YOUR BENEFIT PLAN

STRYKER CORPORATION
All Active Full-time and Part-time Exempt Employees

Short Term Disability

EMPLOYER: STRYKER CORPORATION

PLAN NUMBER: GRH-071674

PLAN EFFECTIVE DATE: January 1, 2006

BENEFITS UNDER THE GROUP SHORT TERM DISABILITY PLAN DESCRIBED IN THE FOLLOWING PAGES ARE PROVIDED AND FUNDED BY THE EMPLOYER.

THE EMPLOYER HAS FULL RESPONSIBILITY FOR PAYMENT OF ANY BENEFITS DUE ACCORDING TO THE TERMS AND CONDITIONS OF THE PLAN.

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SCHEDULE OF BENEFITS

The Plan of short term Disability provides You with short term income protection if You become Disabled from a covered Injury, Sickness, or pregnancy.

The benefits described herein are those in effect as of January 1, 2022

Cost of Coverage:
You do not contribute towards the cost of coverage.

Eligible Class(es) For Coverage:
All Full-time and Part-time Active Employees who are exempt employees of Stryker Corporation who are U.S. citizens or U.S. residents, expatriates or third country nationals, excluding the following:

1) bargaining unit employees,
2) employees employed by a foreign subsidiary, branch, or division,
3) independent contractors and other workers not on the Policyholder's payroll,
4) retired employees,
5) temporary, leased or seasonal employees and
6) employees of Stryker Puerto Rico.

Full-time Employment: at least 40 hours weekly

Part-time Employment: at least 20 hours weekly

Eligibility Waiting Period for Coverage:
None

Benefits Commence:

1) for Disability caused by Injury: on the 1st day of Total Disability or Disabled and Working;
2) for Disability caused by Sickness: on the 8th consecutive day of Total Disability or Disabled and Working.

For hospital confinements, or for an Outpatient Surgical Procedure which necessitates a Total Disability period or a Disabled and Working Disability period, benefits commence:

1) on the first day of hospital confinement; or
2) on the date of the Outpatient Surgical Procedure.

Weekly Benefit:
100% of Your Pre-disability Earnings; reduced by Other Income Benefits.

Maximum Duration of Benefits Payable:

1) 180 day(s) if caused by Injury; or
2) 180 day(s) if caused by Sickness.

(Includes Elimination Period)

Additional Benefits:

Disabled and Working Benefit
See Benefit

Rehabilitative Employment Benefit
See Benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Benefits will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the later of:
1) the Plan Effective Date; or
2) date of hire.

Enrollment: *How do I enroll for coverage?*
All eligible Active Employees will be enrolled automatically by the Employer.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
If You are not required to contribute toward The Plan's cost, Your coverage will start on Your date of hire.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:
1) accidental bodily injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your coverage, or increase in coverage, would otherwise have become effective, Your coverage, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Can I change my benefit options?*

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date the Employer receives notice of the change.

Continuity From A Prior Plan: *Is there continuity of coverage from a Prior Plan?*
If You were:
1) insured under the Prior Plan; and
2) not eligible to receive benefits under the Prior Plan;

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the date The Plan terminates;
2) the date The Plan no longer covers Your class;
3) the date Your Employer terminates Your employment; or
4) the date You cease to be a Full-time or Part-time Active Employee in an eligible class for any reason;

unless continued in accordance with one of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:
1) is subject to any reductions in The Plan; and
2) terminates if:
    a) The Plan terminates; or
    b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Family or Medical Leave, Your coverage may be continued for 3 months after the date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 26 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay-off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued for 3 months after the date the layoff commenced. If the lay-off becomes permanent, this continuation will cease immediately.

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 26 weeks after or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my coverage continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your coverage will be continued:
1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive short term Disability Benefits.

After short term Disability benefit payments have ceased, Your coverage will be reinstated, provided:
1) You return to work for one full day as a Active Employee in an eligible class; and
2) The Plan remains in force.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Plan?*
If, while covered under this Benefit, You:
1) become Totally Disabled;
2) remain Totally Disabled; and
3) submit Proof of Loss to the Claims Evaluator;

The Plan will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:
1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
2) any income received from the Employer for the period You are Totally Disabled.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*
If a Weekly Benefit is payable for less than a week, The Plan will pay 1/5 of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*
When Your return to work as an Active Employee is followed by a Disability, and such Disability is:
1) due to the same cause; or
2) due to a related cause; and
3) within 30 consecutive calendar days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Plan remains in force.

If You return to work as an Active Employee for 30 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Plan.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions will apply to the new cause of Disability.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse the Claims Evaluator's request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the last day benefits are payable according to the Maximum Duration of Benefits;
7) the date Your Current Weekly Earnings exceed 80% of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
8) the date no further benefits are payable under any provision in The Plan that limits benefit duration.

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*
If, while covered under this benefit, You are Disabled and Working, as defined, the Weekly Benefit otherwise payable for Total Disability will be reduced by 50% of Your Current Weekly Earnings.

If You are participating in a program of Rehabilitative Employment approved by the Claims Evaluator, the Claims Evaluator will determine Your Weekly Benefit by the Rehabilitative Employment Benefit.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

Rehabilitative Employment Benefit: *What happens to my benefits if I accept Rehabilitative Employment?*
If, while You are Totally Disabled or Disabled and Working, You accept Rehabilitative Employment, the Employer will continue to pay a Weekly Benefit.

The Weekly Benefit the Employer will pay will be equal to Your Total Disability Weekly Benefit, less 50% of any income received from the Rehabilitative Employment.

The sum of the Weekly Benefit and total income received from Rehabilitative Employment may not exceed 100% of Your Pre-disability Earnings. If this sum exceeds the Pre-disability Earnings, the Weekly Benefit paid by the Employer will be reduced by the excess amount.

The Employer reserves the right to review any Rehabilitative Employment You participate in while benefits are being paid under The Plan.

If You remain Totally Disabled or Disabled and Working after a period of Rehabilitative Employment, You may continue to receive benefits under the Total Disability Benefit or Disabled and Working Benefit, subject to the Maximum Payment Period for such benefit.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Plan does not cover, and will not pay a benefit for any Disability:

1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation;
5) caused or contributed to by an intentionally self inflicted Injury; or
6) caused by cosmetic surgery and elective procedures, except surgery made necessary by illness or disease, or by accidental injury, organ donation, or Workman’s Compensation Waiver.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Plan;

no benefits will be payable for the Disability under The Plan.

GENERAL PROVISIONS

Claims Evaluator: *What is the role of the Claims Evaluator?*
The Claims Evaluator is delegated the duties of the Employer to determine benefits payable according to the terms and conditions of The Program.

The Employer's responsibilities also include, but are not limited to:

1) deciding appeals of claims which were initially denied by the Claims Evaluator; and
2) making final determinations regarding eligibility for coverage.

Employer Role: *What is the role of the Employer in the Claims process?*
The Employer is responsible for making payment for benefits due according to the terms and conditions of The Plan.

The Employer's responsibilities also include, but are not limited to:

1) deciding appeals of claims which were initially denied by the Claims Evaluator; and
2) making final determinations regarding eligibility for coverage.

Notice of Claim: *When should the Claims Evaluator be notified of a claim?*
You, your supervisor or your physician must give the Claims Evaluator written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include your name, your address and the Employer's name.

You, your supervisor or your physician must give the Claims Evaluator notice of claim by calling the special claims telephone number provided to Employees. Such notice must be given on the fifth day of an absence due to the same or a related Disability.

If notice cannot be given within that time, it must be given as soon as possible after that. A representative of the Claims Evaluator will assist the caller through the process, gathering the appropriate information from you, your physician, and the Employer.

Claim Forms: *Are special forms required to file a claim?*
The Claims Evaluator will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If the Claims Evaluator does not send the forms within 15 days, You may submit any other written or telephonic proof which fully describes the nature and extent of Your claim.

Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after the Claims Evaluator receives a notice of claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Weekly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for the Claims Evaluator to obtain and release:

a) medical, employment and financial information; and
b) any other information the Claims Evaluator may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to the Claims Evaluator.

Additional Proof of Loss: *What additional proof of loss is the Claims Evaluator entitled to?*
To assist the Claims Evaluator in determining if You are Disabled, or to determine if You meet any other term or condition of The Plan, the Claims Evaluator has the right to require You to:

1) meet and interview with the Claims Evaluator; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of the Claims Evaluator's choice.

Any such interview, meeting or examination will be:

1) at the Claims Evaluator's expense; and
2) as reasonably required by the Claims Evaluator.

Your Additional Proof of Loss must be satisfactory to the Claims Evaluator. Unless the Claims Evaluator determines You have a valid reason for refusal, the Claims Evaluator may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by the Claims Evaluator.

Sending Proof of Loss: *When must proof of Loss be given?*
Written Proof of Loss must be sent to the Claims Evaluator within 90 day(s) after the start of the period for which the Claims Evaluator is liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

The Claims Evaluator may request Proof of Loss throughout Your Disability. In such cases, the Claims Evaluator must receive the proof within 30 day(s) of the request.

Claim Payment: *When are benefit payments issued?*
When the Claims Evaluator determines that You:

1) are Disabled; and
2) eligible to receive benefits;

accrued benefits will be paid in accordance with the Employer's payment schedule. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to the Claims Evaluator is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then the Employer may pay up to $1,000 to a person who is Related to You and who, at the Employer's sole discretion, is entitled to it. Any such payment shall fulfill the Employer's responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Plan provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*
On any claim, You or Your representative may appeal to the Claims Evaluator for a full and fair review. To do so You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires the Claims Evaluator to make a determination of disability; or

b) 60 days of receipt of claim denial if the claim does not require the Claims Evaluator to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

The Claims Evaluator will respond to You in writing with the final decision on the claim.

Social Security: *When must I apply for Social Security Benefits?*
The Employer may require that You apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of the request. If the Social Security Administration denies Your eligibility for benefits, You will be required:
1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Subrogation: *What are the Employer's subrogation rights?*
If You:
1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Plan in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;
then the Employer will be subrogated to any rights You may have against the Third Party and may, at its option, bring legal action against the Third Party to recover any payments made by The Plan in connection with the Disability.

Third Party as used in this provision means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Plan.

Legal Actions: *When can legal action be taken against the Employer?*
Legal action cannot be taken against the Employer:
1) sooner than 60 days after the date proof of loss is furnished; or
2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Plan.

Misstatements: *What happens if facts are misstated?*
If material facts about You were not stated accurately, the true facts will be used to determine if, and for what amount, coverage should have been in force.

Plan Interpretation: *Who interprets the terms and conditions of The Plan?*
The Employer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Plan. This provision applies where the interpretation of The Plan is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

DEFINITIONS

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:
1) in the usual way; and
2) for Your usual number of hours.
You will be considered Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Benefits.

Claims Evaluator means Hartford Life and Accident Insurance Company.

Current Weekly Earnings means Weekly earnings You receive from Your Employer while You are Disabled and eligible for the Disabled and Working Benefit.

Disabled and Working means that You are prevented by:
1) Injury;
2) Sickness;

3) Mental Illness;
4) Substance Abuse; or
5) pregnancy

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time or limited duty basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

Disability or Disabled means Total Disability or Disabled and Working Disability.

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Injury means bodily injury resulting:
1) directly from accident; and
2) independently of all other causes;

which occurs while You are covered under The Plan. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Plan, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Other Income Benefits means the amount of any benefit for loss of income, provided to You, as a result of the period of Disability for which You are claiming benefits under The Plan. This includes any such benefits for which You are eligible or that are paid to You, or to a third party on Your behalf, pursuant to any:
1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer.

Outpatient Surgical Procedure means a medically necessary surgical procedure performed by a Physician in the outpatient department of a hospital or ambulatory surgical center.

Physician means a person who is:
1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that the Claims Evaluator recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not Related to You by blood or marriage.

Pre-disability Earnings means the weekly benefit eligible wage or salary that You were receiving from Your Employer on the last day You were Actively at Work before You became Disabled. It includes:
1) employee contributions made through a salary reduction agreement with Your Employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee Retirement Plan or deferred compensation arrangement;
2) paid commissions averaged over the preceding 52-week period or length of employment if less;
   a) for direct sales employees, you will receive the average base salary received for 52-week period, length of employment or length of time in your current position, if less; plus average commissions received over the

same period of time. This will include any bonuses that are based on sales and are a part of your regular cadence of pay;
   b) for managers with commissions based on direct report earnings, commissions will continue as normal and will not be based on a 52-week average;
3) amounts contributed to Your fringe benefits according to a salary reduction arrangement under an IRC Section 125 (cafeteria) plan; and
4) any promotion, equity, market adjustment or merit increases to Your rate of pay while Disabled.

It does not include:
1) Your Employer's contribution on Your behalf to a Retirement Plan or deferred compensation arrangement;
2) bonuses;
3) overtime earnings;
4) taxable fringe benefits;
5) stock option compensation;
6) moving expenses;
7) draw that has already been recovered; or
8) any other extra compensation.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:
1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Rehabilitative Employment means employment or service which:
1) prepares a Disabled person to resume gainful work; and
2) is approved, in writing, by the Claims Administrator.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Sickness means a Disability which is:
1) caused or contributed to by:
   a) any condition, illness, disease or disorder of the body;
   b) any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
   c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Plan; or
   d) pregnancy;
2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1) above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:
1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Plan means the Plan which the Claims Evaluator issued to the Contractholder under the Plan number in the Schedule of Benefits.

Total Disability or Totally Disabled means that You are prevented by:
1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or

5) pregnancy;

from performing the Essential Duties of Your Occupation, and as a result, You are earning less than 20% of Your Pre-disability Earnings.

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

You or Your means the person to whom this Plan is issued.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your Plan document are provided under a group plan sponsored by the Employer and are subject to the terms and conditions of that Plan. The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan to the extent permitted by applicable state law.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   STRYKER CORPORATION WELFARE BENEFITS PLAN.

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2. **Plan Number**

   WD - 501

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3. **Employer/Plan Sponsor**

   STRYKER CORPORATION
   2825 Airview Blvd
   Kalamazoo, MI 49002

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4. **Employer Identification Number**

   38-1239739

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Short Term Disability.

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6. **Plan Administrator**

   STRYKER CORPORATION WELFARE BENEFITS PLAN
   2825 Airview Boulevard
   Kalamazoo, MI 49002

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7. **Agent for Service of Legal Process**

For the Plan

STRYKER CORPORATION WELFARE BENEFITS PLAN
2825 Airview Boulevard
Kalamazoo, MI 49002

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions (Short Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Claim Fiduciary fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Claim Fiduciary has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Claim Fiduciary demonstrates that the violation was for good cause or due to matters beyond the control of the Claim Fiduciary and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claim Fiduciary and you. This exception is not available if the violation is part of a pattern or practice of violations by the Claim Fiduciary. Before filing a civil action, you may request a written explanation of the violation from the Claim Fiduciary, and the Claim Fiduciary must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Claim Fiduciary met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Claim Fiduciary's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Claim Fiduciary shall provide you with notice of the resubmission.
Claims for Benefits: If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond the control of the Claim Administrator, that the notice identifies those matters and gives the date by which a decision is expected to be made. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Claim Administrator of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) disability determination regarding you presented by you to the Claim Administrator made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical, necessity or experimental treatment or similar exclusion or limit either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before an adverse benefit determination is issued on review, you shall be provided, free of charge, with any new or additional evidence considered, relied upon, or in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before you are issued an adverse benefit determination on review based on a new or additional rationale, you shall be provided free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Employer will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Plan provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar

criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 90 days after receipt of your properly filed claim. However, if there are special circumstances that require an extension, the time for the claim decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and are given the date by which a decision is expected to be made. If extended, a decision shall be made no more than 180 days after your claim was received. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Employer for a full and fair review. Your appeal request must be in writing and be received by the Employer no later than the expiration of 60 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Employer will make a final decision no more than 60 days after it receives your timely appeal. However, if the Employer determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Employer notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Plan provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.