Stryker Corporation

Health Center

For Employees of Sage, Inc.

SUMMARY PLAN DESCRIPTION

Effective January 1,2018

Contents

INTRODUCTION

This summary is intended to serve as the Summary Plan Description ("SPD"), as required by the Employee Retirement Income Security Act of 1974 ("ERISA") for the Health Center located in Cary, Illinois and operated for Stryker Corporation employees formerly employed by Sage, Inc.

Stryker Corporation reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, Stryker Corporation has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by the Stryker Corporation or to interfere with Stryker Corporation's right to discharge any employee at any time.

ELIGIBILITY

WHO CAN USE THE HEALTH CENTER?

The Health Center will be open to all Stryker Corporation employees located at or near Cary, Illinois.

You are not eligible to participate in the Plan if you are hired as a seasonal employee or an independent contractor. A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

The following family members are eligible to use the Health Center:

- Your legally married spouse;
- Your domestic or civil union partner if your partnership is established under applicable state law;
- Your or your domestic or civil union partner's: biological children, stepchildren, legally adopted children, children placed with you for adoption and children for whom you are legal guardian who are under age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO); and
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26. Any adult child of your civil union partner who satisfies this definition will also be eligible.

ELIGIBILITY: WHO CAN USE THE HEALTH CENTER				
	Choice PPO **Value PPO**	**Premium HSA** **Basic HSA**	**Other Insurance Coverage**	**No Insurance**
Employee	Eligible	Eligible	Eligible	Eligible
Dependents	Eligible	Eligible	Eligible	Eligible

TAX CONSEQUENCES OF DOMESTIC AND CIVIL UNION PARTNER BENEFITS

Unless your domestic or civil union partner or his or her dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes as described below, the Internal Revenue Service currently treats as imputed income to you the value of the coverage provided for your domestic or civil union partner and his or her dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage. In general, a domestic or civil union partner (or his or her child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to consult with your tax advisor to determine if your domestic or civil union partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic or civil union partner benefit coverage. In general, state income tax treatment of domestic or civil union partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic or civil union partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic or civil union partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must notify Stryker Corporation immediately in writing of this special state income tax status.

ENROLLMENT

You do not need to enroll in order to use the Health Center.

HEALTH CENTER BENEFITS

WHY SHOULD I GO TO THE HEALTH CENTER?

The Health Center is a convenient place for you to receive preventive and sick (acute) care as well as health coaching and condition management. There are several benefits for using the Health Center:

- Time: Little or no waiting – most appointments are complete in about 20 minutes, unless your appointment is for a Comprehensive Health Review.
- Cost for PPO participants: If you are not making or receiving contributions to an HSA, there is no cost to use the Health Center services. The only time you may have to pay for something is if the Health Center writes you a prescription that is not fillable by the Center and you have to take it to a pharmacy to have it filled.
- Cost for HSA participants: If you are making or receiving contributions to your HSA, only preventive services are provided free of charge. The Health Center must charge fair market value for all other services and prescriptions; please see the Center's staff for additional information.
- Cost for uninsured Employees: If you are not insured or are insured through another employer's health plan, the cost to use the Health Center services is $20 per visit.

- Convenience: Fast access to care for diagnosis and treatment of illness or injury.
- Efficiency: No need to drive long distances for an appointment or common lab tests and prescriptions.

WHO WILL OPERATE THE HEALTH CENTER AT STRYKER CORPORATION?

IU Health is our onsite health center partner, dedicated to bringing quality health services to employees and their families at the workplace by providing medical care, guidance to help better understand health risks and conditions, and support to help people manage their health.

WHERE WILL THE HEALTH CENTER BE LOCATED?

There is one Health Center, located at the former Sage location in Cary, Illinois. Individuals may be referred to the Pres Physical Therapy facility onsite in Cary or at the Bartlett, Illinois location.

WHAT HOURS WILL THE HEALTH CENTER BE OPEN?

The Cary, Illinois Clinic is open Monday, Tuesday, and Thursday from 7 a.m. to 5 p.m.; Wednesday from 9 a.m. to 7 p.m.; and every first and third Saturday from 8 a.m. to 12 p.m.

HEALTH CENTER STAFF

Who will I see when I visit the Health Center? Is there a physician on the staff?

The Health Center managed by IU Health will be staffed by a licensed family nurse practitioner who is trained in primary care, health coaching, and managing chronic diseases. The family nurse practitioner operates under the guidance and supervision of a practicing physician. The Center staff will also include a medical assistant to help you schedule appointments, access the eHealth Portal, and to answer any questions you may have about the Center or the services you receive.

The Health Center managed by Pres Physical Therapy is staffed by two Physical Therapists, one Occupational Therapist, a Massage Therapist and two technicians. The staff managed by Pres Physical therapy are licensed and trained in physical therapy and/or occupational health.

What is a family nurse practitioner?

A family nurse practitioner, sometimes known as an advance practice nurse, is a registered nurse (RN) who has additional training and education in a specialty area. Nurse practitioners have a master's degree in nursing (MS or MSN) and board certification in their specialty. Licensed as nurse practitioners and registered nurses, FNPs follow all the rules and regulations of the Nurse Practice Act of our state. Some nurse practitioners seek accreditation through a national board exam process to earn additional credentials, such as Certified Family Nurse Practitioners (CFNPs). The duties of an FNP typically include, but are in no way limited to, the following:

- Diagnosing and treating acute illnesses, infections, and injuries.
- Diagnosing, treating and monitoring chronic diseases such as diabetes and high blood pressure.
- Obtaining medical histories and conducting physical examinations.
- Prescribing medications.
- Prescribing physical therapy and other rehabilitation treatments.
- Providing health maintenance care for adults, including annual physicals.
- Collaborating with physicians and other providers as needed, including providing referrals.
- Collaborate with Health Coach (RN) to provide comprehensive health reviews and health coaching.

- Counseling and educating patients on health behaviors, self-care skills, and treatment options.

PATIENT SERVICES

What services are available for me at the Clinic?

Services available:

- **Care:** Primary care, urgent care, wellness services, prevention services, audiogram, physical therapy and lab services, including as ordered by outside providers.
- **Assessments**: health screening for cholesterol, blood pressure, glucose levels, height, weight, and Body Mass Index (BMI).
- **Coaching:** for personal health issues or concerns including weight loss, stress management, tobacco cessation, physical activity.
- **Disease Management:** for diabetes, heart problems, high blood pressure, high cholesterol, and low back pain.

Can someone at the Health Center help me manage my ongoing medical conditions such as diabetes or heart disease?

There are many conditions that can be managed by the clinical staff, including diabetes, COPD, asthma, congestive heart failure, coronary heart disease, hypertension, and low back pain. The clinical team will be careful to coordinate care for patients with chronic conditions who are being actively managed by their primary care provider or specialist.

Does this mean I can't use my family doctor anymore?

Not at all. You may designate the Onsite Clinic as your primary care physician, but you are not required to do so. If you do not, using the Health Center will not impact your relationship with your current primary care physician. In fact, it may strengthen that relationship. The staff at the Clinic can help you make the best use of your doctor's time and can help you better understand the care you receive. Many services may be provided in their entirety at the Clinic, perhaps alleviating the need to see your primary care physician as often. Our staff will act as partners in your health care and will help ensure that the appropriate care is delivered.

Should I drop my health insurance because I will have access to the Health Center?

No. You should carefully weigh your health care needs against the value that any outside insurance and Stryker-offered insurance can bring to you before making decisions about which coverage to elect or whether to drop your existing coverage.

Remember, the Health Center is not designed to provide specialized medical care, emergency care, hospitalization or comprehensive lab and pharmacy services, which are important parts of any health insurance plan.

Can workplace injuries be treated at the Health Center?

During the Clinic's open hours, employees can be treated for minor workplace injuries. There will be no charge for those services. Physical therapy can be performed at the Health Center; however, there is a $40 per visit charge for those services if you are an HSA participant.

Can the Health Center provide me with a return to work release for a workplace injury?

No, the Health Center is unable to provide a return to work release for a workplace injury at this time.

Can I receive FMLA or disability certifications from the Health Center?

No, the Health Center is unable to provide FMLA certifications or disability certifications.

PRESCRIPTIONS & LAB SERVICES

What medications will be dispensed at the Health Center?

The family nurse practitioner at the Health Center is available to prescribe and, in some cases, dispense medications for conditions treated there.

The provider at the Health Center will help you manage chronic conditions including allergies, asthma, back pain, chronic kidney disease, heart and lung diseases, diabetes, GERD, high blood pressure, irritable bowel syndrome, migraines, metabolic syndrome, obesity, osteopenia and peptic ulcer disease. Some maintenance medications associated with these chronic conditions will be available onsite. Additional medications include antibiotics, antifungals, antivirals, topical creams, non-narcotic pain relievers and tobacco cessation drugs. Controlled substances, such as narcotics, will not be available onsite at the Health Center.

It is important to understand that it will probably be more cost effective for you to fill a longer term prescription through a local or mail order pharmacy.

For medications not dispensed onsite, IU Health clinicians electronically prescribe your medication to a pharmacy of your choice. Their e-prescribe application provides a drug utilization review (DUR) checking for proper medication dosage, allergy/adverse reactions, duplicative medications and drug interactions. Patients will be able to pick up their medications upon arrival at the pharmacy, reducing the time spent waiting.

Can prescriptions issued through the Health Center be refilled there?

In most cases, prescriptions from the Health Center will not be able to be refilled. Prescriptions for treatment of chronic conditions will require follow-up with a non-Center provider or specialist who will write a refillable prescription for you to fill at a local or mail order pharmacy.

Can I fill a prescription from a doctor outside the Health Center?

Yes. Prescriptions written by a doctor outside the Health Center can be filled at the Health Center. However, the Health Center pharmacy maintains only a limited supply of a given drug.

If I need a lab test, can I have it done at the Health Center?

Yes, lab tests, whether ordered by your physician or the clinician at the Health Center, can be done there. There are two types of lab services offered at the Health Center:

- Lab tests that can be processed onsite at the Health Center.
- Lab tests that can be performed at the Health Center but need to be sent to a lab for processing.

The Health Center's clinicians can perform and order lab tests for conditions treated there. You may also bring in lab prescriptions from your physician to be performed at the Health Center. If a test is ordered by your physician, the results will be forwarded to your physician. The results of the tests will be discussed with you and recorded in your Personal Health Record (PHR).

What lab tests are available at the Health Center?

The following tests are available:

Tests Processed at the Clinic	Tests Processed Offsite
Rapid Strep	
Urine HCG	
Dipstick Urinalysis	
Fingerstick Glucose	
Hemocult Slides	

CONFIDENTIALITY & MEDICAL RECORDS

Will I still have access to my health record?

Yes, all active employees have a username and password assigned to them and the username and password to the IU e-Health portal will remain the same.

Will my private health information be shared with Stryker Corporation?

No. IU Health operates separately from Stryker Corporation. IU Health staffs and manages the Onsite Clinic to ensure privacy and confidentiality of personal information at all times.

How much information will Stryker Corporation receive about the services provided at the Health Center?

IU Health does not release any personal health information to your employer. IU Health will report to your employer de-identified, aggregate information, for example:

- How many people visited the Health Center.
- How many people participated in health screenings.
- The prevalence rate of certain risk factors (i.e. smoking, obesity, high blood pressure)
- Cost savings associated with Clinic usage.
- Reasons for visiting the Health Center: acute care, health coaching, health screening.

Will the health information related to my visits be available to me in my personal health record (PHR)?

You may request a copy of your PHR by contacting the Health Center. You may be required to fill out a request form. At this time, your PHR is a paper record only.

Will my IU Personal Health Record be shared with my primary care provider or specialist?

You can share your Personal Health Record with your provider at any time. If you would like your (PHR) to be shared directly with your provider, we are happy to do so at your request and with your permission.

APPOINTMENT SCHEDULING

How do I schedule my appointments?

To schedule appointments, you can call the Health Center to schedule your appointment. To schedule an appointment by phone, you may call the Health Center at 847-829-5633 or 847-829-5463.

How long should an appointment take?

Most appointments will take about 20 minutes unless it is a physical or Comprehensive Health Review, which may last 45 minutes.

COST, BILLING & PAYMENT

How much will it cost to use the Health Center?

- There will be no cost for employees for preventive health services, regardless of insurance coverage.
- There is no cost for acute care of physical therapy for any employee and dependent family member covered by a Stryker PPO plan.
- The cost for employees and dependent family covered under an Health Savings Plan (HSA) will be $40 per visit for acute care and physical therapy until the annual deductible is met.
- Employees with other insurance will be charged $20 per visit for care other than preventive care.
- Employees without insurance will be charged $20 for each acute care visit.

Why is there a difference in cost between the Health Reimbursement Plan costs and the Health Savings Plan?

We realize that the features of each medical plan we offer will appeal to each employee differently. The Reimbursement Plan is designed with utilization of the Health Center in mind, so employees and covered family members can visit the Center as needed without costs affecting their Health Reimbursement Account balance.

The Health Savings Plan is designed for people to take greater advantage of the tax benefits of a Health Savings Account and so they have greater flexibility to allocate HSA dollars to health care providers they need or want to see outside of the Health Center. The IRS requires that people who participate in an HSA medical plan must pay fair market value for their non-preventive health care services. As a result, we can't offer Health Center acute care visits for free under this plan.

Will the Health Center bill my health insurance company directly?

If you and your family members are required to pay the cost of a visit to the Health Center and are not covered through the Premium or Basic HSA plan, you will be provided paperwork to complete a claim to your insurance carrier. If you and your family members are covered through the Premium or Basic HSA plan, the information regarding your visit will be submitted to United Healthcare so that the cost of the visit counts toward your plan deductible.

Will the Health Center be a United Healthcare in-network provider?

The Health Center will be an out-of-network United Healthcare provider.

Will the cost of the Health Center apply to my Stryker medical plan deductible?

If you are participating in the HDHP plan option and are making and/or receiving contributions to your HSA, costs associated with the Health Center (including lab and pharmacy) will apply to your deductible amount. If you are making or receiving contributions to an HSA, it is your responsibility to tell the Health Center when you check-in for services at the Center.

How much does it cost to get a lab test done if I am covered by a Stryker medical plan?

Lab tests performed at the Health Center are free of charge for all patients.

How much will on-site lab tests and prescriptions cost for employees without insurance?

There is no cost for medications dispensed from the Health Center. However, if a prescription is given by the Health Center to take to an outside pharmacy, applicable rates will apply based on the pharmacy chosen to fill the prescription and will be billed to the health plan subject to any copayment or coinsurance. Employees enrolled in the Premium or Basic HSA plan are required to fill prescriptions at an outside pharmacy.

Can I use my HSA dollars to pay for my Health Center visit?

Yes. Any costs associated with the Health Center may be paid for with HSA funds, either using checks or a debit/credit card.

When will I have to pay for services performed and medications dispensed at the Health Center?

Payment should be made at the time of service. You can pay by cash, check, credit or debit card.

Can I be billed for Health Center services?

Payment is due at the time of service, however payment plans can be arranged if necessary.

Can the cost of services be deducted from my pay?

No. Payment for services through payroll deduction is not available.

COVERAGE DURING LEAVE OF ABSENCE

FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact Stryker Corporation, 5650 Main Street, Manchester, VT 05255, 1-802-362-8259.

If you take an FMLA leave, you may continue to access the Health Center during the leave.

Any coverage's that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period. If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions. If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see page 12).

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you may continue to use the Health Center for up to 24 months as long as you give Stryker Corporation advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from Stryker Corporation, cannot exceed five years. There are a number of exceptions , however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at Stryker Corporation, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months (see page 12). However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other

words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See COBRA section) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by Stryker Corporation;
- The last day you cease to be employed in one of the eligible classes. This includes your death, reduction in hours, or termination of active employment; or
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the *Military Leave* section above.

Coverage for your spouse and other dependents (including your civil union partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- For your dependent child, the day he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The day your legally married spouse, civil union partner or child is no longer considered an eligible dependent;
- For children covered pursuant to QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

Federal law does not recognize your civil union partner as your spouse and a civil union partner is not recognized as a COBRA qualified beneficiary. However, Stryker Corporation will extend COBRA-like coverage to your civil union partner and his or her covered children. However, COBRA rights and protections do not apply to this extension of civil union partner coverage.

The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

What is COBRA Coverage

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a “qualifying event”. After a qualifying event occurs and any required notice of that event is properly provided to Stryker Corporation, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a “qualified beneficiary”. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan’s group health coverage elected by the qualified beneficiaries, including Open Enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage. The pronoun “you” in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

Who Is Covered

Employees

If you are an employee of Stryker Corporation, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events:

- A reduction in your hours of employment with Stryker Corporation or
- The termination of your employment with Stryker Corporation (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of Stryker Corporation, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;
- The termination of your spouse's employment with Stryker Corporation (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with Stryker Corporation; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with Stryker Corporation (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- you were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- you lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- when you definitively inform Stryker Corporation that you are not returning at the end of the leave; or
- the end of the leave, assuming you do not return to work.

Newly Eligible Child

If you, the former employee of Stryker Corporation, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Stryker Corporation (see Contact Information) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify Stryker Corporation within the 30 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Stryker Corporation during the covered employee's period of employment with Stryker Corporation is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify Stryker Corporation of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify Stryker Corporation (see contact information below) in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Stryker Corporation requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand deliver this notice to Stryker Corporation at the address listed below under Contact Information. If the above procedures are not followed or if the notice is not provided to Stryker Corporation within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to WageWorks, the COBRA Administrator. An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA. If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as

it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects. A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to “similarly situated” employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. “Similarly situated” refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary’s COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election from, you must notify Stryker Corporation if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) 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 COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

All COBRA premiums must be paid by check or money order or another method if permitted by the COBRA Administrator. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to WageWorks, the COBRA Administrator.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact WageWorks, the COBRA Administrator to confirm the correct amount of your first payment. COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify WageWorks, the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify WageWorks, the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;

- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to WageWorks, the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to WageWorks, the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify WageWorks, the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify WageWorks, the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;

- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to WageWorks, the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to WageWorks, the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Stryker Corporation no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee;
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, Stryker Corporation reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. Stryker Corporation, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

COBRA Administrator
Send Premiums to:
WageWorks
PO Box 8363
Pasadena, CA 91109-8363

All Other Correspondence To:
WageWorks
PO Box 226101
Dallas, TX 74222-6101
1-866-599-3141 (FAX)
Email: customerdelivery@conexis.com

Plan Administrator:
Stryker Corporation
2825 Airview Blvd
Kalamazoo, MI 49002

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep Stryker Corporation informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to Stryker Corporation or the COBRA Administrator.

CLAIMS AND APPEALS

In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

The Health Center benefits are self-insured and administered by IU Health Care and the Company has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA.

CLAIM-RELATED DEFINITIONS

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

INITIAL CLAIM DETERMINATION

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue. The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;

- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A
Other Related Notices	Notice that your claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that your claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A

APPEALING A CLAIM

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the Claims Administrator.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 24. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination 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 for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.
Extensions	None.	None.	None.

ACTS OF THIRD PARTIES

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

RECOVERY OF OVERPAYMENT

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Stryker Corporation to the extent of such payment.

MISSTATEMENT OF FACT

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	Stryker Corporation Benefit Plan
Plan Number	501
Plan Sponsor	Stryker Corporation, Inc. 2825 Airview Blvd Kalamazoo, MI 49002
Employer Identification Number	Stryker Corporation: 38-1239739 Stryker Sales Corporation: 38-2902424 Howmedica Osteonics Corp: 22-2183590 Stryker Communications Inc.: 20-1962228 Stryker Sustainability Solutions: 86-0898793 Stryker Performance Solutions LLC: 46-1634423
Plan Administrator	Stryker Corporation 2825 Airview Blvd Kalamazoo, MI 49002
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing on-site clinic benefits, among other benefits.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

Stryker Corporation reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Stryker Corporation reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Stryker Corporation also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Stryker Corporation will be done in accordance with Stryker Corporation's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any

benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Stryker Corporation, the Plan shall terminate unless the Plan is continued by a successor to Stryker Corporation

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Stryker Corporation to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

PLAN ADMINISTRATION

Stryker Corporation is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. Stryker Corporation has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Stryker Corporation will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Stryker Corporation will be liable in any manner for any determination made in good faith.

Stryker Corporation may designate other organizations or persons to carry out specific fiduciary responsibilities for Stryker Corporation in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Stryker Corporation will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your Benefit Booklets or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

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”). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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.