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

Regular Full-Time and Regular Part-Time Employees

> **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).

All regular full-time and regular part-time employees of Stryker (who live and work in the U.S. as described below) are eligible for medical, prescription drug, dental and vision coverage under the Stryker Corporation Welfare Benefits Plan. "Full-time" means the employee is regularly scheduled to work at least 40 hours per week. "Part-time" means the employee is regularly scheduled to work at least 20 hours per week. Newly-hired regular employees who meet these requirements become eligible on their date of hire. In addition, only those regular full-time or part-time employees who both reside and perform their work in the United States, are eligible to participate in the U.S. based Stryker Corporation Welfare Benefits Plan.

Direct Temporary Employees Expected to Work 30 Hours/Week

If you were hired as a direct temporary employee (which means a temporary employee directly hired by Stryker) and Stryker reasonably expects you to work an average of at least 30 hours per week at the time you start work, you will be eligible for medical and prescription drug coverage under the UHC Basic HSA Plan (with no Stryker HSA contribution). This coverage becomes effective as of your 90th day of service. Your cost for medical and prescription drug coverage will be based on whether you are full-time or part-time as described above.

If you live outside of the UHC plan network (based on your ZIP code), you will be eligible for another medical plan based on your network area.

Other Employees

If you are a regular employee who is regularly scheduled to work less than 20 hours per week, a direct temporary employee who is reasonably expected to work less than 30 hours per week upon hire, a variable hours employee (where Stryker cannot reasonably determine whether you will work sufficient hours to otherwise be eligible) or a seasonal employee, you may become eligible for medical and prescription drug coverage under the UHC Basic HSA Plan (with no Stryker HSA contribution) plan after completing an initial measurement period during which you are credited with an average of at least 30 hours of service per week. If you live outside of the UHC plan network (based on your ZIP code), you will be eligible for another medical plan based on your network area.

The initial measurement period is the 11-month period beginning on your date of hire. If you satisfy the 30 hours per week average during your initial 11-month measurement period, you will be notified after the measurement period ends and will be provided with the opportunity to enroll in medical and prescription drug coverage for a 12-month initial stability period beginning no later than the first day of the 14th month after your date of hire. Your eligibility effective date for coverage, should you average 30 hours per week during your initial 11-month period, will not exceed 90 days past the end of your initial measurement period. If you are not credited with an average of at least 30 hours of service per week during the 11-month initial measurement period, you will not be offered medical and prescription drug coverage.

Ineligible Individuals

Independent contractors and temporary employees hired through a temporary staffing agency or other third-party leasing organization are not eligible for healthcare benefits under the Stryker Corporation Welfare Benefits Plan.

Ongoing Eligibility

Standard Measurement Period

For each plan year (January 1 through December 31) there will be a 12-month standard measurement period before the year begins. The standard measurement period for each plan year will end on October 3 immediately preceding the first day of the plan year. For example, for the 2022 plan year, the standard measurement period will begin on October 4, 2020 and end on October 3, 2021.

If you are a regular part-time employee working at least 20 hours per week or a regular full-time employee working at least 40 hours per week, you will remain eligible for benefits as described in the Eligibility section of the SPD , except as described below if your scheduled hours are reduced during the stability period.

If you are a regular employee working less than 20 hours and are credited with at least 30 hours per week during the standard measurement period, you will be eligible for the UHC Basic HSA Plan (with no Stryker HSA contribution) for the next plan year and your cost will be based on part-time rates.

If you are a direct temporary employee, variable hours employee, or seasonal employee and are credited with an average of at least 30 hours per week during the standard measurement period, you will be eligible for the UHC Basic HSA Plan (with no Stryker HSA contribution) for the immediately following plan year, and your cost will be based upon part-time rates unless you are regularly scheduled to work 40 hours per week. If you satisfy the minimum hour requirement during the standard measurement period, you will be notified after the measurement period ends and will be provided with the opportunity to enroll in coverage for the immediately following plan year.

Transfers and Working Hours Changes

If you transfer to a position or change working hours that causes you to become eligible for additional plan benefits or qualifies you for a lower medical cost, you will be offered the additional coverage and the more favorable cost immediately upon your status change. Conversely, if you transfer to a position or change working hours that would ordinarily no longer qualify you for certain benefits, you will continue to be eligible for the UHC Basic HSA Plan (with no Stryker HSA contribution) for the balance of the stability period if you are credited with at least 30 hours per week during the standard measurement period. However, your employee cost will adjust to part-time rates if you drop below 40 hours.

Breaks in Service

If you have a break in service (for example, due to termination of employment or due to taking a non-FMLA leave) during which you are not credited with any hours of service for at least 13 weeks, you will be treated as a new hire upon resumption of service. If the break in service is less than 13 weeks and you were enrolled in healthcare coverage and return during the same stability period or plan year, the coverage will be offered as soon as administratively practicable upon resumption of service. Further, you will be treated as a continuing employee upon resumption of service for purposes of any applicable measurement period.

Dependents

Eligible dependents include:

- Your legal spouse (if your spouse resides outside of the country, he or she may still be eligible for benefits)
- Your children through the last day of the month in which they turn age 26, regardless of their student, 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. Note: registered domestic partnerships are not subject to any requirements for proof of relationship or waiting periods applied to domestic partnerships that are not also applied to marriages.
- For purposes of Stryker's benefit plans, a domestic partnership is defined as:
    - A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry.

OR

- A domestic partnership that meets all of the following requirements for the immediately preceding 12 months:
  - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
  - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely.
  - Has not had another domestic partner within the prior 12 months.
  - Has not been a party to a divorce or annulment proceeding in at least 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 domestic partner's) child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, a child placed for adoption, or a child for whom you have been appointed legal guardianship.

A child who does not fall within this definition of "child" is not eligible for coverage even if you can claim the child as your dependent for federal income tax purposes.

A newly-eligible child, spouse or domestic partner will be covered from the date of birth, adoption, placement for adoption, foster agreement date, guardianship, marriage or domestic partnership as defined above if properly enrolled via the Benefits Enrollment Site at **https://enroll.stryker.com**, or by contacting your Benefits representative and completing an enrollment form within 30 days of the life event (including the date of the event). You also must provide dependent documentation to your Benefits representative within 30 days of the life event. Your contributions will be deducted on a pre-tax basis, unless you request otherwise.

If you fail to enroll your newly eligible child, spouse or domestic partner within this 30-day period (or provide dependent documentation to your Benefits representative within 30 days of the life event), you may still be able to enroll them for coverage, as long as you do so within 120 days of the life event. (In specific locations, HMO and other fully insured plans are offered, which are administered by the insurance carriers. These carriers may not always agree to the extension of benefits for those enrolling after 30 days of their hire date. Please contact your Benefits representative for more information.) Coverage will be effective from the date of birth, adoption, placement for adoption, foster care agreement, legal guardianship date, or the date of the marriage or domestic partnership as defined above; however, in this situation you will have to pay for their coverage on a post-tax basis retroactive to the date of the event through the remainder of the plan year in which you properly completed the enrollment. 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 domestic partner for healthcare coverage, unless you experience another life event that would permit you to enroll them prior to that time.

If satisfactory proof of eligibility is not provided within the enrollment period, the dependent will not be eligible for coverage under the plan.

If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the *Medical and Rx Claims Procedures, Dental or Vision* section.

If both you and your spouse domestic partner or dependent 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 as a dependent 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 and HSA plans
- UnitedHealthcare Out-of-Area plan
- UnitedHealthcare/OptumRx 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 PPOs, HSAs, 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 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. You must enroll via the Benefits Enrollment Site at **https://enroll.stryker.com**, or by completing an enrollment form and returning it to your Benefits representative along with the required dependent documentation within 30 days of your hire date (including your date of hire) in order to complete the enrollment on a pre-tax basis.

Important

You must enroll via the Benefits Enrollment Site (or submit an enrollment form) and provide the required dependent documentation within 30 days of your hire date (including your date of hire) in order for you and/or your dependents to be enrolled in health coverage on a pre-tax basis. For example, if you are hired on May 1, your enrollment deadline is May 30 and the deadline to submit proof of dependent status is May 30.

The cost of a domestic partner's, and their children's coverage, will be deducted from your paycheck on a post-tax basis, and the cost Stryker pays for this coverage will be treated as imputed income unless they qualify as a tax dependent.

If you fail to enroll or provide dependent documentation to your Benefits representative within 30 days of your date of hire, you may still be able to enroll them for coverage, as long as you do so within 120 days of your date of hire (including your date of hire). **However, contributions will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment and will be payable retroactively to your date of hire.** (In specific locations, HMO and other fully insured plans are offered, which are administered by the insurance carriers. These carriers may not always agree to the extension of benefits for those enrolling after 30 days of their hire date. Please contact your Benefits representative for more information.)

If you don't properly enroll and submit all of the requested documentation within 120 days of your date of hire (including your hire date), 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, Dental or Vision* section.

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

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

You must check your enrollment confirmation for any errors. If you do not correct any errors within the enrollment period, you will not be permitted to make any changes unless you subsequently have a qualifying life event or qualify for HIPAA special enrollment rights as described under "Making Changes" beginning on page 9.

Making Changes

You may change your enrollment once each year during the annual enrollment period (unless you have a qualifying life event). You will be notified in advance of the annual enrollment dates. Coverage changes will take effect the following January 1.

Qualifying Life Events

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

When Changes Take Effect

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

- Legal marital status—including marriage, death of a spouse, divorce or annulment. **Note:** Legal separation is not considered a qualifying life event. If you cover your spouse under your Stryker healthcare benefits, you may not drop him or her from your coverage in the event of legal separation.
- Domestic Partner Status—declaration or termination of partnership, or registering a domestic partnership or civil union partnership established under state or local jurisdiction law, or termination of domestic partnership or civil union partnership registered under state or local jurisdiction law
- Number of dependents—including birth, adoption, placement for adoption, acquiring a stepchild, acquiring a foster child, obtaining legal guardianship of a child, or death
- Dependent status—a dependent child either satisfies or fails to meet Stryker's eligibility requirements (e.g., by reaching age 26 or because of disability status)
- Compliance with a court order regarding medical coverage of a dependent child or a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)
- Employment status—you, your spouse, domestic partner, or dependent child either start or stop working and lose coverage through another health plan
- Work schedule—standard working hours for you, your spouse, domestic partner, or 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. If your spouse or domestic partner is covered under his or her employer's benefits plan, and your change in work schedule is considered a qualifying life event under your spouse's or domestic partner's plan, you may become eligible to participate in that plan. In this situation, you may be able to drop Stryker coverage in order to enroll for coverage under your spouse's or domestic partner's plan.
- Residence or worksite—you move in or out of your medical plan's service area as the result of a change in the place where you or your spouse or domestic partner live or work resulting in loss of eligibility under your current plan.
- Dependent's legal residence—your eligible spouse, domestic partner or other dependent moves to the United States from another country. **Note:** In the event that you enroll your spouse, domestic partner or other dependent for coverage in this situation, your contributions for his or her coverage will be made on an after-tax basis for the remainder of the plan year. Pre-tax contributions may begin the following plan year.
- Loss of other health plan coverage—you, your spouse, domestic partner or your dependent child lose coverage under another employer-sponsored health plan
- Significant change in coverage under another employer plan—coverage provided by your spouse's, domestic partner's or dependent's employer changes
- Enrollment period under another employer plan—the enrollment period for benefits under your spouse's, domestic partner's or dependent's employer plan occurs while your elections are in effect
- Eligibility for Medicare or Medicaid—you or a covered dependent becomes eligible for or loses eligibility for Medicare or Medicaid

- Reduction in hours of service—you and your dependents may drop your group health plan coverage, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week
  - You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the second month after you drop Stryker's coverage.
  - **Note:** You are not permitted to change your health care FSA elections because of a reduction in hours of service.
- Enrollment in a health plan offered through the public Marketplace—If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop group healthcare coverage under the Stryker plan, even if you remain eligible for coverage under this plan. You (and any dependents whose coverage is dropped at this time) must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under the Stryker plan is dropped. You are not permitted to change your health care FSA elections because you intend to enroll in a plan offered through the public Marketplace.

If you need to change your healthcare benefit election due to one of these life events, your Benefits representative must approve any benefit election changes. See "Life Event Guide—Healthcare" on page 12 for details about making benefit changes as a result of a qualifying life event.

Qualifying Life Event Rules

Documentation Required

You will be asked to provide proof of the life event (if applicable) within 30 days of any qualifying event and dependent documentation, such as a marriage or birth certificate, within 30 days of any qualifying life event in order to enroll on a pre-tax basis.

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

- Add yourself or your spouse to Stryker's plan, or
- Drop coverage under Stryker's plan if you enroll for coverage under your spouse's health plan.

If you are enrolled in a medical plan option other than the UnitedHealthcare PPO, HSA or Out-of-Area plan, see the supplemental summary plan description for the applicable plan (provided in the *Location-Based Provisions* section) or contact your Benefits representative for specific information regarding eligibility requirements. You will be asked to provide proof of the life event (for example, loss of coverage under another health plan) and dependent documentation, such as a marriage or birth certificate, of any qualifying life event. See "Life Event Guide—Healthcare" on page 12 for further details on Qualifying Life Events.

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, domestic partnership, birth, adoption or placement for adoption, you may enroll yourself and your new dependent (and your spouse or domestic partner, if you are acquiring a dependent child for any of the reasons listed here) in Stryker's plan. If you are already enrolled for health coverage when you acquire a new dependent, you may enroll your dependent.

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

If you don't enroll within 30 days, you may still enroll within the 120-day period described in "Eligibility" on page 5 and "Making Changes" on page 9, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and will be payable retroactively to the date the child was acquired). 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(this does not include the reduction or end of a COBRA subsidy).

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

  - A loss of coverage that results from termination of employment, reduction in hours of employment, or divorce, termination of domestic partnership, 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; 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.** If you or an eligible family member loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (CHIP), you may have special enrollment rights.

  To exercise your special enrollment rights, you must enroll yourself and/or your dependents no more than 30 days after the date the other coverage ends. In the case of a loss of Medicaid or CHIP eligibility, the special enrollment period continues until 60 days after the loss of eligibility.

  If you don't enroll within 30 days, you may still enroll within the 120-day period described in "Eligibility" on page 5 and "Making Changes" on page 9, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and will be payable retroactively to the date eligibility was lost). If you don't enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

  You will be asked to provide documentation regarding the date the other health plan coverage ended.

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

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

If you don't enroll within 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 in which you properly completed the enrollment (and will be payable retroactively to the qualifying life event). If you don't enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

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

Life Event Guide—Healthcare

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

Important Note about Life Events...

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

Your Benefits representative must approve benefit election changes. In order to complete the enrollment on a pre-tax basis for a qualifying life event as provided in the following chart, you must properly change your enrollment via the Benefits Enrollment Site at **https://enroll.stryker.com**, or by contacting your Benefits representative and completing an enrollment form, and provide proof of the life event (if applicable) within 30 days of the life event (including the date of the life event). You must also provide the required dependent documentation within 30 days of the life event (including the date of the event) as requested. In addition, if you wish to change health plan options as specified in the following chart, you must do so within 30 days of the eligible life event.

You cannot drop coverage via the Benefits Enrollment Site without HR approval. If you are dropping coverage for yourself or a dependent, you must complete the enrollment form and return it to your Benefits representative along with proof of the qualifying life event within 90 days of the life event (including the date of the event). If you do not meet this deadline, you will not be able to change your election until the next annual enrollment period, unless you experience another qualifying life event that would permit an election change.

Please note that if you have a COBRA qualifying life event, you must notify your Benefits representative and submit the appropriate documentation within 60 days of the qualifying event date in order to be eligible for COBRA continuation coverage.

If you are adding coverage and submit all of the requested documentation more than 30 days (including dependent documentation) 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 in which you properly completed the enrollment (and payable retroactively to the date of the qualifying life event). However, you may not switch health plan options as specified in the following chart more than 30 days after your qualifying life event. If you don't properly change your enrollment and submit all of the requested documentation within 120 days of the event, you will have to wait until the next annual enrollment period to make any changes to your healthcare benefit election, unless you experience another qualifying life event that would permit an election change prior to that time. (Fully insured plans are administered by insurance carriers that do not always agree to the extension of benefits. Please contact your Benefits representative for confirmation.)

If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the *Medical and Rx Claims Procedures, Dental or Vision* section.

Life Event Guide	
Qualifying Life Event	***Permissible Election Change***
Marriage, declaration or registration of a domestic partner with any state or local government, birth, adoption, placement for adoption, appointment of legal guardianship, acquiring a stepchild or placement of a foster child	You may add your new spouse, new domestic partner or newly acquired dependent child to the medical and prescription drug, dental and/or vision coverage. You may also add any other eligible dependents who were not previously covered under this plan. If you previously declined coverage, you may enroll yourself, your spouse, your domestic partner and/or any eligible dependent child in the medical and prescription drug, dental and/or vision coverage. You may drop medical and prescription drug, dental and/or vision coverage if you become enrolled for similar coverage under your spouse's or domestic partner's plan. With a marriage, domestic partnership, birth, adoption or placement of adoption, you may change health plan options (e.g. from an HMO to PPO).
Death of dependent, divorce, annulment or termination of domestic partnership, termination of an adopted or foster child's placement or end of guardianship appointment **Note:** Legal separation is not considered a qualifying life event	You must drop the affected dependent's medical and prescription drug, dental and/or vision coverage. You may enroll yourself and any eligible dependents in similar coverage if the event causes a loss of coverage under your spouse or domestic partner's plan.
Change in the employment status of employee, spouse, domestic partner 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. If there is a change in employment status of your spouse, domestic or civil union partner or dependent that results in a loss of eligibility under their employer's plan, you may enroll them in similar coverage as well as other eligible dependents not previously covered. 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 under Stryker's plan (for example, the dependent reaches age 26)	You may drop the affected dependent's medical and prescription drug, dental and/or vision coverage.
Dependent newly satisfies eligibility requirement under Stryker's plan	You may add the newly eligible dependent that satisfies the plan eligibility requirement as well as other previously eligible dependents not covered under the plan.
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.
Dependent moves to the United States from another country	You may enroll your dependent(s) for medical and prescription drug, dental and/or vision coverage. Your contributions for any coverage you elect will be made on an after-tax basis for the remainder of the plan year in which Stryker was notified.

Life Event Guide	
Qualifying Life Event	***Permissible Election Change***
Loss of other employer, government or educational institution sponsored medical coverage by employee, spouse, domestic partner or dependent	You may enroll yourself and/or your spouse, domestic partner or dependents in the medical and prescription drug, dental and/or vision plan(s) if other similar coverage is lost due to: ▪ Exhaustion of COBRA; ▪ Loss of eligibility; or ▪ Termination of employer contributions as an active employee only. You may add any other eligible dependents that were not previously covered under this plan. You may change health plan options (e.g. from an HMO to PPO).
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 entitlement to Medicare or Medicaid. You may enroll yourself and/or the affected individual for medical and prescription drug, dental and/or vision coverage upon loss of similar coverage through Medicare, Medicaid or CHIP eligibility, and if you are already covered under the Stryker Health and Welfare Plan. You may also change health plan options (e.g. HMO to PPO).
Court issues order regarding medical coverage of child (qualified medical child support order (QMCSO)) or National Medical Support Notice (NMSN)	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 or NMSN and coverage is in fact provided.
Significant increase in cost or significant curtailment of coverage under an employer-sponsored plan	If the plan increase occurs mid-year under this plan and you have other plan options under this plan, you may elect similar coverage under this plan or you may drop coverage if you enroll in a similar plan with another employer. If no other plan options are available to you under this plan, you may drop coverage for the medical, dental or vision plan to which the cost increase is associated. If you are electing similar coverage, you may also add any other eligible dependents that were not previously covered 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 become enrolled for similar coverage under another employer's plan. You may enroll for medical and prescription drug, dental and/or vision coverage if similar coverage under the other employer's plan was dropped during that plan's enrollment period.
Reduction in hours of service	You and your covered dependents may drop your group health plan coverage, even if you remain eligible for such coverage, if: ▪ You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week ▪ You enroll yourself and your covered dependents that are dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop Stryker health coverage.

Life Event Guide	
Qualifying Life Event	***Permissible Election Change***
Enrollment in a health plan offered through the public Marketplace	If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop Stryker group health plan coverage, even if you remain eligible for Stryker coverage. You (and any dependents whose coverage is dropped at this time) must enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under the Stryker Health and Welfare Plan is dropped.

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

Your Cost for Healthcare Benefits

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

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

Tobacco Surcharge

If you or your spouse or domestic partner is covered under the Stryker medical plan, is a tobacco-user (see tobacco-user definition below), and has not completed Strive tobacco cessation Journey this year or other program recommended by a physician, you will pay a surcharge for medical coverage.

You and your covered spouse or domestic partner must be tobacco free for at least six months or have completed a Strive tobacco cessation Journey or other program recommended by a physician this year when certifying your tobacco status to be considered a non-tobacco user.

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

Tobacco Cessation Program

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

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

Tobacco-Use Verification

Current employees must verify their tobacco use status along with their covered spouse or domestic partner tobacco use certifying their tobacco status every year during annual enrollment.

New hires must verify their tobacco use status along with their covered spouse or domestic partner tobacco use certifying their tobacco status during their initial benefits enrollment period.

If an employee fails to certify their tobacco status, they will be considered a tobacco user for purposes of the Tobacco Cessation Program.

Tobacco Surcharge

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

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

The Tobacco Surcharge can be removed by completing a Strive tobacco cessation Journey, or by complying with a program recommended by your physician, or by confirming via the Benefits Enrollment Site that the employee and/or spouse or domestic partner has quit using tobacco for a period of six months prior to the signature date. The Tobacco Surcharge will be removed within four pay periods following completion of the certification on the Benefits Enrollment Site. You will be credited with any surcharges paid for the year.

If you identify yourself and your spouse or domestic partner as a tobacco user, both individuals must complete Strive tobacco cessation Journey for the surcharge to be removed.

Definition of a Tobacco User

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

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

Visit **https://totalrewards.stryker.com** and search for tobacco cessation to find details on how to enroll in the program.

Non-Grandfathered Status

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

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

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

When Coverage Begins

For You

If you enroll when you are first eligible, your coverage under the Stryker Corporation Welfare Benefits Plan begins immediately as of your date of hire.

For Your Dependents

If you are covered, new dependents will be covered as of the event date if you enroll them within 30 days after they first become eligible, or within 120 days as described in “Eligibility” on page 5 and “Making Changes” on page 9.

For Re-Hired Employees and Their Dependents

If you have a break in service (for example, due to termination of employment or the taking of a non-FMLA leave) during which you are not credited with any hours of service for at least 13 weeks, you will be treated as a new hire upon resumption of service. If the break in service is less than 13 weeks and you were enrolled in medical, dental and/or vision plan coverage and return during the same stability period or plan year, the coverage will be offered as soon as administratively practicable upon resumption of service. Further, you will be treated as a continuing employee upon resumption of service for purposes of any applicable measurement period.

When Coverage Ends

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

- The date you leave Stryker or fail to pay required coverage costs (unless you are on an approved leave and payments are made upon your return)
- The date you are no longer an eligible employee
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, on the December 31 following the annual enrollment period

- The date the plan is terminated
- The date the plan administrator terminates your coverage for reasons as described in the "Termination of Coverage for Cause" box that follows

In addition, dependent coverage also ends:

- On the date your coverage ends
- On the last day of the month in which your dependent child turns age 26
- On the date your dependent child otherwise ceases to qualify as a dependent under the plan
- In the case of your spouse, on the date your divorce or annulment is final. In the case of your domestic partner, on the date you and your partner complete a Termination of Domestic Partnership form and have it approved by your Benefits representative

Termination of Coverage for Cause

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

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to eligibility or status; or
- You commit an act of physical or verbal abuse that imposes a threat to the plan's staff, third party or insurance carrier's staff, a provider or another covered person.

When your coverage ends, claims will be paid for covered healthcare services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for healthcare 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, HSA, or Out-of-Area plan, check the supplemental summary plan description for the applicable plan (provided in the *Location-Based Provisions* section) or contact your Benefits representative for specific information regarding eligibility requirements. If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see "COBRA: Continuing Healthcare Coverage" on page 17.

COBRA: Continuing Healthcare Coverage

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying life event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose health plan coverage because of a qualifying life event. Depending on the type of qualifying life event, employees, spouses, domestic partners 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 Program because either one of the following qualifying life events happens:

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

Note: If you are enrolled in a medical plan option other than the UnitedHealthcare PPO, HSA or Out-of-Area plan, see the supplemental summary plan description for the applicable plan (provided in the *Location-Based Provisions* section) or contact your Benefits representative for specific information about eligibility for COBRA Continuation Coverage for your spouse or domestic partner and dependent children.

If you are the spouse or domestic partner of an employee who is enrolled in the UnitedHealthcare PPO, HSA or Out-of-Area plan, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying life events happens:

- Your spouse or domestic partner dies,
- Your spouse's or domestic partner's hours of employment are reduced or your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct,

- You become divorced from your spouse,
- Your domestic partnership is terminated, or
- Your spouse or domestic partner becomes enrolled in Medicare (Part A or Part B).

Your dependent children who are enrolled in the UnitedHealthcare PPO, HSA or Out-of-Area plan will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying life events happens:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced or the parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parents become divorced,
- Your parent's domestic partnership is terminated,
- 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).

Voluntary termination of coverage during Annual Enrollment is not a COBRA Qualifying Life Event.

The Stryker Corporation Welfare Benefits Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified in writing that a qualifying life event has occurred. You do not have to notify the plan administrator when the qualifying life event is the end of employment, reduction of hours of employment or death of the employee. **However, for the other qualifying life events (divorce, termination of a domestic partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator, via your Benefits representative, in writing, within 60 days after the date the qualifying life event occurs or the date coverage is lost, whichever is later. You will be required to provide documentation—such as a divorce decree—that a qualifying life event has occurred within 60 days of the event.**

Once the plan administrator receives notice that a qualifying life event has occurred and supporting documentation has been provided, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying life event.

Duration of COBRA Continuation Coverage

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

Second Qualifying Life Event Extension of 18-Month Period of Continuation Coverage

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

Medicare Entitlement Prior to Termination of Employment or Reduction in Hours

If you enroll in Medicare (Part A, Part B or both) in the 18-month period immediately preceding your termination of employment or reduction in hours, your spouse, domestic partner 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

HealthEquity/WageWorks
P.O. Box 660453
Dallas, TX 75266-0453
866 206 5751

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
- 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 health care FSA, that coverage will continue until the end of the calendar year during which the qualifying life event occurred as long as timely premiums continue to be made.

Electing COBRA Continuation Coverage

Each qualified beneficiary has an independent right to elect continuation coverage. For example, either you or your spouse or domestic partner 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 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 or domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying life event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost of COBRA Continuation Coverage

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

The Trade Preferences Extension Act of 2015 has extended the Trade Reform Act of 2002, which created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals) through December 31, 2020. The program could be renewed beyond that date. Under these provisions, eligible individuals can

either take a tax credit or get advance payment of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Healthcare Tax Credit Customer Contact Center toll-free at **800 829 1040** or visit **www.IRS.gov/HCTC**. More information about the Trade Act is also available at **www.doleta.gov/tradeact/.**

Paying for COBRA Continuation Coverage

First Payment for Continuation Coverage

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

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

Periodic Payments for Continuation Coverage

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

Grace Periods for Periodic Payments

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

COBRA Coverage for Domestic Partners

Although not required by COBRA law, under the UnitedHealthcare plan's provided through Stryker, 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.

Note: If you are enrolled in a medical plan option other than the UnitedHealthcare PPO, HSA or Out-of-Area plan, see the supplemental summary plan description for the applicable plan (provided in the *Location-Based Provisions* section) or contact your Benefits representative for specific information about eligibility for COBRA Continuation Coverage for your spouse or domestic partner and dependent children.

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 Stryker Corporation 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 Stryker Corporation 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.

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, dental and/or vision benefits from another plan.

Medical Benefits

This section describes how benefits under this Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense. Allowable expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

B. Each plan determines its order of benefits using the first of the following rules that apply:

   1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, or retiree subscriber is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

   2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

      a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

         (1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

         (2) If both parents have the same birthday, the plan that covered the parent longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) f there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent.

b. The plan covering the custodial parent's spouse.

c. The plan covering the non-custodial parent.

d. The plan covering the non-custodial parent's spouse.

For purpose of this section, custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.
7. The Stryker medical plan is primary to medical coverage provided under a personal vehicle insurance policy, unless state insurance law requires otherwise.

How Are Benefits Paid When This Plan is Secondary?

If this plan is secondary, it determines the amount it will pay for a covered health services by following the steps below.

- The plan determines the amount it would have paid based on the allowable expense.
- If this plan would have paid the same amount or less than the primary plan paid, this plan pays no benefits.
- If this plan would have paid more than the primary plan paid, the plan will pay the difference.

You will be responsible for any applicable copayment, coinsurance or deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an **a**llowable **e**xpense? 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 provider is a network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and an out-of-network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is an out-of-network provider for the primary plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is an out-of-network provider for both the primary plan and this Plan, the allowable expense is the greater of the two plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the allowable expense. When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the allowable expense.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated

Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UnitedHealthcare to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information?

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UHC any facts needed to apply those rules and determine benefits payable. If you do not provide UHC the information needed to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, Stryker may recover the amount in the form of salary, wages, or benefits payable under any Company-funded benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for benefits for expenses incurred on account of a covered person, that covered person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits that are payable in connection with services provided to other covered persons under the Plan. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

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.

Other Important Information

Bundled Payments

Certain network providers receive a bundled payment for a group of covered health services for a particular procedure or medical condition. Your copayment and/or coinsurance will be calculated based on the provider type that received the bundled payment. The network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the covered person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional copayment and/or coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some covered health services that are not considered part of the inclusive bundled payment and those covered health services would be subject to the applicable copayment and/or coinsurance.

UnitedHealthcare uses various payment methods to pay specific network providers. From time to time, the payment method may change. If you have questions about whether your network provider's contract with UHC includes any financial incentives, UHC encourages you to discuss those questions with your provider. You may also call UnitedHealthcare at the telephone number on your ID card. UHC can advise whether your network provider is paid by any financial incentive.