested in Company matching contributions as shown in the chart below.

Years of service	Vested portion of Company match
Less than one year of service	0%
One year of service	25%
Two years of service	50%
Three years of service	75%
Four years of service	100%

[1]Eligible earnings include regular salary, bonus, commission and overtime.

[2]Although you have a vested right to the amount, you may only receive a distribution upon certain events provided by the 401(k) plan, such as retirement or separation of employment. Prior to vesting, you may forfeit all or a portion of the Company's contributions if your employment terminates before you retire, become disabled or die.

Financial Engines

Financial Engines, a leading investment advisor and manager, provides investment services to help you prepare for retirement by providing investment and savings recommendations about your Zimmer Biomet Savings and Investment 401(k) Program.

Their services include:

- **Online Advice.** This service gives you access to expert recommendations and tools so you can create a retirement plan and fine tune your investing strategy yourself, at no additional cost to you.
- **Professional Management.** You can enroll in the Professional Management program which creates, implements and monitors a personalized retirement plan for you. Contact Financial Engines regarding fee information. You are responsible for the professional management fee (a portion of which is paid by Financial Engines to Fidelity).

financial engines®

Customer service

1-877-401-5762

Monday through Friday,
9 a.m. to 9 p.m. ET

Stock Purchase and Bonus Plan

Employee Stock Purchase Plan

The Employee Stock Purchase Plan (ESPP) is a simple way for you to purchase Zimmer Biomet stock at a 15% discount through payroll deductions and share in the Company's continued growth. Fidelity is the administrator of the ESPP.

To be eligible for the ESPP, you must:

• Be actively employed on the first day of an Offering Period. The six-month Offering Periods begin January 1 and July 1.

You determine how much of your pay you want to contribute to the Plan. You may contribute a fixed dollar amount each pay period. You must contribute at least $20 per pay period if you enroll in the Plan. The maximum you can contribute is $25,000 per year. In addition, U.S. tax regulations limit the amount of your total payroll deductions for each year.

Team Member contributions are made through convenient payroll deductions during each six-month Offering Period, and shares are then purchased at a 15% discount of the fair market value of the stock on the first day of the offering period or 15% discount of the fair market value of the stock on the last day of the offering period, whichever is lower. Team Members can begin or change their participation level in the ESPP twice a year during designated enrollment periods.

Performance Incentive Plan (The Bonus Plan)

Our Bonus Plan focuses on key drivers of the Company's success, which align your financial interests with those of the Company and its shareholders. We also reward you for your contributions — allowing you to share in the financial and operational successes that you help create. The performance measurements that determine Bonus Plan payments depend on your job assignment.

Throughout the Company, these measurements emphasize adjusted earnings per share, cash flow, revenue and operating earnings. These are key factors that reflect the success of our business performance — especially in the eyes of the financial and investment communities that are vitally important to us as a publicly traded Company.

You must be employed by the Company on the date of the Bonus payment, if any is made, to be eligible for a Bonus Plan payment, except where otherwise required by applicable law. This includes any applicable Sales bonus plan as well.

Fidelity INVESTMENTS

Customer service

1-800-544-9354

Sunday 5 p.m. ET through Friday midnight ET

Website

netbenefits.com

Have questions about the Bonus Plan?

Contact your local Human Resources representative.

Special Notices

Mastectomy Benefits Under the Zimmer Biomet Group Medical Plan

Under a federal law known as the Women's Health and Cancer Rights Act, the Zimmer Biomet Group Medical Plan is required to provide certain coverage to participants and beneficiaries who are receiving benefits in connection with a mastectomy.

If you are a participant or beneficiary under the Zimmer Biomet Group Medical Plan who is receiving benefits in connection with a mastectomy, the Plan will provide, in a manner determined in consultation with you and your attending physician, coverage for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy; including lymphedema.

This coverage will be subject to the annual deductibles, copayments and other limitations applicable to your other benefits under the Plan.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-**866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

Alabama - Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

Alaska - Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arkansas - Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

Florida - Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

Georgia – Medicaid

Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

Indiana - Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864

Iowa - Medicaid

Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563

Kansas - Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

Kentucky - Medicaid

Website: https://chfs.ky.gov
Phone: 1-800-635-2570

Louisiana - Medicaid

Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

Maine- Medicaid

Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

Massachusetts - Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

Minnesota - Medicaid

Website:
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

Missouri - Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana - Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

Nebraska - Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada - Medicaid

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire - Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid

New Jersey - Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

New York - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina - Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

North Dakota - Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

Oklahoma - Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon - Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania - Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

Rhode Island - Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

South Carolina - Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas - Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

Utah - Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

Vermont - Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Virginia - Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

Washington - Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

West Virginia - Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin - Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

Wyoming - Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)

Benefits Contact Information

Zimmer Biomet Benefits Service Center

- Enrollment Questions
- Benefit Elections
- Changes to your benefits due to Qualified Status Changes
- COBRA (continuation of group health insurance coverage)
- Life Insurance and Death Benefit Claims
- Appeal Information
- Dependent Verification Service
  - Documentation of Qualified Status Changes and Newly Eligible Dependents

1-877- 588-0933
Monday through Friday,
9 a.m. to 7 p.m. ET
benefits.zimmerbiomet.com

Benefit	Provider	Phone	Online
24/7 Nurseline	Anthem	1-800-700-9184	
COBRA	Alight	1-877-588-0933	benefits.zimmerbiomet.com
Commuter Benefit	WageWorks	1-877-924-3967	wageworks.com
Dental	Aetna	1-800-279-1434	aetna.com
Disability ▸ Family Medical Leave Act ▸ Short-Term and Long-Term Disability	Unum	1-866-779-1037	unum.com
Engage	Anthem	1-800-693-5406	engage-wellbeing.com
Equity ▸ Employee Stock Purchase Plan ▸ Team Member Long-Term Incentives	Fidelity	1-800-544-9354	netbenefits.com
Flexible Spending Accounts	WageWorks	1-877-924-3967	wageworks.com
Health Savings Account	HealthEquity	1-877-713-7712	myhealthequity.com
Life and AD&D Insurance and Survivor Income Plan	The Hartford	1-877-320-0484	N/A
LiveHealth Online	Anthem	1-888-548-3432	livehealthonline.com or the LiveHealth Online app
Medical	Anthem ▸ Anthem Health Guide	 1-800-693-5406	anthem.com
Prescription Drugs	Express Scripts	1-866-544-6884	express-scripts.com
Savings and Investment 401(k) Program	Fidelity Investments Financial Engines	1-800-835-5095 (English) 1-800-587-5282 (Spanish) 1-877-401-5762	netbenefits.com
Vision	VSP Vision Care	1-800-877-7195	vsp.com
Wellness	RedBrick Health	1-855-479-7626	myredbrick.com/ZimmerBiomet
Work-Life Solutions	Anthem	1-833-600-4759	anthem.com/wls

ZIMMER BIOMET
Your progress. Our promise.™