Stryker Benefits Summary

Stryker is pleased to provide you with this summary plan description (“SPD” or “Benefits Summary”) describing the healthcare, welfare and retirement benefits available to eligible Stryker employees as of January 1, 2014.

When the unexpected occurs—a serious illness, a long absence from work, even death—we count on Stryker-sponsored healthcare and welfare benefits for financial protection. In addition, Stryker Corporation sponsors the Stryker Corporation 401(k) Savings and Retirement Plan so that you and other employees of Stryker and its participating subsidiaries (all referred to in this Summary as the “Company”) may save for retirement on a “before-tax” basis. The benefits provided under the 401(k) Plan are in addition to Social Security.

To get the maximum value from your benefit plans, you need to understand how they work: what’s covered, what’s not, who is eligible and when. This Stryker Benefits Summary provides information about the plan provisions and guidelines governing your healthcare, welfare and retirement benefits.

The information presented in the Benefits Summary makes it easy to understand your benefits. Consider this handbook, which is available in print and online at totalrewards.stryker.com/spd, your first resource whenever you have a question about what is covered, how to file claims or your rights as a plan participant. The benefits described are summaries of the official plan documents and contracts, which govern the plans. They are written in plain language to help you understand how the plans work.

When you have questions that are not answered here, please refer to the section called Contacts. The information provided in the Contacts section includes toll-free phone numbers and web site addresses for Stryker’s claims administrators and insurance carriers. Please contact the claim administrators or insurance carriers first when you have questions about coverage or claim status. As always, your Benefits Representative is also available to assist you with complex questions or situations that require special handling.
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About this Summary

This Benefits Summary describes the main features of the Stryker Healthcare Benefits, Flexible Spending Accounts, Life Insurance and Disability Benefits, 401(k) Savings and Retirement Plan and Additional Benefits in non-technical language. These descriptions are part of the formal plan documents that govern plan operation. To the extent that separate plan documents contain additional terms and conditions governing the plans’ operation, the provisions in the plan document will govern.

The following benefits are described in this Benefits Summary:

- Healthcare Benefits
  - Medical Benefits
  - Prescription Drug Benefits
  - Dental Benefits
  - Vision Benefits
  - Location-Based Provisions (supplemental information about location-specific benefits)
- Flexible Spending Accounts
- Life and AD&D Insurance
- Disability Benefits
- 401(k) Savings and Retirement Plan
- Additional Benefits
  - Adoption Assistance Plan
  - Employee Assistance Program

For More Information

Administrative details and procedures for the healthcare and welfare benefits can be found in the Your Rights and Responsibilities section. (See the 401(k) Retirement Plan section for administrative information for those plans.)

If you have questions about the information in this Benefits Summary, you can also contact your Benefits Representative.

Important Note: For the healthcare and welfare benefits, the applicable sections of this Benefits Summary and applicable vendor contracts or certificates of coverage together constitute the summary plan description (SPD) for that benefit. The 401(k) Savings and Retirement Plan that applies to you is described in its entirety (including administrative details governing the plan) within the 401(k) Retirement Plan section, with the appropriate section constituting the SPD for that plan.

An Important Note!

Stryker Corporation, as the plan administrator and plan sponsor, has the sole discretion to interpret the plan documents and the information set out in this summary. Except to the extent that the plan administrator has delegated such authority, no other person has the authority to interpret the plans or to make any representations about them. For example, the plan administrator may delegate to the claims administrator the authority to process benefit claims and administer the appeal procedure with respect to denied benefit claims. Further, any fully insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and for the payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurer is the exclusive source of payment for a fully insured benefit.

The information in this Benefits Summary has been prepared as accurately as possible. The information for all plans reflects provisions in effect as of January 1, 2014, unless noted otherwise.

All determinations and decisions of the plan administrator are final and conclusive for all parties. These determinations and decisions will not be overturned unless it is determined that they are arbitrary and capricious.

If there is any conflict between the information in these SPDs and the official plan documents, the plan documents will always govern. In no event may any representations by any person change the terms of the plans. General information about other Stryker-sponsored benefits is also included for your reference.

Stryker reserves the right to terminate any plan or make changes to any plan at any time, for any reason. Your participation in these plans is not a contract of employment.
Updated Information

If You Have Questions
If you have any questions about this Benefits Summary or any provision of the benefits provided by Stryker, see the Contacts section for phone numbers and web addresses, or contact your Benefits Representative.

If You Need Help Understanding This Summary
This Benefits Summary contains a summary of your rights and benefits under the plans described in it. If you have difficulty understanding any part of this Summary, contact your Benefits Representative.
Healthcare Benefits

This Healthcare Benefits section describes Stryker’s healthcare benefits and includes the following information:

- Participating in Healthcare Benefits
- Medical Benefits
- Prescription Drug Benefits
- Medical and Rx Claims Procedures
- Vision Benefits
- Dental Benefits
- Location-Based Provisions

Because of the amount of claims and appeal information that is required in SPDs, this Benefits Summary includes a separate section on Medical and Rx Claims Procedures. Claims filing information for dental and vision benefits, however, are explained within the Dental Benefits and Vision Benefits sections, respectively.

Notice Regarding Maternity Stays

Stryker’s medical plan allows hospital stays of at least 48 hours for a normal delivery and at least 96 hours for cesarean sections. Preauthorization is not required for stays that do not exceed these guidelines.

The law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). Early discharge is permitted only if the mother receives written information on the advantages and disadvantages of early discharge, the mother consents in writing to an early discharge and her attending provider is in agreement.

Notice Regarding Post-Mastectomy Care

If you or a covered dependent receives benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Coverage will be subject to any applicable deductibles, coinsurance and/or co-payment provisions under the plan.
Participating in Healthcare Benefits

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides preventive care benefits to help keep you well.

This section includes information about who is eligible for healthcare benefits, how to enroll or make changes to your benefit elections, when coverage is effective and when it ends.

**Eligibility**

**Employees**

All full-time and part-time employees of Stryker who are regularly scheduled to work an average of at least 20 hours a week are eligible for this plan. Temporary and seasonal employees, as well as interns, are not eligible. Newly hired employees who meet this requirement become eligible on their date of hire.

**Dependents**

Eligible dependents include:

- Your legal spouse (if your spouse resides outside of the country, he or she may still be eligible for benefits)
- Your children through the day before their 26th birthday, regardless of their marital or employment status
- Your child of any age who relies on you for at least 51% of his or her support due to a physical or mental disability. (Eligibility will continue if you provide proof of the disability within 30 days after the child reaches the age at which coverage would otherwise end. Coverage will then remain in effect as long as the disability continues and you maintain dependent coverage under the plan.)
- Your domestic partner who meets all of the following requirements:
  - Is of your same gender
  - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began
  - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely
  - Has not had another domestic partner within the prior 12 months
  - Has not been a party to a divorce or annulment proceeding within the prior 12 months
  - Is not related to you in a way that would prohibit a legal marriage
  - Is not legally married to anyone else, and any prior marriages have been dissolved through death, divorce or nullity
  - Shares a household with you that is the primary residence of both of you (although you may live apart for reasons of education, healthcare, work or military service)
  - Shares joint responsibility with you for each other’s basic living expenses incurred during the domestic partnership

For purposes of determining eligibility under the Stryker Corporation Welfare Benefits Plan, the term “child” means your (or your spouse’s or same-sex domestic partner’s) child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, a child placed for adoption, or a child for whom you have been appointed legal guardianship.

A child who does not fall within this definition of “child” is not eligible for coverage even if you can claim the child as your dependent for federal income tax purposes.
A newly-eligible child, spouse or declared same-sex domestic partner will be covered from the date of birth, adoption, placement for adoption, foster agreement date, marriage or declaration date if properly enrolled via the employee self service web site, My Stryker Info (https://myinfo.stryker.com/), or by contacting your Benefits Representative and completing an enrollment form within 30 days of the life event (including the date of the event). You also must provide dependent documentation to your Benefits Representative within 45 days of the life event. Your contributions will be deducted on a pre-tax basis, unless you request otherwise. If satisfactory proof of eligibility is not provided within the enrollment period, the dependent will not be eligible for coverage under the plan.

If you fail to enroll your newly eligible child, spouse or declared same-sex domestic partner within this 30-day period, you may still be able to enroll them for coverage, as long as you do so within 120 days of the life event. (Fully insured plans are administered by insurance carriers that do not always agree to the extension of benefits. Please contact your Benefits Representative for confirmation.) Coverage will be effective from the date of birth, adoption, placement for adoption, foster care agreement, or the date of the marriage or declaration date; however, in this situation you will have to pay for their coverage on a post-tax basis from the date of the event through the remainder of the plan year. Coverage will be denied for any enrollment requests made more than 120 days after the qualifying life event and you will have to wait until the next annual enrollment period to enroll your child, spouse or declared same-sex domestic partner for healthcare coverage, unless you experience another life event that would permit you to enroll them prior to that time. If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the Medical and Rx Claims Procedures, Dental or Vision section.

If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.
Enrollment

You must enroll in order to be covered for any of the benefits under the Stryker Corporation Welfare Benefits Plan.

You are required as a condition of enrollment to provide your Social Security number and the Social Security numbers of each family member for whom you are requesting coverage. If you do not properly enroll via the employee self service web site, My Stryker Info (https://myinfo.stryker.com/), or by completing an enrollment form and returning it to your Benefits Representative, within 30 days of your hire date (including your hire date) and provide all the required dependent documentation as requested within 45 days (including your hire date), including Social Security numbers, you will not be enrolled in any of the healthcare coverages. You will not be able to enroll for medical, prescription drug, dental or vision coverage during the year unless you have a qualifying life event or qualify for HIPAA special enrollment period. If failure to enroll with all of the required documentation within the applicable timeframes is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the Medical and Rx Claims Procedures, Dental or Vision section.

You may choose to waive coverage under the plan. If you waive coverage, you will not be able to enroll until the next annual enrollment period unless you experience a qualifying life event.

In certain circumstances, you may also have the option to enroll in a Stryker medical plan not listed among your available options in My Stryker Info. If you wish to enroll in a plan that’s available in your area but not listed as an option, you must contact your Benefits Representative during the annual enrollment period (or within 30 days if you are newly hired or have a qualifying life event that permits a medical plan election) to request a change.

Important

If you do not complete and submit an enrollment form (or enroll via My Stryker Info) within 30 days of your hire date (including your date of hire) and provide the required dependent documentation within 45 days of your hire date, you and/or your dependents will not be enrolled in health coverage. For example, if you are hired on May 1, your enrollment deadline is May 30 and the deadline to submit proof of dependent status is June 14. You will not be able to enroll for medical, prescription drug, dental or vision coverage during the year unless you have a qualifying life event.

You must check your enrollment confirmation for any errors. If you do not correct any errors within the enrollment period, you will not be permitted to make any changes unless you subsequently have a qualifying life event or qualify for HIPAA special enrollment rights as described below.

Making Changes

You may change your enrollment once each year during the annual enrollment period. You will be notified in advance of the annual enrollment dates. Coverage changes will take effect the following January 1.

Qualifying Life Events

In most cases, you cannot change your healthcare benefit election during the year. However, you may be permitted to add or drop a dependent, or enroll for or drop coverage, if you experience a change in one of the following areas:

- Legal marital status—including marriage, death of a spouse, divorce or annulment. Note: Legal separation is not considered a qualifying life event. If you cover your spouse under your Stryker healthcare benefits, you may not drop him or her from your coverage in the event of legal separation.
- Declaration of same-sex Domestic Partner Status—declaration or termination of partnership
- Number of dependents—including birth, adoption, placement for adoption, acquiring a stepchild, acquiring a foster child or death
- Dependent status—a dependent child either satisfies or fails to meet Stryker's eligibility requirements (e.g., by reaching age 26 or because of disability status)
- Compliance with a court order regarding medical coverage of a dependent child or a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
- Employment status—you, your spouse or your dependent child either start or stop working and lose coverage through another health plan
- Work schedule—standard working hours for you, your spouse or your dependent child either increase or decrease. A change in work schedule includes a switch between full-time and part-time employment (or vice versa), a strike or lockout or...
Participating in Healthcare Benefits

an unpaid leave of absence. If your spouse is covered under his or her employer’s benefits plan, and your change in work schedule is considered a qualifying life event under your spouse’s plan, you may become eligible to participate in that plan. In this situation, you may be able to drop Stryker coverage in order to enroll for coverage under your spouse’s Plan.

- Residence or worksite—you move in or out of your medical plan’s service area as the result of a change in the place where you or your spouse live or work
- Dependent’s legal residence—your eligible spouse or other dependent moves to the United States from another country. **Note:** In the event that you enroll your spouse or other dependent for coverage in this situation, your contributions for his or her coverage will be made on an after-tax basis for the remainder of the plan year.
- Loss of other health plan coverage—you, your spouse or your dependent child lose coverage under another employer-sponsored health plan
- Significant change in coverage under another employer plan—coverage provided by your spouse’s or dependent’s employer changes
- Enrollment period under another employer plan—the enrollment period for benefits under your spouse’s or dependent’s employer plan occurs while your elections are in effect
- Eligibility for Medicare or Medicaid—you or a covered dependent becomes eligible for or loses eligibility for Medicare or Medicaid

If you need to change your healthcare benefit election due to one of these life events, your Benefits Representative must approve any benefit election changes.

You may have the option at this time to enroll in a Stryker medical plan not listed among your available options. If you wish to enroll in a plan that is available in your area, but not listed as an option, you must contact your Benefits Representative during the annual enrollment period (or within 30 days of your date of hire or the qualifying life event provided that the life event permits a medical plan change) to request this change.

If you have a qualifying life event, you must properly change your enrollment via the employee self service web site, My Stryker Info ([https://myinfo.stryker.com/](https://myinfo.stryker.com/)), or by contacting your Benefits Representative and completing an enrollment form, and provide proof of the life event (if applicable) within 30 days of the life event (including the date of the event). You must also provide dependent documentation within 45 days as requested. If you meet these deadlines, your contributions will be deducted on a pre-tax basis.

If you are adding coverage and submit all of the requested documentation more than 30 days (or dependent documentation more than 45 days), but less than 120 days of the event, your change will be effective but all new contributions will be deducted from your paycheck on a post-tax basis for the remainder of the plan year. If you don’t properly change your enrollment and submit all of the requested documentation within 120 days of the event, you will have to wait until the next annual enrollment period to make any changes to your healthcare benefit election, unless you experience another qualifying life event that would permit an election change prior to that time.

You cannot drop coverage via My Stryker Info. If you are dropping coverage for yourself or a dependent due to a qualifying life event, you must complete the enrollment form and provide proof of the qualifying event to your Benefits Representative within 30 days of the life event. If you do not meet this deadline, you will not be able to change your election until the next annual enrollment period, unless you experience another qualifying life event that would permit an election change.

**Qualifying Life Event Rules**

Changes to your healthcare benefit election must be consistent with the qualifying life event. This means that the event must affect eligibility for health benefits under Stryker’s plan or a plan sponsored by your spouse’s or dependent’s employer. For example, if you get married, your new spouse becomes eligible for coverage under the Stryker Corporation Welfare Benefits Plan. In addition, you may become eligible for health plan coverage through your spouse’s employer. In this situation, the qualifying life event permits you to:

- Add yourself or your spouse to Stryker’s plan, or
- Drop coverage under Stryker’s plan if you enroll for coverage under your spouse’s health plan.
If you are enrolled in a medical plan option other than the UnitedHealthcare PPO or Out-of-Area plan, see the supplemental summary plan description for the applicable plan (provided in the Location-Based Provisions section) or contact your Benefits Representative for specific information regarding eligibility requirements. You will be asked to provide proof of the life event (for example, loss of coverage under another health plan) and dependent documentation, such as a marriage or birth certificate, of any qualifying life event.

**HIPAA Special Enrollment Rights**

There are four circumstances under which you will qualify for HIPAA special enrollment rights:

- **You acquire a new dependent.** If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, or placement of a foster child, you may enroll yourself and your new dependent (and your spouse, if you are acquiring a dependent child for any of the reasons listed here) in Stryker’s plan. If you are already enrolled for health coverage when you acquire a new dependent, you may enroll your dependent.

  To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 30 days after the date you acquire the new dependent. If you acquire a dependent child through birth, adoption or placement for adoption, or placement of a foster child, the new election will be effective on the date the dependent child was acquired. If you acquire a dependent through marriage, the new election will be effective on your date of marriage.

  If you don’t enroll within 30 days, you may still enroll within the 120-day period described in “Eligibility” on page 5 and “Making Changes” on page 7, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year. If you don’t enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

- **You or a dependent loses other coverage.** If you waived health coverage because you or your dependent had other medical coverage (including COBRA coverage), you may enroll yourself and your dependents if you or your dependents subsequently lose eligibility for that other coverage (or exhaust your COBRA coverage) or if employer contributions for that coverage are terminated.

  For this purpose, “loss of eligibility” includes, but is not limited to:

  - A loss of coverage that results from termination of employment, reduction in hours of employment, or divorce, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan);
  - In the case of HMO coverage, a loss of coverage that results when an individual no longer resides, lives or works in a HMO service area and there is no other benefit package available to the individual;
  - A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other plan; and
  - A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part.

  Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis, voluntary termination or termination of coverage for cause (such as fraud), or loss of coverage with no qualifying life event. See “When Coverage Ends” on page 14 for more information about termination of coverage for cause.

- **You lose Medicaid/CHIP eligibility.** If you or an eligible family member loses eligibility for coverage under Medicaid or a State Children’s Health Insurance Program (CHIP), you may have special enrollment rights.

  To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 30 days after the date the other coverage ends. However, in the case of an individual who loses other coverage due to the application of a plan’s lifetime limit on all benefits, this special enrollment period continues until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. In the case of a loss of Medicaid or CHIP eligibility, the special enrollment period continues until 60 days after the loss of eligibility. In all other situations, if you don’t enroll within 30 days, you may still enroll within the 120-day period described in “Eligibility” on page 5 and “Making Changes” on page 7, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year. If you don’t enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.
You will be asked to provide documentation regarding the date the other health plan coverage ended.

- **You gain Medicaid or CHIP eligibility (i.e., become eligible for a Medicaid or CHIP premium assistance subsidy).** If you or a family member becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the Plan, you may have special enrollment rights.

  If you or an eligible dependent becomes eligible to have Medicaid or CHIP assist in the payment of your coverage under the Stryker Health and Welfare Plan, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you contact your Benefits Representative no more than 60 days after you or your dependent is determined to be eligible for such assistance.

  If you don’t enroll with the 60-day period, you may still enroll within the 120-day period but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year. If you don’t enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

  Documentation regarding the loss of Medicaid or CHIP coverage or eligibility for premium assistance under those programs will be required.

### Life Event Guide—Healthcare

When you experience an important life event—like getting married or having a baby—your benefits under the Stryker Corporation Welfare Benefits Plan may be affected. The “Life Event Guide” below provides an overview of these events and the actions you may want to take to update your healthcare benefits, including medical, prescription drug, vision and dental coverage.

Your Benefits Representative must approve benefit election changes. If you have a qualifying life event as provided in the following chart, you must properly change your enrollment via the employee self service web site, My Stryker Info ([https://myinfo.stryker.com/](https://myinfo.stryker.com/)), or by contacting your Benefits Representative and completing an enrollment form, and provide proof of the life event (if applicable) within 30 days of the life event (including the date of the life event). You must also provide the required dependent documentation within 45 days of the life event (including the date of the event) as requested. You cannot drop coverage via My Stryker Info. If you are dropping coverage for yourself or a dependent, you must complete the enrollment form and return it to your Benefits Representative along with proof of the qualifying life event within 30 days of the life event (including the date of the event). If you do not meet this deadline, you will not be able to change your election until the next annual enrollment period, unless you experience another qualifying life event that would permit an election change.

If you are adding coverage and submit all of the requested documentation more than 30 days (or dependent documentation more than 45 days) but less than 120 days of the event, your change will be effective but all new contributions will be deducted from your paycheck on a post-tax basis for the remainder of the plan year. If you don’t properly change your enrollment and submit all of the requested documentation within 120 days of the event, you will have to wait until the next annual enrollment period to make any changes to your healthcare benefit election, unless you experience another qualifying life event that would permit an election change prior to that time.

If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the *Medical and Rx Claims Procedures, Dental or Vision* section.
<table>
<thead>
<tr>
<th>Qualifying Life Event</th>
<th>Permissible Election Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage, declaration of same-sex domestic partner, birth, adoption, placement for adoption, appointment of legal guardianship, acquiring a stepchild or placement of a foster child</td>
<td>You may add your new spouse or newly declared same-sex domestic partner or newly acquired dependent child to the medical and prescription drug, dental and/or vision coverage. If you previously declined coverage, you may enroll yourself, your spouse, your same-sex domestic partner and/or any eligible dependent child in the medical and prescription drug, dental and/or vision coverage. You may drop medical and prescription drug, dental and/or vision coverage if you become enrolled for similar coverage under your spouse’s or domestic partner’s plan.</td>
</tr>
<tr>
<td>Death of dependent, divorce, annulment or termination of domestic partnership or termination of an adopted or foster child’s placement</td>
<td>Note: Legal separation is not considered a qualifying life event You must drop the affected dependent’s medical and prescription drug, dental and/or vision coverage.</td>
</tr>
<tr>
<td>Change in the employment status of employee, spouse or dependent (e.g., change in work hours, change between salaried and hourly and leaves of absence)</td>
<td>You may enroll for medical and prescription drug, dental and/or vision coverage if the change in employment status results in a loss of eligibility for other similar coverage. You may drop medical and prescription drug, dental and/or vision coverage if the change in employment status results in eligibility for other similar coverage and you are enrolled in another medical and prescription drug, dental and/or vision plan(s).</td>
</tr>
<tr>
<td>Dependent loses benefit eligibility (for example, the dependent reaches age 26)</td>
<td>You may drop the affected dependent’s medical and prescription drug, dental and/or vision coverage.</td>
</tr>
<tr>
<td>Change in residence or work site</td>
<td>You may change to another similar plan option or drop coverage if the event results in loss of eligibility under your current plan option.</td>
</tr>
<tr>
<td>Dependent moves to the United States from another country</td>
<td>You may enroll your dependent(s) for medical and prescription drug, dental and/or vision coverage. Your contributions for any coverage you elect will be made on an after-tax basis for the remainder of the plan year.</td>
</tr>
<tr>
<td>Loss of other employer, government or educational institution sponsored medical coverage by employee, spouse or dependent</td>
<td>You may enroll yourself and/or your spouse or dependents in the medical and prescription drug, dental and/or vision plan(s) if other coverage is lost due to: Exhaustion of COBRA; Loss of eligibility; or Termination of employer contributions as an active employee only.</td>
</tr>
<tr>
<td>Employee or dependent becomes eligible for or loses eligibility for Medicare or Medicaid</td>
<td>You may drop medical and prescription drug, dental and/or vision coverage for the affected individual upon entitlement to Medicare or Medicaid. You may enroll yourself and/or the affected individual for medical and prescription drug, dental and/or vision coverage upon loss of similar coverage through Medicare, Medicaid or CHIP eligibility, and if you are already covered under the Stryker Health and Welfare Plan.</td>
</tr>
</tbody>
</table>
Life Event Guide

<table>
<thead>
<tr>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court issues order regarding medical coverage of child (qualified medical child support order or QMCSO)</td>
<td>You may enroll your child in medical and prescription drug, dental and/or vision coverage. If you are not currently covered, you must also be added to the same plan(s). You may drop similar coverage for your child if another individual is ordered to provide medical and prescription drug, dental and/or vision coverage for the child under a QMCSO and coverage is in fact provided.</td>
</tr>
<tr>
<td>Significant increase in cost or significant curtailment of coverage under another plan</td>
<td>If you drop the medical and prescription drug, dental and/or vision coverage, you may elect a similar benefit under this plan.</td>
</tr>
<tr>
<td>Enrollment period for coverage under another employer’s plan occurs while your elections are in effect</td>
<td>You may drop medical and prescription drug, dental and/or vision coverage if you become enrolled for similar coverage under another employer’s plan. You may enroll for medical and prescription drug, dental and/or vision coverage if similar coverage under the other employer’s plan was dropped during that plan’s enrollment period.</td>
</tr>
</tbody>
</table>

Remember, election changes are permitted only when the qualifying life event has a direct effect on eligibility for health coverage.

Your Cost for Healthcare Benefits

Stryker and you share the cost of medical, prescription drug, dental and vision coverage. As Stryker’s cost for healthcare benefits changes from year to year, your cost for healthcare coverage may also change. Your contribution toward the cost of healthcare benefits is based on your full-time or part-time status, the number of people you cover, and the plans you select. Your cost for each plan is shown on My Stryker Info (https://myinfo.stryker.com/) or your enrollment form by coverage level.

To encourage you to live a healthy life style, if you or your spouse/declared same-sex domestic partner is covered under the Stryker medical plan, is a tobacco-user (see tobacco-user definition below), and have not completed the Quit For Life® program this year or other program recommended by your physician, you will pay a surcharge for medical coverage.

Unless you elect otherwise, your contribution is deducted from your pay on a pre-tax basis—that is, before most federal, state and local taxes are withheld. This results in lower taxable income and therefore less taxes and more take-home pay.

Tobacco Surcharge

If you or your spouse/declared same-sex domestic partner is covered under the Stryker medical plan, is a tobacco-user (see tobacco-user definition below), and has not completed the Quit For Life® program this year or other program recommended by your physician, you will pay a surcharge for medical coverage.

You and your covered spouse/declared same-sex domestic partner must be tobacco free for at least six months or have completed the Quit For Life® program or other program recommended by your physician this year when signing the Tobacco-Use Affidavit to be considered a non-tobacco user.

The surcharge is applied once per employee regardless of the number of tobacco users you cover.

Tobacco Cessation Program

We are committed to promoting the health and wellbeing of our employees and their families. The goal of our healthcare program is not only to make sure you have access to the services you need when you are sick but also to help you live a healthier life.

If you or your spouse/declared same-sex domestic partner/adult dependent is a tobacco user, you already know that one of the best things you can do for your health is to quit. We support those efforts and have put a program in place to help you beat the addiction.
Tobacco-Use Affidavit

Current employees must verify their tobacco status along with their covered spouse/declared same-sex domestic partner tobacco status by signing a Tobacco-Use Affidavit every year during annual open enrollment.

New hires must verify their tobacco status along with their covered spouse/declared same-sex domestic partner tobacco status by signing a Tobacco-Use Affidavit during their initial benefits enrollment period.

If an employee fails to sign the Tobacco-Use Affidavit, they will be considered a tobacco user for purposes of the Tobacco Cessation Program.

Tobacco Surcharge

For employees who are required to pay the Tobacco Surcharge, the following apply:

- For current employees, the Tobacco Surcharge will be charged automatically starting with the first pay period of the following calendar year.
- For new hires, the Tobacco Surcharge will be charged automatically with the first medical plan contribution.

The Tobacco Surcharge can be removed by completing the Quit For Life® Tobacco Cessation Program, or by complying with a program recommended by your physician, or by confirming via the affidavit that the employee and/or spouse/declared same-sex domestic partner has quit using tobacco for a period of six months prior to the signature date. The Tobacco Surcharge will be removed within two pay periods following completion of the affidavit on My Stryker Info. You will be credited with any surcharges paid for the year.

If you identify yourself and your spouse/declared same-sex domestic partner as a tobacco user, both individuals must complete the entire Quit For Life® Program for the surcharge to be removed.

Definition of a Tobacco User

You will be considered a tobacco user if you used tobacco products during the last six months, including but not limited to cigarettes, cigars, pipes, cigarettes, chewing tobacco and snuff. You will not be considered a tobacco user if you used tobacco products at the rate of once per month or less on average (such as an occasional celebratory cigar).

If you falsify your non-tobacco use, you will be immediately subject to the surcharge and may face termination of employment and/or termination of the medical plan.

Call the Quit For Life® Program today at 866-QUIT-4-LIFE (866-784-8454) or enroll online at www.quitnow.net.

Wellness Assessment Requirements

You are eligible to receive the wellness incentive toward your medical plan for 2015 if you and your covered spouse / declared same-sex domestic partner complete the Wellness Assessment via the www.LiveWell-Stryker.com website by the following deadlines:

- If you were hired or added as a new spouse / declared same-sex domestic partner prior to January 1, 2014, the deadline is March 31, 2014.
- If you are hired or added as a new spouse / declared same-sex domestic partner between January 1 and July 31, 2014, the deadline is August 31, 2014.
- If you are hired or added as a new spouse / declared same-sex domestic partner after August 1, 2014, you will automatically receive the lower employee contributions for 2015.

Even if you, your spouse /declared same-sex domestic partner plans to elect other coverage (e.g., through another employer), it is to your advantage for both of you to take the Wellness Assessment by the specified deadline. If you or your spouse / declared same-sex domestic partner loses coverage during the plan year due to an unforeseen life event and you want to add him or her to your Stryker benefits, you will miss out on the wellness incentive toward your medical plan if both of you have not taken a Wellness Assessment by the specified deadline.

To confirm if you have completed the Wellness Assessment in the current year, log on to www.LiveWell-Stryker.com.
Non-Grandfathered Status

The Company believes the medical and prescription drug benefits under the healthcare plan do not constitute a grandfathered health plan under the Patient Protection and Affordable Care Act (also known as Health Care Reform). Being a non-grandfathered health plan means that the healthcare plan must include certain consumer protections of Health Care Reform.

Questions regarding which protections apply and which protections do not apply to a non-grandfathered health plan can be directed to the plan administrator (see the Your Rights and Responsibilities section). You may also contact the Employee Benefits and Security Administration, U.S. Department of Labor at 866 444 3272 or www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Even though the dental and vision benefits are not subject to the insurance market reforms of Health Care Reform, the Company has voluntarily amended the definition of dependent child for purposes of those benefits to align with the new definition required under Health Care Reform for the medical and prescription drug benefits.

When Coverage Begins

For You

If you enroll when you are first eligible, your coverage under the plan begins immediately as of your date of hire.

For Your Dependents

If you are covered, new dependents will be covered as of the event date if you enroll them within 30 days after they first become eligible, or within 120 days as described in “Eligibility” on page 5 and “Making Changes” on page 7.

For Re-Hired Employees and Their Dependents

If you are re-hired after a break in service, coverage begins immediately on your date of rehire. There is no waiting period. If the break in service is 30 days or less and you are rehired in the same calendar year, your previous benefit elections will be reinstated as of your rehire date. This is not considered a qualifying life event. If the break in service is longer than 30 days or if you are rehired in a new calendar year, you will make new benefit elections which will become effective as of your rehire date.

When Coverage Ends

Coverage for you and your dependents under the Stryker Corporation Welfare Benefits Plan ends on the earliest of the following dates:

- The date you leave Stryker or fail to pay required coverage contributions
- The date you are no longer an eligible employee
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, on the December 31 following the annual enrollment period
- The date the plan is terminated
- The date the plan administrator terminates your coverage for reasons as described in the “Termination of Coverage for Cause” box that follows

In addition, dependent coverage also ends:

- On the date your coverage ends
- On the day prior to your dependent child’s 26th birthday
- On the date your dependent child otherwise ceases to qualify as a dependent under the plan
- In the case of your spouse, on the date your divorce or annulment is final. In the case of your same-sex domestic partner, on the date you and your partner complete a Termination of Domestic Partnership form and have it approved by your Benefits Representative

Termination of Coverage for Cause

The plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a dependent; or
- You commit an act of physical or verbal abuse that imposes a threat to the plan’s staff, UnitedHealthcare’s staff, a provider or another covered person.
When your coverage ends, claims will be paid for covered health services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

If you are enrolled in a medical plan option other than the UnitedHealthcare PPO or Out-of-Area plan, check the supplemental summary plan description for the applicable plan (provided in the Location-Based Provisions section) or contact your Benefits Representative for specific information regarding eligibility requirements. If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see “COBRA: Continuing Healthcare Coverage.”

If coverage ends during the month, there will be no proration of contributions.

### COBRA: Continuing Healthcare Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Stryker Corporation Welfare Benefits Plan when coverage might otherwise be lost.

#### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a “qualifying life event.” COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose health plan coverage because of a qualifying life event. Depending on the type of qualifying life event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Stryker Corporation Welfare Benefits Plan, Health Care Flexible Spending Account, and Employee Assistance Plan because either one of the following qualifying life events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying life events happens:

- Your spouse dies,
- Your spouse's hours of employment are reduced or your spouse's employment ends for any reason other than his or her gross misconduct,
- You become divorced or legally separated from your spouse,
- Your Domestic Partner Declaration is terminated, or
- Your spouse becomes enrolled in Medicare (Part A or Part B).

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying life events happens:

- The parent-employee dies,
- The parent-employee’s hours of employment are reduced or the parent-employee’s employment ends for any reason other than his or her gross misconduct,
- The parents become divorced or legally separated,
- The child stops being eligible for coverage under the plan as a “dependent child,” or
- The parent-employee becomes eligible for Medicare (Part A or Part B).

The Stryker Corporation Welfare Benefits Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified in writing that a qualifying life event has occurred. You do not have to notify the plan administrator when the qualifying life event is the end of employment, reduction of hours of employment or death of the employee. **However, for the other qualifying life events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the plan administrator, via your Benefits Representative, in writing, within 60 days after the date the qualifying life event occurs or the date coverage is lost, whichever is later. You will be required to provide documentation—such as a divorce decree—that a qualifying life event has occurred within 60 days of the event.**
Once the plan administrator receives notice that a qualifying life event has occurred and supporting documentation has been provided, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying life event.

**Duration of COBRA Continuation Coverage**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying life event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both), your divorce or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying life event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability Extension of 18-Month Period of Continuation Coverage**

If you or anyone in your family covered under the Stryker Corporation Welfare Benefits Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, you and your entire family who are entitled to COBRA because of the same qualifying life event can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum coverage period of 29 months. To be eligible for this extension, you must make sure that the plan administrator is notified in writing of the Social Security Administration’s determination within 60 days of the date of the later of the date of the aware notice from the Social Security Administration, the date of the qualifying life event, or the benefit termination date, and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the plan’s COBRA administrator. You will be required to supply a copy of Social Security Administration’s disability determination. If you or your family member is subsequently determined by the Social Security Administration to no longer be disabled, you must notify the plan’s COBRA Administrator of that fact within 30 days of the Social Security Administration’s determination.

**Second Qualifying life event Extension of 18-Month Period of Continuation Coverage**

If your family experiences a second qualifying life event while receiving COBRA continuation coverage (either during the initial 18-month continuation period or during the following 11 months if there is an extension due to disability), the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the plan administrator is notified of the second qualifying life event within 60 days of the second qualifying life event via your Benefits Representative. This notice must be sent to the plan’s COBRA Administrator. You will be required to supply documentation—such as a marriage or birth certificate—that a second qualifying life event has occurred.

**Medicare Entitlement Prior to Termination of Employment or Reduction in Hours**

If you enroll in Medicare (Part A, Part B or both) in the 18-month period immediately preceding your termination of employment or reduction in hours, your spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the date you enrolled in Medicare.

**Contacting the COBRA Administrator**

Ceridian COBRA Continuation Services
3201 34th Street South
St. Petersburg, FL 33711
800 877 7994
www.ceridian-benefits.com

**When COBRA Coverage Ends**

COBRA continuation coverage will terminate on the earliest of the following dates:

- The end of the applicable maximum coverage period
- If any required premium is not paid on time, the last day of the period for which a timely payment was made
- The date, after the date of the COBRA election, that a qualified beneficiary first becomes covered under another group health plan that does not impose any exclusion or limitation due to a pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary.
- The date after the date of the COBRA election, that a qualified beneficiary first enrolls in Medicare.
- The last date on which the employer ceases to provide any group health plan for its employees.
- In the case of the disability extension, the last day of the 11-month extension period.

Continuation coverage may also be terminated for any reason the plan administrator would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

If you elect COBRA continuation coverage under the HCFSA, that coverage will continue until the end of the calendar year during which the qualifying life event occurred as long as timely premiums continue to be made.

**ELECTING COBRA CONTINUATION COVERAGE**

Each qualified beneficiary has an independent right to elect continuation coverage. For example, either you or your spouse may elect continuation coverage, or only one of you may choose to do so. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election form. Failure to do so will result in loss of the right to elect continuation coverage under the plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that if you fail to elect COBRA:

- You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you to avoid this coverage gap.
- You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

Also, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying life event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**COST OF COBRA CONTINUATION COVERAGE**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under these provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Healthcare Tax Credit Customer Contact Center toll free at 866 628 4282. TTD/TTY callers may call toll free at 866 626 4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

**PAYING FOR COBRA CONTINUATION COVERAGE**

**FIRST PAYMENT FOR CONTINUATION COVERAGE**

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. If you do not make your first payment for continuation coverage within this 45-day period, you will lose all continuation coverage rights under the plan.

**Note:** Depending on the date you submit your election your first payment could include several months, because coverage is retroactive to the date that benefits terminated under the plan as a result of the qualifying life event.
Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. If you make a periodic payment on or before its due date, your coverage under the Stryker Corporation Welfare Benefits Plan will continue for that coverage period without any break. The plan will send an annual notice of payments due for these coverage periods.

Grace Periods for Periodic Payments

You will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, your coverage will be terminated as of the last fully paid period of coverage, and you will lose all rights to continuation coverage under the plan.

COBRA Coverage for Domestic Partners

Although not required by COBRA law, under the Stryker Plan, a covered domestic partner has the same COBRA rights as a spouse. Termination of the domestic partner relationship is treated in the same manner as divorce.

Continuing Healthcare Coverage upon Military Leave

If you cease to be eligible for health coverage under the Stryker Corporation Welfare Benefits Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

You may elect to continue health coverage under the Welfare Benefits Plan for yourself and your eligible dependents for the period that is the lesser of:

- Twenty-four months, beginning with the first day you are absent from work to perform military service; or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

ELECTING USERRA CONTINUATION COVERAGE

If you give the Company advance notice of a period of military service that will be 30 days or less, the plan administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform the Company, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give the Company advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are enrolled in health coverage under the Welfare Benefits Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.
A special rule applies if you do not give the Company advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity),
- You affirmatively elect to reinstate the coverage, and
- You pay all unpaid premiums for the retroactive coverage.

**Paying for USERRA Continuation Coverage**

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting period, except for illnesses or injuries connected to the military service.

**HIPAA Certificates**

Under the Health Insurance Portability and Accountability Act (HIPAA), group health plans are required to provide “certificates of creditable coverage” whenever coverage ends.

When medical coverage under the Stryker Corporation Welfare Benefits Plan ends for you or one of your covered dependents, Stryker provides a certificate of coverage that indicates the beginning and ending dates of coverage. If you or your dependent is covered under another group health plan that includes a pre-existing condition limit, you may need to present this HIPAA certificate in order to reduce or eliminate the plan’s pre-existing condition waiting period.

HIPAA certificates are issued by the claim administrators for the medical plans. You will receive a HIPAA certificate each time you change from one Stryker-sponsored medical plan to another.

If you have questions about HIPAA certificates or need additional copies, contact the claims administrator or your Benefits Representative department.

**If You Have Other Coverage**

Due to coordination of benefits rules, the Stryker Corporation Welfare Benefits Plan may not pay benefits if you also are eligible for medical, prescription drug and/or dental benefits from another plan.

**Medical Benefits**

Your Stryker medical benefits are coordinated with benefits from:

- Other employers’ medical plans
- Government plans
- Motor vehicle plans when permitted by law
The Stryker medical plan is primary to medical coverage provided under a personal vehicle insurance policy, unless state insurance law requires otherwise.

Under the coordination of benefits provision, the amount normally payable by Stryker’s plan is reduced to take into account payments from other plans. Your Stryker benefits, when combined with another plan’s benefits, will not exceed what Stryker’s plan would pay by itself. Refer to “Coordination of Benefits Examples” on page 21 to see how coordination of benefits works under the medical plan.

However, the fact that you or your dependent may be covered by Medicaid or Medicare will not be taken into account in enrolling you or your dependent as a participant or in providing benefits to you or your participant under the Stryker plan.

**Which Plan Pays First**

If the other plan has no coordination of benefits provision, the other plan is considered primary and pays its normal benefits first. If both plans have a coordination of benefits provision, the plan covering the patient as an employee is primary and pays first. When Stryker’s plan is primary, it pays benefits without considering what the secondary plan might pay. The secondary plan then pays its benefits, if any are due. When Stryker’s plan is secondary, it pays only the difference between Stryker’s normal benefits and the primary plan’s payments. The Stryker medical plan is primary to medical coverage provided under a personal automobile insurance policy, unless state insurance law requires otherwise.

**Determining the Allowable Expense If This Plan Is Secondary**

When the UnitedHealthcare plan is secondary, the allowable expense is the primary plan’s in-network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan’s reasonable and customary charge. If both the primary plan and this plan do not have a contracted rate, the allowable expense will be the greater of the two plans’ reasonable and customary charges.

**For Dependent Children**

When both parents’ plans cover an eligible child, the plan of the parent whose birthday comes first in the calendar year is primary. If both parents have the same birthday, the plan that has covered either parent for the longer period of time is primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

If the parents are divorced, the following guidelines apply:

- If the parents have joint custody and there is no court decree stating which parent is responsible for healthcare expenses, the birth rule stated above will apply.
- If one parent has custody, his or her plan is primary and the other parent’s plan is secondary unless the divorce decree states otherwise.
- If the parent with custody remarries, the stepparent’s plan is secondary. If the remarried parent with custody has no healthcare coverage, the stepparent’s plan is primary and the plan of the natural parent without custody is secondary.
- The plan that covers a parent as a retired or laid-off employee (or the dependent of a retired or laid-off employee) is secondary to a plan that covers a parent as an active employee (or the dependent of an active employee). However, if the other plan does not have the same rule, this provision will not apply.

If none of the above situations apply, the plan that has covered the patient for the longest period of time is primary.

**Coordination with Medicare**

This plan coordinates with Medicare based on the reason for Medicare eligibility, as described below.

**Age 65**

If you are still working for Stryker when you reach age 65:

- You may continue your Stryker coverage as primary, with Medicare secondary.
- You may choose to be covered only by Medicare.

If he or she is covered under the Stryker medical plan, your spouse also has these options at age 65 no matter how old you are at that time.

**End-Stage Renal Disease**

If you or a covered dependent are eligible for Medicare due to end-stage renal disease, Stryker’s medical plan is primary during the first 30 months of dialysis treatment; after this initial period, Stryker’s plan is secondary to Medicare.
Disability

A disabled individual becomes eligible for Medicare (regardless of age) if the disability is certified by the Social Security Administration and has lasted at least 24 months. If this applies to you or a covered dependent, and you are still actively employed, Stryker’s plan is primary and Medicare is secondary. Medicare will become primary when any one of the following events occurs:

- The disabled individual declines coverage under Stryker’s plan,
- The disabled individual is no longer covered by Stryker’s plan, or
- The disabled individual has exhausted benefits under Stryker’s plan.

**COBRA Coverage**

Medicare is primary to the Stryker’s medical plan if you or a family member is enrolled for COBRA continuation coverage and:

- You or your spouse is enrolled for Medicare based on age, or
- You or a family member is enrolled for Medicare due to disability.

**Effect of Prior Coverage**

If coverage for you or a dependent under this plan replaces any prior coverage, either partially or completely, any benefits provided under the prior coverage may reduce benefits payable under this plan. Prior coverage is any health plan sponsored by an employer.

**Coordination of Benefits Examples**

Your spouse is covered by Stryker’s plan as well as his or her employer’s medical plan. After any deductibles or copayments, covered medical expenses total $2,000.

**CASE #1:** The other plan is the primary payer and pays 75% of covered expenses. Stryker’s plan is secondary and pays 80% of covered expenses. Here’s how to determine how much Stryker’s plan pays as the secondary payer:

<table>
<thead>
<tr>
<th>Stryker’s plan normally pays 80% of covered expenses:</th>
<th>80% × $2,000 = $1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other plan actually pays 75% of covered expenses:</td>
<td>75% × $2,000 = $1,500</td>
</tr>
<tr>
<td>Balance to be paid by Stryker’s plan:</td>
<td>$1,600 – $1,500 = $100</td>
</tr>
</tbody>
</table>

**Dental Benefits**

Coordination of benefits (COB) is used to pay dental expenses when you are covered by more than one plan. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

When you or your family members are covered by more than one plan, Delta Dental follows coordination of benefits rules established by Michigan law to decide which plan is primary and pays first, which plan is secondary and how much the secondary plan must pay. You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Delta Dental pays benefits for eligible care only when you follow its rules and procedures. If these rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

**CASE #2:** If the other plan is primary and pays 80% or more of covered expenses, Stryker’s plan would not pay any benefits, as shown below:

<table>
<thead>
<tr>
<th>Stryker’s plan normally pays 80% of covered expenses:</th>
<th>80% × $2,000 = $1,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other plan actually pays 80% of covered expenses:</td>
<td>80% × $2,000 = $1,600</td>
</tr>
<tr>
<td>Balance to be paid by Stryker’s plan:</td>
<td>$1,600 – $1,600 = $0</td>
</tr>
</tbody>
</table>
Medical Benefits

Stryker’s medical benefits are designed to provide comprehensive coverage and freedom of choice while also controlling costs for you and for Stryker. You may use any licensed healthcare provider and receive benefits for medical services that are required for the care of a sickness or an accidental injury.

This section of the Stryker Benefits Summary describes the UnitedHealthcare plans available to most Stryker employees. In specific locations, HMO and other fully insured medical plans are offered as alternatives to the UHC plans. If you are enrolled in one of those medical plans, refer to the Location-Based Provisions section and the benefit summary or certificate of coverage provided by the insurance company or HMO for detailed information regarding your covered services and supplies.

Stryker’s Medical Options

Stryker offers most employees two UnitedHealthcare PPO plans—the Choice PPO and the Value PPO. However, depending on where you live, you may have alternative options. Your options are described below.

The UnitedHealthcare Choice and Value PPO Plans

A PPO (Preferred Provider Organization) is a managed care arrangement that allows you to choose in- or out-of-network care each time you need a medical service or supply. When you use in-network providers, PPO plans pay a higher percentage of covered charges.

UnitedHealthcare manages Stryker’s PPO network. UnitedHealthcare is also the claims administrator for the PPOs and the Out-of-Area plan.

Other Medical Plan Options

While both UnitedHealthcare PPO options are available to employees in most Stryker locations, in the following states, alternative medical plans are offered:

- **Alabama**—The BCBS of Alabama PPO plan is the only medical and prescription plan offered in Alabama. The UnitedHealthcare PPO options are not available in Alabama. If you enroll in the BCBS of Alabama PPO plan, your prescription drug benefits will be provided through BCBS of Alabama.

- **California**—The Kaiser Permanente HMO is offered as an alternative to the UnitedHealthcare PPO options. If you select the HMO, your prescription drug benefits are provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.

- **Hawaii**—The Kaiser Permanente plan is the only medical plan offered in Hawaii. The UnitedHealthcare PPO options are not available in Hawaii. If you enroll in the Kaiser Permanente plan, your prescription drug benefits will be provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.

The Out-Of-Area Plan

You are eligible for the Out-of-Area plan if there are no PPO or HMO networks available in your area. The Out-of-Area plan is an “indemnity” plan, which means that claims are paid at the same benefit level no matter which doctor or hospital you use.

How the UnitedHealthcare PPOs Work

The following explains information you need to know about how the Choice and Value PPOs work, and how using participating or non-participating providers impacts your benefits.

Both plans work the same way, use the same network of providers and offer the same benefits. The only differences are the employee contributions for coverage, the deductibles and the out-of-pocket maximums.
Medical Benefits

Your Choices for Receiving Care

Each time you need care, you choose between:
- In-network services received from participating providers
- Out-of-network services received from non-participating providers

The plans pay benefits either way, but at a higher level for in-network care. In addition, participating providers file claims and generally handle notification requirements for you.

In-network benefits are based on negotiated fees paid to participating providers. When Covered Health Services are received from out-of-network providers, eligible expenses are based on fees that are negotiated with the provider, a percentage of the published rates allowed by Medicare for the same or similar service, or in rare circumstances, 59% of the billed charge or a fee schedule that is determined at the time of service. When reasonable and customary fee guidelines apply, you are responsible for paying the provider for any difference between the reasonable and customary fee and the provider’s actual charge.

Out-of-Network Benefit Exception

Most of the healthcare services you need are available within the network. However, if there is no in-network provider within a 20-mile radius of your home ZIP code, you may be eligible for in-network benefits in connection with specific Covered Health Services. UnitedHealthcare must approve any benefits that fall under this exception prior to receipt of care. These benefits are subject to any plan limitations or exclusions outlined in this Benefits Summary.

If a covered service or supply qualifies for the out-of-network benefit exception, benefits are subject to the in-network deductible and are paid at 80% of the in-network benefit level. However, eligible expenses are based on fees that are negotiated with the provider, a percentage of the published rates allowed by Medicare for the same or similar service, or in rare circumstances, 59% of the billed charge or a fee schedule that is determined at the time of service. When reasonable and customary fee guidelines apply, you are responsible for paying the provider for any difference between the reasonable and customary fee and the provider’s actual charge.

Participating Providers

All participating providers are carefully selected according to objective requirements and standards. The criteria for doctors include professional credentials, education, medical training and experience and hospital admitting privileges. Whenever possible, doctors are either board certified or board-eligible in their areas. For hospitals, the criteria include accessibility, quality of care, community reputation, available services and cost efficiency. Network managers regularly re-evaluate participating providers to make sure they continue to meet requirements.

Network participation status changes from time to time, so it is important to verify that your doctor or hospital participates with the UnitedHealthcare PPO network before scheduling an appointment or procedure. Participating provider information is available via the UnitedHealthcare web site (www.myuhc.com) and/or by calling 800 387 7508 toll free.

UnitedHealth Premium℠ Program

UnitedHealthcare designates network physicians and facilities as UnitedHealth Premium Program physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels—quality and efficiency of care. The UnitedHealth Premium Program was designed to:
- Help you make informed decisions on where to receive care
- Provide you with decision support resources
- Give you access to physicians and facilities across areas of medicine that have met UnitedHealthcare’s quality and efficiency criteria

For details on the UnitedHealth Premium Program, including how to locate a UnitedHealth Premium physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.

Eligible Expenses

Eligible expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in “Medical Plan Definitions” on page 46. For certain Covered Health Services, the Plan will not pay these expenses until you have met your annual deductible. Stryker has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the eligible expense will be determined and otherwise covered under the Plan.
Participating providers have agreed to negotiated fees, which help control costs for both you and Stryker. When an in-network provider provides a covered service, the eligible expense is the contracted rate the provider has agreed to accept. When you use in-network providers, you are not responsible for the difference between the negotiated rate and the provider’s actual charge.

If you are enrolled in either PPO plan and use out-of-network providers, or if you are enrolled in the Out-of-Area plan, UnitedHealthcare determines eligible expenses by calculating competitive fees in the geographic area where the service is provided. In some cases, out-of-network providers agree to accept rates negotiated by UnitedHealthcare or one of its vendors, affiliates or subcontractors. In these cases, eligible expenses are based on the negotiated rate.

When eligible expenses are lower than the out-of-network provider’s charge, you are responsible for paying the difference directly to the provider. This is true even when services or supplies are not available from in-network providers or an in-network doctor has referred you, unless you have been granted an out-of-network benefit exception. Emergency care services are always paid at the in-network benefit level.

Benefits for ambulance services are not subject to eligible expense guidelines.

Your Deductible

A deductible is money you must spend out-of-pocket for covered medical expenses before the plan pays benefits. Your deductible is determined by the plan you choose, the number of people you cover and whether you use in-network or out-of-network providers. See the chart in “Your Medical Benefits” on page 26 for specific deductible amounts. The family deductible may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual deductible amount. The deductible applies to all expenses except:

- Only expenses incurred for in-network services apply toward the in-network deductible. Likewise, only expenses incurred for out-of-network services apply toward the out-of-network deductible.

Family Deductible Example

When you use in-network doctors and facilities, the annual family deductible is $1,050 under the Choice PPO and $2,250 under the Value PPO. Assume that you enroll in the Choice PPO and have a family of four. Here is an example of how the family deductible might be satisfied:

<table>
<thead>
<tr>
<th>Participant</th>
<th>Covered Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee:</td>
<td>$250</td>
</tr>
<tr>
<td>Spouse:</td>
<td>$350</td>
</tr>
<tr>
<td>Child #1:</td>
<td>$250</td>
</tr>
<tr>
<td>Child #2:</td>
<td>$200</td>
</tr>
<tr>
<td>Total:</td>
<td>$1,050</td>
</tr>
</tbody>
</table>

Your Share in the Cost of Covered Services

The plan pays a certain portion of covered medical expenses. The portion you must pay is your coinsurance percentage or a copayment, depending on the type of service provided:

- Coinsurance is a percentage of a covered expense (for example, you pay 20% and the plan pays 80%). You pay your coinsurance share in addition to the deductible.

- A copayment is a fixed charge like $25 or $40 for an office visit. When a flat dollar copayment is required, the covered expense is not subject to the annual deductible. For example, you pay $25 for an office visit with a primary care physician—the plan pays the balance and the annual deductible does not apply.

Your coinsurance share or copayment requirement differs depending on whether you are enrolled in the UnitedHealthcare Choice PPO plan, the UnitedHealthcare Value PPO plan or the Out-of-Area plan. If you are enrolled in a PPO plan, your coinsurance share and copayment requirements differ when you use in-network versus out-of-network providers. See the chart in “Your Medical Benefits” on page 26 for specific coinsurance and copayment amounts.
Your Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay towards the cost of covered medical expenses (including your medical copays, coinsurance and payments toward satisfying the annual deductible) in a calendar year. Your out-of-pocket maximum is based on the plan you are enrolled in and the number of people you cover. If you are enrolled in either PPO plan, the out-of-pocket maximum is also determined by whether you use in-network or out-of-network providers. See the chart in “Your Medical Benefits” on page 26 for specific out-of-pocket maximums.

The individual out-of-pocket maximum is the most that will apply to any one family member. Once you or a covered dependent reaches the individual out-of-pocket maximum, the plan pays 100% of that person’s eligible expenses for the rest of the calendar year. Once your family out-of-pocket maximum is reached, the plan pays 100% of eligible expenses for the rest of the calendar year for you and all your covered dependents.

The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual out-of-pocket maximum.

The out-of-pocket maximum includes your medical copays, your share of the coinsurance and payments toward satisfying the annual deductible. It does not include:

- Your contributions toward the cost of medical coverage (your premium)
- Your fixed dollar copayments for prescription drugs
- Temporomandibular joint (TMJ) disorder treatment expenses
- Any amounts over reasonable and customary fee limits or the allowance based on the Minimum Necessary Reimbursement Program (MNRP), as outlined under “Your Choices for Receiving Care” on page 24 and defined in “Medical Plan Definitions” on page 46.
- Notification penalties
- Any amounts over plan limits for organ transplants

Out-of-pocket expenses incurred for in-network services apply toward the in-network out-of-pocket maximum only. Only out-of-pocket expenses incurred for out-of-network services apply toward the out-of-network out-of-pocket maximum.

Your Medical Benefits

The chart below lists the deductibles, coinsurance, copayments and out-of-pocket maximums that currently apply under the UnitedHealthcare Choice and Value PPO plans and the Out-of-Area plan.

<table>
<thead>
<tr>
<th>Deductibles, Coinsurance, Copayments and Out-of-Pocket Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UHC Choice PPO Plan</strong></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
</tr>
<tr>
<td>Employee</td>
</tr>
<tr>
<td>Employee + 1</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td><strong>Your Share in the Cost of Covered Services—After Deductible Unless Noted</strong></td>
</tr>
<tr>
<td><strong>Office visit copayment—primary care</strong></td>
</tr>
</tbody>
</table>
### Benefit Maximums

There is no lifetime benefit maximum for covered individuals.

### Emergency Room Care

When you need emergency care and use an emergency room, you pay a $125 copayment and the plan pays the balance of emergency room charges; no deductible applies.

These benefits apply only when you use a hospital emergency room for a true medical emergency. A “true medical emergency” is defined as a serious medical condition or symptom resulting from injury, sickness or mental illness, which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to life or health.

The emergency room copayment is waived if you are admitted to the hospital as an inpatient through the emergency room.

### Special Services and Procedures

To ensure you receive the appropriate care in the appropriate setting, the medical plan has a number of special services and requirements. This section describes what you need to know when you need medical care or services.

---

<table>
<thead>
<tr>
<th>Special Services and Procedures</th>
<th>UHC Choice PPO Plan</th>
<th>UHC Value PPO Plan</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office visit copayment—specialist</strong></td>
<td>$40; not subject to deductible</td>
<td>$40; not subject to deductible</td>
<td>$40; not subject to deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office visits</strong></td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
</tr>
<tr>
<td><strong>Other covered services</strong></td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
<td>$0 (Plan pays 100% of eligible expenses)</td>
</tr>
</tbody>
</table>

### Emergency Room Visits—After Deductible Unless Noted

| Facility and physician charges | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible |
| Inpatient hospital care | 20% | 40% | 20% | 40% | 20% |
| Inpatient mental health and substance abuse treatment | 20% | 40% | 20% | 40% | 20% |

### Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee + 1</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>$2,600</td>
<td>$5,200</td>
<td>$3,850</td>
</tr>
<tr>
<td><strong>Employee + 1</strong></td>
<td>$5,200</td>
<td>$10,400</td>
<td>$7,700</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$5,550</td>
<td>$11,100</td>
<td>$8,450</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Special Services and Procedures</th>
<th>UHC Choice PPO Plan</th>
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</tr>
<tr>
<td><strong>Other covered services</strong></td>
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<td>$0 (Plan pays 100% of eligible expenses)</td>
</tr>
</tbody>
</table>

### Emergency Room Visits—After Deductible Unless Noted

| Facility and physician charges | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible | $125; not subject to deductible |
| Inpatient hospital care | 20% | 40% | 20% | 40% | 20% |
| Inpatient mental health and substance abuse treatment | 20% | 40% | 20% | 40% | 20% |

### Annual Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee + 1</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
<td>$2,600</td>
<td>$5,200</td>
<td>$3,850</td>
</tr>
<tr>
<td><strong>Employee + 1</strong></td>
<td>$5,200</td>
<td>$10,400</td>
<td>$7,700</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$5,550</td>
<td>$11,100</td>
<td>$8,450</td>
</tr>
</tbody>
</table>
Notification Requirements

Personal Health Support is a program provided by UnitedHealthcare designed to encourage an efficient system of medical care for you and your covered dependents. You must notify Personal Health Support before you are admitted to a hospital as an inpatient. In most cases, in-network providers will handle notification requirements for you, but it is your responsibility to ensure that notification takes place. If you are enrolled in either PPO plan and use out-of-network providers or if you are enrolled in the Out-of-Area plan, you are responsible for notifying Personal Health Support.

Notification is also required for:

- Inpatient hospitalization
- Mental health or substance abuse treatment
- Emergency services if you are admitted to an out-of-network hospital
- Congenital heart disease
- Maternity care exceeding the standard timeframe
- Reconstructive procedures
- Home healthcare
- Hospice care
- Skilled nursing facility admissions
- Durable medical equipment purchase or rental over $1,000
- Blepharoplasty
- Ligation
- Vein stripping
- Sclerotherapy
- Accidental dental services
- Transplant services
- Breast reconstruction or reduction (except after cancer surgery)

Important to Remember...

Personal Health Support does not have the ability to make enrollment changes, such as to add a newborn. All enrollment modifications must be directed to your Benefits Representative.

Non-Urgent Admissions or Care

If the admission is for a non-urgent condition, you must call Personal Health Support at least five days before the scheduled admission or treatment date. Working with your doctor, Personal Health Support will decide how many days of confinement or treatment are appropriate and will provide written notice to you and your doctor. If Personal Health Support determines that the proposed admission or treatment is not covered, you and your doctor will be notified.

Urgent and Emergency Admissions or Care

If the patient’s condition requires urgent or emergency admission, you, the patient’s physician or the hospital must notify Personal Health Support:

- Before confinement for an urgent admission
- Within 48 hours after confinement because of an emergency admission, unless it is not possible for the physician to notify Personal Health Support within that time. In that case, it must be done as soon as reasonably possible (If the confinement starts on a Friday or Saturday, the 48-hour requirement will be extended to 72 hours.)

To Continue Treatment

If your doctor feels it is necessary for the confinement or treatment to continue longer than already approved, you, the physician or the hospital may request additional days by calling Personal Health Support. This request must be made no later than the last day that has already been approved. You must pay for continued treatment days that the reviewer determines are not covered.

Penalties

A $400 penalty will apply if you do not notify Personal Health Support when required. Any penalty amounts you pay will not count toward your deductible or out-of-pocket maximum.

To contact Personal Health Support when required, call UnitedHealthcare at 800 387 7508.
Special Note: Mental Health and Substance Use Disorder Services

To receive the highest level of benefits and to avoid incurring penalties, you must call the Mental Health or Substance Abuse Disorder Administrator for pre-service authorization before obtaining the services listed below:

- **Mental health services.** Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility):
  - intensive outpatient program treatment;
  - outpatient electro-convulsive treatment;
  - psychological testing;
  - extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

- **Neurobiological disorders.** Inpatient mental health services for Autism Spectrum Disorders (including partial hospitalization/day treatment and services at a residential treatment facility):
  - intensive outpatient program treatment;
  - outpatient electro-convulsive treatment;
  - psychological testing;
  - extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

- **Substance use disorder services.** Inpatient services (including partial hospitalization/day treatment and services at a residential treatment facility):
  - intensive outpatient program treatment;
  - outpatient electro-convulsive treatment;
  - psychological testing;
  - extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

For a scheduled admission, you must notify the Mental Health or Substance Abuse Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including emergency admissions). If you fail to notify the Mental Health or Substance Abuse Disorder Administrator as required, a $400 penalty will apply.

In addition, you must notify the Mental Health or Substance Abuse Disorder Administrator before the following services are received. If you fail to notify the Mental Health or Substance Abuse Disorder Administrator as required, the $400 pre-notification penalty will apply.

- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment

- Psychological testing
- Extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management

See “Mental Health, Substance Use Disorder and Neurobiological Disorder Services” on page 38 of “Covered Medical Expenses” for more information about these types of services.

Treatment Decision Support

In order to help you make informed decisions about your healthcare, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions. This program offers:

- Access to accurate, objective and relevant healthcare information
- Coaching by a nurse through decisions in your treatment and care
- Expectations of treatment
- Information on high quality providers and programs

Conditions for which this program is available include:

- Back pain
- Knee and hip replacement
- Prostate disease
- Prostate cancer
- Benign uterine conditions
- Breast cancer
- Coronary disease
- Bariatric surgery

Participation in Treatment Decision Support is completely voluntary and does not cost extra. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Second Surgical Opinions

If your doctor recommends surgery that is covered under the plan, you may want to get a second opinion. This is voluntary and will not affect your benefits. A second surgical opinion may include an exam, X-ray and lab work and a written report by the doctor. It must be performed by a doctor who is not
Medical Benefits

associated or in practice with the physician who recommended the surgery, and who is certified by the American Board of Surgery or other specialty board.

If you are enrolled in either PPO plan and choose to get a second opinion from an in-network provider, you pay a $25 (or $40 for a specialist) office visit copayment and the plan pays the balance. If you receive X-rays and/or lab work, you will also pay 20% of the eligible expense for those services after you have met your deductible. If you use an out-of-network provider for a second opinion, you pay 40% of the eligible expense, including any X-rays or lab work you receive. The annual deductible applies to second surgical expense consultations provided by out-of-network physicians. If you are enrolled in the Out-of-Area plan, you pay 20% of the eligible expense after you have met your deductible for a second surgical opinion consultation, including X-rays and lab work.

MyNurseLine℠

Making sure that you make good healthcare choices for yourself and your family can be challenging. For example, when your child has the flu, should you make a doctor’s appointment or use self-care to bring the fever down at home? Or, if your spouse trips and falls, how can you tell if he or she should get an X-ray? MyNurseLine can provide information to help you decide what to do in situations when you may not be sure whether you should go to the emergency room, see your doctor or treat yourself at home.

MyNurseLine also provides information and education about good nutrition, exercise and regular health screenings to help keep you and your family healthy. Call MyNurseLine any time—24 hours a day, 365 days a year at no cost to you—at 888 206 1623. You can also contact MyNurseLine via www.myuhc.com. Be sure to register at www.myuhc.com so that you can access special members-only areas, including Live Nurse Chat and Health Topics and Tools.

Covered Medical Expenses

The UnitedHealthcare plan has no pre-existing condition limitation.

The following chart shows plan benefits for each Covered Health Service. Benefits are available only when all of the following conditions are met:

- Covered health services are provided while coverage is in effect.
- Covered health services are provided before the date your coverage under the plan is terminated.
- The person who receives Covered Health Services meets all the plan’s eligibility requirements.

Plan Benefits for Covered Medical Expenses

<table>
<thead>
<tr>
<th></th>
<th>UHC Choice PPO Plan</th>
<th>UHC Value PPO Plan</th>
<th>UHC Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>(MNRP guidelines apply)</td>
<td>(MNRP guidelines apply)</td>
<td>(R&amp;C guidelines apply)</td>
</tr>
<tr>
<td>Hospital Charges: Inpatient and Outpatient Services*—After Deductible Unless Noted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and board charges up to the semi-private room rate</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Services and supplies, including diagnostic testing, laboratory services and X-rays</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Surgery</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHC Choice PPO Plan</td>
<td>UHC Value PPO Plan</td>
<td>UHC</td>
<td></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong> (MNRP guidelines apply)</td>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong> (MNRP guidelines apply)</td>
</tr>
<tr>
<td>------------------</td>
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</tr>
<tr>
<td><strong>Emergency Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room for medical emergencies and accidental injuries</strong></td>
<td>100% after $125 copayment</td>
<td>100% after $125 copayment</td>
<td>100% after $125 copayment</td>
</tr>
<tr>
<td><strong>Emergency room for non-emergency conditions</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Urgent care/walk-in facility</strong></td>
<td>100% after $40 copayment</td>
<td>60%</td>
<td>100% after $40 copayment</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine physical exam</strong></td>
<td>100%; not subject to deductible</td>
<td>60%; not subject to deductible</td>
<td>100%; not subject to deductible</td>
</tr>
<tr>
<td><strong>Other preventive services, including children’s immunizations, mammograms, PAP smears, X-rays and lab tests based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and Patient Protection Affordable Care Act (PPACA).</strong></td>
<td>100%; not subject to deductible</td>
<td>60%; not subject to deductible</td>
<td>100%; not subject to deductible</td>
</tr>
<tr>
<td><strong>Doctors and Healthcare Professionals—After Deductible Unless Noted</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office visit – primary care physician</strong></td>
<td>100% after $25 copayment</td>
<td>60%</td>
<td>100% after $25 copayment</td>
</tr>
<tr>
<td><strong>Office visit – specialist</strong></td>
<td>100% after $40 copayment</td>
<td>60%</td>
<td>100% after $40 copayment</td>
</tr>
<tr>
<td><strong>Medical care</strong></td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>
### Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>UHC Choice PPO Plan</th>
<th>UHC Value PPO Plan</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td></td>
<td>(MNRP guidelines</td>
<td>(MNRP guidelines</td>
<td>(MNRP guidelines</td>
</tr>
<tr>
<td></td>
<td>apply)</td>
<td>apply)</td>
<td>apply)</td>
</tr>
<tr>
<td>Obstetrician or certified nurse</td>
<td>First visit at 100%</td>
<td>First visit at 100%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>after $40 copayment;</td>
<td>after $40 copayment;</td>
<td>then 80%</td>
</tr>
<tr>
<td></td>
<td>then 80%</td>
<td>then 80%</td>
<td></td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>Office visits:</td>
<td>Office visits:</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>100% after $40</td>
<td>100% after $40</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>copayment</td>
<td>copayment</td>
<td>then 80%</td>
</tr>
<tr>
<td></td>
<td>Injections: 80%</td>
<td>Injections: 80%</td>
<td></td>
</tr>
<tr>
<td>Physical and occupational therapy</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Chiropractic treatment</td>
<td>100% after $40</td>
<td>100% after $40</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>copayment</td>
<td>copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Podiatric treatment</td>
<td>100% after $40</td>
<td>100% after $40</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>copayment</td>
<td>copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Private duty nursing by an RN or LPN</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Fertility testing</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Durable medical equipment (DME)*</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Anesthetics and their administration</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Fertility testing</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>First part of an office visit</td>
<td>100% after $40</td>
<td>100% after $40</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>copayment</td>
<td>copayment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Prosthetic and orthotic devices</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

*Medical necessity documentation required after 15 visits per calendar year. If visits exceed 30 in any calendar year, UnitedHealthcare must review and approve additional benefits for chiropractic treatment.
### Medical Benefits

<table>
<thead>
<tr>
<th></th>
<th>UHC Choice PPO Plan</th>
<th>UHC Value PPO Plan</th>
<th>UHC</th>
<th>Out-of-Area Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Injectable drugs not intended for self administration</td>
<td>80%</td>
<td>60%</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

|                      |                      |                      |                      |                      |                      |
| Mental Health and Substance Abuse Disorder Treatment—After Deductible Unless Noted |                      |                      |                      |                      |                      |
| Inpatient*           | 80%                  | 60%                  | 80%                  | 60%                  | 80%                  |
| Residential day care*| 80%                  | 60%                  | 80%                  | 60%                  | 80%                  |
| Outpatient           | 100% after $40 copayment | 60%                  | 100% after $40 copayment | 60%                  | 80%                  |

| Special Facilities   |                      |                      |                      |                      |                      |
| Birthing centers     | 80%                  | 60%                  | 80%                  | 60%                  | 80%                  |
| Home healthcare*     | 80%                  | 60%                  | 80%                  | 60%                  | 80%                  |
| Hospice care— inpatient and outpatient* | 80% | 60% | 80% | 60% | 80% |
| Skilled nursing facility* | 80% | 60% | 80% | 60% | 80% |

**Reminder:** The LifeWorks Employee Assistance Program (EAP) provides free and confidential access to behavioral health professionals 24 hours a day, seven days a week. The EAP also provides up to three face-to-face counseling sessions per issue or problem at no cost to you. Contact LifeWorks at **888 267 8126**.

* Notification to Personal Health Support or the Mental Health or Substance Abuse Disorder Administrator required.

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### Maternity Benefits

Stryker’s Health Plan covers expenses for hospital stays or birthing centers and obstetrics provided by a doctor or certified nurse-midwife for pregnancy, childbirth or related complications. Newborn expenses, including hospital nursery charges, routine in-hospital pediatric care for a healthy infant and circumcision, also are covered separate from the mother.

Pregnancy-related expenses of employees and dependents must be incurred while the person is covered under the plan. If expenses are incurred after coverage ends, no benefits will be paid. If there are benefits payable from a previous plan, these will be subtracted from benefits payable for the same expenses under this plan.

Expenses related to elective induced abortions and any complication related to an abortion are covered.

If you need to change your healthcare benefit election as the result of the birth of the baby, you must properly change your enrollment via the employee self service web site, My Stryker Info ([https://myinfo.stryker.com](https://myinfo.stryker.com)), or by contacting your Benefits Representative and completing an enrollment form, within 30 days of the life event (including the date of the event). You must also provide all of the required dependent documentation within 45 days as requested in order to change your elections on a pre-tax basis. See “Making Changes” in the Participating in Health Care Benefits section for more information.

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### Healthy Pregnancy Program

If you are pregnant and enrolled in the medical plan, you can get valuable educational information and advice by calling **800 387 7508**. This program offers:

- Pregnancy consultation to identify special needs
- Written and online educational materials and resources
• 24-hour toll-free access to experienced maternity nurses
• A phone call from a care coordinator during your pregnancy
• A phone call from a care coordinator approximately four weeks postpartum, to give you information on infant care, feeding, nutrition, immunizations and more

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of pregnancy. You can enroll any time, up to your 34th week. To enroll, call 800 387 7508. As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

**Benefits for Outpatient Rehabilitation Services**

Stryker’s medical plan covers outpatient rehabilitation services for:

• Physical therapy
• Occupational therapy
• Manipulative treatment (chiropractic and spinal manipulation)
• Speech therapy
• Post-cochlear implant aural therapy
• Vision therapy
• Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident
• Pulmonary rehabilitation therapy
• Cardiac rehabilitation therapy

Rehabilitation services must be performed by a licensed therapy provider under the direction of a physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement within two months of the start of treatment.

Recertification of the continued need for spinal manipulations is required after the first 30 visits and will be subject to review by Personal Health Support.

Speech therapy services are covered only when the speech impediment or speech dysfunction results from injury, stroke, congenital anomaly, developmental delay or is required following placement of a cochlear implant.

The plan does not cover any type of therapy, service or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

**Preventive Care Benefits**

One of the best ways to prevent illness is to take care of yourself. Regular check-ups and immunizations are important, so preventive care services provided in an outpatient setting are covered.

Eligible preventive care services are covered at 100% without deductibles or copayments. Routine tests and related lab and X-ray expenses are covered once per calendar year.

The plan pays for services for preventive care services provided on an outpatient basis at a physician’s office, an alternative facility or a hospital and encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

• Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force
• Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
• With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
• With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and in accordance with the Patient Protection and Affordable Care Act (PPACA).
In general, the plan pays preventive care benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

- Routine physical exam (one per year after age 3)
- Well child care through age 3
- Routine lipid profile
- Routine mammogram
- Routine PAP test
- Additional women’s preventive care (per PPACA guidelines):
  - Gestational diabetes screening
  - HPV DNA testing for women age 30 and older
  - Screening for sexually transmitted infections
  - Screening and counseling for HIV
  - Screening and counseling for domestic violence
  - Counseling for and payment of generic FDA-approved contraception methods
  - Counseling for breastfeeding and payment of rental equipment and supplies, except breast pump rentals
- Routine prostate exam
- Routine PSA
- Routine lab tests and X-rays related to covered preventive testing (facility and professional charges)
- Immunizations:
  - Covered childhood immunizations generally include: Diphtheria-tetanus-pertussis (DTP), Oral poliovirus (OPV), Measles - mumps-rubella (MMR), Conjugate haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18.
  - The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.

Preventive care benefits do not include:

- Services for the diagnosis or treatment of a disease, except for those women’s preventive services noted above
- Medicines, drugs, appliances, equipment or supplies, except for those women’s preventive services noted above
- Psychiatric, psychological or emotional testing or exams
- Exams related to employment
- Premarital exams
- Vision, hearing or dental exams

**HealtheNotes℠**

- UnitedHealthcare provides a service called HealtheNotes℠ to help educate members and make suggestions regarding your medical care. HealtheNotes℠ provides you and your Physician with suggestions regarding preventive care, testing or medications and potential interactions with medications you have been prescribed and certain treatments.

- In addition, your HealtheNotes℠ report may include health tips and other wellness information. UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process, patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine, as described in Medical Plan Definitions under the definition of Covered Health Services.

- If your Physician identifies any concerns after reviewing his or her HealtheNotes℠ report, he or she may contact you. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician. If you have questions or would like additional information about this service, please call 800 387 7508.
Cancer Resource Center (CRS)

The Plan pays benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facilities are defined in the “Medical Plan Definitions” on page 46.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- Be referred to CRS by a Personal Health Support Nurse;
- Call CRS toll-free at 866 936 6002; or

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays benefits as described under:

- Physician’s Office Services - Sickness and Injury
- Physician Fees for Surgical and Medical Services
- Scopic Procedures - Outpatient Diagnostic and Therapeutic
- Therapeutic Treatments - Outpatient
- Hospital - Inpatient Stay
- Surgery - Outpatient

Note: The services described under Travel and Lodging are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that network).

UnitedHealthcare provides a program that identifies, assesses and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card, or call the program directly at 866 936 6002. For information regarding specific beneficiers for cancer treatment within the Plan, see under the heading Cancer Resource Services (CRS).

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted
- Cardiovascular disease (cardiac/stroke) which is not life threatening for which, as determined by UnitedHealthcare, a clinical trial meets the qualifying clinical trial criteria
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which UnitedHealthcare determines a clinical trial meets the qualifying clinical trial criteria
- Other disease or disorders which are not life threatening for which, UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the covered member is clinically eligible for participation in the qualifying clinical trial as defined by the researchers.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are typically provided absent a clinical trial
- Covered health services required solely for the provision of the investigational item or service, that clinically appropriately monitoring of the effects of the item or service, or the prevention of the complications
- Covered health services needed for reasonable and necessary care arising from the provision of the investigational item or service

Please remember, that you must notify Personal Health Support as soon as the possibility of participation in a clinical trial arises. If Personal Health Support is not notified, you will be responsible for paying all charges and no benefits will be paid.

**Home Healthcare**

Covered home healthcare expenses include charges by an approved home healthcare agency for the following services furnished as part of a home healthcare plan:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN), or services from a home health aide, up to the maximum of 120 visits per year
- Respiratory, occupational, speech and physical therapies provided by a home healthcare agency
- Medical supplies, appliances and equipment, drugs and medicines prescribed by a physician and provided by the home healthcare agency, if such items would have been covered under the plan while hospital-confined
- Nutrition counseling or services, or special meals provided by or under the supervision of a registered dietitian or nutritionist

Benefits for home healthcare treatment will be reduced by $400 when UnitedHealthcare is not notified in advance of the first treatment date.

Home healthcare services provided by a social worker or a family member are not covered.

**Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are covered by the Plan. Benefits include:

- Room and board in a semi-private room (a room with two or more beds)

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

Benefits for other physician services, including anesthesiologists, consulting physicians, pathologists and radiologists, are described in this section under Physician Fees for Surgical and Medical Services.

UnitedHealthcare will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost effective alternative to an inpatient stay in a hospital; and
- You will receive skilled care services that are not primarily custodial care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
**Note:**
- The Plan does not pay benefits for custodial care or domiciliary care, even if ordered by a physician, as defined in “Medical Plan Definitions” on page 46.
- Any combination of network benefits and non-network benefits is limited to 120 days per calendar year.

Please remember that you should notify Personal Health Support as follows:
- For elective admissions: five business days before admission
- For Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

If Personal Health Support is not notified, benefits will be reduced by $400.

### Mental Health, Substance Use Disorder and Neurobiological Disorder Services

Mental health and substance use disorder services include those received on an inpatient basis in a hospital or alternate facility, and those received on an outpatient basis in a provider’s office or at an alternate facility.

Covered neurobiological disorder services include psychiatric services for Autism Spectrum Disorders that are both of the following:
- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

**Note:** The benefits described here are for the psychiatric component of treatment for Autism Spectrum Disorders only. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories, as described elsewhere in this “Medical Benefits” section.

Mental health, substance use disorder and neurobiological disorder benefits include the following services provided on either an outpatient or inpatient basis:
- Diagnostic and evaluation assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention
- For substance use disorder only, detoxification (sub-acute/non-medical)

The plan pays benefits for the following services provided on an inpatient basis:
- Partial hospitalization/day treatment
- Services at a residential treatment facility

Benefits also are paid for services provided for intensive outpatient treatment.

The Mental Health or Substance Abuse Disorder Administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis.

You are encouraged to contact the Mental Health or Substance Abuse Disorder Administrator for referrals to providers and coordination of care.

Please remember that you **must** notify the Mental Health or Substance Abuse Disorder Administrator in advance of any treatment to receive benefits for these services. Please call the phone number that appears on your ID card. Without notification, a $400 pre-notification penalty will apply.
Special Mental Health and Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health or Substance Abuse Disorder Administrator may become available to you as part of your mental health and substance use disorder services benefit. The mental health and substance abuse services benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient or a transitional care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your mental illness or substance use disorder that may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health or Substance Abuse Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the covered person and is not mandatory.

Exclusions for Mental Health/Substance Use Disorders

In addition to any exclusions or limits that may be described in “Expenses Not Covered” on page 43, the plan does not pay benefits for the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health or Substance Abuse Disorder Administrator, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental
  - Not consistent with the Mental Health or Substance Abuse Disorder Administrator’s level of care guidelines or best practices as modified from time to time
- Not clinically appropriate for the patient’s mental illness, substance use order or condition based on generally accepted standards of medical practice and benchmarks
- Mental health services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental health services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal)
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction
- Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders
- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered experimental or investigational or unproven services
**Organ Transplant Benefits**

UnitedHealthcare offers specialized case management services for individuals who have been recommended for an organ transplant, bone marrow transplant or tissue replacement. UnitedHealthcare must be notified regarding any of these procedures. During the notification process, UnitedHealthcare may recommend that you receive transplant services at a facility that is nationally recognized as a center of excellence for specific organ transplant procedures.

Each case must meet specific criteria. If treatment at a Designated Facility is recommended, covered charges in connection with the transplant procedure will be covered at 80% of the in-network benefit level. Reasonable and customary fee limits will not apply. In addition, you may qualify for reimbursement of travel and lodging expenses.

If treatment at a Designated Facility is recommended but you decide to have the transplant procedure performed elsewhere, the plan will pay 60% of covered charges in connection with the transplant procedure. The 60% benefit level will apply even when the facility is considered in-network for other non-transplant procedures.

Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a “Covered Health Service” and cannot be experimental or investigational, or unproven. Examples of transplants for which benefits are available include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy (Not all bone marrow transplants meet the definition of a Covered Health Service.)
- Transplantation of non-human organs is not covered.

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**Other Transplant Benefits**

Charges for the following services are covered:

- Preparation, acquisition, transportation and storage of human organs, bone marrow or human tissue
- Approved travel and lodging expenses in connection with transportation of the organ recipient to the transplant procedure site

**Limitations**

The plan pays benefits for approved charges incurred by the organ donor and the transplant recipient when both are covered under Stryker’s medical plan.

When the organ recipient is covered under Stryker’s medical plan but the donor is not, the plan pays benefits for approved charges incurred by the organ donor to the extent that those charges are not covered by any other source.

When only the organ donor is covered under Stryker’s medical plan, the plan covers any charges related to donor services up to a maximum benefit of $5,000. This benefit is payable only when the transplant recipient’s plan does not cover donor services.

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**Durable Medical Equipment (DME)**

The plan pays for durable medical equipment (DME) that is:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a sickness, injury or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home
- Is not implantable within the body

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.
Examples of DME include but are not limited to:

- Equipment to administer oxygen
- Wheelchairs
- Hospital beds
- Delivery pumps for tube feedings
- Burn garments
- Insulin pumps and all related necessary supplies
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Cranial helmets used to facilitate a successful post-surgical outcome are also covered as DME. **Note:** Only braces that are used to stabilize an injured body part or treat curvature of the spine are considered Durable Medical Equipment and therefore covered under the Plan. Braces that straighten or change the shape of a body part (with the exception of cranial helmets) are considered orthotic devices and are not covered. Dental braces are also excluded from coverage.
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Ostomy supplies. Covered supplies are limited to:
  - Pouches, face plates and belts
  - Irrigation sleeves, bags and ostomy irrigation catheters
  - Skin barriers

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME. **Note:** DME is different from prosthetic devices—see “Prosthetic Devices” on page 41.

Benefits are provided for the repair/replacement of a type of durable medical equipment once every calendar year.

Please remember for out-of-network benefits, you must notify Personal Health Support if the purchase, rental, repair or replacement of the equipment will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, benefits will be subject to a $400 reduction.

At UnitedHealthcare’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the covered person’s medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary equipment is only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three-year timeline for replacement.

Benefits also include speech aid devices and tracheoesophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury. Benefits for the purchase of speech aid devices and tracheoesophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

**Hearing Aids**

The plan pays benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a physician, and are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which benefits are available under the applicable medical/surgical Covered Health Services categories in this “Medical Benefits” section, and only for covered persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

**Prosthetic Devices**

At UnitedHealthcare’s discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the covered person’s medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be
covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

**Obesity Treatment**

The Plan covers surgical treatment of obesity provided by or under the direction of a physician when all of the following are true:

- You have a minimum Body Mass Index (BMI) of 40;
- You have documentation from a physician of a diagnosis of morbid obesity for a minimum of five years; and
- You are over the age of 21

In addition to meeting the above criteria, the following must also be true:

- You have completed a six-month physician-supervised weight loss program; and
- You have completed a pre-surgical psychological evaluation

Benefits for obesity surgery services are covered only if they meet the definition of a Covered Health Service (see “Medical Plan Definitions” on page 46) and are not considered experimental, investigational or unproven.

**Specialty Pharmacy**

Specialty drugs are managed differently than every day prescriptions. UnitedHealthcare broadly defines “specialty drugs” as:

- **Self-administered injectable drugs.** These are drugs that can be administered by the patient or a non-skilled caregiver. Self-administered injectable drugs are covered under the pharmacy benefit or may be excluded from coverage; a limited number of self-administered injectable drugs may also be covered under the medical benefit.

- **Injectable drugs** (not intended for self-administration). These are drugs that must be administered by a healthcare professional in a physician's office or other outpatient setting, usually by infusion or intra-muscular injection. This includes plasma or recombinant-derived products, such as factors to treat hemophilia or immune globulins. Chemotherapy agents are a significant component of this category. Injectable drugs are covered under the medical benefit with the deductible and coinsurance applied.

- **Biotech drugs.** These are drugs manufactured through genetic engineering. This includes oral, self-administered, injectable or infusion products given in an ambulatory setting.

- **Orphan drugs.** These are drugs that have been given a seven-year market exclusivity by the Orphan Drug Act.

Based on stipulations of the pharmaceutical manufacturers, certain specialty medications are only available through select specialty pharmacies.

Patient education materials are provided with specialty medications along with information on how to contact the appropriate specialty pharmacy, which differ by type of medication. Pharmacists are available 24 hours a day, seven days a week, to answer any questions and provide information about the medication, such as administration, storage, general drug information and side effect management.

Certain medical conditions require specialty medications, such as anemia, asthma, cancer, cystic fibrosis, growth hormone deficiency, hemophilia, hepatitis C, HIV/AIDS, immune deficiencies, low white blood cells, multiple sclerosis, osteoporosis, psoriasis, pulmonary hypertension, rheumatoid arthritis and RSV prevention to name a few. Note that some drugs may be excluded from coverage under our plan. Please contact UnitedHealthcare (UHC) Customer Service at 800 387 7508 for more information.

When a patient who needs a specialty medication is identified by UnitedHealthcare, UHC’s specialty pharmacy contacts the physician to provide information, make initial transition plans and obtain a prescription(s). UHC’s specialty pharmacy then contacts the patient to answer any questions and inform him or her of the process. For more information contact UHC Customer Service at 800 387 7508.

Pharmacy customer service centers are open 24 hours a day, seven days a week, except for Thanksgiving and Christmas. Specialty pharmacies guarantee round-the-clock access to a pharmacist for any medication or administration-related questions.
Expenses Not Covered

The following medical expenses are not covered under the plan.

- Health services and supplies that do not meet the definition of a Covered Health Service. (See “Medical Plan Definitions” on page 46.)
- Services and supplies that are not necessary for the diagnosis, care or treatment of the disease or injury involved
- Services or supplies, other than outpatient mental health counseling, not prescribed, recommended or approved by a licensed healthcare provider (Outpatient mental health counseling services provided by a fully licensed psychologist, licensed clinical social worker or other licensed counselor are covered.)
- The experimental or investigational services or items, with the exception of:
  - Certain Category B devices
  - Certain promising interventions for patients with terminal illnesses
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies
- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial
- Services or supplies that are experimental, investigational or unproven (However, this exclusion will not apply to services or supplies [other than drugs] received in connection with a disease if UnitedHealthcare determines that the disease is expected to cause death within one year in the absence of effective treatment, and the service or supply is effective or shows promise of being effective for that disease. This exclusion will not apply to drugs that have been designated as an investigational new drug or are being studied at the Phase III level in a national clinical trial by the National Cancer Institute, if UnitedHealthcare determines that the drug is effective or shows promise of being effective for the disease.) If you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for the treatment, UnitedHealthcare may at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.
- Services, treatment, educational testing or training related to learning disabilities or developmental delays except for speech therapy services
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person’s disease or injury
- Treatment of covered healthcare providers who specialize in the mental healthcare field and who receive treatment as part of their training in that field
- Services of a resident physician or intern rendered in that capacity
- Expenses above the eligible expense fee limits set by UnitedHealthcare
- Hospital or other facility expenses for custodial care
- Services and supplies furnished, paid for or for which benefits are provided or required because of a person’s past or present service in the armed forces
- Services and supplies furnished, paid for or for which benefits are provided or required under any law of a government (This does not include a plan established by a government for its own employees or their dependents, or Medicaid.)
- Charges for eye refractions or vision examinations
- Charges for eyeglasses or contact lenses to correct refractive errors
- Eye surgery to eliminate refractive errors (such as radial keratotomy or LASIK)
- Services or supplies for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment
Charges for plastic surgery, reconstructive surgery, cosmetic surgery, liposuction or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply if the service or supply is needed to:

- Improve the function of a body part (other than a tooth) that is malformed as a result of a severe birth defect or as a direct result of disease or surgery performed to treat a disease or injury
- Repair an injury as long as surgery is performed in the calendar year of the accident which causes the injury or in the next calendar year

Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis

Charges for sex change surgery or for treatment of gender identity disorders

Charges for artificial insemination, in-vitro fertilization or embryo transfer procedures

Charges for reversal of a sterilization procedure

Charges for surrogate parenting, fees paid for sperm or ovum donation or fees paid for storage of frozen embryos

Charges for food of any kind, including enteral feedings and other nutritional and electrolyte formulas, infant formula and donor breast milk. This exclusion will not apply if the food is the only source of nutrition, as determined by a physician, or it is specifically created to treat inborn errors of metabolism, such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.

Charges for marriage, family, child, career, social adjustment, pastoral or financial counseling without a medical diagnosis

Charges for acupuncture, acupressure, aromatherapy, hypnotism, massage therapy, rolffing and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health

Services provided by a close relative or anyone who resides in the patient’s home (Close relatives include the patient’s spouse, and any child, sibling or parent of the employee or spouse.)

Travel and transportation costs associated with an organ transplant, as well as the expenses incurred by an organ donor whether or not the person is covered by the plan, except as described under “Organ Transplant Benefits” on page 40.

Charges for treatment of an injury or illness due to an act of war (declared or undeclared) or contracted while on duty with any military service for any country

Charges for treatment of obesity, unless the patient meets specific medical criteria as described under “Obesity Treatment” on page 42.

Charges for fertility treatment (However, fertility testing may be covered if part of the diagnosis of a medical condition.)

Charges for insulin syringes, lancets, insulin pen injectors and diabetic test strips (These expenses are covered under the prescription drug plan.)

Charges for the rental of breast pumps

Services provided for comfort or convenience such as televisions, telephones, air conditioners, air purifiers, humidifiers, dehumidifiers, beauty or barbershop services or home remodeling to accommodate a health need

Dental services. This exclusion will not apply to anesthesia and associated hospital and facility charges that are not covered under the dental plan and are provided when, in the opinion of the treating dentist, any of the following criteria apply:

- The related procedure involves extracting six or more teeth in various quadrants
- Use of local anesthesia is considered ineffective because of acute infection, anatomic variation, or allergy
- The procedure involves multiple extractions or restorations for a child under age four
- There is a concurrent hazardous medical condition
- The procedure is intended to address extensive oral-facial and/or dental trauma and would be ineffective or compromised if performed using local anesthesia
The benefits described here are covered only for anesthesia and related hospital and facility charges that are not covered by the dental insurance carrier.

- Prescription drugs and over-the-counter medications or supplies (These expenses may be covered under the prescription drug plan.)
- Routine foot care
- Orthotic appliances and devices, except when both of the following are met:
  - The appliance or device is prescribed by a physician for a medical purpose
  - It is custom manufactured or custom fitted to an individual covered person

Examples of excluded orthotic appliances and devices include but are not limited to cranial bands or any braces that can be obtained without a physician's order (This exclusion does not include diabetic footwear which may be covered for an individual with diabetic foot disease.)

- Health services for organ and tissue transplants except as identified under “Organ Transplant Benefits” on page 40, unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare’s transplant guidelines
- Growth hormone therapy
- Domiciliary care
- Liposuction
- Custodial care
- Respite care
- Rest cures
- Psychosurgery
- Wigs
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer
- Personal trainer

- Naturalist
- Holistic or homeopathic care
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered when:
  - Required solely for purposes of career, education, sports or camp, travel employment insurance, marriage or adoption (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)

- Health services received after the date your coverage under the plan ends, including health services for medical conditions arising before the date your coverage under the plan ends
- In the event that a provider waives copayments, coinsurance and/or the annual deductible for a particular health service (No benefits are provided for the health service for which the copayments, coinsurance and/or annual deductible are waived.)
- Charges in excess of any specified limitation
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), if the services are considered to be dental in nature, including oral appliances
- Non-surgical treatment of obesity, including morbid obesity
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the actual charge (The actual charge is defined as the provider’s lowest routine charge for the service, supply or equipment.)
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
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- Any charges prohibited by federal anti-kickback or self-referral statutes
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to, spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from an injury, stroke, congenital anomaly or developmental delay

How to Obtain Medical Benefits

You have no claims to file when you use in-network providers. If you are enrolled in the Out-of-Area plan or if you are enrolled in either PPO plan and use out-of-network services, you may be required to file a claim.

If you need to file a claim, contact your Benefits Representative or UnitedHealthcare for a claim form. You can also obtain a claim form online at www.myuhc.com. Read the claim form instructions carefully, and fill out each section of the form that applies to you. Be sure to answer all questions and attach all materials specified to ensure complete processing of your claim.

Health Statements

You will receive a Health Statement as an explanation of benefits (EOB) in the mail each month that UnitedHealthcare processes at least one claim for you or a covered dependent. Health Statements make it easy for you to manage your family’s medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper health statements by making the appropriate selection on this site.

If your claim for benefits is denied, you have the right to appeal the denial. If you wish to file an appeal, follow the instructions outlined in the Medical and Rx Claims Procedures section.

How to Reach UnitedHealthcare

UnitedHealthcare
Stryker Group #: 703997
P.O. Box 740800
Atlanta, GA 30374-0800
www.myuhc.com
800 387 7508

Medical Plan Definitions

Annual deductible
The amount you must pay for covered services in a calendar year before the plan begins paying benefits in that calendar year.

Autism spectrum disorders
A group of neurobiological disorders that includes Autistic Disorder, Rhett’s Syndrome, Asperger’s Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Claims administrator
UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the plan (e.g., the claims administrator is responsible for making claim payments according to the terms of the plan).

Clinical Trials

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institute of Health (NIH). (Includes National Cancer Institute (NCI))
- Centers for Disease Control and Prevention (CDC)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare and Medicaid Services (CMS)
- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA)
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the National Institute of Health, and
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application
- The clinical trial must have written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The plan may, at any time, request documentation about the trial, or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

**Coinsurance**
The percentage of eligible expenses you are required to pay toward the cost of certain covered services.

**Congenital anomaly**
A physical developmental defect that is present at birth and is identified within the first twelve months after birth.

**Copayment**
The flat dollar charge you are required to pay for office visits and emergency room services.

**Cosmetic procedures**
Procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare.

**Covered health service**
Includes services, supplies or pharmaceutical products which Stryker determines to be:

- Provided for the purpose of preventing, diagnosing or treating sickness, injury, mental illness, substance use disorders or their symptoms
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below
- Not provided for the convenience of the covered person, physician, facility or any other person
- Included in Plan Highlights and Additional Coverage Details; provided to a covered person who meets the Plan’s eligibility requirements, as described under Eligibility in Section 2, Introduction
- Not identified in “Exclusions for Mental Health/Substance Use Disorders” on page 39

In applying the above definition, “scientific evidence” and “prevailing medical standards” have the following meanings:

- “Scientific evidence” means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community
- “Prevailing medical standards and clinical guidelines” means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines and national specialty society guidelines
The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling 800 387 7508. This information is available to Physicians and other healthcare professionals on UnitedHealthcareOnline.

**Custodial care**

Services that:

- Are non-health related, such as assistance in activities of daily living including, but not limited to, feeding, dressing, bathing, transferring and ambulating
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively

**Designated Facility**

A hospital that has entered into an agreement with UnitedHealthcare to provide covered services for the treatment of specific diseases or conditions. A Designated Facility may not be located in your geographic area. The fact that a hospital is a network hospital does not mean that it is a Designated Facility.

**Durable medical equipment**

Medical equipment that meets all of the following conditions:

- Can withstand repeated use
- Is not disposable
- Is used to serve a medical purpose with respect to treatment of a sickness or injury or their symptoms
- Is generally not useful to a person in the absence of a sickness or injury
- Is appropriate for use in the home
- Is not implantable within the body

**Eligible expenses**

Charges for Covered Health Services that are provided while the Plan is in effect, determined as follows.

- For Network Benefits, eligible expenses are based on contracted rates with the providers.
- For Non-Network Benefits, eligible expenses are based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than pharmaceutical products, eligible expenses are determined based on competitive fees in that geographic area. If no fee information is available for a Covered Health Service, the eligible expense is based on 50% of billed charges, except that certain eligible expenses for mental health services and substance use disorder services are based on 80% of the billed charge.
    - For mental health and substance use disorder services the eligible expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor for Covered Health Services that are pharmaceutical products, eligible expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, the Claims Administrator will use the gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomas Reuters (published in its Red Book) or UnitedHealthcare based on internally developed pharmaceutical pricing resource.
- The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

- These provisions do not apply if you receive Covered Health Services from a non-Network provider in an emergency or as otherwise arranged by the Claims Administrator. In that case, eligible expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of eligible expenses in the form of a copay and/or coinsurance.

Eligible expenses are subject to the Claims Administrator’s reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

**Emergency**

A serious medical condition or symptom resulting from injury, sickness or mental illness which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally within 24 hours of onset, to avoid jeopardy to life or health.

**Experimental or investigational services**

Medical, surgical, diagnostic, psychiatric, mental health, substance abuse disorders or other healthcare services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use,

- Subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the humanitarian use device exemption are not considered to be experimental or investigational), or

- The subject of an ongoing clinical trial that meets the definition of Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

**Home health agency**

A program or organization authorized by law to provide healthcare services in the home.

**Hospital**

An institution, operated as required by law, which meets both of the following conditions:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals (Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of physicians.)

- Has 24-hour nursing services

**Inpatient stay**

An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

**Maximum Non-Network Reimbursement (MNRP)**

This program establishes a benchmark for payment, including use of rates and methodologies established by Medicare to reimburse non-emergency claims. Stryker’s Health and Welfare Plan pays based on 140% of these Medicare established fee limits.

**Medicare**

Parts A, B, C and D of the insurance program established by Title XVIII of the United States Social Security Act, and as later amended.

**Mental health services**

Covered health services for the diagnosis and treatment of mental illness. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental illness**

Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the plan.
Network (also called in-network)
When used to describe a provider of healthcare services, this means a provider that has a participation agreement in effect with UnitedHealthcare or an affiliate to provide Covered Health Services to covered persons. The participation status of providers will change from time to time.

Network benefits
Benefits for Covered Health Services that are provided by a network physician or other network provider.

Out-of-network benefits (also called non-network benefits)
Benefits for Covered Health Services that are provided by a non-network physician or other non-network provider.

Physician
Any doctor of Medicine, “M.D.,” or Doctor of Osteopathy, “D.O.,” who is properly licensed and qualified by law. Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license is considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that benefits for services provided by that provider are available under the plan.

Plan
The Stryker Corporation Welfare Benefits Plan.

Pregnancy
Includes all of the following:
- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with pregnancy

Qualified medical child support order (QMCSO)
Any judgment, order or decree issued by a court or state administrative agency that:
- Provides for child support with respect to a plan participant’s child or directs the participant to provide coverage under a health benefits plan due to a state domestic relations law, or
- Enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan and which satisfies the requirements to be a QMCSO set out in Section 609 of ERISA.

Skilled nursing facility
A hospital or nursing facility that is licensed and operated as required by law.

Substance abuse services
Covered health services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is covered.

UnitedHealth Premium Program
A program that identifies network physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions. To be designated as a UnitedHealth Premium provider, physicians and facilities must meet program criteria. The fact that a physician or facility is a network physician or facility does not mean that it is a UnitedHealth Premium Program physician or facility.

Unproven services
Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:
- Well-conducted randomized controlled trials—two or more treatments are compared to each other and the patient is not allowed to choose which treatment is received
Well-conducted cohort studies—patients who receive study treatment are compared to a group of patients who receive standard therapy (The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described here.

If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may, at its discretion, determine that an unproven service meets the definition of a Covered Health Service for that sickness or condition. For this to take place, UnitedHealthcare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

**Urgent care center**

A facility, other than a hospital, that provides Covered Health Services that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms in order to prevent serious deterioration of your health.
Prescription Drug Benefits

Stryker’s healthcare plan provides benefits for covered prescription drugs, including contraceptives, insulin and diabetic supplies. Benefits are paid for covered drugs that are medically necessary for treatment of a sickness or injury that is not job-related. Covered drugs must be prescribed by a licensed physician or dentist and dispensed by a registered pharmacist.

This section of the Benefits Summary describes the plan administered by UnitedHealthcare. If you are enrolled in an HMO or other insured medical plan that includes prescription drug benefits, please refer to your contract or benefit booklet for information regarding your prescription drug coverage.

How Prescription Drug Benefits Work

UnitedHealthcare administers your prescription drug benefits. You may purchase covered prescriptions through the UnitedHealthcare pharmacy:

- At a participating retail pharmacy, including many chain and local pharmacies
- Through the mail from the convenient home delivery service (for long-term maintenance medications)

Benefits for covered prescription drugs are payable whether or not you use a pharmacy in the UnitedHealthcare network, although your out-of-pocket costs are lower when you use participating pharmacies. There is no deductible or out-of-pocket maximum for prescription drug benefits.

Preferred Drug List

The UnitedHealthcare/OptumRx™ program includes a preferred drug list (PDL) called the Advantage PDL. The PDL is a guide to help providers prescribe cost-effective medication. Use of the list is completely voluntary for you and your provider.

Benefits are available for outpatient prescription drugs that are considered Covered Health Services. Medications delivered during an inpatient stay are typically covered by the medical plan.

The plan pays benefits at different levels for Tier-1, Tier-2 and Tier-3 prescription drugs. All prescription drugs covered by the plan are categorized into these three tiers on the prescription drug list (PDL). The tier status of a prescription drug can change periodically based on the Prescription Drug List Management Committee’s periodic tiering decisions. When that occurs, you may pay more or less for a prescription drug, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call UnitedHealthcare at 800 387 7508 for the most current information.

Each tier is assigned a copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your copay will also depend on whether or not you visit the pharmacy or use the mail order service.

Here’s how the tier system works:

- Tier-1 is your lowest copay option. For the lowest out-of-pocket expense, you should consider Tier-1 drugs if you and your provider decide they are appropriate for your treatment.
- Tier-2 is your middle copay option. Consider a Tier-2 drug if no Tier-1 drug is available to treat your condition.
- Tier-3 is your highest copay option. The drugs in Tier-3 are usually more costly. Sometimes there are alternatives available in Tier-1 or Tier-2.
Prescription Drug Benefits

Your Prescription Drug Benefits

The following table shows your copays and the benefits available to you under this plan.

<table>
<thead>
<tr>
<th>UnitedHealthcare Network Pharmacy or Home Delivery Service</th>
<th>Non-Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ At a pharmacy, you pay:</td>
<td>▪ You pay full cost of covered prescription at time of purchase</td>
</tr>
<tr>
<td>▪ $10 copay for a Tier 1 drug</td>
<td>▪ Your reimbursement is equal to UnitedHealthcare’s discounted drug cost, minus the appropriate copay in the column to the left</td>
</tr>
<tr>
<td>▪ $25 copay for a Tier 2 drug</td>
<td>▪ Claim forms required</td>
</tr>
<tr>
<td>▪ $50 copay for a Tier 3 drug</td>
<td>▪ Up to a 31-day supply</td>
</tr>
<tr>
<td>▪ Through home delivery, you pay:</td>
<td>▪ No claim forms</td>
</tr>
<tr>
<td>▪ $25 copay for a Tier 1 drug</td>
<td>▪ Up to a 31-day supply</td>
</tr>
<tr>
<td>▪ $62.50 copay for a Tier 2 drug</td>
<td>▪ Home delivery service for up to a 90-day supply; refills by phone or via the Internet</td>
</tr>
<tr>
<td>▪ $125 copay for a Tier 3 drug</td>
<td></td>
</tr>
<tr>
<td>▪ No claim forms</td>
<td></td>
</tr>
<tr>
<td>▪ Up to a 31-day supply</td>
<td></td>
</tr>
<tr>
<td>▪ Home delivery service for up to a 90-day supply; refills by phone or via the Internet</td>
<td></td>
</tr>
</tbody>
</table>

Contraceptives for Women

Certain OTC contraceptives, prescription hormonal contraceptives, prescription emergency contraceptives, and prescription diaphragms are covered at 100% when they are:
- Prescribed by a health care professional
- Filled at a network pharmacy

Male contraceptives are not covered.

For an up-to-date list of covered OTC contraceptives, visit www.myuhc.com or call UnitedHealthcare at 800 387 7508.

Smoking Cessation Products

The prescription drug plan covers smoking cessation medications, which require a prescription by a physician (e.g., Chantix, bupropion). Over-the-counter (OTC) smoking cessation products (such as patches and gum) are not covered by the plan even when accompanied by a prescription.

All smoking cessation prescription drugs are subject to the appropriate copay, based on drug tier. There is a lifetime maximum plan benefit of $1,200 (not including copays or discounts).

Generic Drugs

One way that UnitedHealthcare manages costs for both you and Stryker is to use generic drugs when available. Only FDA “A” rated generic equivalent drugs are dispensed through both the network and home delivery pharmacies. “A” rated generics are subject to the same FDA regulations as brand-name drugs and considered to be equal in therapeutic effectiveness and safety when taken as prescribed. The main difference between generic and brand-name drugs is price; generics generally cost substantially less.

Discounts on Non-Covered Medications

Stryker’s prescription drug plan does not cover the cost of medications used for weight loss or infertility treatment. However, you are able to purchase these medications at a discounted cost through UnitedHealthcare’s home delivery (mail-order) program. Your cost for these medications will be based on discounted wholesale prices negotiated by UnitedHealthcare.

Preventive Care Medications

Certain over-the-counter (OTC) prescription drugs and items that are classified for use in preventive care will be covered at 100% when they are:
- Prescribed by a health care professional
- Age and/or gender appropriate
- Filled at a network pharmacy

All brands are covered by the prescription drug benefit.

For an up-to-date list of the covered OTC prescription drugs, visit www.myuhc.com or call UnitedHealthcare at 800 387 7508.
Rebates

UnitedHealthcare receives rebates for certain brand-name medications included on the preferred drug list. A portion of these rebate payments are shared with Stryker and are used to offset the cost of Stryker’s Health Plan. Neither UnitedHealthcare nor Stryker are required to pass on to you, and do not pass on to you, amounts payable under rebate or other discount programs.

Expenses Not Covered

The plan does not cover the following:

- Drugs or medicines lawfully obtainable without a prescription, except for covered OTC preventive care medications and supplements or OTC contraceptives
- Fertility agents and prescription drug products prescribed to treat infertility
- Injectable medication and chemotherapy agents administered by a physician or healthcare professional; these medications are generally covered under the medical plan (Injectable medications that are commonly self-administered, like insulin, are covered.)
- Over-the-counter smoking cessation products and smoking cessation medications not prescribed by a physician.
- Weight loss and appetite suppression products
- Any drug considered to be experimental or investigational by the Food and Drug Administration (FDA) or medications used for experimental indications and/or dosage regimens considered to be experimental
- Durable medical equipment and prescribed and non-prescribed outpatient supplies other than disposable insulin syringes, insulin pen injectors, needles, lancets and test strips prescribed with injectable insulin
- Immunization agents, biological sera, allergens, allergenic extracts (oral or injectable) and blood or blood plasma (These medications are generally covered under the medical plan.)
- Any medication administered and entirely consumed in connection with direct patient care rendered in the home by licensed healthcare professionals (These medications are generally covered under the medical plan.)
- More than a 31-day supply of a covered drug from a retail pharmacy, or more than a 90-day supply of a covered drug from the home delivery program
- Any medication consumed or administered at the place where the prescription is written, including medication taken or administered while the individual is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution
- Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician’s original order
- Any product used for cosmetic purposes without prior approval from UnitedHealthcare
- Any charge for the administration of covered prescription drugs
- Any drug that may be covered under local, state or federal programs, including Workers’ Compensation
- Any amounts over the allowable UnitedHealthcare discounted drug cost
- General vitamins, except prenatal vitamins, vitamins with fluoride, vitamins provided at no cost as described under “Preventive Care Medications,” and single entity vitamins that require a prescription
- Compounded medications
- A prescription drug product that contains an active ingredient available in a therapeutically equivalent to another prescription drug product
- A prescription drug product that contains an active ingredient which is a modified version of and therapeutically equivalent to another prescription drug product

How to Obtain Prescription Drug Benefits

Network Pharmacies

If you use a UnitedHealthcare network retail pharmacy for your covered prescriptions, you pay the appropriate copay, as described in “How Prescription Drug Benefits Work” on page 53. When you present your UnitedHealthcare ID card at a network pharmacy, there are no claims to file.
Home Delivery Service
The home delivery service allows you to order up to a 90-day supply of maintenance medication through the mail. Maintenance medications are prescription drugs taken on a regular or long-term basis. Examples include oral contraceptives and blood pressure medication. Covered prescriptions are delivered directly to your home in unmarked, tamper-resistant packages by First Class mail or a national delivery service. For added convenience, you may order refills by phone or via the Internet.

Non-Network Pharmacies
If you use a pharmacy outside the network, you pay the full cost of the prescription at the time of purchase. You then must submit a claim form and itemized receipt to UnitedHealthcare. Your reimbursement will be equal to UnitedHealthcare’s discounted drug costs, minus the appropriate copay, as described under “How Prescription Drug Benefits Work” on page 53. Because you are responsible for the difference between the discounted drug costs and the actual charge for the prescription, as well as your copay, your final cost will typically be more than if you used a network pharmacy.

Prior Authorization
Certain medications must be reviewed and approved by UnitedHealthcare before your prescription is filled. Your doctor or your pharmacist can obtain prior authorization by calling 800 387 7508. The UnitedHealthcare prior authorization team will obtain information about your diagnosis and your doctor’s drug therapy treatment plan, and determine whether the prescription is approved. Prior authorizations are valid for one year.

The following drugs currently require prior authorization:
- Alfa interferons
- Antiemetic agents
- Avita-Penderm
- Avodart
- Differin-Galderma
- Growth hormones
- Narcotic analgesics
- Neuraminidase inhibitors
- Proscar
- Regranex
- Retin-A
- Tracleer
- Wellbutrin SR

This list may change from time to time, as determined by UnitedHealthcare.

Special Programs

Specialty Pharmacy
Some medications are covered as medical benefits rather than as prescription benefits. Please see “Specialty Pharmacy” in the Medical Benefits section for further details.

Step Therapy
Certain prescription drug products or pharmaceutical products for which benefits are described in this Benefits Summary are subject to step therapy requirements. This means that in order to receive benefits for such prescription drug products or pharmaceutical products, you are required to use a different prescription drug product or pharmaceutical product first.

You may determine whether a particular prescription drug product or pharmaceutical product is subject to step therapy requirements at UnitedHealthcare’s web site at www.myuhc.com or by calling Customer Care at 800 387 7508.

Vacation/Travel Overrides
If you are going to be away from home for an extended period of time, you may want to refill your prescription before you leave—even if you have not used up your current supply of medication. In these situations, contact UnitedHealthcare at 800 387 7508 to request special authorization for the prescriptions you need to take with you on your trip. If you prefer, you can ask your pharmacy to call UnitedHealthcare to make the request on your behalf.

Notice of Creditable Coverage
If you are approaching age 65, you will receive information before your 65th birthday about Medicare Part D, the government’s prescription drug program, and how it will work with Stryker coverage.

How to Reach UnitedHealthcare
UnitedHealthcare
Stryker Group #: 703997
P.O. Box 740800
Atlanta, GA 30374-0800
800 387 7508
Medical and Rx Claims Procedures

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

Medical and Rx Benefits

In-Network Providers

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

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

Out-of-Network Providers

When you receive Covered Health Services from an out-of-network provider, you are responsible for filing a claim in order to obtain reimbursement for the cost of these services. You must file the claim in a format that contains all of the information required, as described in “Required Information” on page 57.

- If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and you believe that the plan should have paid for it, you may submit a claim for reimbursement following the procedures for filing a post-service claim (see “Submitting Medical or Rx Benefit Claims” on page 58). If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement, again following the procedures outlined for filing a post-service claim.

- If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact UnitedHealthcare by submitting a claim for coverage following the procedures described for filing a pre-service claim (see “Submitting Medical or Rx Benefit Claims” on page 58).

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

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

Required Information

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

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

Failure to provide all the information listed above may delay any reimbursement that may be due you.
For medical benefits claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient prescription drug benefits, your claims should be submitted to:

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

**Payment of Benefits**

UnitedHealthcare will make a benefit determination as set forth in “Initial Claim Determinations” on page 59. Benefits will be paid to you unless either of the following is true:

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

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

**Submitting Medical or Rx Benefit Claims**

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

- **A pre-service claim** is a claim for a benefit that requires prior approval or notification under the terms of the plan, such as inpatient admission notification.
- **A post-service claim** is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care, medications or supplies that have already been received.

A pre-service claim is considered submitted when UnitedHealthcare receives a request for prior approval. See “Notification Requirements” in the “Special Services and Procedures” section of Medical Benefits or “Prior Authorization” in the Prescription Drug Benefits section of this Benefits Summary for the procedures for notification or approval.

If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension, not longer than 15 days, and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UnitedHealthcare will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based and provide the claim appeal procedures.

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

A claim is considered submitted when UnitedHealthcare receives it.
Initial Claim Determinations

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

Urgent Care Claims

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

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

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

Concurrent Care Claims

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

Previously Approved Medical Treatments

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

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

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

Post-Service Claims

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

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

If Your Claim Is Denied

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

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

If your question or concern is about a benefit determination, you may informally contact UnitedHealthcare customer service before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in “Initial Claim Determinations” on page 59, you may appeal it as described below, without first informally contacting customer service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address for UnitedHealthcare.

If you are appealing an urgent care claim denial, please refer to “Urgent Claim Appeals that Require Immediate Action” on page 61 and contact customer service immediately. The customer service telephone number is 800 387 7508. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

Submit your appeal to UnitedHealthcare at the following address:

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
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<td>You must then provide your completed request for benefits to UnitedHealthcare within:</td>
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<td>UnitedHealthcare must notify you of the benefit determination within:</td>
<td>72 hours</td>
</tr>
<tr>
<td>If UnitedHealthcare denies your request for benefits, you must appeal the adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
</tbody>
</table>
Urgent Request for Benefits*  

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare must notify you of the appeal decision within:</td>
<td>72 hours after receiving the appeal</td>
</tr>
</tbody>
</table>

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

**Denials of Claims Based on Ineligibility to Participate**

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

Submit your appeal to the following address:

Health Plan Administrator  
Stryker  
2825 Airview Boulevard  
Kalamazoo, MI 49002

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

**Appeal Process**

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

**Determinations on Appeal**

**Urgent Care Claims**

For procedures associated with urgent claims, see “Urgent Claim Appeals that Require Immediate Action” on page 61.

**Denials of Claims Based on Ineligibility to Participate**

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

**Pre-Service Claims**

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

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

<table>
<thead>
<tr>
<th>Pre-Service Request for Benefits</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your request for benefits is filed improperly, UnitedHealthcare must notify you within:</td>
<td>5 days</td>
</tr>
<tr>
<td>If your request for benefits is incomplete, UnitedHealthcare must notify you within:</td>
<td>15 days</td>
</tr>
</tbody>
</table>
Pre-Service Request for Benefits

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You must then provide completed request for benefits information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td>15 days</td>
</tr>
<tr>
<td>• if the initial request for benefits is complete, within:</td>
<td></td>
</tr>
<tr>
<td>• after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>15 days</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>15 days</td>
</tr>
</tbody>
</table>

Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>• if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>• after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) decision</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision no later than:</td>
<td>180 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days</td>
</tr>
</tbody>
</table>

Post-Service Claims

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

The table below describes the timeframes, which you and UnitedHealthcare are required to follow.
Notification of the Determination on Appeal

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

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

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

External Review Program

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

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

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

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

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

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

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

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

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

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

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

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

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

**Designation of an Authorized Representative**

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other healthcare professional who is licensed, accredited or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claim procedures to “you” is intended to include your authorized representative. An assignment to a healthcare provider for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

**Employee Incentive Program**

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

Follow these procedures when reviewing your hospital or doctor bill:

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

Whether your vision is 20/20 or less than perfect, everyone needs regular vision care. That’s why Stryker offers vision benefits as part of the Stryker Corporation Welfare Benefits Plan.

The plan provides for professional vision services as well as glasses and contact lenses. EyeMed administers vision benefits. When you purchase covered vision services and materials through EyeMed’s provider network, your out-of-pocket expenses are limited to your copayments. Out-of-network services and materials are covered, too, but you pay a greater share of the cost.

While the definition of dependent child has been voluntarily amended to align with the medical and prescription benefit pursuant to Health Care Reform, the vision benefit is not otherwise subject to the insurance market reforms of Health Care Reform.

How Vision Benefits Work

Stryker’s vision benefits cover the cost of regular vision exams for you and your covered family members. Prescribed glasses and contact lenses are also covered.

When You Use Participating EyeMed Providers

Examination Benefit

The plan covers a comprehensive spectacle eye examination, including dilation, performed by a participating provider at no cost to you. Please note: there may be an additional charge from a provider for a contact lens exam without the purchase of contacts.

Frame Benefit

You are entitled to a $130 frame allowance every 24 months, with a $0 copay, when you purchase a frame with prescription lenses from a participating provider. If the frame you select costs more than $130, you pay 80% of the balance over $130.

Lens Benefit

When you purchase lenses from a participating provider, you pay a $25 copay for single vision, bifocal, trifocal or lenticular lenses. You also pay the following fixed amounts for lens options:

<table>
<thead>
<tr>
<th>Lens Option</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultra violet coating</td>
<td>$15</td>
</tr>
<tr>
<td>Tint (solid and gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Standard scratch resistant</td>
<td>$15</td>
</tr>
<tr>
<td>Standard polycarbonate</td>
<td>$40</td>
</tr>
</tbody>
</table>

Contact Lens Benefit

If you purchase contact lenses from a participating provider in lieu of spectacle lenses, you are entitled to a $130 contact lens allowance, with a $0 copay, every 12 months. If you purchase disposable contact lenses that cost more than $130, you pay 100% of the balance over $130. If you purchase non-disposable contact lenses that cost more than $130, you pay 85% of the balance over $130.

Laser Vision Benefit

You are entitled to a 15% discount or a 5% discount on promotional pricing for LASIK and PRK treatments provided by a U.S. Laser Network provider. Discounts apply to the procedure itself as well as pre-operative and post-operative care, provided that the same participating provider performs the procedure and provides the pre-operative and post-operative care. For more information about laser vision benefits, call 877 552 7376.

Additional Purchases

When you purchase vision supplies from a participating provider, you are entitled to a 20% discount off items not covered by the plan at network providers. The discount does not apply to professional services, disposable contact lenses or laser vision services and cannot be combined with any other discount or promotional offer.
Secondary Purchase Discount

If you purchase additional pairs of glasses (including prescription sunglasses) from a participating provider, you will receive a 40% discount off a complete pair of eyeglass purchases and a 15% discount off conventional lenses once the funded benefit has been used. Add $15 to these amounts if you live in California, Alaska, Hawaii, Oregon or Washington.

How to Locate Participating Providers

EyeMed’s provider locator service is available seven days a week, 24 hours a day, via an interactive voice response system or the Internet. Call 866 723 0513 or visit www.eyemedvisioncare.com. To speak with a customer service representative, call 866 723 0513.

Expenses Not Covered

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training
- Subnormal vision aids and any associated supplemental testing
- Medical or surgical treatment of the eye, eyes or supporting structures (These services are generally covered under the medical plan.)
- Corrective eyewear required by an employer as a condition of employment and safety eyewear
- Any service or material that may be covered under any Workers’ Compensation law
- Plano non-prescription lenses and non-prescription sunglasses, except for the 20% discount for materials purchased from participating providers
- Two pairs of glasses in lieu of bifocals
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design
- Services that are available without cost from any federal, state, county, city or other governmental organization

Benefits may not be combined with any discount, promotional offering or other group benefit plans. Allowances are one-time use benefits; no remaining balance may be used for additional pairs. Lost or broken materials are not covered.

How to Obtain Vision Benefits

If You Use Participating Providers

Once you’ve located a participating provider, schedule an appointment. Be sure to let the provider’s office know that you are covered under an EyeMed vision plan. Your provider’s office will collect your copays as well as any additional amounts you may owe for optional items such as
designer frames or tinting. The provider’s office also files claims for you.

Please note that the contact lens allowance is a one-time per calendar year benefit. If you purchase disposable contact lenses from a participating provider, be sure to purchase a sufficient quantity so that you use all of the $115 in-network benefit allowance. If you do not use all of the allowance for a single purchase, you won’t have any remaining balance to use for future purchases in the same calendar year.

If You Use Non-Participating Providers

If you do not use a participating provider, you must pay for services and materials and then file a one-time claim for reimbursement of all services and materials. You will need to complete an Out-of-Network claim form and submit the form with itemized receipts for reimbursement to:

EyeMed Vision Care
Attention: OON Claims
P.O. Box 8504
Mason, OH 45040

If your eye exam is provided on a date that is different from the date you receive your glasses or contacts, don’t file your claim for reimbursement until you have all of the necessary receipts.

If you purchase contact lenses from a non-participating provider, you must file a claim in order to obtain the $115 contact lens allowance. This is a one-time reimbursement, so you should wait to file your claim until you have all of the necessary receipts for your contact lens exam, fitting and the contact lenses themselves.

Time Frames for Processing Out-of-Network Claims

<table>
<thead>
<tr>
<th>Health Claim Processing Activity</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Initial Determination</strong></td>
<td></td>
</tr>
<tr>
<td>• Initial review decision</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>• Extension period, including extension for missing information</td>
<td>14 calendar days</td>
</tr>
<tr>
<td><strong>Plan Notice of Incomplete Claim</strong></td>
<td></td>
</tr>
<tr>
<td>• Missing information</td>
<td>Included in extension period above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Claim Processing Activity</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claimant Time to Complete Claim</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Provide additional information</td>
<td>45 calendar days</td>
</tr>
<tr>
<td>▪ Comply with required filing procedure</td>
<td>45 calendar days</td>
</tr>
</tbody>
</table>

Time Frames for Responding to Appealed Claims

<table>
<thead>
<tr>
<th>Health Claim Processing Activity</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claimant Appeal of Adverse Determination</strong> (Denial or Reduction)</td>
<td>180 calendar days</td>
</tr>
<tr>
<td><strong>Plan Decision or Appeal</strong></td>
<td>60 calendar days</td>
</tr>
</tbody>
</table>

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member’s written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable
- The item of your vision coverage that you feel was misinterpreted or inaccurately applied
- Additional information from your eye care provider that will assist EyeMed Vision Care in completing its review your appeal, such as documents, records, questions or comments

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.
Member Grievance Procedure

If you are dissatisfied with the services provided by an EyeMed Vision Care Provider, you should either write to EyeMed at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at 866 723 0513.

The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues you raise. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to communicate back with you within four (4) business days, with a decision or resolution to the issues or questions raised. If you are not satisfied with the resolution, you may file a formal appeal as set forth above related to a denial of benefits.

How to Reach EyeMed

EyeMed Vision Care
Stryker Group # for Active Employees: 9706201
Stryker Group # for COBRA Participants: 9706219
4000 Luxottica Place
Mason, OH 45040
866 723 0513
www.eyemedvisioncare.com or www.eyemedcontacts.com
Dental Benefits

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

While the definition of dependent child has been voluntarily amended to align with the medical and prescription benefit pursuant to Health Care Reform, the dental benefit is not otherwise subject to the insurance market reforms of Health Care Reform.

How Dental Benefits Work

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

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

Your Deductible

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

The deductible does not apply to Class I Benefits or to Class IV Benefits (see “Schedule of Benefits” on page 71).

Before You Have Treatment

When you or a covered dependent expects to have any dental treatment that may cost more than $200, you should request a “predetermination of benefits” from Delta Dental. This lets you and the treating dentist know in advance what benefits are covered, how much the plan will pay and how much you will have to pay.

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

Optional Treatment

Sometimes more than one dental service can treat the same problem. In these cases, Delta Dental pays only for the less expensive treatment unless a valid need is shown and approved by Delta Dental. For example, if a tooth can be satisfactorily restored with a filling and you choose to have a crown, Delta Dental will pay only the amount that would have been payable for the filling. You are responsible for the difference in cost.

If You Lose Coverage During Treatment

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

Schedule of Benefits

Benefits under the plan are divided into four classes:

- **Class I Benefits** cover 100% of diagnostic and preventive services including X-rays.
- **Class II Benefits** cover basic dental services such as oral surgery, minor restorative services, periodontics and endodontics. Class II Benefits are paid at 80% after deductible.
- **Class III Benefits** cover prosthodontics and major restorative services. Benefits are paid at 50% after deductible.
- **Class IV Benefits** cover orthodontics for dependents under age 19. Orthodontics for plan participants age 19 and older may be covered if there is a medical necessity for the orthodontic treatment. Benefits are paid at 50%.
Benefit Maximums
For Class I, Class II and Class III Benefits, the dental plan pays a combined maximum of $1,500 per person per year. For Class IV Benefits, the maximum is $1,500 per person per lifetime.

Covered Dental Expenses
The plan’s benefits for covered services are shown in the chart below:

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Plan Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class I Benefits: Diagnostic and Preventive Services (no deductible applies)</strong></td>
<td></td>
</tr>
<tr>
<td>Oral exams</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to two in any calendar year.</td>
<td></td>
</tr>
<tr>
<td>X-rays, full mouth (including bitewing)</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to one set in any five-year period.</td>
<td></td>
</tr>
<tr>
<td>X-rays, bitewing only</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to once in any consecutive 12-month period.</td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleaning, scaling and polishing)</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to two in any calendar year, including periodontal prophylaxes. May be performed by a licensed dental hygienist.</td>
<td></td>
</tr>
<tr>
<td>Fluoride treatments</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to children under age 19. Limited to two in any consecutive 12-month period. May be performed by a licensed dental hygienist.</td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to occlusal (top biting) surface of first permanent molars for children under age 9 and second permanent molars for children under age 14. Covered once per tooth per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Emergency palliative treatment (to temporarily relieve pain)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Class II Benefits: Basic Services (subject to deductible)</strong></td>
<td>80%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td></td>
</tr>
<tr>
<td>Minor restorative services, including fillings, relines and repairs to bridges, dentures and partials</td>
<td>80%</td>
</tr>
<tr>
<td>Amalgam and resin restorations are payable once within a 24-month period regardless of the number or combination of restorations placed on a tooth surface. Benefits for reline or complete replacement of denture base material are payable once in any three-year period.</td>
<td></td>
</tr>
<tr>
<td>Periodontics (treatment of the gums and supporting structures of the teeth)</td>
<td>100% for cleaning; 80% for all other services</td>
</tr>
<tr>
<td>Endodontics (root canal therapy)</td>
<td>80%</td>
</tr>
</tbody>
</table>
### Covered Service

#### Class III Benefits: Major Restorative Services (subject to deductible)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Plan Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthodontics (treatment to replace missing natural teeth or other dental structures)</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Complete dentures</strong>&lt;br&gt;Limit of one complete upper and one complete lower denture per person in any five-year period.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Partial dentures, fixed bridges or removable partials</strong>&lt;br&gt;Limit of one per person in any five-year period except where the loss of additional teeth requires the construction of a new appliance. Fixed bridges and removable cast partials are not covered for children under age 16.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Major restorative services, including crowns, jackets and onlays</strong>&lt;br&gt;Treatment per tooth is limited to once in any five-year period. Full porcelain, porcelain/resin processed to metal, full cast or 3/4 cast crowns are not covered for children under age 12.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Endosteal implants</strong>&lt;br&gt;An implant for any person can be covered once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Class IV Benefits: Orthodontics (no deductible applies)

Limited to children under age 19. If orthodontia treatment began before coverage under Stryker’s healthcare plan became effective, benefits will be calculated based on the remaining months of treatment. If orthodontia treatment is terminated prior to completion, for any reason, benefit payment will end as of the date treatment is terminated. Orthodontics for individuals age 19 and older may be covered if the treatment is determined to be medically necessary.

<table>
<thead>
<tr>
<th>Benefit Maximums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class I, Class II and Class III combined</strong>&lt;br&gt;$1,500 per person per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Class IV</strong>&lt;br&gt;$1,500 per person lifetime maximum</td>
<td></td>
</tr>
</tbody>
</table>

### Expenses Not Covered

The plan does not pay for the following expenses:

- Services that are not necessary as determined by the standards of generally accepted dental practice
- Treatment by other than a licensed dentist, except for prophylaxis (cleaning and scaling of teeth) and topical application of fluoride performed by a licensed dental hygienist under the supervision and direction of a licensed dentist
- Cosmetic dentistry or dentistry to correct congenital malformations
- Services or appliances, including crowns and bridges, for which treatment began prior to the date the person became covered under the plan
- Prescription drugs, laboratory tests and/or exams, premedications and local anesthesia (These services may be covered under the medical plan.)
- Hospitalization
- General anesthesia and intravenous sedation for restorative dentistry or surgical procedures, unless a specific need is shown (e.g., on account of a child’s age)
- Preventive control programs, including home care items
- Charges for completion of claim forms
- Missed dental appointments
Dental Benefits

- Appliances, surgical procedures or restorations whose primary purpose is to alter vertical dimension, restore occlusion or replace tooth structure loss resulting from attrition, abrasion or erosion
- Inlays
- Replacement, repair, relines or adjustments of occlusal guards (Occlusal guards are limited to one per lifetime.)
- Lost, missing or stolen appliances of any type, and replacement or repair of orthodontic appliances
- Services that are experimental in nature
- Services and supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage
- Services to treat a dental disease, defect or injury due to an act of war, declared or undeclared
- Services that are covered under the healthcare or prescription drug benefits provided under the Stryker Corporation Welfare Benefits Plan
- Services or appliances for the treatment of temporomandibular joint (TMJ) disorder (Note: These services are covered under the medical plan.)
- Services for injuries or conditions covered under Workers’ Compensation or employers’ liability laws
- Services that are available from any government agency, political subdivision, community agency, foundation or similar entity
- Services that are excluded by Delta Dental’s processing policies

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

If You Use Non-Participating Dentists

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

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

Coordination of Benefits

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

How Payment Is Made

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

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

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

How to Obtain Dental Benefits

If You Use Participating Dentists

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

If You Have Other Dental Coverage

If you have other dental coverage, see Participating in Healthcare Benefits for information on how Coordination of Benefits with that coverage may impact your claims.
If the dentist is a PPO dentist but is not a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The PPO dentist schedule.

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

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

- The submitted amount
- The Maximum Approved Fee

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

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

- The submitted amount
- The non-participating dentist Fee

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

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

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

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

**Claims Determinations**

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

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

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

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

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

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

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

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

If the Dental Director’s adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

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

How to Reach Delta Dental

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

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

Dental Plan Definitions

Dentist

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

Diagnostic and preventive services

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

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

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

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

Non-participating dentist

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

Orthodontics

Services and treatment required for the correction of malpositioned teeth.

Participating dentist

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

Predetermination

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

Restorative services

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

This section includes location-specific supplemental benefit information for employees who live in:

- Alabama
- California/Hawaii

Supplemental benefit information is also included in this section for employees who participate in the International Plan.

Alabama

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well.

Healthcare Benefits

If you live or work in Alabama, Stryker offers you one medical option—the Blue Cross and Blue Shield (BCBS) of Alabama PPO. If you select the Blue Cross Blue Shield of Alabama PPO option, your prescription drug benefits are provided through Blue Cross and Blue Shield of Alabama and not through the UnitedHealthcare prescription plan.

This section of the Stryker Benefits Summary, together with other sections of the Stryker Benefits Summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Certificate for Group Health Benefits issued by Blue Cross and Blue Shield of Alabama, constitute the Summary Plan Description for the Blue Cross and Blue Shield of Alabama PPO option.

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker Benefits Summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker Benefits Summary will apply.

For More Information

The Certificate for Group Health Benefits document issued by Blue Cross and Blue Shield of Alabama contains detailed information about plan benefits and how the plan works for your location. If you have questions or want additional information, be sure to refer to the document, available at http://totalrewards.stryker.com/spd/SBC-BCBS-AL.pdf.

Eligibility

Employees

You are eligible to enroll in the Blue Cross and Blue Shield of Alabama PPO option if you are a full-time or part-time employee of Stryker who lives or works in Alabama and the Company has determined that you work an average of at least 30 hours or more per week (including vacation and certain leaves of absence) in accordance with the Affordable Care Act. Temporary and seasonal employees, as well as interns, are not eligible. Coverage begins on the first day of the month following your date of hire.

Eligible dependents include:

- Your legal spouse of the same or opposite sex
- A married or unmarried child up to the age of 26
The term “child” means:

- A natural child
- A legally adopted child
- A child placed for adoption
- A stepchild
- An eligible foster child that is placed with you by an authorized placement agency or by court order

Effective January 1, 2014, a grandchild is eligible only if he or she is the employee’s adopted child, a child placed for adoption or the employee’s eligible foster child. Any grandchildren that do not meet these requirements but were covered on or before December 31, 2013 will be allowed to remain covered until they turn 19 as long as they are unmarried.

“Child” also includes a child who is required to be covered under the Stryker Corporation Welfare Benefits Plan by a qualified medical child support order (QMCSO). See Your Rights and Responsibilities in this Stryker Benefits Summary for more information regarding QMCSOs.

If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the Blue Cross and Blue Shield of Alabama PPO option. Other options may have other requirements.

When Coverage Begins

If you enroll when you are first eligible, your coverage under the plan begins on the first day of the month following your date of hire. If you are re-hired after a break in service, coverage begins on the first of the month following your date of hire.

A newly eligible child or spouse will be covered immediately if you contact your Benefits Representative and complete necessary paperwork to enroll him or her within 30 days of the birth, marriage or date the child joined the family.

When Coverage Ends

Coverage for you and your dependents under the Stryker Corporation Welfare Benefits Plan ends on the last day of the month in which one of the following events occurs:

- The date you leave Stryker or fail to pay required coverage contributions
- The date you are no longer an eligible employee
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, on the December 31 following the annual enrollment period

Dependent coverage ends:

- On the date your coverage ends
- On the last day of the calendar month in which your dependent child reaches the plan’s limit (age 26) or otherwise ceases to be a dependent
- In the case of a spouse, the date of divorce

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see “COBRA: Continuing Healthcare Coverage” in the Participating in Healthcare Benefits section of this Stryker Benefits Summary.

Medical Benefits


Prescription Drug Benefits

Claim Procedures


Other Information

Subrogation Rights

If your illness or injury is caused by a third party’s act or omission, Blue Cross Blue Shield of Alabama may have subrogation rights. For more information, see the “Subrogation” section of the Certificate for Group Health Benefits document, available at http://totalrewards.stryker.com/spd/SBC-BCBS-AL.pdf.

Funding

The Stryker Corporation Welfare Benefits Plan is funded directly by Stryker from its general assets and with employee contributions. Except as provided below, benefits are not insured. Delta Dental and EyeMed perform claim administrative functions only.

Benefits under the Blue Cross Blue Shield of Alabama PPO option are fully insured and disbursements are made pursuant to a contract between Blue Cross Blue Shield of Alabama and Stryker. Information regarding how to contact Blue Cross Blue Shield of Alabama may be found in the Certificate for Group Health Benefits document, available at http://totalrewards.stryker.com/spd/SBC-BCBS-AL.pdf.

The Employee Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured. The Ceridian performs administrative functions only.

Flexible spending accounts are funded by employee contributions made through salary reduction. Flexible spending accounts are not insured. Stryker pays benefits from its general assets. UnitedHealthcare performs claim administrative functions only.

The Adoption Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured.

California and Hawaii

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well.

Healthcare Benefits

If you live or work in California, Stryker offers two medical options for most ZIP codes. One option is the UnitedHealthcare (UHC) PPO option, as described earlier in this Stryker Benefits Summary. The second option is the Kaiser Permanente HMO option. If you select the HMO, your prescription drug benefits are provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.

If you live in Hawaii, Stryker offers Kaiser Permanente HMO. Your prescription drug benefits are provided through Kaiser Permanente and not through the UnitedHealthcare prescription plan.

If you are in an area where no network is available, you will be offered the UnitedHealthcare (UHC) Out-of-Area plan.

This section of the Stryker Benefits Summary, together with other sections of the Stryker Benefits Summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Evidence of Coverage issued by Kaiser Permanente, constitute the Summary Plan Description for the Kaiser Permanente HMO option.

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker Benefits Summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker Benefits Summary will apply.
For More Information

If you have questions or want additional information, refer to the Kaiser documents for your location as shown here:


Eligibility

Employees

You are eligible to enroll in the Kaiser Permanente HMO option if you are:

- A full-time or part-time employee of Stryker who are regularly scheduled to work an average of at least 20 hours a week, and
- You live or work in the HMO’s service area at the time you enroll.

Temporary and seasonal employees, as well as interns, are not eligible. Newly hired employees who met this requirement become eligible on their date of hire.

The applicable service area is described in the “Definitions” section of the Evidence of Coverage for your plan. Special rules apply if you live or move outside of the service area after you enroll as described in the “Premiums, Eligibility and Enrollment” section of the applicable Evidence of Coverage.

Dependents

Eligible dependents include:

- Your spouse
- Your domestic partner who meets all of the following group requirements for the immediately preceding 12 months:
  - Is of your same gender
  - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began
  - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely
  - Has not had another domestic partner within the prior 12 months
  - Has not been a party to a divorce or annulment proceeding within the prior 12 months
  - Is not related to you in a way that would prohibit a legal marriage
  - Is not legally married to anyone else, and any prior marriages have been dissolved through death, divorce or nullity
  - Shares a household with you that is the primary residence of both of you (although you may live apart for reasons of education, healthcare, work or military service)
  - Shares joint responsibility with you for each other’s basic living expenses incurred during the domestic partnership
  - Your or your spouse’s (or declared same sex domestic partner’s) unmarried children who are under age 26
  - Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
    - They are under age 26
    - They receive all of their support and maintenance from you or your spouse
    - They permanently reside with you
    - You or your spouse (or declared same sex domestic partner) is the court-appointed guardian (or was before the person reached age 18) or the person’s parent is an enrolled dependent under your family coverage

Dependents who meet the dependent eligibility requirements except for the age limit may be eligible if they meet all the following requirements:

- They are incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that occurred prior to reaching the age limit for dependents;
- They receive 50% or more of their support and maintenance from you or your spouse; and
- You provide proof of their incapacity and dependency within 60 days after such proof is requested.

For purposes of determining eligibility under the Kaiser HMO option, the term “child” includes your biological child, legally adopted child, a child placed for adoption, a stepchild or a child who is required to be covered under the Stryker Corporation Welfare Benefits Plan by a qualified medical child support order (QMCSO). See Your Rights and Responsibilities in this Stryker Benefits Summary for more information regarding QMCSOs.

If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the Kaiser HMO option. Other options may have other requirements.

When Coverage Begins

If you enroll when you are first eligible, your coverage under the plan begins immediately as of your date of hire. If you are re-hired after a break in service, coverage begins immediately on your date of rehire.

A newly eligible child or spouse will be covered immediately if you contact your Benefits Representative and complete necessary paperwork to enroll him or her within 30 days of the date of birth or marriage or the date the child joined the family.

For a newborn child, coverage is effective from the moment of birth. However, if you do not enroll the newborn child within 30 days, the newborn is covered for only 31 days (including the date of birth).

When Coverage Ends

Coverage for you and your dependents under the Stryker Corporation’s Welfare Benefits Plan ends on the following dates:

- The date you leave Stryker, fail to pay required coverage contributions or otherwise become an ineligible employee. (NOTE: In compliance with the Hawaii Prepaid Health Care Act, if you live in Hawaii when you leave Stryker, your coverage ends on the last day of the month in which your employment ends.)
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, coverage ends on the December 31 following the annual enrollment period

Dependent coverage ends:

- On the date your coverage ends
- On the day prior to their 26th birthday
- On the date your dependent ceases to qualify as a dependent under the plan
- In the case of your spouse, the date of divorce

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see “COBRA: Continuing Healthcare Coverage” in the Participating in Healthcare Benefits section of this Stryker Benefits Summary.

Medical Benefits

For specific and detailed information about the medical benefits offered under the Kaiser Permanente HMO option, refer to the Evidence of Coverage for your plan.

If you live in California, you may also refer to a Benefit Summary for an overview of your plan’s benefits:


Prescription Drug Benefits

The Kaiser Permanente HMO option provides benefits for covered prescription drugs, including contraceptives, insulin and diabetic supplies. Specific information is set out in the “Outpatient Prescription Drugs, Supplies and Supplements” section of the Evidence of Coverage for your plan.
Claim Procedures

Information about filing claims for benefits is set out in the “Requests for Payment or Services” section of the Evidence of Coverage for your plan. Kaiser Permanente is the fiduciary for purposes of deciding claims for benefits under this healthcare option.

Other Information

Continuation of Coverage After COBRA

Under certain circumstances, coverage may be continued after the maximum COBRA coverage period ends. For more information, see the “Continuation of Membership” section of the Evidence of Coverage for your plan.

Subrogation Rights

If your illness or injury is caused by a third party’s act or omission, the Kaiser Permanente may have subrogation rights. For more information, see the “Exclusions, Limitations, Coordination of Benefits and Reductions” section of the Evidence of Coverage for your plan.

Funding

The Stryker Corporation Welfare Benefits Plan is funded directly by Stryker from its general assets and with employee contributions. Except as provided below, benefits are not insured. Delta Dental and EyeMed perform claim administrative functions only.

HMO benefits are fully insured by Kaiser Permanente and disbursements are made pursuant to a contract between Kaiser Permanente and Stryker. Information regarding how to contact Kaiser Permanente may be found in the Evidence of Coverage.

The Employee Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured. The Ceridian performs administrative functions only.

Flexible spending accounts are funded by employee contributions made through salary reduction. Flexible spending accounts are not insured. Stryker pays benefits from its general assets. UnitedHealthcare performs claim administrative functions only.

The Adoption Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured.

International Plan

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well. The plan also provides life and accidental death and dismemberment (AD&D) insurance, as well as long-term disability insurance, at no cost to you. These plans offer you income protection for you and your dependents in the face of unforeseen events.

If you are a U.S. Expatriate employee, you are not eligible for life and AD&D benefits under the International Plan. You are, however, eligible for life and AD&D insurance through the U.S. benefit plan. For more information on these benefits, see the Life and AD&D Insurance Coverage section in this Stryker Benefits Summary or refer to the Life and Accident Certificate of Insurance, available at http://totalrewards.stryker.com/spd/Stryker-1-1-2014-Life-ADD-Cert-as-of-12-20-2013.pdf.
The following chart summarizes the benefits available to you.

**Benefits at a Glance**

| Medical Coverage | • Comprehensive medical benefits for you and your covered dependents  
|                  | • You must meet a small annual deductible before the plan begins to pay benefits  
|                  | • Preventive care (as outlined in the benefit highlights) is free  
|                  | • Most other services are 100% covered once you meet the annual deductible  
|                  | • Includes coverage for prescription drugs purchased outside the U.S.  
|                  | • You and Stryker share the cost of medical coverage  
| Prescription Drug Coverage | • Applies for prescription drugs purchased in the U.S. only  
|                          | • Prescription drug benefits for you and your covered dependents  
|                          | • You pay a set copayment for prescription drugs purchased through participating retail pharmacies (30-day supply) or mail-order (90-day supply)  
|                          | • Your cost depends on whether the medication is generic or brand-name  
|                          | • You and Stryker share the cost of prescription drug coverage  
| Dental Coverage | • Comprehensive dental benefits for you and your covered dependents  
|                | • You must meet a small annual deductible before the plan begins to pay benefits  
|                | • Preventive care (as outlined in the benefit highlights) is free  
|                | • You pay a portion of the cost for basic and major services once you meet the annual deductible  
|                | • Orthodontia services are covered at 50%, up to $1,000  
|                | • You and Stryker share the cost of dental coverage  
| Vision Coverage | • Vision benefits for you and your covered dependents  
|                  | • Plan reimburses you for eligible eye care and eye wear expenses, up to certain amounts  
|                  | • You and Stryker share the cost of vision coverage  
| Life Insurance | • Pays benefits to your beneficiary in the event of your death  
|                | • Coverage of two times your annual basic earnings, up to $500,000  
|                | • Stryker provides this coverage automatically at no cost to you  
|                | • *U.S. Expatriate employees are excluded from this coverage and are eligible for the U.S. Life and AD&D benefits.*  
| (AD&D) Insurance | • Pays benefits to you for certain injuries or other conditions resulting from an accident, and benefits to your beneficiary in the event of your death  
|                   | • Coverage of two times your annual basic earnings, up to $500,000  
|                   | • Stryker provides this coverage automatically at no cost to you  
|                   | • *U.S. Expatriate employees are excluded from this coverage and are eligible for the U.S. Life and AD&D benefits.*
Healthcare Benefits

If you are on International Assignment and meet the eligibility requirements, Stryker offers you one medical option—the Cigna International Expatriate Benefits option provided through Cigna. The UnitedHealthcare PPO plan or other carrier options are not available.

This section of the Stryker Benefits Summary, together with other sections of the Stryker Benefits Summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Schedule of Benefits issued by Cigna, constitute the Summary Plan Description for the Cigna option. It is intended to supplement the information contained elsewhere in the Stryker Benefits Summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker Benefits Summary will apply.

For More Information

The Schedules of Benefits issued by Cigna contains detailed information about the benefits for each plan offered under the Cigna option. If you have questions or want additional information, refer to the Cigna Schedule of Benefits, available at:


Eligibility

Employees

You are eligible to enroll in the Cigna option if you are a full-time employee of Stryker who is on International Assignment and meets all other eligibility requirements as outlined in the Certificate, available at:


Dependents

Eligible dependents include:

- Your legal spouse

- Your declared domestic partner who meets all of the following requirements for the immediately preceding 12 months:
  - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began
  - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely.
  - Has not had another domestic partner within the prior 12 months
  - Has not been a party to a divorce or annulment proceeding within the prior 12 months
  - Is not related to you in a way that would prohibit a legal marriage
  - Is not legally married to anyone else, and any prior marriages have been dissolved through death, divorce or nullity
  - Shares a household with you that is the primary residence of both of you (although you may live apart for reasons of education, healthcare, work or military service)
Shares joint responsibility with you for each other’s basic living expenses incurred during the domestic partnership

- Your child under age 26
- A disabled child, who is not able to support himself because of a physical or mental disability that existed before age 26 and who relies primarily on you for support, provided the child has had continuous coverage with Cigna since the child’s 26th birthday

The term “child” means:

- A natural child
- A stepchild or declared domestic partner’s child
- A foster child
- A legally adopted child
- A child placed for adoption.

“Child” also includes a child who is required to be covered under the Stryker Corporation Welfare Benefits Plan by a qualified medical child support order (QMCSO). See the Your Rights and Responsibilities section in this Stryker Benefits Summary for more information regarding QMCSOs.

If both you and your spouse work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the Cigna option. Other options may have other requirements.

When Coverage Begins

If you enroll when you are first eligible, your coverage under the plan begins immediately as of your date of hire. If you are re-hired after a break in service, coverage begins immediately on your date of rehire.

A newly eligible child or spouse will be covered immediately if you contact your Benefits Representative and complete the necessary paperwork to enroll him or her within 30 days of the date of birth or marriage or the date the child joined the family.

Effective Date of Dependent Insurance

Insurance for your dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for dependent insurance. All of your dependents as defined will be included.

If you are a late entrant for dependent insurance, the insurance for each of your dependents will not become effective until Cigna agrees to insure that dependent. Your dependent will not be denied enrollment for medical insurance due to health status. Your dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a late entrant for dependent insurance if:

- You elect that insurance more than 30 days after you become eligible for it
- You again elect it after you cancel your payroll deduction.

Exception for Newborns

Any dependent child born while you are insured for medical insurance will become insured for medical insurance on the date of his birth if you elect dependent medical insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception to Late Entrant Definition

A person will not be considered a late entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; Employer contributions toward the other coverage have been terminated; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted: and he enrolls for this coverage within 30 days after losing or exhausting prior coverage. In addition, a dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a late entrant.
If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

Any applicable pre-existing condition limitation will apply to you and your dependents upon enrollment, reduced by prior creditable coverage, but will not be extended as for a late entrant.

**Pre-Existing Condition Limitation for Late-Entrant**

For plans which include a pre-existing condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months from the date a late entrant applies for coverage.

For plans which do not include a pre-existing condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan if you are a late entrant.

For plans which do not standardly include a pre-existing condition limitation and which do not include an annual open enrollment period, a pre-existing condition limitation of 18 months applies.

**When Coverage Ends**

Coverage for you and your dependents under the Stryker Corporation Welfare Benefits Plan ends on the date on which any of the following take place:

- You leave Stryker or fail to pay required coverage contributions
- You are no longer an eligible employee
- You drop coverage due to a qualifying life event

If you elect to drop healthcare benefits during annual enrollment, coverage ends on the December 31 following the annual enrollment period.

Dependent coverage ends:

- On the date your coverage ends
- On the last day of the calendar month in which your dependent child reaches age 26
- On the date your dependent child ceases to qualify as a dependent under the plan
- In the case of a spouse, the date of divorce

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see “COBRA: Continuing Healthcare Coverage” in the Participating in Healthcare Benefits section of this Stryker Benefits Summary.

**Medical Benefits**


**Prescription Drug Benefits**


**Dental Benefits**


**Vision Benefits**


**Claim Procedures**

**Other Information**

**Subrogation Rights**

If your illness or injury is caused by a third party’s act or omission, Cigna may have subrogation rights. For more information, see the “Expenses for Which a Third Party May Be Liable” section of the Schedule of Benefits, available at http://totalrewards.stryker.com/spd/Stryker-Med-Dent-Certificate-07-2013.pdf.

**Funding**

Benefits under the Cigna option are fully insured. Medical, prescription drug, dental and vision benefit disbursements are made pursuant to a contract between Cigna Health and Life Insurance Company and Stryker. Life, AD&D and disability benefit disbursements are made pursuant to a contract between Life Insurance Company of North America and Stryker. Information regarding how to contact both Cigna Health and Life Insurance Company and Life Insurance Company of America may be found in the Summary of Benefits.

Flexible spending accounts are funded by employee contributions made through salary reduction. Flexible spending accounts are not insured. Stryker pays benefits from its general assets. UnitedHealthcare performs claim administrative functions only.

The Employee Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured. The Ceridian performs administrative functions only.

The Adoption Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured.
Flexible Spending Accounts

Flexible spending accounts (FSAs) help you budget for expected out-of-pocket health and day care expenses and save money on taxes at the same time. Stryker offers two FSAs:

- The healthcare flexible spending account (HCFSA)
- The day care (child and adult) flexible spending account (DCFSA)

How FSAs Work

When you enroll in an FSA, you select an annual contribution amount. Amounts you contribute to the HCFSA and/or DCFSA are deducted from your paycheck before federal and state income taxes are withheld. Because FSA contributions are deducted from your pay before these taxes are calculated, you are taxed on a lower amount. When you incur expenses the IRS considers tax deductible, you use your FSA contributions to reimburse yourself.

FSA participation is not automatic. If you want to participate, you must complete an enrollment form. In addition, you must make new enrollment and contribution elections every year you choose to participate. You do not need to be enrolled in a Stryker healthcare plan to participate in one or both FSAs. You may enroll in the FSAs even if you don’t enroll in a Stryker healthcare plan.

Eligible expenses for the HCFSA include annual deductibles, copayments and healthcare expenses that are not covered by a healthcare plan. Eligible DCFSA expenses include amounts you pay for child or adult day care so that you and your spouse can work, look for work or attend school full-time. More detailed lists of eligible expenses under both FSAs are included in “Healthcare Flexible Spending Account (HCFSA)” on page 95 and “Day Care (Child and Adult) Flexible Spending Account (DCFSA)” on page 100.

An Example

The following example, based on 2014 tax rates, shows how an FSA can save you money. Assume that you earn $35,000 annually, are single, you claim the standard allowable deduction on your income taxes and you normally pay $800 each year for healthcare expenses that are not covered by a health plan.

By paying out-of-pocket costs with before-tax versus after-tax money, you save $170 in taxes.

You should be aware that FSA contributions lower Social Security (FICA) taxes paid by you and Stryker. These lower taxes could result in slightly lower Social Security benefits in the event of your retirement, death or disability.

How FSAs Save You $$$

<table>
<thead>
<tr>
<th></th>
<th>With an FSA</th>
<th>Without an FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross pay</td>
<td>$35,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Annual before-tax HCFA contribution</td>
<td>$800</td>
<td>$0</td>
</tr>
<tr>
<td>Estimated federal income tax and social security taxes</td>
<td>$6,320</td>
<td>$6,490</td>
</tr>
<tr>
<td>Annual tax savings</td>
<td>$170</td>
<td>$0</td>
</tr>
</tbody>
</table>

$6,490 - $6,320 = $170

By paying out-of-pocket costs with before-tax versus after-tax money, you save approximately $170 in federal income taxes.
Enrolling in an FSA

Participation in an FSA is entirely voluntary. If you are a part-time employee working at least 20 hours per week, or a full-time employee working at least 40 hours a week, you’re eligible to enroll in the HCFSA, the DCFSA or both. If you don’t enroll in an FSA when you are first eligible or during an annual enrollment period, you normally are not eligible to enroll again until the next annual enrollment period.

- If you are a new employee. You are eligible to participate in the HCFSA and the DCFSA on your date of hire. In order to participate in either FSA, you must complete the appropriate sections of your enrollment form and indicate how much you want to contribute to each account. FSA contributions begin on the first day of the payroll period following the date of your election and continue through the last pay period of the calendar year.

- If you are rehired after a break in service. If the break in service is 30 days or less and you are rehired in the same calendar year, your previous flexible spending account elections will be reinstated as of your rehire date. Contributions will be recalculated to deduct the full amount of your election by the end of the plan year.

If the break in service is longer than 30 days or if you are rehired in a new calendar year, you will make new FSA elections which will become effective as of your rehire date.

- Annual enrollment. You have a new opportunity to enroll in the HCFSA and the DCFSA each year. During the annual enrollment period, you decide whether you want to participate in one or both FSAs and how much you want to contribute. Your participation status and the amount you contribute can change from one year to the next.

FSA contributions do not roll over from one year to the next, so you must enroll and select a new annual contribution amount each year if you want to continue participation in an FSA. FSA elections made during an annual enrollment period become effective on the following January 1. You may participate in one or both FSAs even if you are not covered under a Stryker healthcare plan.

ELECTING DIRECT DEPOSIT REIMBURSEMENT

When you enroll in the HCFSA or the DCFSA, you can choose to have reimbursements deposited directly to your bank account. If you choose the direct deposit reimbursement option, you will receive a verification notice, which indicates the deposit amount and the date, each time a reimbursement payment is deposited to your account. You can elect direct deposit reimbursement by visiting the UnitedHealthcare web site at www.myuhc.com. If you don’t elect direct deposit reimbursement, your FSA claim reimbursement will be paid by check, which will be mailed to your home.

Life Event Guide – FSA

Under current federal tax rules, your ability to change your HCFSA and DCFSA elections is limited. You may change your enrollment once each year during the annual enrollment period. You will be notified in advance of the annual enrollment dates. Coverage changes will take effect the following January 1. You must check your enrollment confirmation for any errors. If you do not correct any errors within the enrollment period or, with the permission of Stryker, after the end of the enrollment period but before January 1, you will not be permitted to make any changes unless you subsequently have a qualifying life event or qualify for HIPAA special enrollment rights as described next.
In most cases, you cannot change your HCFSA or DCFSA election during the year. However, mid-year election changes may be permitted if you experience a qualifying life event as provided in the following chart. Note: If you enroll in the HCFSA, you will not be permitted to stop or decrease your contributions during the year even if you have a qualifying life event.

<table>
<thead>
<tr>
<th>Qualifying Life Event</th>
<th>Healthcare Flexible Spending Account (HCFSA)</th>
<th>Day Care (Child and Adult) Flexible Spending Account (DCFSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marriage, declaration of same-sex domestic partnership, birth or adoption</strong></td>
<td>You may enroll or increase your HCFSA election.</td>
<td>You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.</td>
</tr>
<tr>
<td><strong>Death of dependent, divorce, annulment or termination of domestic partnership</strong></td>
<td>You may enroll or increase your HCFSA election if coverage is lost under another health plan.</td>
<td>You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.</td>
</tr>
<tr>
<td><em>Note: Legal separation is not considered a qualifying life event</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change in the employment status of employee, spouse, dependent or domestic partner (e.g., change in work hours, change between salaried and hourly, loss of employer sponsored coverage and leaves of absence)</strong></td>
<td>You may enroll or increase your HCFSA election if eligibility under another employer health plan is affected.</td>
<td>You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.</td>
</tr>
<tr>
<td><strong>Change in residence or work site</strong></td>
<td>N/A</td>
<td>You may enroll, increase or decrease your DCFSA election if the event affects day care expenses and the change is consistent with the event.</td>
</tr>
<tr>
<td><strong>Employee or dependent becomes eligible or loses eligibility for Medicare or Medicaid</strong></td>
<td>You may enroll or increase your HCFSA election.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Court issues order regarding medical coverage of child (qualified medical child support order or QMCSO)</strong></td>
<td>You may enroll or increase your HCFSA election if you are required to provide coverage for a dependent not previously covered.</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Change in amount charged by current day care provider</strong></td>
<td>N/A</td>
<td>You may increase or decrease your DCFSA election based on whether your costs increase or decrease, but only if the change in cost is not imposed by a relative.</td>
</tr>
<tr>
<td><strong>Change in day care provider</strong></td>
<td>N/A</td>
<td>You may increase or decrease your DCFSA election, based on whether the change causes your costs to increase or decrease, regardless of whether the new provider is a relative.</td>
</tr>
</tbody>
</table>
Changes to your healthcare and/or day care (child and adult) flexible spending account elections must be consistent with the qualifying life event. Your Benefits Representative must approve benefit election changes. If you have a qualifying life event as shown in the previous chart, you must contact your Benefits Representative and provide proof of the event (if applicable) within 30 days of the event in order to change your healthcare and/or day care election. Additional elected amounts will be eligible for use on all services incurred on and after the effective date of the change.

**Taking a Family or Medical Leave of Absence**

If you qualify for an approved leave of absence under the Family and Medical Leave Act (FMLA), your HCFSA and/or DCFSA participation will continue while you are away from work. If your FMLA leave is paid, your contributions will continue to be deducted from your paycheck—just as though you were actively at work. If your leave is unpaid, your per-paycheck contributions will resume when you return to work. The new per-paycheck contributions will be based on the number of remaining pay periods, your remaining annual contribution amount and the contributions that were missed during your absence. All FSA election change requests are subject to review and approval by your Benefits Representative.

**Reporting Qualifying Life Events**

You have 30 days following a qualifying life event (including the date of the event) to contact your Benefits Representative and submit an enrollment form to request an FSA election change. You will also be asked to provide documentation that verifies your qualifying life event within 30 days of the qualifying life event. If you miss the 30-day election change period, you won’t be able to change your FSA election until the next annual enrollment period.

**The Importance of Estimating Carefully**

FSAs are tailor-made for people who like to plan and budget for expenses they know they will have during the year. But, there are other reasons to carefully plan FSA contributions:

- HCFSA and DCFSA contributions can be changed during the year, but only if you experience a specific qualifying life event. Even then, participation or contribution changes must be directly related to your qualifying life event.
- You cannot move money from one FSA to another. Money deposited in the HCFSA must be used only for healthcare expenses. The DCFSA can be used only for qualified day care expenses.

**Use It or Lose It**

Under IRS regulations, amounts remaining in an HCFSA or a DCFSA following the March 31st claim-filing deadline must be forfeited and cannot be applied to the next year’s expenses.
- You can submit claims for expenses incurred and paid in a calendar year until March 31 of the following year. For example, you can submit expenses incurred in 2013 until March 31, 2014. UnitedHealthcare must receive claims no later than March 31.

According to Internal Revenue Service regulations, amounts remaining in an HCFSA or a DCFSA following the March 31st claim-filing deadline must be forfeited under the Stryker plan. Amounts that have not been used in one calendar year cannot be applied toward expenses incurred in the next calendar year.

### Keeping You Informed

Regularly, you will receive an FSA statement showing contributions, claims processed and your account balance as of the statement date. You can also check your account balance at any time by visiting [www.myuhc.com](http://www.myuhc.com).

### When FSA Participation Ends

If you leave Stryker or stop contributing to an FSA for any reason, your participation will end on the date your employment ends or you stop contributions to either or both accounts. You may continue to submit claims for expenses incurred prior to the date your participation ended up to March 31 of the following year. If you are eligible, you may elect to continue participating in the HCFSA after you leave Stryker through COBRA continuation. For details, see “COBRA: Continuing Healthcare Coverage” in the *Participating in Healthcare Benefits* section.

### Healthcare Flexible Spending Account (HCFSA)

This section describes rules that apply to HCFSAs, such as how much you can contribute, eligible expenses that can be reimbursed from your HCFSA and the claims procedures you need to follow to be reimbursed.

#### How Much You Can Contribute

When you enroll in the HCFSA, you select an annual calendar year contribution amount that will be prorated and deducted from each of your paychecks on a before-tax basis. Annual HCFSA contributions cannot exceed $2,500. The minimum annual HCFSA contribution is $100.

Actual per-paycheck deductions are determined by your annual calendar year contribution amount, your payroll frequency and the number of remaining pay periods in the calendar year.

**An Example**

Assume that you are hired in May and your HCFSA participation begins in June. If you elect to contribute the annual maximum and you are paid semi-monthly, your per-paycheck contribution would be $178.57, as shown in the following chart.

<table>
<thead>
<tr>
<th>Annual Contribution</th>
<th>Remaining Pay Periods (June – December)</th>
<th>Per Paycheck Contribution Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500</td>
<td>14</td>
<td>$178.57</td>
</tr>
</tbody>
</table>

#### Eligible Expenses

You can use the HCFSA to reimburse yourself for medical, dental, vision and hearing care expenses incurred by you or your dependents. Dependents include:

- Your spouse
- Your children who are eligible for coverage under Stryker’s healthcare plan, even if they are not enrolled for coverage under the plan
- Other family members, such as your domestic partner’s children, who you claim as dependents for federal income tax purposes
Flexible Spending Accounts

Your domestic partner is not eligible for coverage under the HCFSA unless he or she qualifies as your tax dependent.

Generally, eligible HCFSA expenses are physicians’ or dentists’ services or related supplies that are not covered by any employer-sponsored benefit plan or a personal insurance policy. Examples of eligible HCFSA expenses include:

- Acupuncture services
- Auto equipment to assist the physically handicapped
- The difference in cost between Braille and non-Braille books and magazines
- Special schools for the mentally or physically handicapped
- Contact lenses, solutions and supplies
- Deductibles and amounts paid as coinsurance or copayments under medical, dental, vision and prescription drug plans
- Detoxification or substance abuse treatment to the extent that treatment is not covered by a medical plan
- Equipment installed in your home and certain home improvements, if the main purpose is medical care
- Expenses in excess of medical, dental or vision coverage limits
- Expenses for eye examinations, frames, lenses and tinting that are not covered under Stryker’s vision benefits
- Guide dogs for the blind and deaf
- Hearing exams and hearing aids
- Medically necessary mattresses and bed boards
- Nursing home care
- Orthopedic shoes (portion of the cost that exceeds the cost of a regular pair of shoes)
- Oxygen equipment
- Preventive healthcare services not covered under a group medical plan
- Radial keratotomy and laser eye surgery
- Smoking cessation programs
- Special equipment for the handicapped
- Transportation expenses related to medical care
- Weight loss programs, but only if part of a treatment plan for a specific condition and prescribed by a physician

Expenses that are eligible for reimbursement under the HCFSA are subject to IRS guidelines and may change from time to time (see the UnitedHealthcare web site at www.myuhc.com for current detailed information regarding eligible HCFSA expenses or call UnitedHealthcare customer service toll free at 800 387 7508. In addition, information is available online at www.irs.gov or by calling the IRS at 800 TAX FORM (800 829 3676) and requesting Publication #502: Medical and Dental Expenses.) Publication #502 describes healthcare expenses that may be deductible for income tax purposes. While that list and the list of eligible expenses for HCFSA purposes are similar, please note that there are some differences.

Expenses Not Covered

Please note that the HCFSA is not a Health Savings Account or HSA. Expenses that are not eligible for HCFSA reimbursement include:

- Expenses for cosmetic surgery, medications or any other treatment or procedure directed at improving appearance that does not promote proper functioning of the body or prevent or treat illness or disease is excluded
- Claims for expenses that were not incurred during the current plan year or that were incurred prior to the date of mid-year election increase due to a qualifying event
- Expenses for items that are merely beneficial to general health, such as health/fitness club memberships or weight loss programs
- Over-the-counter (OTC) drugs and medicines not prescribed by your doctor
- Claims for expenses incurred after your HCFSA plan participation stops
Flexible Spending Accounts

Expenses that have been reimbursed, or are reimbursable, by another source such as a group medical plan

Healthcare expenses (or the portion of healthcare expenses) that exceed your annual HCFSA contribution election

Any expense, other than for non-prescription drugs, that could not be claimed as an income tax deduction under Section 213 of the Internal Revenue Code without regard to the 7.5% adjusted gross income threshold

Insurance premiums

Failure to Cash Reimbursement Checks

In the event you fail to present a reimbursement check for payment within 12 months of issuance, please contact your Benefits Representative for instructions.

Qualified Reservist Distribution

In accordance with the “Heroes Earning Assistance and Relief Tax Act of 2008” (“HEART Act”), a qualified reservist distribution (QRD) is permitted of all or part of any unused HCFSA amounts if you are a reservist called to active duty provided that:

- You are called up for a period of 180 days or more or for an indefinite period of time, and
- The request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the HCFSA for that plan year.

To receive a QRD of all or part of any unused HCFSA amounts, or additional details on how to request a qualified distribution, contact your Benefits Representative as soon as you receive your orders or are called to active duty.

HCFSA Claim Procedures

Submitting a Claim for Reimbursement

Simply submit a claim form, called a request for withdrawal, for the eligible healthcare expenses that you have incurred. Claim forms are available from your Benefits Representative, by calling UnitedHealthcare customer service at 800 387 7508 or by visiting the UnitedHealthcare web site at www.myuhc.com.

You must include proof of the expenses incurred along with your claim form. Proof can be a bill, invoice or an Explanation of Benefits form (EOB) from any group medical/dental plan under which you are covered. An EOB will be required for reimbursement of services that are usually covered under group medical and dental plans, such as charges by surgeons, doctors or hospitals. In these cases, an EOB will verify the amount of your out-of-pocket expenses after benefit payments under other group medical/dental plans.

HCFSA claims should be submitted to the following address:

Health Care Account Service Center
P.O. Box 981506
El Paso, TX 79998-1506

If you prefer, you can submit your claims via fax at 915 231 1709.

Only expenses incurred while you are a participant in the HCFSA are reimbursable. In addition, expenses incurred during one plan year cannot be reimbursed during another plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

Important

Only expenses incurred while you are a participant in the HCFSA are reimbursable. In addition, expenses incurred during one plan year cannot be reimbursed during another plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.
Flexible Spending Accounts

HCFSA claims will be accepted until March 31 of the following year. Any claims submitted prior to March 31 and denied due to a lack of proper documentation will be reconsidered only if the appropriate documentation is submitted and received by UnitedHealthcare by April 30. In accordance with IRS regulations, amounts contributed to your HCFSA during the plan year but remaining in your account after March 31 of the following year cannot be returned to you or used to reimburse expenses incurred in a subsequent plan year. These amounts are forfeited.

Remember, you cannot be reimbursed for any expenses paid by an employer-sponsored medical or dental plan. Any expenses reimbursed by your HCFSA cannot be included as a deduction or credit on your income tax return.

**Automatic Reimbursement**

If you enroll in a UnitedHealthcare plan and elect to contribute to the HCFSA, your medical and prescription drug copayments and coinsurance amounts will automatically roll over to the HCFSA. Medical and prescription drug expenses that are not covered under your UnitedHealthcare plans, including copayments and coinsurance amounts, are automatically submitted to your HCFSA for reimbursement. This automatic claim submission feature eliminates extra paperwork and makes it more convenient for you to use your HCFSA.

If you do not want to use the automatic submission feature, call UnitedHealthcare customer service at 800 387 7508 in order to request that it be discontinued. You can also discontinue automatic claim submission by visiting the UnitedHealthcare web site at www.myuhc.com.

If you have medical or dental coverage through another carrier, you cannot select the automatic claim submission feature. In addition, automatic submission cannot be selected for your spouse if your spouse is not covered under Stryker’s Health Plan.

Unless you use your Consumer Account Card, an HCFSA claim form must be submitted for any other types of expenses, such as dental or vision expenses that are not covered by a plan administered by UnitedHealthcare.

**Initial Claim Determination**

UnitedHealthcare will decide your claim no more than 30 days after it is received as long as all needed information was provided with the claim. This time period may be extended for an additional 15 days if additional information is needed to process the claim when necessary due to matters beyond the control of UnitedHealthcare or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period, and a determination will be made no more than 45 days after the date the claim was submitted.

If the extension is needed because your claim is incomplete, the notice will specifically describe the information necessary to complete your claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the 45 days, your claim will be decided within 15 days after the information is received. If you do not provide the requested information within the prescribed timeframe, your claim will be denied. A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based and explain claim appeal procedures.

**If Your Claim Is Denied**

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

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

### Review of Denied Claims

If you have a question or concern about a benefit determination, you may informally contact a UnitedHealthcare customer service representative before requesting a formal appeal. The customer service telephone number is **800 387 7508**. If the customer service representative cannot resolve the issue to your satisfaction, you may request a formal appeal.

If you wish to request a formal appeal of a denied claim, you should contact customer service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid and any written information to support your appeal.

Your first level appeal request must be made in writing to the claim administrator within 180 days after you receive the written notice that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

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

UnitedHealthcare will review the first level appeal request and notify you of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted in writing to UnitedHealthcare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for a second level appeal.

UnitedHealthcare has the exclusive right to interpret and administer Stryker’s healthcare spending account plan, and these decisions are conclusive and binding.

The review will take into account all comments, documents, records and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual’s subordinate.

UnitedHealthcare may consult with a health professional in deciding your appeal of a denial of a claim for HCFSA reimbursement, except that any health professional consulted in connection with your appeal will not have been involved in the original benefit determination nor be a subordinate of the health professional who was involved.
Flexible Spending Accounts

You will be notified in writing of the decision on appeal. If the decision upholds the initial denial of your claim, the notification will provide:

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

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claim procedures to “you” is intended to include your authorized representative.

Denials of Claims Based on Ineligibility to Participate

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

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

Submit your appeal to the following address:

Health Plan Administrator
Stryker
2825 Airview Boulevard
Kalamazoo, MI 49002

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

Day Care (Child and Adult) Flexible Spending Account (DCFSA)

This section of the Benefits Summary describes rules that apply to DCFSAs, such as how much you can contribute, eligible expenses that can be reimbursed from your DCFSA and the claims procedures you need to follow to be reimbursed.

How Much You Can Contribute

When you enroll in the DCFSA, you select an annual contribution amount that will be prorated and deducted from each of your paychecks on a before-tax basis. Annual DCFSA contributions cannot exceed $5,000 per year if you are married and filing jointly or if you are single. If you are married and file a separate tax return, your maximum annual contribution cannot exceed $2,500. The minimum annual DCFSA contribution is $100.
Actual per-paycheck deductions are determined by your annual calendar year contribution amount, your payroll frequency and the number of remaining pay periods in the year.

**An Example**

Assume that you are hired in May and your DCFSA participation begins in June. If you elect to contribute the annual maximum, and you are paid semi-monthly, your per-paycheck contribution would be $357.14, as shown in the chart below.

<table>
<thead>
<tr>
<th>Annual Contribution</th>
<th>Remaining Pay Periods (June – December)</th>
<th>Per Paycheck Contribution Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>÷ 14</td>
<td>$357.14</td>
</tr>
</tbody>
</table>

Day care expenses that enable you and your spouse to work, look for work or attend school full-time are eligible for reimbursement under the DCFSA.

**Eligible Expenses**

Eligible expenses under the DCFSA are determined according to current Internal Revenue Service guidelines. Generally, amounts you pay for the care of a qualifying dependent so that you (and your spouse, if you are married) can work, look for work or attend school full-time are eligible expenses. Qualifying dependents under the DCFSA include:

- A child younger than the age of 13 who lives with you more than 50% of the year. A non-custodial parent is not eligible even if that parent is responsible for paying child care expenses. The child must be your child, stepchild or eligible foster child.
- Your spouse who is physically or mentally incapable of caring for himself or herself and who resides with you for more than 50% of the year.
- An adult relative (including a child age 13 or over) who is physically or mentally incapable of caring for himself or herself and who resides with you for more than 50% of the year. If the individual is your adult relative, he or she must be able to qualify as your tax dependent except that he or she had too much income (more than $3,650 for 2011), filed a joint return, or you, or your spouse if filing jointly, and could be claimed as a dependent on someone else’s tax return.

Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes, such as one of your older children. If the care is provided by a facility that cares for more than six individuals, the facility must be licensed and comply with state and local laws. Expenses for care outside your home for any individual age 13 or over are eligible only if the dependent regularly spends at least eight hours each day in your household.

Examples of eligible expenses include:

- Day care center charges, provided that the center complies with appropriate state and local regulations
- Babysitter charges for care inside or outside your home (you must provide a Social Security number for your sitter to claim reimbursement from the DCFSA)
- Expenses paid to a preschool or kindergarten provided that charges related to education cannot be separated from the charges for the care of a qualifying dependent child
- Charges made by a relative who cares for your dependents, so long as the relative is not your dependent or is not your child under age 19 at the end of the calendar year, even if that child is no longer your dependent
- Charges for care of an elderly or incapacitated dependent, either in your home or outside your home (the dependent must spend at least eight hours each day in your home if you are seeking reimbursement for care provided outside your home)
- Charges for day care at a day camp during school vacations
Expenses Not Covered

Expenses that are not eligible for DCFSA reimbursement include:

- The cost of food, clothing and education
- The cost of transportation between your house and the place where day care services are provided, unless transportation is provided by your day care provider
- Medical and dental expenses for you or your eligible dependents
- Overnight camp expenses
- Nursing home expenses
- Any expenses you incur if your spouse is not employed, looking for work, disabled or a full-time student
- Any day care expenses that you have also claimed under the federal child and day care tax credit
- Care provided by the children’s parent

Expenses that are eligible for reimbursement under the DCFSA are subject to IRS guidelines and may change from time to time. See the UnitedHealthcare web site at www.myuhc.com for current detailed information regarding eligible DCFSA expenses or call customer service toll free at 800 387 7508. In addition, information is available online at www.irs.gov or by calling the IRS at 800 TAX FORM (800 829 676) and requesting Publication #503: Child and Day care Expenses.

The Federal Tax Credit

A portion of your qualified day care expenses can also be applied as a credit when you complete your federal income tax return. However, expenses that have been reimbursed through the DCFSA cannot be applied toward the credit. In addition, all amounts reimbursed through the DCFSA reduce the maximum available tax credit on a dollar-for-dollar basis. Therefore, you should consider both options and decide which one produces the greater tax savings for you.

Eligible expenses under the tax credit are the same as those eligible for reimbursement through the DCFSA. Depending on your family’s total gross income, your tax credit could be as much as 35% of your annual day care expenses, subject to certain maximums.

The maximum amount of day care expenses you can use to calculate the tax credit is $3,000 if you have one dependent or $6,000 if you have two or more.

The maximum available tax credit is $1,050 for one dependent or $2,100 for two or more. It’s up to you to determine whether the federal dependent and child care tax credit or the DCFSA is more advantageous for you. In order to make this decision, you should consider:

- Your total annual day care expenses
- Your family’s adjusted gross income (the amount you pay taxes on after you’ve claimed exemptions)
- The maximum available tax credit

You can obtain detailed information about the federal tax credit by calling UnitedHealthcare toll free at 800 387 7508 or by visiting the UnitedHealthcare web site at www.myuhc.com. Information also is available directly from the Internal Revenue Service online at www.irs.gov or by calling toll free at 800 TAX FORM (800 829 3676) and requesting Publication #503: Child and Day care Expenses.

Failure to Cash Reimbursement Checks

In the event you fail to present a reimbursement check for payment within 12 months of issuance, please contact your Benefits Representative.
Other Things You Should Know

- If your spouse does not work, you cannot use the DCFSA or the tax credit unless your spouse is looking for work, a full-time student or is disabled and incapable of self-care.

- The amount of work-related day care expenses that can be used to calculate the tax credit or submitted to the DCFSA cannot exceed the lower of your annual income or your spouse’s annual earned income. For example, if you earn $30,000 annually, and your spouse earns $3,000, the most you can contribute to the DCFSA or apply toward the tax credit is $3,000—regardless of the actual amount of your expenses or the number of qualified dependents.

- If your spouse is a full-time student or is disabled, you may assume a minimum amount of earned income in order to determine the maximum allowable DCFSA contribution, or the maximum available tax credit. If you claim expenses for one dependent, your spouse’s minimum earning assumption is $250 monthly. If you claim expenses for two or more dependents, your spouse is assumed to earn $500 per month.

- In order to use the DCFSA or the tax credit, you must report your day care provider’s name, address and taxpayer identification number on your federal income tax return. If an individual instead of a day care center provides care, the taxpayer identification number is the individual’s social security number.

- You must file a claim in order to be reimbursed for qualified day care expenses.

How to Obtain DCFSA Benefits

UnitedHealthcare processes DCFSA claims. You must submit a claim form and appropriate documentation in order to receive payment from the DCFSA. Examples of acceptable documentation include:

- A receipt or itemized statement from a licensed day care center showing dates of service and the amount charged

- A canceled check showing the dates of service and the name of your day care provider (This is adequate documentation only if a relative provides services.)

- Completed claim forms are not considered acceptable documentation.

- DCFSA claims are processed every week. If your claim is in order, it will be processed promptly, and a reimbursement check (or direct deposit verification notice) will be sent to your home. However, you should be aware that claim processing might be delayed in the following circumstances:

  - If your claim form is incomplete or if you have not provided necessary documentation, your claim form will be returned to you.
  
  - If your claim exceeds your current DCFSA balance, claim payment will be based on the account balance amount. The remaining claim amount will be held until the next claim-processing period.
  
  - If your claim includes amounts paid in advance, payment is based upon services actually provided as of the claims processing date. Amounts paid for future services will be held until charges are incurred.

You can be reimbursed only for expenses incurred during the same year you put money in the DCFSA. For example, only day care expenses incurred during 2011 and filed with UnitedHealthcare by March 31, 2012 can be reimbursed from your 2011 DCFSA.

DCFSA claim forms are available from your Benefits Representative, by calling UnitedHealthcare toll free at 800 387 7508 or at www.myuhc.com, the UnitedHealthcare web site. You can elect to have DCFSA reimbursements deposited to your checking account by visiting the UnitedHealthcare web site at www.myuhc.com.
If Your Claim is Denied

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

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including, in the case of a denial of a claim for reimbursement under the DCFSA:
  - Your right to submit written comments and have them considered
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
- If the claim administrator relied on an internal rule, guideline, protocol or other similar criterion in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request

Review of Denied Claims

If you have a question or concern about a benefit determination, you may informally contact a UnitedHealthcare customer service representative before requesting a formal appeal. The customer service telephone number is 800 387 7508. If the customer service representative cannot resolve the issue to your satisfaction, you may request a formal appeal.

If you wish to request a formal appeal of a denied claim, you should contact customer service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid and any written information to support your appeal.

Your first level appeal request must be made in writing to the claim administrator within 180 days after you receive the written notice that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

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

UnitedHealthcare will review the first level appeal request and notify you of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted in writing to UnitedHealthcare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for a second level appeal.

UnitedHealthcare has the exclusive right to interpret and administer Stryker’s day care (child and adult) flexible spending account plan, and these decisions are conclusive and binding.

The review will take into account all comments, documents, records and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual’s subordinate.
UnitedHealthcare may consult with a health professional in deciding your appeal of a denial of a claim for DCFSA reimbursement, except that any health professional consulted in connection with your appeal will not have been involved in the original benefit determination nor be a subordinate of the health professional who was involved.

You will be notified in writing of the decision on appeal. If the decision upholds the initial denial of your claim, the notification will provide:

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on; or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request

### Denials of Claims Based on Ineligibility to Participate

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

Life and AD&D insurance offers you and your eligible dependents financial support and peace of mind in the face of unforeseen events.

- Stryker provides basic life and accidental death and dismemberment (AD&D) insurance coverage through Hartford Life at no cost to you.
- You also have the opportunity to purchase additional life insurance coverage for yourself and your covered dependents, through Hartford Life.

This section of the Stryker Benefits Summary provides an overview of your life and accident benefits. For more detailed information about these benefits, refer to the Life and Accident Certificate of Insurance, available at the following links:

Together, this section of the Stryker Benefits Summary and the Certificate of Insurance issued by Hartford Life constitute the Summary Plan Description for this plan.

### Coverage at a Glance

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life Insurance</strong> for you</td>
<td>Pays benefits to your beneficiary in the event of your death</td>
</tr>
<tr>
<td></td>
<td>Coverage of one times your basic earnings, up to $425,000</td>
</tr>
<tr>
<td></td>
<td>Provided automatically at no cost to you</td>
</tr>
<tr>
<td><strong>Basic AD&amp;D Insurance</strong> for you</td>
<td>Pays benefits to you for certain injuries or other conditions resulting from an accident, and benefits to your beneficiary in the event of your death</td>
</tr>
<tr>
<td></td>
<td>Coverage of one times your basic earnings, up to $425,000</td>
</tr>
<tr>
<td></td>
<td>Provided automatically at no cost to you</td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance</strong> for you</td>
<td>Pays benefits to your beneficiary in the event of your death</td>
</tr>
<tr>
<td></td>
<td>You may purchase additional coverage for yourself in any of the following amounts, up to $1,000,000:</td>
</tr>
<tr>
<td></td>
<td>- $1/2 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>- 1 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>- 2 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>- 3 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>- 4 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>- 5 x your basic earnings</td>
</tr>
<tr>
<td></td>
<td>Evidence of Good Health may be required</td>
</tr>
<tr>
<td><strong>Dependent Life</strong> for your spouse</td>
<td>Pays benefits to your spouse’s beneficiary in the event of his or her death</td>
</tr>
<tr>
<td></td>
<td>You may purchase coverage for your spouse equal to $10,000</td>
</tr>
<tr>
<td></td>
<td>Evidence of Good Health may be required</td>
</tr>
<tr>
<td><strong>Dependent Life</strong> for your child(ren)</td>
<td>Pays benefits to your dependent child(ren)’s beneficiary(ies) in the event of their death</td>
</tr>
<tr>
<td></td>
<td>You may purchase coverage for your dependent child(ren) equal to $10,000, with benefits reduced for child(ren) under six months of age</td>
</tr>
</tbody>
</table>

**Important**

Disability Coverage

Stryker provides short-term disability (STD) and long-term disability (LTD) coverage through The Hartford. Disability coverage offers you income protection in case a non-work-related sickness or injury, or pregnancy, leaves you unable to work.

This section of the Stryker Benefits Summary provides an overview of your short-term and long-term disability benefits.

For more information about the STD plan, refer to the applicable benefits booklet as shown here:


For more information on the LTD plan, all eligible employees should refer to the LTD Certificate of Insurance, available at http://totalrewards.stryker.com/spd/Stryker LTD SPD 05_16_2012.pdf.

Together, this section of the Stryker Benefits Summary and the STD booklets and LTD Certificate of Insurance issued by Hartford Life constitute the Summary Plan Description for these plans.
### Coverage at a Glance

#### STD Coverage

| Eligibility | ▪ Active full-time employees scheduled to work 40 hours per week  
▪ Active part-time employees scheduled to work 20 hours per week |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost for Coverage</td>
<td>▪ Stryker pays the full cost of your STD coverage. You do not contribute toward the cost of STD coverage</td>
</tr>
<tr>
<td>Enrollment</td>
<td>▪ Eligible employees are automatically enrolled for STD coverage as of their date of hire</td>
</tr>
</tbody>
</table>
| When Coverage Ends | ▪ Generally, coverage under the STD plan ends on the earliest of the following:  
  ▪ The date you leave Stryker  
  ▪ The date you’re no longer actively employed  
  ▪ The date the plan is terminated |
| Weekly Benefit | ▪ Exempt employees: Weekly benefit equal to 100% of weekly earnings  
▪ Non-exempt employees: Weekly benefit equal to 60% of weekly earnings (if you are a non-exempt Endoscopy employee, refer to your booklet for benefit details)  
▪ Benefits are reduced by the amount of any other income benefits, such as state disability or workers’ compensation |
| When Benefits are Payable | ▪ Benefits are payable beginning on the:  
  ▪ Eighth day of your total disability due to sickness  
  ▪ First day of total disability due to an accident, outpatient surgery, or a hospital stay |
| How Long Benefits Last | ▪ Generally, benefits are payable for up to:  
  ▪ 173 days if disability is due to sickness  
  ▪ 180 days if disability is due to an accident |
## LTD Coverage

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Active full-time employees scheduled to work 40 hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost for Coverage</td>
<td>Stryker pays the full cost of your LTD coverage. You do not contribute toward the cost of LTD coverage</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Eligible employees are automatically enrolled for LTD coverage as of their date of hire</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>Generally, coverage under the LTD plan ends on the earliest of the following:</td>
</tr>
<tr>
<td></td>
<td>- The date you leave Stryker</td>
</tr>
<tr>
<td></td>
<td>- The date you're no longer actively employed (including temporary layoff or leave of absence) or become otherwise ineligible</td>
</tr>
<tr>
<td></td>
<td>- The date the plan is terminated</td>
</tr>
<tr>
<td>Monthly Benefit</td>
<td>Disability income equal to 60% of your monthly pre-disability earnings, up to $15,000 a month</td>
</tr>
<tr>
<td></td>
<td>Benefits are reduced by the amount of any other income benefits, such as worker’s compensation, no fault disability insurance, Social Security disability, veteran’s benefits, and state disability</td>
</tr>
<tr>
<td>When Benefits are Payable</td>
<td>Benefits are payable beginning on the 181st day of your total disability, provided you are under the regular care of a physician</td>
</tr>
<tr>
<td>How Long Benefits Last</td>
<td>Generally, benefits are payable up to the earlier of the date:</td>
</tr>
<tr>
<td></td>
<td>- You are no longer totally disabled as defined by the plan</td>
</tr>
<tr>
<td></td>
<td>- Your current pay exceeds 80% of your indexed pre-disability earnings</td>
</tr>
<tr>
<td></td>
<td>- You reach your normal retirement age (rules vary if you are age 64 or older when you become totally disabled)</td>
</tr>
<tr>
<td></td>
<td>- You die</td>
</tr>
</tbody>
</table>
401(k) Retirement Plan

Stryker sponsors the Stryker Corporation 401(k) Savings and Retirement Plan (the “Plan”) so that you and other employees of Stryker and its participating subsidiaries (all referred to in this summary as the “Company”) may save for retirement on a “before-tax” basis. The benefits provided under the Plan are in addition to Social Security.

The Plan provides different benefits for sales representatives and eligible employees other than sales representatives. To help each participant understand the Plan without confusion, the benefits are described separately, in two summary plan descriptions (SPDs):

- 401(k) Plan (Non-Sales Rep Employees)
- 401(k) Plan (Sales Reps)

The SPD’s purpose is to explain your rights under the overall Plan. Note that each version of the SPD contains all the information required to be a complete SPD for the Plan. You do not need to read any other sections of the Stryker Benefits Summary to obtain the information you need for this Plan.

You are urged to read the SPD that applies to you carefully and to acquaint your family or beneficiaries with the Plan. You should retain a copy of the SPD for future reference.

As of January 1, 2014, this Benefits Summary replaces all earlier descriptions of Stryker Healthcare Benefits, Spending Accounts, 401(k) Savings and Retirement Plans and Additional Benefits. The summary plan descriptions outline the Plans, which are complex and technical legal documents. In the event of any difference between the summary plan descriptions and the Plan, the terms of the Plan will control.
401(k) Plan (Non-Sales Rep Employees)

The Stryker Corporation 401(k) Savings and Retirement Plan gives participants a way to save for their future financial needs.

Important

This summary plan description (SPD) describes the main features of the Plan that apply to Stryker employees who are not sales representatives (different Plan features for employees who are sales representatives are described in a separate SPD). As used in this SPD, “sales representative” means an employee who has an HR function of “Sales Direct” in the job classification segment within the Company’s human resources management system. If an employee’s status changes from a sales representative to a non-sales position or vice versa, the features described in this SPD apply only with respect to the period of employment in a non-sales representative position.

Overview of the Plan

The Plan is a type of profit-sharing retirement plan known as a “401(k)” plan. This means that you may elect to defer part of your compensation and have the Company contribute the deferred amount to the Plan instead of receiving it in your paychecks. The Company may also make discretionary contributions and will make matching contributions, as explained in “Contributions to the Plan” on page 116.

Your Accounts

Your pay deferrals and the other Company contributions made for you are placed in accounts in your name. Your accounts are invested together with the other participants’ accounts in certain investment funds. The investment earnings are allocated to the accounts.

Your Benefits

Your benefits from the Plan are the vested amounts in your accounts. When you leave the Company and become eligible for benefit payments, the Trustee will make the payments in the form you choose until you have received the full amount owed to you from your accounts. The amount in your accounts will largely depend on the amount of your deferrals, the amount of Company discretionary and matching contributions, and the investment performance of the funds in which you are invested.

Tax Deferral

You will not be taxed on the contributions to the Plan, or on the investment earnings credited to your accounts, until these amounts are actually distributed to you from your accounts.

Contacting Vanguard

Plan records are administered by The Vanguard Group located in Valley Forge, Pennsylvania. You can access information about the Plan and your accounts (including information on your investment performance, account balance, loan information, current investment elections and your recent activity) by

- Calling Vanguard’s VOICE Network automated phone service (at 800 523 1188), which is available 24 hours a day,
- Accessing your account through the Vanguard web site (www.vanguard.com), or
- Speaking directly to a Participant Service Associate (“PSA”) during business hours (at 800 523 1188).

You can also use any of these methods to make or cancel a pay deferral election, change your pay deferrals, change how your existing account balance is invested, change the investment mix of future contributions or your current account balance, and change your Personal Identification Number.
Eligibility

You will become a participant in the Plan on the date you become an eligible employee of the Company (but not before your 18th birthday).

You are not eligible to participate in the Plan if:

- You are a temporary employee (that is, you were hired for a position that is not permanent and is not expected to continue for more than one year), unless and until you complete 1,000 hours of service during the first 12 months of your employment or during any Plan Year thereafter;
- You are a “leased” employee;
- You are a union employee (unless your collective bargaining agreement provides for participation in the Plan);
- You are employed by one of the Company’s foreign branches;
- You actively participate in another 401(k) or similar plan to which the Company or an affiliate of the Company contributes;
- You are not on the Company’s payroll, or you are classified as an independent contractor (even if an agency or court later determines that your relationship to the Company was that of a common law employee); or
- You actively participate in a non-U.S. retirement plan or government retirement system to which the Company or an affiliate of the Company contributes.

Contributions to the Plan

The Plan has four types of contributions:

- Company Discretionary Contributions
- Pay Deferral Contributions
- Catch-Up Contributions
- Company Matching Contributions

Company Discretionary Contributions

At the end of each Plan Year, the Company will decide on the amount of its discretionary contribution for that year. The Company is not required to make a discretionary contribution.

Who Is Eligible

After you become a participant, you will share in the Company’s discretionary contribution, if one is made, for a Plan Year if:

- You are employed on the last day of the Plan Year and have at least 1,000 hours of service during the Plan Year; or
- You terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

An hour of service is each hour for which you are paid or entitled to be paid by the Company or an affiliate of the Company.

Contribution Amount

Your share of the Company’s discretionary contribution will be a percentage of your compensation while you are a participant during the Plan Year.

Example

For example, assume the Company makes a 7% discretionary contribution for a Plan Year in which your compensation is $30,000. Your share of the Company discretionary contribution is $2,100.

Pay Deferral Contributions

You may contribute to the Plan by deferring a portion of your compensation.

How to Make Pay Deferral Contributions

You may elect to defer a portion of your compensation and have the Company contribute your deferred compensation to the Plan on your behalf. These contributions are called “pay deferrals” and are credited to your “pay deferral account.”

Contact Vanguard (see “Contacting Vanguard” on page 115) to make a pay deferral election.
Your pay deferrals may be any whole percentage up to 75% of your compensation during a Plan Year. However, your total pay deferrals may not exceed the dollar limit described in “Dollar Limit,” and the Company may limit pay deferrals for highly paid employees to ensure that IRS nondiscrimination tests are met.

**Automatic Enrollment**

If, upon becoming eligible to participate in the Plan, you fail to make an election either to make pay deferral contributions or to opt out, you will automatically be treated as having made a pay deferral election. Your automatic election will start at 2% of your compensation and will increase by 1% each year until it reaches 8%. This automatic election will cease to apply, however, if and when you make your own pay deferral election or elect not to make pay deferral contributions.

**Changing, Stopping, Resuming Contributions**

You may change your pay deferral percentage or stop or resume your pay deferrals at any time by contacting Vanguard (see “Contacting Vanguard” on page 115). Your instructions will be implemented as soon as administratively feasible.

**Discrepancies**

If you think there is a discrepancy between the percentage of pay you elected to defer (or the automatic enrollment percentage, if applicable) and the percentage actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise you will be deemed to have elected the percentage that is actually being contributed.

**Benefits of Deferring Compensation**

There are four benefits of deferring compensation under the Plan.

- First, any amounts contributed to the Plan as a result of your pay deferral election are not subject to current income taxes. As a result, your current taxable income will be reduced.

- Second, the amount contributed to the Plan is invested on a tax-deferred basis. This means you will not pay income tax on the investment earnings that are allocated to your accounts. You will pay income taxes only when you receive your benefits from the Plan. As a result, this tax deferral permits a much more rapid accumulation of funds for your retirement.

- Third, under current provisions of the tax law, you may be ineligible to make deductible contributions to a traditional individual retirement account (“IRA”). Pay deferrals under the Plan allow you to save for retirement on a before-tax basis.

- Fourth, the Company will contribute 50¢ for each $1 that is contributed to the Plan as a result of your pay deferrals (up to a maximum match equal to 4% of your compensation). The portion of your matching contribution that does not exceed 2% of your compensation will be invested in the Stryker Stock Fund. Matching contributions above 2% of compensation will be invested according to your investment election. See “Company Matching Contributions” on page 118 for a discussion of “matching” contributions.

**Example**

Here is an example of how these benefits can affect you:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral for the year is $3,000. The Company contributes your deferral of $3,000 to the Plan for you, along with a $1,200 matching contribution, of which $600 is invested in the Stryker Stock Fund.

In addition, the $4,200 contribution in your name is increased by any discretionary contribution that the Company makes for you and will reflect any change in value of the investment funds in which your accounts are invested. You will not pay income tax on your $3,000 pay deferral, the $1,200 match, any discretionary Company contribution, or any change in investment value until you eventually receive the amount in your accounts after terminating employment (or as a hardship withdrawal or other withdrawal).
401(k) Plan (Non-Sales Rep Employees)

Dollar Limit

Federal law limits the amount of your pay deferrals in a calendar year to $17,500, subject to adjustments for inflation after 2014 (the “dollar limit”).

If your pay deferrals under all 401(k) plans or other qualified plans in which you participate during a calendar year exceed the dollar limit for that calendar year (January 1 through December 31), the excess amount will be included in your taxable income for the year of the deferral. The excess amount will also be taxed again in the year it is distributed to you if it is not withdrawn by April 15 of the following year. To receive a distribution of the excess amount before April 15, your request for distribution must be made to the Plan Administrator by March 1.

The Company will attempt to make sure that your pay deferral contributions to the Plan do not exceed the dollar limit. However, if you participate in another employer’s 401(k) plan or a pay deferral simplified employee plan (SEP) during the same calendar year, the dollar limit applies to the total deferral contributions to both plans. Also, if you participate in a tax-sheltered annuity plan of another employer, there is an increased combined limit that applies to deferrals to the Plan and the tax-sheltered annuity. You should monitor your pay deferral contributions so that you do not exceed the dollar limit.

Catch-Up Contributions

If you will be at least 50 years old by the end of the Plan Year and you make the maximum amount of pay deferral contributions allowed under the Plan, you are eligible to make “catch-up” contributions in addition to your pay deferral contributions. The law allows up to $5,500 in catch-up contributions.

Company Matching Contributions

To give you an incentive to defer a portion of your compensation, the Company will make “matching” contributions based upon the amount of your pay deferrals. The Company will contribute 50¢ for each $1 of your pay deferrals, up to a maximum matching contribution equal to 4% of your compensation.

The matching contributions are made as of the end of each Plan Year. To receive a matching contribution, you must be employed on the last day of the Plan Year and must have at least 1,000 hours of service during the Plan Year. You will also be eligible for a matching contribution if you terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

These matching contributions made for you are credited to your “matching contribution account” as soon as administratively feasible following the end of the Plan Year. The portion of your matching contributions that does not exceed 2% of your compensation will be credited to a “2% subaccount” within your matching contribution account, and will be initially invested in the Stryker Stock Fund. Any additional matching contributions are invested in accordance with your election.

Example

Here is an example of how matching contributions work:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral is $3,000. Your pay deferrals up to 8% of your compensation ($2,400) qualify for a matching contribution at the rate of 50¢ for each $1 of deferrals, for a total matching contribution of $1,200. Of that total matching contribution, $600 (2% of your compensation) will be invested in the Stryker Stock Fund. The remainder of your matching contribution will be invested in accordance with your election.

Compensation

The compensation used in calculating the amount of the Company’s contributions (including pay deferral contributions) on your behalf consists of the following (unless listed under “Items Excluded”):

- Wages, salary, and other taxable amounts received for services to the Company;
- Commissions and bonuses;
- Pay deferral contributions to this Plan;
- Pay reduction contributions to a “cafeteria” plan or qualified transportation fringe benefit program; and
- Differential wage payments (wage amounts paid by the Company during any period in which you are performing active military service for at least 30 days) that would have been paid had you been actively employed by the Company during that period.
Items Excluded
The following items are excluded from compensation for Plan purposes:

- Amounts paid to you before you met the requirements for participating in the Plan;
- Pay reduction amounts or other contributions to a nonqualified deferred compensation plan;
- Distributions from a nonqualified or qualified deferred compensation plan;
- Income from the exercise of a stock option;
- Income from restricted property that becomes taxable under Section 83 of the Internal Revenue Code when the restrictions lapse;
- Income realized on the sale of stock acquired under a statutory stock option;
- Amounts subject to special tax benefits which are not includible in income;
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits; and
- Severance pay.

Federal law requires the Plan to limit to $260,000 the amount of an employee’s compensation during a Plan Year that may be used in figuring the amount of contributions on behalf of an employee under the Plan for the Plan Year. The IRS may increase the $260,000 limit in future years for inflation.

Rollovers
The Plan includes rollover provisions, as follows.

Rollovers from Eligible Employer Plans
If you receive an “eligible rollover distribution” from an eligible retirement plan of a prior employer, you may be eligible to roll over that distribution to the Plan. An eligible retirement plan means any of the following types of plans:

- A qualified defined contribution or defined benefit plan (other than Roth or other after-tax contributions);
- A Section 403(b) tax-sheltered annuity (other than Roth or other after-tax contributions); or
- A Section 457 plan maintained by a governmental employer.

Such a distribution may be rolled over in either of two ways. The distribution may either be paid directly to the Plan by the other plan in a “direct rollover,” or the other plan may pay the distribution to you (subject to any applicable withholding tax), and you will have 60 days after you receive it to contribute it to the Plan.

Rollovers from IRAs
You may also roll over to the Plan the portion of a distribution from a Section 408 individual retirement account or annuity (IRA) that would otherwise be taxable to you and that is eligible to be rolled over.

More information regarding rollovers is available from the Plan Administrator. Any amount you roll over is placed in your “rollover account.”

Vesting
The term “vested” refers to the amount in your accounts that cannot be taken away from you regardless of the reason or time that you leave the Company.

Vested Interest in Your Accounts
The following rules are used to determine if you are “vested”:

- Amounts in your pay deferral account and rollover account are always 100% vested.
- Amounts in your discretionary contribution account and matching contribution account are 100% vested if you attain age 65, become totally disabled, or die while employed by the Company.

You are “totally disabled” if you have a mental or physical condition that makes you eligible to receive Social Security disability benefits. However, total disability does not include disability resulting from:

- Military service
- Criminal activity
- Alcoholism
- Drug abuse
- Intentional self-inflicted injury

- Amounts in your discretionary contribution account and matching contribution account are 100% vested if you have at least five “years of vested service.”
If you leave the Company (for a reason other than retirement after age 65, total disability, or death) before completing five "years of vested service," all or a portion of the amounts in your discretionary contribution account and your matching contribution account will be forfeited. You will receive only your vested percentage of your discretionary contribution account and your matching contribution account. Your vested percentage is determined as follows:

<table>
<thead>
<tr>
<th>Years of Vested Service</th>
<th>Vested Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>3</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>60%</td>
</tr>
<tr>
<td>5 or more</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Year of Vested Service

You will receive a “year of vested service” for each Plan Year in which you are credited with at least 1,000 hours of service.

### Forfeitures

The portion of your discretionary contribution account and matching contribution account in which you are not vested is “forfeited.” The forfeiture will occur on the date you receive a distribution of your vested benefits (or the end of the Plan Year in which you have five consecutive breaks in service, if earlier). Any forfeitures from your accounts will be used to pay Plan expenses or to reduce the amount of the Company’s contributions.

### Vesting Rules Upon Reemployment

If you leave the Company and are later reemployed by the Company, the following rules apply to you:

- For information on your eligibility to join the plan after you are rehired, see “Eligibility” on page 116.
- Your former years of vested service will be restored if your Plan account was partially or fully vested before you terminated employment or if you have fewer than five consecutive vesting breaks in service. You must perform a year of vested service after being reemployed in order for your prior service to be credited.

- The amount you forfeited will be restored if you have fewer than five consecutive vesting breaks in service and you repay the vested amount previously distributed to you within five years after being reemployed.
- If you have five or more consecutive vesting breaks in service and you left the vested portion of the discretionary contribution account or matching contribution account in the Plan, when you are reemployed you will have two subaccounts. The first subaccount, consisting of the vested portion of the discretionary contribution and matching contribution accounts, will be 100% vested. The second subaccount, consisting of amounts added to the discretionary contribution and matching contribution accounts after you are rehired, will vest under the Plan’s normal vesting schedule, based on your years of vested service after the break in service plus your years of vested service before the break in service that are restored under the above rules.

### Vesting Breaks in Service

A “vesting break in service” is a Plan Year during which you have not completed more than 500 hours of service. Solely for determining whether a vesting break in service has occurred, if you are absent from work for maternity or paternity reasons you will receive credit for hours of service (but not more than 501) that would have been credited except for the absence. An absence from work for maternity or paternity reasons means an absence caused by pregnancy or childbirth, placement or adoption of a child, or child care immediately following birth or adoption.

If you have performed at least 500 hours of service in the Plan Year in which your absence for maternity or paternity reasons begins, then solely for purposes of preventing a break in service for the Plan Year subsequent to the Plan Year in which such leave begins, you will receive service credit of up to 500 hours for your absence during that Plan Year.

For example, if you take maternity leave in October and have more than 500 hours of service, there is no break in service that year. In addition, in order to avoid a break in service the following year, you will be credited with up to 500 hours of service.
Plan Investments

The Plan offers you a choice of funds to invest the money in your accounts.

Investment of Your Accounts

You may direct the investment of contributions to your accounts in different investment funds made available by the Trustee. Information regarding these funds, including prospectuses, may be obtained by contacting Vanguard (see “Contacting Vanguard” on page 115) or your human resources department.

If you do not make an investment election, contributions to your accounts (other than the 2% subaccount that is invested in the Stryker Stock Fund) will be invested in the age-appropriate Vanguard Target Retirement fund.

You may change your investment election at any time by contacting Vanguard (see “Contacting Vanguard” on page 115). Your change in investment election may apply to future contributions, amounts already invested, or both.

You may transfer at any time all or a portion of your 2% subaccount that is invested in the Stryker Stock Fund to any of the other investment funds available under the Plan, and all or a portion of your 2% subaccount that is invested in other investment funds back into the Stryker Stock Fund. However, you may not transfer any portion of your accounts other than the 2% subaccount into the Stryker Stock Fund.

The Plan is intended to meet the requirement of ERISA Section 404(c) and its regulations. Under these rules, plan fiduciaries may be relieved of liability for losses that are a direct and necessary result of participants’ and beneficiaries’ investment instructions.

Valuation and Adjustment of Your Accounts

The Trustee will calculate the value of your accounts as of each business day (“valuation date”). The value of your accounts is the total of your investments in the Stryker Stock Fund and each of the other investment funds. Other than the various types of contributions that are credited to your accounts, the following events will also change the value of your accounts:

- **Distributions.** If you receive a distribution or withdrawal, the account or accounts from which it is made are reduced by the amount of the distribution.

- **Investment Results.** As of each valuation date, the Trustee will calculate the value of the investment funds. You should note that the value may increase or decrease and your accounts will be adjusted accordingly. You will receive a quarterly statement that will state both the value of your interest in each investment fund and the total value of your accounts.

- **Expenses.** Investment management fees are paid by the investment funds to which they relate. In addition, accounts are charged with their share of Plan administration expenses that are paid by the Plan. Administrative expenses deducted from your accounts will appear on your quarterly statements.

- **Loans.** If you receive a hardship loan, the account or accounts from which it is made will be reduced by the amount of the loan. Your account or accounts will be increased as you make payments of principal and interest on the loan.

- **Forfeitures.** If you resign or are dismissed before you are fully vested, you will not receive the full amount in your accounts. The portion of your accounts in which you are not vested is “forfeited” and used to reduce the Company’s matching or discretionary contributions.

When your active participation in the Plan ends, you will no longer share in the Company’s matching or discretionary contributions. However, as long as you have not yet received the full amount in your accounts, your accounts will still be adjusted for expenses, investment earnings, gains and losses as well as for distributions.

Distributions from the Plan

This section describes when you may receive a distribution from the Plan.

When Benefits Are Distributed

You may request payment of your benefits at any time after you stop working for the Company, after you reach age 65 (even if you are still working), or upon total disability. Once you retire, federal law requires that your benefit payments begin no later than the April 1 after the calendar year in which you attain age 70½ (or in which you retire, if later).
Severance from Employment for a Reason Other than Death

You are entitled to the vested amount in your accounts if you leave the Company for any reason. (See “Vesting” on page 119 for more information.)

If your vested account balance (other than your rollover account) exceeds $5,000, you have the option of requesting a distribution of benefits or maintaining your accounts in the Plan. Your benefits will be paid as soon as administratively feasible after you request the distribution.

If your vested account balance (other than your rollover account) does not exceed $5,000, you do not have the option of maintaining your accounts in the Plan. Your benefits will be distributed to you in a lump sum payment as soon as administratively feasible following your severance from employment.

Whether or not your vested account balance exceeds $5,000, you may elect to have your lump sum distribution transferred to an eligible retirement plan in a “direct rollover.”

Automatic Rollovers

If the value of your account exceeds $1,000 but does not exceed $5,000, and after receiving all required notices you do not affirmatively elect to receive your distribution directly or to have it rolled over, the vested amount in your accounts will be automatically rolled over by the Plan to an IRA with The Vanguard Group. Your account will be automatically invested in Vanguard Prime Money Market Fund, a fund designed to preserve principal, provide a reasonable rate of return, and maintain liquidity. You will be responsible for paying all fees and expenses assessed against your automatic rollover IRA. The fees and expenses will be comparable to the fees and expenses charged by Vanguard for other IRAs. For additional information on the Plan’s automatic rollover rules, a Vanguard IRA, and the fees and expenses associated with a Vanguard IRA, call Vanguard at 800 523 1188.

If you receive a distribution before age 59½, the distribution may be subject to a 10% excise tax in addition to being considered taxable income in the year it is distributed to you.

Forms of Distribution of Benefits

If your vested account balance (other than your rollover account) exceeds $5,000, you may elect whichever of the following forms of payment you prefer:

- **A lump sum payment.** This payment will be made in cash, unless you elect to receive shares of stock for your vested 2% subaccount invested in the Stryker Stock Fund, provided that such vested portion is at least $1,000 in value (see “Election to Receive Distribution of Stryker Stock” on page 124 for details on this election).

- **Cash payments** in roughly equal annual, quarterly, or monthly installments for a specific number of years. The specific number of years for which the payments will last cannot exceed either your life expectancy or the joint life expectancy of you and your beneficiary.

- **A combination** of a single sum cash payment and cash payments in roughly equal annual, quarterly or monthly installments.

If you elect installments, you may at any time elect to shorten the period over which the installments are being paid or receive a lump-sum distribution of your remaining balance.

Distribution of Benefits upon Death

Death Before Receiving Benefits

If you die before you have begun receiving your benefits, the Trustee will pay your vested account balance to your beneficiary in the form (lump sum, installments, or a combination) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described in “Forms of Distribution of Benefits” on page 122.

Payments to your surviving spouse are required to begin by December 31 of the year following the year of your death or by December 31 of the year in which you would have attained age 70½, if later. Payments to a designated beneficiary other than your spouse are required to begin by December 31 of the year following the year of your death unless you or your beneficiary elect by September 30 of the year following the year of your death to apply the “five-year rule.” If the five-year rule is elected, your entire vested account balance must be distributed no later than December 31 of the year containing the fifth anniversary of your death.
Death While Receiving Benefits

If you die while receiving your benefits in the form of installment payments, payments will continue to your beneficiary according to the same schedule of installment payments until the amount in your accounts has been completely distributed. Your beneficiary may instead choose to receive the remaining benefits in a lump sum payment.

Beneficiary

If you are married at the time of your death, your spouse will be the beneficiary of the death benefit unless you elect otherwise. If you wish to designate a beneficiary other than, or in addition to, your spouse, your spouse must consent to waive the right to receive the entire death benefit. Your spouse’s consent must be in writing and be witnessed by a notary or Plan representative.

You may appoint one or more beneficiaries by completing and returning a beneficiary designation form to the Plan Administrator. You may change your beneficiary at any time before your death by completing and returning a new beneficiary designation form to the Plan Administrator. If you have not named a beneficiary or your beneficiary predeceases you, payment will be made to your surviving spouse, if any, and otherwise in equal shares to your children or their then living issue by right of representation. If you have not named a beneficiary or your beneficiary predeceases you, and you have neither a surviving spouse nor children (or their living issue) at the time of your death, payment will be made to your estate.

If you designate your spouse as your beneficiary and later become divorced, that designation will no longer be valid.

Income Tax Withholding/Direct Rollovers

Direct Rollovers

Distributions and withdrawals from the Plan are generally “eligible rollover distributions.” This means that all or a portion of the distributions can be rolled over in a “direct rollover” to an eligible retirement plan (which may be a qualified plan, a Section 408 individual retirement account or annuity (IRA), a Section 403(a) annuity, a Section 403(b) tax-sheltered annuity, a Section 457 governmental plan, or a Roth IRA) that accepts rollovers. If you choose a direct rollover, the Plan will issue a check directly to the eligible retirement plan, and you will not be taxed until you later take it out of the eligible retirement plan (unless the direct rollover is to a Roth IRA, in which case you will be taxed at the time of the rollover).

Required Withholding

If you receive an eligible rollover distribution from the Plan and do not choose a direct rollover, the Plan is required by law to withhold Federal income taxes of 20% of that amount. The amount of the distribution will be subject to tax in that year unless, within 60 days, you roll it over to an eligible retirement plan that accepts rollovers.

Other Distributions

A distribution or withdrawal from the Plan is not an eligible rollover distribution, and is not subject to the above rules, if:

- It is paid in installments over a period of 10 years or more;
- It is paid in installments over your life expectancy (or joint life expectancy of you and your beneficiary); or
- It is a hardship withdrawal.

In addition, beginning in the year you reach 70 1/2 or retire (whichever is later), a certain portion of your payment cannot be rolled over because it is a “required minimum payment” that must be paid to you.

A payment from the Plan that is not an eligible rollover distribution is not subject to the direct rollover and mandatory withholding rules described above. If any portion of your distribution is not an eligible rollover distribution, you may elect not to have withholding apply to that portion.
Excise Tax on Certain Early Distributions

All distributions from the Plan that are not rolled over to an IRA or another plan are taxable income. Further, if you receive a distribution from the Plan before age 59½, federal law imposes an excise tax equal to 10% of the amount of the distribution in addition to regular income tax. The 10% excise tax is imposed unless one of the following exceptions applies:

- The distribution is made as a result of your termination of employment during or after the year you attain age 55;
- The distribution is made as a result of your death or disability;
- The distribution does not exceed your deductible medical expenses (medical expenses which exceed 7.5% of your adjusted gross income);
- The distribution is made under a qualified domestic relations order;
- The distribution consists of excess pay deferral amounts; or
- The distribution is part of a series of substantially equal payments over your life expectancy or over the joint life expectancy of you and your spouse.

Special Tax Rule for Net Unrealized Appreciation

If you make the election to receive shares of Stryker common stock as part of your lump sum distribution, you may have the option of not paying tax on the “net unrealized appreciation” of the stock until you sell it. Net unrealized appreciation generally is the increase in the value of the Stryker common stock while it was held by the Plan. If, for example, Stryker common stock was contributed to your account when it was worth $1,000, but the stock is worth $1,200 when you receive it, you would not have to pay tax on the $200 increase in value until you later sell the stock.

Opting Out of the Special Tax Rule

You may instead elect not to use the special net unrealized appreciation rule. In that case the net unrealized appreciation will be taxed in the year you receive the stock unless you roll over the stock.

Effect on Withholding

If you receive a distribution of both cash and Stryker common stock in a payment that can be rolled over, the 20% withholding will be based on the entire taxable amount paid to you (including the value of the Stryker common stock determined by excluding the net unrealized appreciation). However, the amount withheld will taken from (and limited to) the cash part of the distribution.

Loans and Withdrawals

The following describes situations when you may be allowed to request a loan or distribution from your Plan account.

Hardship Loans

Hardship loans are available to eligible participants who demonstrate that a hardship (as defined below) exists, and that a hardship loan is necessary to relieve the hardship. Additional information on hardship loans will be provided at the time you request a loan application.
Hardship
A “hardship” means an immediate and heavy need resulting from one of the following:
- Expenses for medical care for you, your spouse, or your dependents;
- Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
- Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents; or
- Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence.

Eligibility
To qualify for a hardship loan, you must be an active employee of the Company or an affiliate of the Company.

Minimum Amount
The minimum amount you may borrow is $1,000.

Maximum Amount
The maximum amount you may borrow is whichever of following amounts is the smallest:
- The sum of the balances in your pay deferral account and your rollover account
- One-half your vested account balance
- $50,000 (reduced, if you have had a hardship loan outstanding at any time during the past 12 months, by the highest balance of that loan during that 12-month period)
- The amount necessary to alleviate your hardship

Number of Loans
You may not have more than one hardship loan outstanding at any time. Not more than one hardship loan will be approved in any 12-month period.

Collateral
Your hardship loan will be secured by 50% of your vested account balance (measured as of the time you take out the loan).

Interest
The interest rate charged on your hardship loan will be one percentage point above the prime rate in effect on the first business day of the month in which you apply for the hardship loan.

Repayments
The maximum period of repayment for any hardship loan is 54 months. A loan account will be set up in your name under the Plan. Your repayments of principal on the loan, together with interest, are made through payroll deductions. The amount of each principal repayment reduces the amount in your loan account and is invested, along with the interest you pay, in the Plan’s investment funds in accordance with your investment election for new Plan contributions.

The amount of your hardship loan may be prepaid in full at any time without penalty. Partial prepayments are not allowed.

If your employment terminates, any outstanding balance on your hardship loan will become due and payable. If it is not repaid within 31 days (or, if earlier, by the valuation date used to determine the amount of your distribution from the Plan), your vested account will be used to repay your loan.

If a hardship loan is not repaid in accordance with the terms of the promissory note and there is a default, the Plan may use your vested account to repay your loan. (However, amounts in your pay deferral account will not be used for this purpose until the time they could otherwise be distributed to you.)

Processing Charge
You may be charged a processing fee for the cost of processing your loan as well as an annual loan maintenance fee.
**Hardship Withdrawals**

If you have a “hardship,” you may be eligible to receive a hardship withdrawal from the Plan. Additional information on hardship withdrawals will be provided at the time you request a withdrawal application. A “hardship” has the same meaning as under the hardship loan rules—namely, an immediate and heavy need resulting from one of the following:

- Expenses for medical care for you, your spouse, or your dependents;
- Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
- Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents; or
- Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence.

You are not eligible for a hardship withdrawal unless you have received the maximum hardship loan available under the Plan (except to the extent that a hardship loan would increase the amount of your need).

**Eligibility**

To qualify for a hardship withdrawal, you must be an employee of the Company or an affiliate of the Company.

**Hardship Proof and Certification**

You must demonstrate that a hardship (as defined above) exists, and that your hardship cannot reasonably be relieved by any of the following actions (except to the extent those actions would increase the amount of your need):

- Reimbursement or compensation through insurance or otherwise
- Liquidation of your assets
- Discontinuing your pay deferrals
- Plan loans (or loans or distributions from other plans)
- Borrowing from commercial sources on reasonable commercial terms

**Amount Available**

The maximum amount you may receive as a hardship withdrawal is whichever of the following amounts is the smallest:

- The sum of the balances in your pay deferral account (excluding investment gains) and your rollover account
- The amount which you certify is necessary to relieve your hardship (including any amounts necessary to pay any Federal, state, or local income tax or penalties expected to result from the hardship withdrawal)

**12-Month Suspension**

If you receive a hardship withdrawal, your pay deferrals under the Plan and employee contributions under all other plans (including stock purchase, stock option, and similar plans) maintained by the Company will be suspended for a period of 12 months after the hardship withdrawal.

**Frequency Limit**

You may make only one hardship withdrawal during any 12-month period.

**Withdrawals After Age 59½**

You may request a withdrawal of all or part of your pay deferral account at any time after you reach age 59½.

**Rollover Account Withdrawals**

You may request a withdrawal of all or part of your rollover account at any time.

**Other Important Plan Information**

The following describes additional information you should know about the Plan.

**Top-Heavy Status of the Plan**

Federal law imposes certain requirements on “top-heavy” plans. The Plan is top-heavy if more than 60% of the balance in all accounts belongs to certain officers and shareholders of the Company. The Plan is not top-heavy and is not likely to become top-heavy.
If the Plan is top-heavy at the end of the Plan Year, a minimum contribution may be required to the Plan. You will be notified if the Plan is top-heavy and this new requirement applies.

**Distributions Under Qualified Domestic Relations Orders**

Generally plan benefits may be paid only to you or possibly your beneficiaries or survivors. However, an exception to this may be made as a result of a qualified domestic relations order.

A domestic relations order is a court-ordered payment of benefits in connection with a support order, divorce, legal separation, or custody case. This means the Plan may be obligated to pay part of your account to someone else—for example, your former spouse, children or other dependents—to comply with such an order.

There are specific legal requirements a domestic relations order must meet to be recognized by the Plan Administrator. If you are affected by such an order, you will be notified by the Plan Administrator. You may obtain from the Plan Administrator, without charge, a copy of the procedures applicable to domestic relations orders.

**Benefits Are Not Insured**

The benefit provisions under the Plan are not covered by the Pension Benefit Guaranty Corporation insurance provisions, because the benefits are determined solely by the amount in your accounts.

**Claims and Appeals**

If you disagree about a benefit, the Plan allows you to file a written application for review of the issue with the Plan Administrator.

If a claim for benefits is denied in whole or in part, the Plan Administrator will give you written notice within 90 days after the Plan Administrator receives your claim, unless special circumstances outside the control of the Plan Administrator require an extension of the time limit. (The Plan Administrator will notify you of the need and reasons for any such extension, and the date by which the Plan expects to render a decision, before the end of the 90-day period.) The written notice will set forth:

- The specific reasons for denial of the claim;
- Reference to the particular provisions of the Plan on which denial of the claim is based;
- A statement as to any additional facts or information necessary to perfect the claim and an explanation as to why the same is required; and
- A reference to the procedures (described below) for review of the denial of the claim, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of a claim.

If your claim for benefits under the Plan is denied in whole or in part by the Plan Administrator, you have the right to request a review of such denial. The review will be granted upon written request, filed by you with the Plan Administrator within 60 days following receipt of written notice of the denial. A full and fair review will be conducted by the Company’s Retirement Plan Committee. You will be permitted to submit written comments, records and other information relating to the claim and provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. The Retirement Plan Committee will consider all comments, documents and other information you submitted, without regard to whether that information was submitted or considered in the initial determination.

At any hearing by the Retirement Plan Committee, you will have reasonable notice and an opportunity to be present and be heard in person or by a duly authorized representative. The Retirement Plan Committee will decide the matter with reasonable promptness and in any event within 60 days following receipt of a request for review unless special circumstances exist which require an extension of such time limit. The Retirement Plan Committee will notify you of the need and reasons for such extension, and the date by which the Plan expects to render a decision, prior to the end of the 60 day period. Its decision will be provided to you in writing and will set forth its reasons for the decision; the provisions of the Plan on which the decision is based; 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; and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The above appeal procedure applies not only to you but also to a beneficiary or other person who disagrees about a benefit.

If you wish to bring a civil action against the Plan following a denial of your claim on appeal, you must do so within one year of the Retirement Plan Committee’s final decision on your claim.
Termination or Amendment of the Plan

Although the Company intends to continue the Plan from year to year, it reserves the right to amend or terminate the Plan at any time. However, because the Plan was established for the exclusive benefit of the Company’s employees and their beneficiaries, termination or amendment cannot subtract from your accounts as they exist when the amendment or termination occurs.

If the Plan is terminated, you will have a 100% vested right to your accounts regardless of your years of vested service. After paying the expenses of terminating the Plan, the remaining amounts in the Plan will be distributed to you and the other participants in lump sum payments.

Your Rights as a Participant

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office, all documents governing the Plan (the Plan document and trust agreement), and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan (the Plan document and trust agreement), and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The Plan Administrator will make a reasonable charge for the copies.)
- Receive a summary of the Plan’s annual financial report (The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the 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 benefit under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan 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 (these rights are described in “Claims and Appeals” on page 127 of this summary plan description).

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 Plan 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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.

Additional Information

Name of Plan
Stryker Corporation 401(k) Savings and Retirement Plan

Name, Address and Telephone Number of the Company
Stryker Corporation
2825 Airview Blvd.
Kalamazoo, MI 49002
269 389 2600

Company’s Identification Number
38-1239739

Plan Number
002

Type of Plan
Profit-Sharing/Section 401(k) Plan

Type of Administration
Self-Administered

Plan Administrator
Stryker Corporation is the Plan Administrator.

Name and Address of Agent for Service of Legal Process
Stryker Corporation
2825 Airview Blvd.
Kalamazoo, MI 49002

Service of legal process may also be made on the Plan Administrator or the Trustee.

Name and Address of Trustee
Vanguard Fiduciary Trust Company
Vanguard Financial Center
P.O. Box 2900
Valley Forge, PA 19482

Plan Year
January 1 through December 31

Names and Employer Identification Numbers of Participating Employers

<table>
<thead>
<tr>
<th>Company</th>
<th>Emp. Id. No.</th>
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</thead>
<tbody>
<tr>
<td>Stryker Corporation 2825 Airview Blvd</td>
<td>38-1239739</td>
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<tr>
<td>Kalamazoo, MI 49002</td>
<td></td>
</tr>
<tr>
<td>Howmedica Osteonics Corp 325 Corporate Drive</td>
<td>22-2183590</td>
</tr>
<tr>
<td>Mahwah, NJ 07430</td>
<td></td>
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<tr>
<td>Stryker Communications Inc.,</td>
<td>20-1962228</td>
</tr>
<tr>
<td>1410 Lakeside Parkway #100,</td>
<td></td>
</tr>
<tr>
<td>Flower Mound, TX 75028</td>
<td></td>
</tr>
<tr>
<td>Stryker Sales Corporation 2825 Airview Blvd</td>
<td>38-2902424</td>
</tr>
<tr>
<td>Kalamazoo, MI 49002</td>
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<tr>
<td>Stryker Sustainability Solutions</td>
<td>86-0898793</td>
</tr>
<tr>
<td>1810 West Drake Drive Tempe, AZ 85283</td>
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<tr>
<td>Medicycle</td>
<td>20-5001951</td>
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<tr>
<td>2850 S. 36th St. Suite A-9</td>
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<tr>
<td>Phoenix, AZ 85034</td>
<td></td>
</tr>
<tr>
<td>Stryker Performance Solutions LLT</td>
<td>46-1634423</td>
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Special Provisions Applicable to eTrauma Participants

The following special rules apply to you if you were employed by eTrauma.com Corp. ("eTrauma") at the time it became a Stryker company or are a former participant in the eTrauma.com Corp. 401(k) Retirement Plan (the “eTrauma Plan”) whose account balance was transferred to the Plan as of September 30, 2005.
Prior Eligibility Service Credit
You will be credited for eligibility purposes of the Plan with your service with eTrauma, including service credited to you under the eTrauma Plan, as if you had been an employee of the Company when that service was performed.

Accounts
You will have the following additional account in the Plan:

- **eTrauma Matching Contribution Account.** A separate account reflecting your matching contributions to the eTrauma Plan through September 30, 2005 and any other amounts allocable to or chargeable to that account. This account will be subject to the vesting rules described in “Vesting” on page 119.

Total Disability
You will be considered to have suffered a total disability for purposes of the Plan if your condition meets either the Plan’s definition of “total disability” (see “Vesting” on page 119) or the following definition of “disability” (which is based on the eTrauma Plan).

- “Disability” means that the Participant is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

In-Service Withdrawals
In addition your other withdrawal rights under the Plan, you have the following in-service withdrawal rights:

- **Withdrawals After Age 59½.** You may request a withdrawal of all or a portion of your eTrauma Matching Contribution Account at any time after you have attained age 59½.

Special Provision Applicable to PlasmaSol Participants
The following special rule applies to you if you were employed by PlasmaSol Corp. (“PlasmaSol”) at the time it became a Stryker company.

Prior Service Credit
You will be credited for all purposes of the Plan with your service with PlasmaSol as if you had been an employee of the Company when that service was performed.

Special Provision Applicable to Porex Surgical, Inc. Participants
The following special rule applies to you if you were employed by Porex Surgical, Inc. or its affiliate (“Porex”) and you became an employee of the Company upon Stryker’s acquisition of Porex.

Prior Service Credit
You will be credited for all purposes of the Plan with your service with Porex as if you had been an employee of the Company when that service was performed.

Special Provision Applicable to Boston Scientific Corporation Participants
The following special rule applies to you if you were employed by Boston Scientific Corporation or its affiliate (“Boston Scientific”) and you became an employee of the Company upon Stryker’s acquisition of Boston’s neurovascular unit.

Prior Service Credit
You will be credited for all purposes of the Plan with your service with Boston Scientific as if you had been an employee of the Company when that service was performed.

Special Provision Applicable to Gaymar Industries, Inc. Participants
The following special rule applies to you if you were employed by Gaymar Industries, Inc. (“Gaymar”) at the time it became a Stryker company.

Prior Service Credit
You will be credited for all purposes of the Plan with your service with Gaymar as if you had been an employee of the Company when that service was performed.
Special Provisions Applicable to Divested Biotech Participants

The following special rules apply to you if you were employed by Stryker Biotech L.L.C. and ceased to be an employee as a result of the sale of the OP-1 portion of Stryker Biotech L.L.C. (the “OP-1 Divestiture”) on the date of the OP-1 Divestiture.

Waiver of Certain Contribution Eligibility Requirements

You will be deemed to have satisfied the Plan’s eligibility requirements to receive a discretionary contribution and matching contribution for the 2010 Plan Year.

Full Vesting

Your discretionary contribution account and matching contribution account will be fully vested and nonforfeitable as of the date you ceased to be an employee.

Acquisitions After September 30, 2012

If you were employed on the acquisition date by a company that Stryker acquires after September 30, 2012, and as a consequence become employed by Stryker at that time, you will be credited for all purposes of the Plan with your service with that acquired company as if you had been an employee of the Company when that service was performed.
401(k) Plan (Sales Reps)

The Stryker Corporation 401(k) Savings and Retirement Plan gives participants a way to save for their future financial needs.

Important
Effective September 30, 2012 the former Stryker Corporation 401(k) Savings and Retirement Plan for Sales Employees was merged into the Stryker Corporation 401(k) Savings and Retirement Plan (the “Plan”).

This summary plan description (SPD) describes the main features of the Plan that apply to Stryker sales representatives (different Plan features for employees who are not sales representatives are described in a separate SPD). As used in this SPD, “sales representative” means an employee who has an HR function of “Sales Direct” in the job classification segment within the Company’s human resources management system. If an employee’s status changes from a sales representative to a non-sales position or vice versa, the features described in this SPD apply only with respect to the period of employment as a sales representative.

Overview of the Plan

The Plan is a type of profit-sharing retirement plan known as a “401(k)” plan. This means that you may elect to defer part of your compensation and have the Company contribute the deferred amount to the Plan instead of receiving it in your paychecks. The Company will make matching contributions, as explained in “Contributions to the Plan” on page 134.

Your Accounts

Your pay deferrals and the Company matching contributions made for you are placed in accounts in your name. Your accounts are invested together with the other participants’ accounts in certain investment funds. The investment earnings are allocated to the accounts.

Your Benefits

Your benefits from the Plan are the vested amounts in your accounts. When you leave the Company and become eligible for benefit payments, the Trustee will make the payments in the form you choose until you have received the full amount owed to you from your accounts. The amount in your accounts will largely depend on the amount of your deferrals, the amount of matching contributions, and the investment performance of the funds in which you are invested.

Tax Deferral

You will not be taxed on the contributions to the Plan, or on the investment earnings credited to your accounts, until these amounts are actually distributed to you from your accounts.

Contacting Vanguard

Plan records are administered by The Vanguard Group located in Valley Forge, Pennsylvania. You can access information about the Plan and your accounts (including information on your investment performance, account balance, loan information, current investment elections and your recent activity) by

- Calling Vanguard’s VOICE Network automated phone service (at 800 523 1188), which is available 24 hours a day,
- Accessing your account through the Vanguard web site (www.vanguard.com), or
- Speaking directly to a Participant Service Associate (“PSA”) during business hours (at 800 523 1188).

You can also use any of these methods to make or cancel a pay deferral election, change your pay deferrals, change how your existing account balance is invested, change the investment mix of future contributions or your current account balance, and change your Personal Identification Number.

Eligibility

You will become a participant in the Plan on the date you become an eligible employee of the Company (but not before your 18th birthday).

You are not eligible to participate in the Plan if:

- You are a temporary employee (that is, you were hired for a position that is not permanent and is not expected to continue for more than one year), unless and until you complete 1,000 hours of service during the first 12 months of your employment or during any Plan Year thereafter;
You are a “leased” employee;

You are a union employee (unless your collective bargaining agreement provides for participation in the Plan);

You are employed by one of the Company’s foreign branches;

You actively participate in another 401(k) or similar plan to which the Company or an affiliate of the Company contributes;

You are not on the Company’s payroll, or you are classified as an independent contractor (even if an agency or court later determines that your relationship to the Company was that of a common law employee); or

You actively participate in a non-U.S. retirement plan or government retirement system to which the Company or an affiliate of the Company contributes.

If you terminate employment with the Company after you have become a participant, and you later become reemployed, you will resume participation in the Plan on your reemployment date.

Contributions to the Plan

The Plan has three types of contributions:

- Pay Deferral Contributions
- Catch-Up Contributions
- Company Matching Contributions

Pay Deferral Contributions

You may contribute to the Plan by deferring a portion of your compensation.

How to Make Pay Deferral Contributions

You may elect to defer a portion of your compensation and have the Company contribute your deferred compensation to the Plan on your behalf. These contributions are called “pay deferrals” and are credited to your “pay deferral account.” Contact Vanguard (see “Contacting Vanguard” on page 133) to make a pay deferral election.

Your pay deferrals may be any whole percentage up to 75% of your compensation during a Plan Year. However, your total pay deferrals may not exceed the dollar limit described in “Dollar Limit,” and the Company may limit pay deferrals for highly paid employees to ensure that IRS nondiscrimination tests are met.

Automatic Enrollment

If, upon becoming eligible to participate in the Plan, you fail to make an election either to make pay deferral contributions or to opt out, you will automatically be treated as having made a pay deferral election. Your automatic election will start at 2% of your compensation and will increase by 1% each year until it reaches 8%. This automatic election will cease to apply, however, if and when you make your own pay deferral election or elect not to make pay deferral contributions.

Changing, Stopping, Resuming Contributions

You may change your pay deferral percentage or stop or resume your pay deferrals at any time by contacting Vanguard (see “Contacting Vanguard” on page 133). Your instructions will be implemented as soon as administratively feasible.

Discrepancies

If you think there is a discrepancy between the percentage of pay you elected to defer (or the automatic enrollment percentage, if applicable) and the percentage actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise you will be deemed to have elected the percentage that is actually being contributed.

Benefits of Deferring Compensation

There are four benefits of deferring compensation under the Plan.

- First, any amounts contributed to the Plan as a result of your pay deferral election are not subject to current income taxes. As a result, your current taxable income will be reduced.

- Second, the amount contributed to the Plan is invested on a tax-deferred basis. This means you will not pay income tax on the investment earnings that are allocated to your accounts. You will pay income taxes only when you receive your benefits from the Plan. As a result, this tax deferral permits a much more rapid accumulation of funds for your retirement.

- Third, under current provisions of the tax law, you may be ineligible to make deductible contributions to a traditional individual retirement account (“IRA”). Pay deferrals under the Plan allow you to save for retirement on a before-tax basis.
Fourth, the Company will contribute 50¢ for each $1 that is contributed to the Plan as a result of your pay deferrals (up to a maximum match equal to 3% of your compensation). The portion of your matching contribution that does not exceed 1% of your compensation will be invested in the Stryker Stock Fund. Matching contributions above 1% of compensation will be invested according to your investment election. See “Company Matching Contributions” on page 135 for a discussion of “matching” contributions.

Example

Here is an example of how these benefits can affect you:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral for the year is $3,000. The Company contributes your deferral of $3,000 to the Plan for you, along with a $900 matching contribution, of which $300 is invested in the Stryker Stock Fund.

In addition, the $3,900 contribution in your name will reflect any change in value of the investment funds in which your accounts are invested. You will not pay income tax on your $3,000 pay deferral, the $900 match, or any change in investment value until you eventually receive the amount in your accounts after terminating employment (or as a hardship withdrawal or other withdrawal).

Dollar Limit

Federal law limits the amount of your pay deferrals in a calendar year to $17,500, subject to adjustments for inflation after 2014 (the “dollar limit”).

If your pay deferrals under all 401(k) plans or other qualified plans in which you participate during a calendar year exceed the dollar limit for that calendar year (January 1 through December 31), the excess amount will be included in your taxable income for the year of the deferral. The excess amount will also be taxed again in the year it is distributed to you if it is not withdrawn by April 15 of the following year. To receive a distribution of the excess amount before April 15, your request for distribution must be made to the Plan Administrator by March 1.

The Company will attempt to make sure that your pay deferral contributions to the Plan do not exceed the dollar limit. However, if you participate in another employer’s 401(k) plan or a pay deferral simplified employee plan (SEP) during the same calendar year, the dollar limit applies to the total deferral contributions to both plans. Also, if you participate in a tax-sheltered annuity plan of another employer, there is an increased combined limit that applies to deferrals to the Plan and the tax-sheltered annuity. You should monitor your pay deferral contributions so that you do not exceed the dollar limit.

Catch-Up Contributions

If you will be at least 50 years old by the end of the Plan Year and you make the maximum amount of pay deferral contributions allowed under the Plan, you are eligible to make “catch-up” contributions in addition to your pay deferral contributions. The law allows up to $5,500 in catch-up contributions.

Company Matching Contributions

To give you an incentive to defer a portion of your compensation, the Company will make “matching” contributions based upon the amount of your pay deferrals. The Company will contribute 50¢ for each $1 of your pay deferrals, up to a maximum matching contribution equal to 3% of your compensation.

The matching contributions are made as of the end of each Plan Year. To receive a matching contribution, you must be employed on the last day of the Plan Year and must have at least 1,000 hours of service during the Plan Year. You will also be eligible for a matching contribution if you terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

These matching contributions made for you are credited to your “matching contribution account” as soon as administratively feasible following the end of the Plan Year. The portion of your matching contributions that does not exceed 1% of your compensation will be credited to a “1% subaccount” within your matching contribution account, and will be initially invested in the Stryker Stock Fund. Any additional matching contributions are invested in accordance with your election.
Example
Here is an example of how matching contributions work:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral is $3,000. Your pay deferrals up to 6% of your compensation ($1,800) qualify for a matching contribution at the rate of 50¢ for each $1 of deferrals, for a total matching contribution of $900. Of that total matching contribution, $300 (1% of your compensation) will be invested in the Stryker Stock Fund. The remainder of your matching contribution will be invested in accordance with your election.

Compensation
The compensation used in calculating the amount of the Company's contributions (including pay deferral contributions) on your behalf consists of the following (unless listed under “Items Excluded”):

- Wages, salary, and other taxable amounts received for services to the Company;
- Commissions and bonuses;
- Pay deferral contributions to this Plan;
- Pay reduction contributions to a “cafeteria” plan or qualified transportation fringe benefit program; and
- Differential wage payments (wage amounts paid by the Company during any period in which you are performing active military service for at least 30 days) that would have been paid had you been actively employed by the Company during that period.

Items Excluded
The following items are excluded from compensation for Plan purposes:

- Amounts paid to you before you met the requirements for participating in the Plan;
- Pay reduction amounts or other contributions to a nonqualified deferred compensation plan;
- Distributions from a nonqualified or qualified deferred compensation plan;
- Income from the exercise of a stock option;
- Income realized on the sale of stock acquired under a statutory stock option;
- Amounts subject to special tax benefits which are not includible in income;
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits; and
- Severance pay.

Federal law requires the Plan to limit to $260,000 the amount of an employee’s compensation during a Plan Year that may be used in figuring the amount of contributions on behalf of an employee under the Plan for the Plan Year. The IRS may increase the $260,000 limit in future years for inflation.

Rollovers
The Plan includes rollover provisions, as follows.

Rollovers from Eligible Employer Plans
If you receive an “eligible rollover distribution” from an eligible retirement plan of a prior employer, you may be eligible to roll over that distribution to the Plan. An eligible retirement plan means any of the following types of plans:

- A qualified defined contribution or defined benefit plan (other than Roth or other after-tax contributions);
- A Section 403(b) tax-sheltered annuity (other than Roth or other after-tax contributions); or
- A Section 457 plan maintained by a governmental employer.

Such a distribution may be rolled over in either of two ways. The distribution may either be paid directly to the Plan by the other plan in a “direct rollover,” or the other plan may pay the distribution to you (subject to any applicable withholding tax), and you will have 60 days after you receive it to contribute it to the Plan.

Rollovers from IRAs
You may also roll over to the Plan the portion of a distribution from a Section 408 individual retirement account or annuity (IRA) that would otherwise be taxable to you and that is eligible to be rolled over.

More information regarding rollovers is available from the Plan Administrator. Any amount you roll over is placed in your “rollover account.”
Vesting

The term “vested” refers to the amount in your accounts that cannot be taken away from you regardless of the reason or time that you leave the Company.

Vested Interest in Your Accounts

The following rules are used to determine if you are “vested”:

- Amounts in your pay deferral account and rollover account are always 100% vested.
- Amounts in your matching contribution account are 100% vested if you attain age 65, become totally disabled, or die while employed by the Company.

You are “totally disabled” if you have a mental or physical condition that makes you eligible to receive Social Security disability benefits. However, total disability does not include disability resulting from:

- Military service
- Criminal activity
- Alcoholism
- Drug abuse
- Intentional self-inflicted injury

- Amounts in your matching contribution account are 100% vested if you have at least five “years of vested service.”

If you leave the Company (for a reason other than retirement after age 65, total disability, or death) before completing five “years of vested service,” all or a portion of the amounts in your matching contribution account will be forfeited. You will receive only your vested percentage of your matching contribution account. Your vested percentage is determined as follows:

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Year of Vested Service

You will receive a “year of vested service” for each Plan Year in which you are credited with at least 1,000 hours of service.

Forfeitures

The portion of your matching contribution account in which you are not vested is “forfeited.” The forfeiture will occur on the date you receive a distribution of your vested benefits (or the end of the Plan Year in which you have five consecutive breaks in service, if earlier). Any forfeitures from your accounts will be used to pay Plan expenses or to reduce the amount of the Company’s contributions.

Vesting Rules Upon Reemployment

If you leave the Company and are later reemployed by the Company, the following rules apply to you:

- For information on your eligibility to join the plan after you are rehired, see “Eligibility” on page 133.
- Your former years of vested service will be restored if your Plan account was partially or fully vested before you terminated employment or if you have fewer than five consecutive vesting breaks in service. You must perform a year of vested service after being reemployed in order for your prior service to be credited.
- The amount you forfeited will be restored if you have fewer than five consecutive vesting breaks in service and you repay the vested amount previously distributed to you within five years after being reemployed.
- If you have five or more consecutive vesting breaks in service and you left the vested portion of the matching contribution account in the Plan, when you are reemployed you will have two subaccounts. The first subaccount, consisting of the vested portion of the matching contribution accounts, will be 100% vested. The second subaccount, consisting of amounts added to the matching contribution accounts after you are rehired, will vest under the Plan’s normal vesting schedule, based on your years of vested service after the break in service plus your years of vested service before the break in service that are restored under the above rules.
**Vesting Breaks in Service**

A “vesting break in service” is a Plan Year during which you have not completed more than 500 hours of service. Solely for determining whether a vesting break in service has occurred, if you are absent from work for maternity or paternity reasons you will receive credit for hours of service (but not more than 501) that would have been credited except for the absence. An absence from work for maternity or paternity reasons means an absence caused by pregnancy or childbirth, placement or adoption of a child, or child care immediately following birth or adoption.

If you have performed at least 500 hours of service in the Plan Year in which your absence for maternity or paternity reasons begins, then solely for purposes of preventing a break in service for the Plan Year subsequent to the Plan Year in which such leave begins, you will receive service credit of up to 500 hours for your absence during that Plan Year.

For example, if you take maternity leave in October and have more than 500 hours of service, there is no break in service that year. In addition, in order to avoid a break in service the following year, you will be credited with up to 500 hours of service.

**Plan Investments**

The Plan offers you a choice of funds to invest the money in your accounts.

**Investment of Your Accounts**

You may direct the investment of contributions to your accounts in different investment funds made available by the Trustee. Information regarding these funds, including prospectuses, may be obtained by contacting Vanguard (see “Contacting Vanguard” on page 133) or your human resources department.

If you do not make an investment election, contributions to your accounts (other than the 1% subaccount that is invested in the Stryker Stock Fund) will be invested in the age-appropriate Vanguard Target Retirement fund.

You may change your investment election at any time by contacting Vanguard (see “Contacting Vanguard” on page 133). Your change in investment election may apply to future contributions, amounts already invested, or both.

You may transfer at any time all or a portion of your 1% subaccount that is invested in the Stryker Stock Fund to any of the other investment funds available under the Plan, and all or a portion of your 1% subaccount that is invested in other investment funds back into the Stryker Stock Fund. However, you may not transfer any portion of your accounts other than the 1% subaccount into the Stryker Stock Fund.

The Plan is intended to meet the requirement of ERISA Section 404(c) and its regulations. Under these rules, plan fiduciaries may be relieved of liability for losses that are a direct and necessary result of participants’ and beneficiaries’ investment instructions.

**Valuation and Adjustment of Your Accounts**

The Trustee will calculate the value of your accounts as of each business day (“valuation date”). The value of your accounts is the total of your investments in the Stryker Stock Fund and each of the other investment funds. Other than the various types of contributions that are credited to your accounts, the following events will also change the value of your accounts:

- **Distributions.** If you receive a distribution or withdrawal, the account or accounts from which it is made are reduced by the amount of the distribution.

- **Investment Results.** As of each valuation date, the Trustee will calculate the value of the investment funds. You should note that the value may increase or decrease and your accounts will be adjusted accordingly. You will receive a quarterly statement that will state both the value of your interest in each investment fund and the total value of your accounts.

- **Expenses.** Investment management fees are paid by the investment funds to which they relate. In addition, accounts are charged with their share of Plan administration expenses that are paid by the Plan. Administrative expenses deducted from your accounts will appear on your quarterly statements.

- **Loans.** If you receive a hardship loan, the account or accounts from which it is made will be reduced by the amount of the loan. Your account or accounts will be increased as you make payments of principal and interest on the loan.
• **Forfeitures.** If you resign or are dismissed before you are fully vested, you will not receive the full amount in your accounts. The portion of your accounts in which you are not vested is “forfeited” and used to reduce the Company’s matching contributions.

When your active participation in the Plan ends, you will no longer share in the Company’s matching contributions. However, as long as you have not yet received the full amount in your accounts, your accounts will still be adjusted for expenses, investment earnings, gains and losses as well as for distributions.

### Distributions from the Plan

This section describes when you may receive a distribution from the Plan.

#### When Benefits Are Distributed

You may request payment of your benefits at any time after you stop working for the Company, after you reach age 65 (even if you are still working), or upon total disability. Once you retire, federal law requires that your benefit payments begin no later than the April 1 after the calendar year in which you attain age 70¹/₂ (or in which you retire, if later).

#### Severance from Employment for a Reason Other than Death

You are entitled to the vested amount in your accounts if you leave the Company for any reason. (See “Vesting” on page 137 for more information.) If your vested account balance (other than your rollover account) exceeds $5,000, you have the option of requesting a distribution of benefits or maintaining your accounts in the Plan. Your benefits will be paid as soon as administratively feasible after you request the distribution.

If your vested account balance (other than your rollover account) does not exceed $5,000, you do not have the option of maintaining your accounts in the Plan. Your benefits will be distributed to you in a lump sum payment as soon as administratively feasible following your severance from employment.

Whether or not your vested account balance exceeds $5,000, you may elect to have your lump sum distribution transferred to an eligible retirement plan in a “direct rollover.”

#### Automatic Rollovers

If the value of your account exceeds $1,000 but does not exceed $5,000, and after receiving all required notices you do not affirmatively elect to receive your distribution directly or to have it rolled over, the vested amount in your accounts will be automatically rolled over by the Plan to an IRA with The Vanguard Group. Your account will be automatically invested in Vanguard Prime Money Market Fund, a fund designed to preserve principal, provide a reasonable rate of return, and maintain liquidity. You will be responsible for paying all fees and expenses assessed against your automatic rollover IRA. The fees and expenses will be comparable to the fees and expenses charged by Vanguard for other IRAs. For additional information on the Plan’s automatic rollover rules, a Vanguard IRA, and the fees and expenses associated with a Vanguard IRA, call Vanguard at **800 523 1188**.

If you receive a distribution before age 59¹/₂, the distribution may be subject to a 10% excise tax in addition to being considered taxable income in the year it is distributed to you.

### Forms of Distribution of Benefits

The Plan includes automatic forms of distribution, depending on your marital status, and alternative forms, as follows:

#### Automatic Forms of Distribution

If your vested account balance (other than your rollover account) exceeds $5,000, the Plan provides for the following “automatic” forms of distribution unless you elect an alternative form of payment:

- **Married Participants.** If you are married when your benefits begin, your vested benefits will be used to purchase a “joint and survivor annuity” that pays a monthly benefit to you for your life, and after your death, a 50% monthly benefit to your surviving spouse for his or her life (for example, monthly payments of $1,500 during your lifetime, and, if your spouse survives you, monthly payments of $750 for the rest of your surviving spouse’s life). Please note that under a joint and survivor annuity:
  - If your spouse dies before you, your monthly payments will continue at their previous level ($1,500 in the above example).
If your spouse survives you, your spouse does not have the option of converting the survivor benefit ($750 per month in the above example) to any other form of payment such as a lump sum.

- **Unmarried Participants.** If you are unmarried when benefits begin, the vested amount in your accounts will be used to purchase a “single life annuity,” that is, an annuity that pays a monthly benefit to you for your life. No benefits are paid after your death.

The Plan will purchase your single life annuity or joint and survivor annuity from an insurance company using the vested amount in your accounts. The amount of the monthly benefit paid under the annuity will depend on market conditions for annuity contracts at the time payments under the annuity begin. The monthly benefit will also depend on your age and (in the case of a joint and survivor annuity) your spouse’s age.

**Waiving the Automatic Form**

You may waive the “automatic” form of distribution and elect one of the alternative forms of benefit payment described in “Alternative Forms of Distribution.” This waiver cannot be made more than 90 days before your benefits begin, and, if you are married, your election of an alternative form is effective only if your spouse consents in writing to the waiver of the joint and survivor annuity within that 90-day period. Your spouse’s consent must be witnessed by a Plan representative or by a notary public.

**Alternative Forms of Distribution**

If you (and your spouse, if you are married) waive the automatic form of payment, you may elect the alternative form of payment you prefer. The alternative forms of payment are as follows:

- **A lump sum payment.** This payment will be made in cash, unless you elect to receive shares of stock for your vested 1% subaccount invested in the Stryker Stock Fund, provided that such vested portion is at least $1,000 in value (see “Election to Receive Distribution of Stryker Stock” on page 142 for details on this election).
- **Cash payments** in roughly equal annual, quarterly, or monthly installments for a specific number of years. The specific number of years for which the payments will last cannot exceed either your life expectancy or the joint life expectancy of you and your beneficiary.
- **A combination** of a single sum cash payment and cash payments in roughly equal annual, quarterly or monthly installments.
- **If you are married,** a single life annuity immediately payable over your life.

If you elect installments, you may at any time elect to shorten the period over which the installments are being paid or receive a lump-sum distribution of your remaining balance.

### Distribution of Benefits upon Death

#### Death Before Receiving Benefits

If you die before you have begun receiving your benefits, the amount in your accounts will be distributed to your designated beneficiary under one of the following methods:

- **Annuity.** If you are married, under the first method of payment the Trustee will use the amount in your accounts to purchase (from an insurance company) a preretirement survivor annuity for your surviving spouse. The annuity will pay a monthly benefit to your spouse until his or her death. The amount of the monthly benefit paid under the annuity will depend on market conditions for annuity contracts at the time the annuity contract is purchased. This form of death benefit is automatic unless you and your spouse waive it.

- **Waiver of Annuity Form.** You may waive the annuity form of death benefit any time after the beginning of the Plan Year in which you reach age 35. In order for your waiver to be valid, it must also be signed by your spouse. Your spouse’s signature must be witnessed by a Plan representative or by a notary public. You may revoke this waiver at any time.

- In addition, your spouse may waive the annuity form of death benefit any time after the beginning of the Plan Year in which you reach age 35. In order for your waiver to be valid, it must also be signed by your spouse. Your spouse’s signature must be witnessed by a Plan representative or by a notary public. You may revoke this waiver at any time.

- In addition, your spouse may waive the annuity form of death benefit after your death. In that case, your spouse would receive the amount in your accounts in the form elected in writing by your spouse from the optional methods of payment described above.

If you and your spouse waive the annuity form of death benefit, or if you are not married at the time of your death, the beneficiary you have named will receive the type of death benefit described in “Payments to Beneficiary” on page 141. You may appoint one or more beneficiaries by completing and returning a beneficiary designation form to the Plan Administrator. You may change your beneficiary at
any time before your death by completing and returning a new beneficiary designation form to the Plan Administrator. If you have not named a beneficiary or your beneficiary predeceases you, payment will be made to your surviving spouse, if any, and otherwise in equal shares to your children or their then living issue by right of representation. If you have not named a beneficiary or your beneficiary predeceases you, and you have neither a surviving spouse nor children (or their living issue) at the time of your death, payment will be made to your estate.

If you designate your spouse as your beneficiary and later become divorced, that designation will no longer be valid.

Payments to Beneficiary

Under the alternative method of payment, the Trustee will pay the amount in your accounts to the beneficiary you have named if either:

- You have no surviving spouse; or
- You and your spouse waive the annuity form of death benefit.

The distribution will be made in the form (lump sum, installments, etc.) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described above.

If you die before you have begun receiving your benefits, the Trustee will pay your vested account balance to your beneficiary in the form (lump sum, installments, or a combination) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described above.

Payments to your surviving spouse are required to begin by December 31 of the year following the year in which you would have attained age 70-1/2, if later.

Payments to a designated beneficiary other than your spouse are required to begin by December 31 of the year following the year of your death unless you or your beneficiary elects by September 30 of the year following the year of your death to apply the “five-year rule.” If the five-year rule is elected, your entire vested account balance must be distributed no later than December 31 of the year containing the fifth anniversary of your death.

Death While Receiving Benefits

If you die while receiving your benefits in the form of installment payments, payments will continue to your beneficiary according to the same schedule of installment payments until the amount in your accounts has been completely distributed. Your beneficiary may instead choose to receive the remaining benefits in a lump sum payment.

Income Tax Withholding/Direct Rollovers

Direct Rollovers

Distributions and withdrawals from the Plan are generally “eligible rollover distributions.” This means that all or a portion of the distributions can be rolled over in a “direct rollover” to an eligible retirement plan (which may be a qualified plan, a Section 408 individual retirement account or annuity (IRA), a Section 403(a) annuity, a Section 403(b) tax-sheltered annuity, a Section 457 governmental plan, or a Roth IRA) that accepts rollovers. If you choose a direct rollover, the Plan will issue a check directly to the eligible retirement plan, and you will not be taxed until you later take it out of the eligible retirement plan (unless the direct rollover is to a Roth IRA, in which case you will be taxed at the time of the rollover).

Required Withholding

If you receive an eligible rollover distribution from the Plan and do not choose a direct rollover, the Plan is required by law to withhold Federal income taxes of 20% of that amount. The amount of the distribution will be subject to tax in that year unless, within 60 days, you roll it over to an eligible retirement plan that accepts rollovers.

Other Distributions

A distribution or withdrawal from the Plan is not an eligible rollover distribution, and is not subject to the above rules, if:

- It is paid in the form of a joint and survivor annuity or single life annuity;
- It is paid in installments over a period of 10 years or more;
- It is paid in installments over your life expectancy (or joint life expectancy of you and your beneficiary); or
- It is a hardship withdrawal.
In addition, beginning in the year you reach 70½ or retire (whichever is later), a certain portion of your payment cannot be rolled over because it is a “required minimum payment” that must be paid to you.

A payment from the Plan that is not an eligible rollover distribution is not subject to the direct rollover and mandatory withholding rules described above. If any portion of your distribution is not an eligible rollover distribution, you may elect not to have withholding apply to that portion.

**Excise Tax on Certain Early Distributions**

All distributions from the Plan that are not rolled over to an IRA or another plan are taxable income. Further, if you receive a distribution from the Plan before age 59½, federal law imposes an excise tax equal to 10% of the amount of the distribution in addition to regular income tax. The 10% excise tax is imposed unless one of the following exceptions applies:

- The distribution is made as a result of your termination of employment during or after the year you attain age 55;
- The distribution is made as a result of your death or disability;
- The distribution does not exceed your deductible medical expenses (medical expenses which exceed 7.5% of your adjusted gross income);
- The distribution is made under a qualified domestic relations order;
- The distribution consists of excess pay deferral amounts; or
- The distribution is part of a series of substantially equal payments over your life expectancy or over the joint life expectancy of you and your spouse.

**Election to Receive Distribution of Stryker Stock**

If you take a lump sum distribution from the Plan you may elect to have your vested 1% subaccount that is invested in the Stryker Stock Fund distributed in shares of stock instead of in cash. To qualify for the election, the value of the Stryker common stock in your vested 1% subaccount must be at least $1,000. Fractional shares of Stryker common stock, and the part of your vested 1% subaccount that is not invested in Stryker common stock, will be distributed in cash. Hardship withdrawals and withdrawals after age 59-1/2 while you are still an employee do not qualify for the election.

**Special Tax Rule for Net Unrealized Appreciation**

If you make the election to receive shares of Stryker common stock as part of your lump sum distribution, you may have the option of not paying tax on the “net unrealized appreciation” of the stock until you sell it. Net unrealized appreciation generally is the increase in the value of the Stryker common stock while it was held by the Plan. If, for example, Stryker common stock was contributed to your account when it was worth $1,000, but the stock is worth $1,200 when you receive it, you would not have to pay tax on the $200 increase in value until you later sell the stock.

**Opting Out of the Special Tax Rule**

You may instead elect not to use the special net unrealized appreciation rule. In that case the net unrealized appreciation will be taxed in the year you receive the stock unless you roll over the stock.

**Effect on Withholding**

If you receive a distribution of both cash and Stryker common stock in a payment that can be rolled over, the 20% withholding will be based on the entire taxable amount paid to you (including the value of the Stryker common stock determined by excluding the net unrealized appreciation). However, the amount withheld will taken from (and limited to) the cash part of the distribution.

**Loans and Withdrawals**

The following describes situations when you may be allowed to request a loan or distribution from your Plan account.
Hardship Loans

Hardship loans are available to eligible participants who demonstrate that a hardship (as defined below) exists, and that a hardship loan is necessary to relieve the hardship. Additional information on hardship loans will be provided at the time you request a loan application.

Hardship

A “hardship” means an immediate and heavy need resulting from one of the following:

▪ Expenses for medical care for you, your spouse, or your dependents;
▪ Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
▪ Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
▪ Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
▪ Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents; or
▪ Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence.

Eligibility

To qualify for a hardship loan, you must be an active employee of the Company or an affiliate of the Company.

Spouse’s Consent

If you are married, you must receive your spouse’s written consent to obtain a hardship loan. Your spouse’s consent must be witnessed by a Plan representative or a notary public.

Minimum Amount

The minimum amount you may borrow is $1,000.

Maximum Amount

The maximum amount you may borrow is whichever of following amounts is the smallest:

▪ One-half your vested account balance
▪ $50,000 (reduced, if you have had a hardship loan outstanding at any time during the past 12 months, by the highest balance of that loan during that 12-month period)
▪ The amount necessary to alleviate your hardship

Number of Loans

You may not have more than one hardship loan outstanding at any time. Not more than one hardship loan will be approved in any 12-month period.

Collateral

Your hardship loan will be secured by 50% of your vested account balance (measured as of the time you take out the loan).

Interest

The interest rate charged on your hardship loan will be one percentage point above the prime rate in effect on the first business day of the month in which you apply for the hardship loan.

Repayments

The maximum period of repayment for any hardship loan is 54 months. A loan account will be set up in your name under the Plan. Your repayments of principal on the loan, together with interest, are made through payroll deductions. The amount of each principal repayment reduces the amount in your loan account and is invested, along with the interest you pay, in the Plan’s investment funds in accordance with your investment election for new Plan contributions.

The amount of your hardship loan may be prepaid in full at any time without penalty. Partial prepayments are not allowed.

If your employment terminates, any outstanding balance on your hardship loan will become due and payable. If it is not repaid within 31 days (or, if earlier, by the valuation date used to determine the amount of your distribution from the Plan), your vested account will be used to repay your loan.

If a hardship loan is not repaid in accordance with the terms of the promissory note and there is a default, the Plan may use your vested account to repay your loan. (However, amounts in your pay deferral account will not be used for this purpose until the time they could otherwise be distributed to you.)
Processing Charge
You may be charged a processing fee for the cost of processing your loan as well as an annual loan maintenance fee.

Hardship Withdrawals
If you have a “hardship,” you may be eligible to receive a hardship withdrawal from the Plan. Additional information on hardship withdrawals will be provided at the time you request a withdrawal application. A “hardship” has the same meaning as under the hardship loan rules—namely, an immediate and heavy need resulting from one of the following:

- Expenses for medical care for you, your spouse, or your dependents;
- Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
- Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents; or
- Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence.

You are not eligible for a hardship withdrawal unless you have received the maximum hardship loan available under the Plan (except to the extent that a hardship loan would increase the amount of your need).

Eligibility
To qualify for a hardship withdrawal, you must be an employee of the Company or an affiliate of the Company.

Hardship Proof and Certification
You must demonstrate that a hardship (as defined above) exists, and that your hardship cannot reasonably be relieved by any of the following actions (except to the extent those actions would increase the amount of your need):

- Reimbursement or compensation through insurance or otherwise
- Liquidation of your assets
- Discontinuing your pay deferrals
- Plan loans (or loans or distributions from other plans)
- Borrowing from commercial sources on reasonable commercial terms

Amount Available
The maximum amount you may receive as a hardship withdrawal is whichever of the following amounts is the smallest:

- The sum of the balances in your pay deferral account (excluding investment gains) and your rollover account
- The amount which you certify is necessary to relieve your hardship (including any amounts necessary to pay any Federal, state, or local income tax or penalties expected to result from the hardship withdrawal)

12-Month Suspension
If you receive a hardship withdrawal, your pay deferrals under the Plan and employee contributions under all other plans (including stock purchase, stock option, and similar plans) maintained by the Company will be suspended for a period of 12 months after the hardship withdrawal.

Frequency Limit
You may make only one hardship withdrawal during any 12-month period.

Annuity Waiver
To obtain a hardship withdrawal, you must waive the joint and survivor form of distribution for the amount to be withdrawn and, if you are married, obtain your spouse’s written consent (witnessed by a Plan representative or notary public) to the withdrawal.
Withdrawals After Age 59½
You may request a withdrawal of all or part of your pay deferral account at any time after you reach age 59½. To receive a single-sum cash withdrawal, you must waive the joint and survivor form of distribution for the withdrawn amount and, if you are married, obtain your spouse’s written consent (witnessed by a Plan representative or notary public) to the withdrawal.

Rollover Account Withdrawals
You may request a withdrawal of all or part of your rollover account at any time. To receive a single-sum cash withdrawal, you must waive the joint and survivor form of distribution for the withdrawn amount and, if you are married, obtain your spouse’s written consent (witnessed by a Plan representative or notary public) to the withdrawal.

Other Important Plan Information
The following describes additional information you should know about the Plan.

Top-Heavy Status of the Plan
Federal law imposes certain requirements on “top-heavy” plans. The Plan is top-heavy if more than 60% of the balance in all accounts belongs to certain officers and shareholders of the Company. The Plan is not top-heavy and is not likely to become top-heavy.

If the Plan is top-heavy at the end of the Plan Year, a minimum contribution may be required to the Plan. You will be notified if the Plan is top-heavy and this new requirement applies.

Distributions Under Qualified Domestic Relations Orders
Generally plan benefits may be paid only to you or possibly your beneficiaries or survivors. However, an exception to this may be made as a result of a qualified domestic relations order.

A domestic relations order is a court-ordered payment of benefits in connection with a support order, divorce, legal separation, or custody case. This means the Plan may be obligated to pay part of your account to someone else—for example, your former spouse, children or other dependents—to comply with such an order.

There are specific legal requirements a domestic relations order must meet to be recognized by the Plan Administrator. If you are affected by such an order, you will be notified by the Plan Administrator. You may obtain from the Plan Administrator, without charge, a copy of the procedures applicable to domestic relations orders.

Benefits Are Not Insured
The benefit provisions under the Plan are not covered by the Pension Benefit Guaranty Corporation insurance provisions, because the benefits are determined solely by the amount in your accounts.

Claims and Appeals
If you disagree about a benefit, the Plan allows you to file a written application for review of the issue with the Plan Administrator.

If a claim for benefits is denied in whole or in part, the Plan Administrator will give you written notice within 90 days after the Plan Administrator receives your claim, unless special circumstances outside the control of the Plan Administrator require an extension of the time limit. (The Plan Administrator will notify you of the need and reasons for any such extension, and the date by which the Plan expects to render a decision, before the end of the 90-day period.) The written notice will set forth:

- The specific reasons for denial of the claim;
- Reference to the particular provisions of the Plan on which denial of the claim is based;
- A statement as to any additional facts or information necessary to perfect the claim and an explanation as to why the same is required; and
- A reference to the procedures (described below) for review of the denial of the claim, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of a claim.

If your claim for benefits under the Plan is denied in whole or in part by the Plan Administrator, you have the right to request a review of such denial. The review will be granted upon written request, filed by you with the Plan Administrator within 60 days following receipt of written notice of the denial. A full and fair review will be conducted by the Company’s Retirement Plan Committee. You will be permitted to submit written comments, records and other information relating to the claim and provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other
information relevant to the claim. The Retirement Plan Committee will consider all comments, documents and other information you submitted, without regard to whether that information was submitted or considered in the initial determination.

At any hearing by the Retirement Plan Committee, you will have reasonable notice and an opportunity to be present and be heard in person or by a duly authorized representative. The Retirement Plan Committee will decide the matter with reasonable promptness and in any event within 60 days following receipt of a request for review unless special circumstances exist which require an extension of such time limit. The Retirement Plan Committee will notify you of the need and reasons for such extension, and the date by which the Plan expects to render a decision, prior to the end of the 60 day period. Its decision will be provided to you in writing and will set forth its reasons for the decision; the provisions of the Plan on which the decision is based; 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; and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The above appeal procedure applies not only to you but also to a beneficiary or other person who disagrees about a benefit.

If you wish to bring a civil action against the Plan following a denial of your claim on appeal, you must do so within one year of the Retirement Plan Committee’s final decision on your claim.

### Termination or Amendment of the Plan

Although the Company intends to continue the Plan from year to year, it reserves the right to amend or terminate the Plan at any time. However, because the Plan was established for the exclusive benefit of the Company's employees and their beneficiaries, termination or amendment cannot subtract from your accounts as they exist when the amendment or termination occurs.

If the Plan is terminated, you will have a 100% vested right to your accounts regardless of your years of vested service. After paying the expenses of terminating the Plan, the remaining amounts in the Plan will be distributed to you and the other participants in lump sum payments.

### Your Rights as a Participant

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

#### Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office, all documents governing the Plan (the Plan document and trust agreement), and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan (the Plan document and trust agreement), and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The Plan Administrator will make a reasonable charge for the copies.)

- Receive a summary of the Plan’s annual financial report (The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.)

#### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the 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 benefit under the Plan or exercising your rights under ERISA.

#### Enforce Your Rights

If your claim for a benefit under the Plan 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 (these rights are described in “Claims and Appeals” on page 145 of this summary plan description).

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 Plan 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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.

**Additional Information**

**Name of Plan**

Stryker Corporation 401(k) Savings and Retirement Plan

**Name, Address and Telephone Number of the Company**

Stryker Corporation  
2825 Airview Blvd.  
Kalamazoo, MI 49002  
269 389 2600

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**Company’s Identification Number**

38-1239739

**Plan Number**

002

**Type of Plan**

Section 401(k) Plan

**Type of Administration**

Self-Administered

**Plan Administrator**

Stryker Corporation is the Plan Administrator.

**Name and Address of Agent for Service of Legal Process**

Stryker Corporation  
2825 Airview Blvd.  
Kalamazoo, MI 49002

Service of legal process may also be made on the Plan Administrator or the Trustee.

**Name and Address of Trustee**

Vanguard Fiduciary Trust Company  
Vanguard Financial Center  
P.O. Box 2900  
Valley Forge, PA 19482

**Plan Year**

January 1 through December 31

**Names and Employer Identification Numbers of Participating Employers**

<table>
<thead>
<tr>
<th>Company</th>
<th>Emp. Id. No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stryker Corporation</td>
<td>38-1239739</td>
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<tr>
<td>Howmedica Osteonics Corp</td>
<td>22-2183590</td>
</tr>
<tr>
<td>Stryker Communications Inc.,</td>
<td>20-1962228</td>
</tr>
<tr>
<td>1410 Lakeside Parkway #100,</td>
<td></td>
</tr>
<tr>
<td>Flower Mound, TX 75028</td>
<td></td>
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<tr>
<td>Stryker Sales Corporation</td>
<td>38-2902424</td>
</tr>
<tr>
<td>2825 Airview Blvd.</td>
<td></td>
</tr>
<tr>
<td>Kalamazoo, MI 49002</td>
<td></td>
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<tr>
<td>Stryker Sustainability Solutions</td>
<td>86-0898793</td>
</tr>
<tr>
<td>1810 West Drake Drive</td>
<td></td>
</tr>
<tr>
<td>Tempe, AZ 85283</td>
<td></td>
</tr>
</tbody>
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Special Provisions Applicable to eTrauma Participants

The following special rules apply to you if you were employed by eTrauma.com Corp. ("eTrauma") at the time it became a Stryker company or are a former participant in the eTrauma.com Corp. 401(k) Retirement Plan (the "eTrauma Plan") whose account balance was transferred to the Plan as of September 30, 2005.

Prior Eligibility Service Credit

You will be credited for eligibility purposes of the Plan with your service with eTrauma, including service credited to you under the eTrauma Plan, as if you had been an employee of the Company when that service was performed.

Accounts

You will have the following additional account in the Plan:

- **eTrauma Matching Contribution Account.**
  A separate account reflecting your matching contributions to the eTrauma Plan through September 30, 2005 and any other amounts allocable to or chargeable to that account. This account will be subject to the vesting rules described in “Vesting” on page 137.

Total Disability

You will be considered to have suffered a total disability for purposes of the Plan if your condition meets either the Plan’s definition of “total disability” (see “Vesting” on page 137) or the following definition of “disability” (which is based on the eTrauma Plan).

- “Disability” means that the Participant is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

In-Service Withdrawals

In addition your other withdrawal rights under the Plan, you have the following in-service withdrawal rights:

- **Withdrawals After Age 59½.** You may request a withdrawal of all or a portion of your eTrauma Matching Contribution Account at any time after you have attained age 59½.

Special Provision Applicable to PlasmaSol Participants

The following special rule applies to you if you were employed by PlasmaSol Corp. ("PlasmaSol") at the time it became a Stryker company.

Prior Service Credit

You will be credited for all purposes of the Plan with your service with PlasmaSol as if you had been an employee of the Company when that service was performed.

Special Provision Applicable to Porex Surgical, Inc. Participants

The following special rule applies to you if you were employed by Porex Surgical, Inc. or its affiliate ("Porex") and you became an employee of the Company upon Stryker’s acquisition of Porex.

Prior Service Credit

You will be credited for all purposes of the Plan with your service with Porex as if you had been an employee of the Company when that service was performed.

Special Provision Applicable to Boston Scientific Corporation Participants

The following special rule applies to you if you were employed by Boston Scientific Corporation or its affiliate ("Boston Scientific") and you became an employee of the Company upon Stryker’s acquisition of Boston’s neurovascular unit.

Prior Service Credit

You will be credited for all purposes of the Plan with your service with Boston Scientific as if you had been an employee of the Company when that service was performed.
**Special Provision Applicable to Gaymar Industries, Inc. Participants**

The following special rule applies to you if you were employed by Gaymar Industries, Inc. ("Gaymar") at the time it became a Stryker company.

**Prior Service Credit**

You will be credited for all purposes of the Plan with your service with Gaymar as if you had been an employee of the Company when that service was performed.

**Special Provisions Applicable to Divested Biotech Participants**

The following special rules apply to you if you were employed by Stryker Biotech L.L.C. and ceased to be an employee as a result of the sale of the OP-1 portion of Stryker Biotech L.L.C. (the “OP-1 Divestiture”) on the date of the OP-1 Divestiture.

**Waiver of Certain Contribution Eligibility Requirements**

You will be deemed to have satisfied the Plan’s eligibility requirements to receive a matching contribution for the 2010 Plan Year.

**Full Vesting**

Your matching contribution account will be fully vested and nonforfeitable as of the date you ceased to be an employee.

**Acquisitions After September 30, 2012**

If you were employed on the acquisition date by a company that Stryker acquires after September 30, 2012, and as a consequence become employed by Stryker at that time, you will be credited for all purposes of the Plan with your service with that acquired company as if you had been an employee of the Company when that service was performed.
Additional Benefits

In addition to the healthcare, flexible spending account and retirement benefits described elsewhere in this Benefits Summary, Stryker offers the following additional benefits to eligible employees:

- Adoption Assistance Plan
- Employee Assistance Program

Adoption Assistance Plan

Stryker's Adoption Assistance Plan reimburses you for legal fees and certain other costs associated with adopting a child.

How Adoption Assistance Benefits Work

The plan reimburses you—up to $5,000 per adoption—for necessary fees and expenses related to the legal adoption of an eligible child. The plan defines an eligible child as an individual who is either:

- A child under the age of 18
- Any disabled person who is unable to care for himself/herself due to a physical or mental disability

Eligibility

You are eligible for adoption assistance benefits on your date of hire if you are a full-time employee regularly scheduled to work at least 40 hours each week, or you are a part-time employee regularly scheduled to work at least 20 hours each week.

Eligible Expenses

Eligible expenses include:

- Court costs
- Attorney fees
- Adoption agency fees
- Charges for immigration services, including immunizations and translation fees

Eligible expenses must meet all of the following requirements:

- They are directly related to your legal adoption of an eligible child.
- They are incurred after you become eligible for adoption assistance benefits.
- They are filed while you are employed by the Company.

Benefit Maximums

The maximum plan reimbursement is $5,000 per adoption. The plan pays benefits for up to two adoptions per employee per lifetime. If you are attempting two adoptions at the same time, you must provide adequate documentation of both adoption attempts in order to qualify for benefits in excess of $5,000. If you are married to another Stryker employee and are seeking to adopt a child, the two of you are subject to the same dollar and lifetime maximum benefits as an individual employee.

Special Tax Treatment

All amounts paid by the Adoption Assistance Plan are subject to Social Security and Medicare taxes (FICA) as well as federal unemployment tax (FUTA). Federal and state income taxes are also withheld from adoption assistance benefit payments.

Under current tax law, and depending on your circumstances, adoption assistance benefits may qualify for federal income tax exclusion. You may also be able to claim an adoption tax credit on your federal income tax return for any adoption expenses you incur in excess of $5,000. You should consult a tax advisor to determine the ultimate taxation of the benefits paid to you under this plan.
Expenses Not Covered

The Adoption Assistance Plan does not provide reimbursement for the following:

- Expenses related to a surrogate parenting arrangement
- Expenses incurred in violation of a federal or state law
- Expenses that have been reimbursed through another plan or any state, local or federal program
- Expenses incurred in connection with travel
- Expenses incurred in connection with the adoption of your spouse’s child
- Expenses incurred and/or filed for reimbursement before you were eligible for adoption assistance benefits
- Expenses incurred and/or filed for reimbursement after your employment terminates
- Expenses that you claim as a credit or deduction on your federal income tax

Claim forms for adoption assistance benefits are available from your Benefits Representative.

How to Obtain Adoption Assistance Benefits

During the adoption process, be sure to keep itemized receipts for all of the expenses you incur. File your claim only after the adoption is final and you have incurred all of your expenses. Complete a claim form, attach all of the itemized receipts and submit the claim to your Benefits Representative.

Your claim must be submitted before December 1 of the year following the year in which adoption expenses were incurred. For example, you have until December 1, 2015 to file a claim for expenses incurred at any time in 2014.

In most cases, your claim will be paid within 60 days or less. The total approved reimbursement amount will be added to your paycheck, less applicable FICA, FUTA and income taxes.

Employee Assistance Program (Lifeworks)

Stryker’s Employee Assistance Program provides you and members of your household with professional confidential help in dealing with everyday issues. The program is administered by Ceridian LifeWorks Services.

Services include:

- Professional confidential counseling, customized searches and referrals for life or family problems, work problems or emotional or substance abuse disorders
- Up to three short-term counseling sessions (per issue or problem) available to you and members of your household at no cost
- Child care and elder care research and referral services for day care, home care, special schools or camps
- College search service provides detailed information regarding hundreds of colleges and universities
- Specially designed financial calculators help you plan for retirement, figure out how much you can afford to pay for a house, estimate how long it will take to pay off credit card debt and much more

You and members of your household are eligible for LifeWorks services on your date of hire. Enrollment in Stryker’s medical plan is not required. The issues you bring to Ceridian LifeWorks Services are held in strict confidence and are not shared with anyone at Stryker.

All LifeWorks services are available by calling 888 267 8126 seven days a week, 24 hours per day. You also can log on to www.lifeworks.com (Company name: Stryker; password: 4260).
Your Rights and Responsibilities

This Benefits Summary is the summary plan description (SPD), effective January 1, 2014, for:

- The Stryker Corporation Welfare Benefits Plan (which includes Stryker’s medical, prescription drug, dental, vision, life insurance, disability and flexible spending accounts plans)
- The Stryker Adoption Assistance Plan
- The 401(k) Savings and Retirement Plans

These plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

This section contains legal and administrative information for the healthcare, welfare and adoption assistance plans described in this Benefits Summary, which you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if, for example, you want to know:

- How to contact the plan sponsor and administrator
- Time limits that apply to filing and appealing claims
- Your rights under ERISA

Important Note

For the healthcare, welfare and adoption assistance plan benefits, the applicable sections of this Benefits Summary describing each benefit, along with this Your Rights and Responsibilities section and applicable vendor contracts or certificates of coverage together constitute the SPD for that benefit.

The 401(k) Savings and Retirement Plan that applies to you is described in its entirety (including administrative details governing that plan) within the 401(k) Retirement Plans section, with that section constituting the SPD for that plan. See the 401(k) Retirement Plans section for all details about your 401(k) plan.

The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any “qualifying exigency” arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a “single 12-month period” to care for a covered service member with a serious injury or illness.

To be eligible for an FMLA leave, you must have worked 1,250 hours of active work during the 12 consecutive month period before your leave is scheduled to begin. Any paid or unpaid leave time taken during the year is counted against your annual FMLA allowance. You must provide 30 days notice when the need for an FMLA leave is foreseeable. When the need for a leave comes up unexpectedly, you must provide as much advance notice as possible. Medical certification regarding your or a family member’s serious health condition may be required.
While you are away from work on an FMLA leave, your coverage under the Stryker Corporation Welfare Benefits Plan will continue for the duration of your approved leave period. You must make arrangements to pay required healthcare benefit contributions on a regular basis while you are away from work.

If your coverage contributions have not been paid for 30 days, your health coverage may be canceled. You will be notified of a potential coverage cancellation. If Stryker elects to pay your contributions while you are on leave, you will reimburse the Company through payroll deduction when you return to work. If you do not return to work, you must repay the Company for the cost of Company-paid health coverage provided during your leave, unless you are not able to return to work due to the continuation, recurrence or onset of a serious health condition, or other circumstances beyond your control.

If you return to work when your leave ends, Stryker must restore you to your former position or an equal position with equal pay, benefits and terms and conditions of employment.

For full details on FMLA provisions in your state and how they affect your coverage under the plan, contact your Benefits Representative.

Qualified Medical Child Support Orders

You may be required to enroll your child for coverage in the healthcare plan in accordance with the terms of a qualified medical child support order (QMCSO), even if you have not previously enrolled the child for coverage. If the plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, Stryker may withhold any contributions required for such coverage.

A QMCSO is a judgment, decree or order issued by a court or an authorized government agency that:

- Provides for child support and/or health benefit coverage for your child
- Is made according to a state domestic relations law that relates to group health benefits under the Stryker Corporation Welfare Benefits Plan; or enforces a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act

- Creates or recognizes the existence of the child’s right to receive the healthcare benefits for which you are eligible under the Stryker Corporation Welfare Benefits Plan
- Meets the following requirements:
  - Clearly specifies your name and last known mailing address and the name and mailing address of each child covered by the order
  - Clearly specifies a reasonable description of the type of coverage to be provided to each child
  - Does not require the Stryker Corporation Welfare Benefit Plan to provide any type or form of benefit or any option not otherwise provided, except to the extent necessary to meet requirements relating to medical child support described in Section 1396g of Title XIX of the Social Security Act

Coverage for a child who is eligible under a QMCSO becomes effective on the latest of the following dates:

- The first day of the month specified in the order
- The first day of the month following the date the plan administrator determines that the order is qualified
- The effective date of a court order requiring Stryker to withhold coverage contributions for dependent health coverage from your earnings

Coverage for a child who is eligible under a QMCSO ends on the earliest of the following:

- The date, if any, specified in the order as the last day of coverage
- The day prior to the covered child’s 26th birthday
- The date the covered child otherwise ceases to qualify as a dependent under the plan

If the plan administrator receives a judgment, decree or order that relates to the provision of healthcare benefits for your child, the plan administrator will notify you, the child’s custodial parent and/or the appropriate governmental agency of the plan’s procedures for determining whether the judgment, decree or order is “qualified.” You can obtain, without charge, a copy of the procedures from the plan administrator. Within a reasonable period of time, the plan administrator will determine whether the order is a qualified medical child support order. You and the child’s custodial parent or representative will be notified of the decision.
**Patient Protection Notices**

The claims administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the claims administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the claims administrator for your medical plan at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the claims administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the claims administrator’s network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the claims administrator at the number on the back of your ID card.

**Time Limits for Claims Filings**

**Medical and Dental Claims**

Claims related to a period of illness or treatment of an injury must be filed within one year of the date you first become ill or injured and require covered medical or dental services. All other claims must be filed within one year of the date covered charges were incurred. If you are not able to meet this claim-filing deadline through no fault of your own, your claim will be accepted if you file the claim as soon as possible. Unless you are legally incapacitated, claims will not be accepted if they are filed more than two years after the claim-filing deadline.

**Prescription Drug Claims**

Claims must be filed within one year following the date the prescription is filled.

**Vision Claims**

Claims must be filed within one year following the date covered services or materials are provided.

**Flexible Spending Accounts Claims**

Claims must be received by March 31st following the end of the plan year during which you participated in the FSA and incurred eligible expenses.

**Adoption Assistance Claims**

Claims must be filed by December 1 of the year following the year in which eligible adoption expenses were incurred.

**Legal Action**

If legal action is to be brought against the plans, it must be done no later than one year from the date a claim is required.

**Subrogation and Reimbursement**

**What This Section Includes**

How your benefits are impacted if you suffer a sickness or injury caused by a third party.  
The Plan has a right to subrogation and reimbursement, as defined below.

**Right of Recovery**

The Plan has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error
- Due to a mistake in fact
- Advanced during the time period of meeting the calendar year deductible
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested, or
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.
If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan

**Right to Subrogation**

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

**Right to Reimbursement**

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

**Third Parties**

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages
- Stryker in workers’ compensation cases

- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise)
  - Workers’ compensation coverage
  - Any other insurance carrier or third party administrator

**Subrogation and Reimbursement Provisions**

As a covered person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.

- The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys’ fees. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No “collateral source” rule shall limit the Plan’s subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.
You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- Complying with the terms of this section
- Providing any relevant information requested
- Signing and/or delivering documents at its request
- Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable
- Responding to requests for information about any accident or injuries
- Appearing at medical examinations and legal proceedings, such as depositions or hearings
- Obtaining the Plan’s consent before releasing any party from liability or payment of medical expenses

If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney’s trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

If the Plan incurs attorneys’ fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

Upon the Plan’s request, you will assign to the Plan all rights of recovery against third parties to the extent of benefits the Plan has provided for a sickness or injury caused by a third party.

The Plan’s rights will not be reduced due to your own negligence.

The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.

The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor’s sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

If a third party causes you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a covered person.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Assignment of Benefits

When completing a healthcare claim form, you may choose to have payment made directly to the provider. To do so, complete the “Assignment” section of the claim form. If you do not want payment made directly to the provider, leave this section of the form blank and any payment due will be sent to you.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those benefits.
Incorrect Claim Payments

If a claim is not paid correctly for any reason, an adjustment will be made. For instance, if a claim is underpaid, the additional benefit amount will be paid directly to you or the provider of service. If a claim is overpaid, the claims administrator has the right to recover the overpayment amount from you. Overpayments may be repaid directly to the claim administrator or deducted from future benefit payments.

Other Information

Name of Plans

- Stryker Corporation Welfare Benefits Plan
- Stryker Adoption Assistance Plan
- Stryker Corporation 401(k) Savings and Retirement Plan

Note

The remaining portion of this section pertains to the Stryker Corporation Welfare Benefits Plan and the Stryker Corporation Adoption Assistance Plan. All information in this SPD concerning the 401(k) Savings and Retirement Plans is set forth in the 401(k) Retirement Plans section.

Types of Plans

The Stryker Corporation Welfare Benefits Plan is an employee benefit welfare plan as defined by ERISA. The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental, vision, flexible spending accounts and employee assistance benefits which are further described in this summary plan description. In addition, the Stryker Corporation Welfare Benefits Plan provides life and Accidental Death and Dismemberment (AD&D) insurance and short-term and long-term disability insurance benefits through insurance policies. Those benefits are described briefly in this summary plan description. Employees participating in those benefits will receive a certificate of coverage from the insurer describing those fully insured benefits. The Stryker Adoption Assistance Plan is a fringe benefit plan under the Internal Revenue Code and is not subject to ERISA.

Plan Documents

This summary plan description is intended to give a simple explanation of the following components of the Stryker Corporation Welfare Benefits Plan: the UnitedHealthcare PPO, Out-of-Area and prescription drug plans; the Delta Dental plan; the EyeMed vision plan; flexible spending accounts; and the employee assistance benefit. HMO plans, as well as life and AD&D insurance and short-term and long-term disability insurance are described briefly here and detailed in separate documents. The booklet also explains the Stryker Adoption Assistance Plan. Note that the plans are set out and operate under the terms of plan documents and related contracts. If there is any conflict between this booklet and the plan documents and contracts, the plan documents and contracts will govern.

You or your beneficiary may examine any or all plan documents at the principal office of the plan administrator or available from your Benefits Representative. Upon written request to the plan administrator, a copy of a plan document will be sent to any participant or beneficiary.

Future of the Plans

Stryker Corporation presently intends to continue these plans for employees. However, Stryker Corporation has the right to amend or terminate the plans at any time. If the plans were terminated, the rights of covered persons to benefits are limited to claims incurred and due up to the date of termination. The benefits under these plans are not vested.

Plan Administrator

These benefit plans are sponsored and administered by Stryker Corporation (also referred to as Stryker or the Company). Stryker Corporation has appointed people who are responsible for the plans’ day-to-day operations. You may contact the plan administrator at:

Stryker
Attention: Corporate Benefits
2825 Airview Boulevard
Kalamazoo, MI 49002
269 389 2600
Agent for Service of Legal Process

If legal papers are to be served concerning any aspect of the plans, the designated agent is Stryker’s General Counsel at:

Stryker Attention: General Counsel
2825 Airview Boulevard
Kalamazoo, MI 49002
269 389 2600

Plan Year

The plan year for the Stryker Corporation Welfare Benefits Plan and Adoption Assistance Plan begins on January 1 and ends on December 31 each year.

Identification

The plans cover eligible employees of Stryker Corporation, the plan sponsor and plan administrator, as well as eligible employees of its participating subsidiaries. The IRS has assigned the following employer ID numbers for the Company and its participating subsidiaries:

- Stryker Corporation 38-1239739
- Stryker Sales Corporation 38-2902424
- Howmedica Osteonics Corp 22-2183590
- Stryker Communications Inc. 20-1962228
- Stryker Biotech LLC 20-0470801
- Stryker Sustainability Solutions 86-0898793
- Medicycle 20-5001951
- Stryker Performance Solutions LLT 46-1634423

Stryker must use these numbers when corresponding with the IRS and the U.S. Department of Labor on any matters related to any of its employee benefit plans. By law, Stryker must also assign plan numbers to each of its ERISA plans. The plan number for the Stryker Corporation Welfare Benefits Plan is 501. When referring to this plan in claim appeals or other correspondence, you will receive help more quickly if you identify it fully and accurately. Use the full plan name and number.

Funding

The Stryker Corporation Welfare Benefits Plan is funded directly by Stryker from its general assets and with employee contributions. Benefits are not insured. UnitedHealthcare, Delta Dental and EyeMed perform claim administrative functions only.

HMO plans and Blue Cross Blue Shield plans offered to employees in Alabama, California, Connecticut, Hawaii, Maine, Massachusetts, New Hampshire, Vermont and Rhode Island are fully insured.

Flexible spending accounts are funded by employee contributions made through before-tax salary deductions. Flexible spending accounts are not insured. Stryker pays benefits from its general assets. UnitedHealthcare performs claim administrative functions only.

Basic Life and Accidental Death and Dismemberment (AD&D) coverage for employees is funded directly by Stryker from its general assets. Supplemental and dependent life insurance coverage for are funded entirely by employee contributions made through after-tax salary deductions. Life and accident coverage is not insured.

The Adoption Assistance Plan is funded directly by Stryker from its general assets. The plan is not insured.

Examinations

Through its claims administrators, Stryker will have the right and opportunity to examine any person when and so often as it may reasonably require while a healthcare claim is pending.

Adjustment Rule

Stryker may change the level of benefits provided under the plans at any time. If a change is made, benefits for claims incurred after the date the adjustment takes effect will be paid according to the revised plan provisions. In other words, once an adjustment is made, there are no vested rights to benefits based on earlier plan provisions.

Notice About HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of your privacy rights is found in the Notice of Privacy Practices that has been distributed to you.

The plan and those administering it will use and disclose health information only as allowed by law. If you have a complaint, questions, concerns or need a copy of the Notice of Privacy Practices, you may contact:

HIPAA Privacy Officer
Stryker
2825 Airview Boulevard
Kalamazoo, MI 49002
Your Rights and Responsibilities

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to the benefits subject to ERISA. All benefits under the Stryker Corporation Welfare Benefits Plan are subject to ERISA with the exception of the day care (child and adult) flexible spending account. The Adoption Assistant Plan is also not subject to ERISA.

ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and copies of all documents filed by the plan, 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.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The administrator may make a reasonable charge for the copies.)

- Receive a summary of the plan’s annual financial report (The plan administrator is required by law to furnish each participant with a copy of this summary annual report.)

**Continue Group Health Plan Coverage**

In addition, if you are a participant in a group health plan, you have the right to:

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying life event. You or your dependents will have to pay for such coverage (Review this summary plan description and the documents governing the plan for information regarding your COBRA continuation coverage rights.)

- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer—when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases and you may request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the summary plan description. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**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 plans. The people who operate your plans, called “plan fiduciaries,” have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer 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.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 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.
# Contacts

This section gives you telephone numbers, web site addresses and other important information about your benefits.

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<tr>
<th>For Information About</th>
<th>Use These Resources</th>
<th>Important Details</th>
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<tr>
<td><strong>Participating UnitedHealthcare PPO plan providers</strong></td>
<td>800 387 7508; follow prompts Customer service hours: Monday - Friday, 8am - 8pm ET <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>Registration is not required to view this site. Network – Choice Plus</td>
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<tr>
<td><strong>UnitedHealthcare PPO and Out-of-Area plans</strong></td>
<td>800 387 7508; follow prompts Customer service hours: Monday - Friday, 8am - 8pm ET <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>You must register on the <a href="http://www.myuhc.com">www.myuhc.com</a> web site in order to access your claim status and eligibility information. To register, go to <a href="http://www.myuhc.com">www.myuhc.com</a> and click on Register Now.</td>
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<tr>
<td><strong>UnitedHealthcare special services</strong></td>
<td>MyNurseLine: 888 206 1623 Customer service hours: 7 days a week, 24 hours a day <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>Click on Look Up Health Topics or Live Nurse Chat.</td>
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<tr>
<td><strong>Participating UnitedHealthcare OptumRx pharmacies</strong></td>
<td>800 387 7508; follow prompts Customer service hours: Monday - Friday, 8am - 8pm ET <a href="http://www.myuhc.com">www.myuhc.com</a></td>
<td>You must register on the <a href="http://www.myuhc.com">www.myuhc.com</a> web site to access the pharmacy locator service.</td>
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<tr>
<td><strong>Blue Cross Blue Shield of Alabama</strong></td>
<td>800 292 8868 Customer service hours: Monday - Friday, 8:30am - 7pm ET <a href="http://www.bcbsal.com">www.bcbsal.com</a></td>
<td></td>
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<tr>
<td><strong>Kaiser Permanente - California</strong></td>
<td>800 464 4000 Customer service hours: 7 days a week, 7am - 7pm PT <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
<td>Kaiser HMO includes prescription drug coverage.</td>
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<tr>
<td><strong>Kaiser Permanente – Hawaii</strong></td>
<td>808 432 5955 (Oahu), 800 966 5955 (Neighbor Islands) Customer service hours: Monday - Friday, 8am - 5pm PT, Saturday 8am – noon <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
<td>Kaiser HMO includes prescription drug coverage.</td>
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<td><strong>Cigna International</strong></td>
<td><strong>800 441 2668 (US/Canada), 302 797 3100 (call collect)</strong>&lt;br&gt;<strong><a href="http://www.cignaenvoy.com">www.cignaenvoy.com</a></strong></td>
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<td><strong>Delta Dental</strong></td>
<td><strong>800 524 0149</strong>&lt;br&gt;Customer service hours: Monday - Friday, 8:30am - 7:50pm ET&lt;br&gt;<strong><a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a></strong></td>
<td>Registration not required to view this site.</td>
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<td><strong>EyeMed Vision Care</strong></td>
<td><strong>866 939 3633</strong>&lt;br&gt;Customer service hours: Monday - Saturday, 8am - 11pm; Sunday, 11am - 8pm ET&lt;br&gt;<strong><a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a></strong> or&lt;br&gt;<strong><a href="http://www.eyemedcontacts.com">www.eyemedcontacts.com</a></strong></td>
<td>Web site registration required. To locate participating providers, log on to&lt;br&gt;<strong><a href="http://www.enrollwitheyemed.com">www.enrollwitheyemed.com</a></strong>.</td>
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<td><strong>UnitedHealthcare Flexible Spending Accounts</strong></td>
<td><strong>800 387 7508</strong>; follow prompts&lt;br&gt;Customer service hours: Monday - Friday, 8am - 8pm ET&lt;br&gt;<strong><a href="http://www.myuhc.com">www.myuhc.com</a></strong></td>
<td>Web site registration and group number 703998 required.</td>
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<tr>
<td><strong>The Hartford Life and Accident Insurance Company</strong></td>
<td><strong>888 563 1124</strong>; follow prompts&lt;br&gt;Customer service hours: Monday - Friday, 8am - 8pm ET</td>
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<tr>
<td><strong>The Hartford Life and Accident Insurance Company</strong></td>
<td><strong>800 741 4306</strong>; follow prompts&lt;br&gt;Customer service hours: Monday - Friday, 8am - 8pm ET</td>
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<tr>
<td><strong>LifeWorks</strong></td>
<td><strong>888 267 8126</strong>&lt;br&gt;Customer service hours: 24 hours a day, seven days a week&lt;br&gt;<strong><a href="http://www.lifeworks.com">www.lifeworks.com</a></strong></td>
<td>User name: Stryker&lt;br&gt;Password: 4260</td>
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<tr>
<td><strong>401(k) Savings and Retirement Plan</strong></td>
<td><strong>800 523 1188</strong>&lt;br&gt;Customer service hours: Monday - Friday, 8:30am - 9pm ET&lt;br&gt;<strong><a href="http://www.vanguard.com">www.vanguard.com</a></strong></td>
<td>Web site registration and group number required.&lt;br&gt;Group Number: 090081</td>
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