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 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.

Important

You will be asked to provide documentation that establishes proof of eligibility for your covered dependents.

In addition, see *Your Rights and Responsibilities* in this Stryker Benefits Summary for more information regarding Qualified Medical Child Support Orders (QMCSOs).

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 until 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, or a child placed for adoption.

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, MyStrykerInfo (**www.myinfo.stryker.com**), or by contacting your Benefits Representative or the

Benefits Service Center, within 30 days of the life event and completing an enrollment form. You also must provide required proof of eligibility with 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 or the Benefits Service Center 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 our control, please submit an appeal for further consideration as instructed in the *Medical and Rx Claims Procedures* 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.

Eligibility Requirements

The eligibility requirements and age limitations discussed in this "Eligibility" section apply to the following plans:

- UnitedHealthcare PPO plan
- UnitedHealthcare Out-of-Area plan
- UnitedHealthcare/Medco prescription drug plan
- Delta dental plan
- EyeMed vision plan

HMOs and other insured medical plans may have eligibility requirements which are different than those outlined in this booklet. 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 in the *Location-Based Provisions* section or contact your Benefits Representative or the Benefits Service Center for specific information regarding eligibility requirements.

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, MyStrykerInfo (**www.myinfo.stryker.com**), or by contacting your Benefits Representative or the Benefits Service Center, within 30 days of your hire date and provide all the required documentation as requested within 45 days of 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 a 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* section.

Important

If you do not complete and submit an enrollment form within 30 days of your hire date and provide required proof within 45 days of your hire date, you and/or your dependents will not be enrolled in health coverage. You will not be able to enroll for medical, prescription drug, dental or vision coverage during the year unless you have a qualifying change in status or status change event.

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 specific status change 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 change in status 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.

Changes in Status

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:

When Changes Take Effect

If your enrollment change is approved, it will become effective on the date the qualifying change in status event occurred.

- Legal marital status—including marriage, death of a spouse, divorce, legal separation or annulment
- Declaration of 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
- 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 an unpaid leave of absence
- 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)
- 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
- Loss of other health plan coverage—you, your spouse or your dependent child lose coverage under another employer-sponsored health plan
- Change in coverage under another employer plan—coverage provided by your spouse's or dependent's employer changes provided that the period of coverage under the other plan is different than the period of coverage under Stryker's plan

If you need to change your healthcare benefit election as the result of one of these changes, you must contact your Benefits Representative or the Benefits Service Center within 30 days of the change date and submit the necessary forms within 45 days in order to have your contributions deducted on a pre-tax basis.

Your Benefits Representative or the Benefits Service Center must approve benefit election changes. If you have a qualifying change in status event, you must properly change your enrollment via the employee self service web site, MyStrykerInfo (**www.myinfo.stryker.com**), or by contacting your Benefits Representative or the Benefits Service Center, within 30 days of the life event and providing all of the required documentation within 45 days as requested. If you are dropping coverage for yourself or a dependent, and 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 event that would permit an election change. If you are adding coverage and submit all of the requested 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 health care benefit election, unless you experience another qualifying life event that would permit an election change prior to that time.

Qualified Change in Status Rules

Changes to your healthcare benefit election must be consistent with the status change 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 qualified change in status event permits you to:

Documentation Required

You will be asked to provide documentation, such as a marriage or birth certificate, within 45 days of any qualified change in status event.

- Add your spouse to Stryker's plan, or
- Drop coverage under Stryker's plan and 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 or the Benefits Service Center for specific information regarding eligibility requirements.

You will be asked to provide documentation, such as a marriage or birth certificate, of any qualified change in status 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, in the case of birth, adoption of a child or placement of a foster child) 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 9 and "Making Changes" on page 11, 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, legal separation 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 16 for more information about termination of coverage for cause.

- **You *lose* Medicaid/CHIP eligibility (i.e., loss of eligibility for a Medicaid or CHIP premium assistance subsidy).** If an individual's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated as a result of loss of eligibility, the affected individual(s) 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 (or the premium assistance subsidy terminates). 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. Further, in the case of the 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 9 and "Making Changes" on page 11, 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 an individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under the Plan, the affected individuals have special enrollment rights.

  If you or an eligible dependent become eligible to have Medicaid or CHIP assist in the payment of your coverage under the plan, you may enroll yourself and your eligible dependent for medical coverage under the plan, provided you contact your Benefits Representative or the Benefits Service Center 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.

  You will be asked to provide documentation regarding the loss of Medicaid or CHIP coverage or eligibility for premium assistance under those programs.

Life Event Guide

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.

Important Note about Life Events...

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

Your Benefits Representative or the Benefits Service Center must approve benefit election changes. If you have a qualifying change in status event as provided in the following chart, you must properly change your enrollment via the employee self service web site, MyStrykerInfo (**www.myinfo.stryker.com**), or by contacting your Benefits Representative or the Benefits Service Center, within 30 days of the life event and providing all of the required documentation within 45 days as requested. If you are dropping coverage for yourself or a dependent, and 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 event that would permit an election change. If you are adding coverage and submit all of the requested 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 health care 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* section.

Life Event Guide

Change in Status Event	***Permissible Election Change***
Marriage, declaration of same sex domestic partner, birth, adoption or placement of a foster child	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 are enrolled for similar coverage under your spouse's or domestic partner's plan.
Death of dependent, divorce, annulment or termination of domestic partnership or termination of an adopted or foster child's placement	You may drop the affected dependent's medical and prescription drug, dental and/or vision coverage.
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)	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).
Dependent loses benefit eligibility (for example, the dependent reaches age 26)	You may drop the affected dependent's medical and prescription drug, dental and/or vision coverage.
Change in residence or work site	You may change to another similar plan option or drop coverage if the event results in loss of eligibility under your current plan option.
Loss of other employer, government or educational institution sponsored medical coverage by employee, spouse or dependent (revised effective 5/1/2011 to include government or educational institution)	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.
Employee or dependent becomes eligible for or loses eligibility for Medicare or Medicaid	You may drop medical and prescription drug, dental and/or vision coverage for the affected individual upon enrollment for Medicare or Medicaid. You may enroll the affected individual for medical and prescription drug, dental and/or vision coverage upon loss of similar coverage through Medicare or Medicaid.

Life Event Guide	
Court issues order regarding medical coverage of child (qualified medical child support order or QMCSO)	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.
Significant increase in cost or significant curtailment of coverage under another plan	If you drop the medical and prescription drug, dental and/or vision coverage, you may elect a similar benefit under this plan.
Enrollment period for coverage under another employer's plan occurs while your elections are in effect	You may drop medical and prescription drug, dental and/or vision coverage if you are 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.

Remember, election changes are permitted only when the qualifying change in status 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 the number of people you cover and the plans you select. Your cost for each plan is shown on MyStrykerInfo (**www.myinfo.stryker.com**) or your enrollment form by coverage level.

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.

Grandfathered Status

The Company believes the medical and prescription drug benefits under the healthcare plan constitute a grandfathered health plan under the Patient Protection and Affordable Care Act (also known as Health Care Reform). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the healthcare plan may not include certain consumer protections of Health Care Reform that apply to other plans. However, the Company has voluntarily amended coverage for preventive services, eliminated most benefit limits/maximums and extended coverage to dependents up to age 26.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause the plan to change from grandfathered health plan status 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 9 and "Making Changes" on page 11.

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 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 change in status event
- If you elect to drop healthcare benefits during annual enrollment, on the December 31 following the annual enrollment period
- If the plan is terminated
- If the plan administrator terminated your coverage for fraud or intentional misrepresentation

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, legal separation 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 or the Benefits Service Center

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 or the Benefits Service Center 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 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 event. Depending on the type of qualifying 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 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 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 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 event has occurred. You do not have to notify the plan administrator when the qualifying event is the end of employment, reduction of hours of employment or death of the employee. **However, for the other qualifying events (divorce or legal separation 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 or the Benefits Service Center, in writing, within 60 days after the date the qualifying 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 event has occurred within 60 days of the event.**

Once the plan administrator receives notice that a qualifying 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 event.

Duration of COBRA Continuation Coverage

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

When the qualifying 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 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 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 Event Extension of 18-Month Period of Continuation Coverage

If your family experiences a second qualifying 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 event within 60 days of the second qualifying event via your Benefits Representative or the Benefits Service Center. 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 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 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 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/2002act_index.cfm.**

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 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 or legal separation.

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 or the Benefits Service Center 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 23 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 When this Plan Is Secondary

Allowable Expenses

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

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 legally separated or 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 birthday 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 85% of covered expenses. Here's how to determine how much Stryker's plan pays as the secondary payer:

Stryker's plan normally pays 85% of covered expenses:	85% × $2,000 = $1,700
Other plan actually pays 75% of covered expenses:	75% × $2,000 = $1,500
Balance to be paid by Stryker's plan:	$1,700 – $1,500 = $200

CASE #2: If the other plan is primary and pays 85% or more of covered expenses, Stryker's plan would not pay any benefits, as shown below:

Stryker's plan normally pays 85% of covered expenses:	85% × $2,000 = $1,700
Other plan actually pays 85% of covered expenses:	85% × $2,000 = $1,700
Balance to be paid by Stryker's plan:	$1,700 – $1,700 =$0

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.