stryker

Flexible spending accounts

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

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

Keep in mind that IRS rules prohibit you from participating in both a Health Savings Account (HSA) and an HCFSA. Therefore, you are not eligible to participate in the HCFSA if you are enrolled in the Basic HSA or Premium HSA plans. You can, however, participate in the DCFSA if you are enrolled in one of these HSA-eligible plans.

How FSAs work

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

Annual enrollment to participate

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

FSA participation is not automatic. If you want to participate, you must enroll online or complete an enrollment form. In addition, you must make new enrollment and contribution elections every year you choose to participate. You do not need to be enrolled in a Stryker healthcare plan to participate in one or both FSAs. **The HCFSA is not available to employees enrolled in the UnitedHealthcare Basic HSA Plan or Premium HSA Plan.**

You may set aside money for one FSA, both FSAs, or neither. The amounts you choose to contribute should reflect your best estimate of expected out-of-pocket expenses for the calendar year (January through December).

Eligible expenses for the HCFSA include annual deductibles, copayments and healthcare expenses that are not covered by a healthcare plan. Eligible DCFSA expenses include amounts you pay for child or adult day care so that you and your spouse can work, look for work or attend school full-time. More detailed lists of eligible expenses under both FSAs are included in "Healthcare Flexible Spending Account (HCFSA)" on page 150 and "Day Care (child and adult) Flexible Spending Account (DCFSA)" on page 156.

An example

This hypothetical illustration is for educational purposes only. Dollar amounts or savings will vary depending on income, state and city tax rules, and other factors. Please consult a tax, legal or financial advisor about your own personal situation.

Tax saving example on $2,000 contribution to an FSA	
28% in federal income tax	$560
5% state income tax*	$100
7.65% in Federal Insurance Contributions Act (FICA) tax	$153
Total tax savings for year with an FSA	$813

* Tax savings apply if you are subject to state taxation (except for New Jersey residents)

By paying out-of-pocket costs with before-tax versus after-tax money, you can save $813 in taxes in this example.

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

Enrolling in an FSA

Participation in an FSA is entirely voluntary. If you are a part-time employee working at least 20 hours per week, or a full-time employee working at least 40 hours a week, you're eligible to enroll in the HCFSA, the DCFSA or both. **However, due to IRS rules, you may not participate in the HCFSA if you are enrolled in the UnitedHealthcare Basic HSA Plan or Premium HSA Plan and participate in an HSA.** If you don't enroll in an FSA when you are first eligible or during an annual enrollment period, you normally are not eligible to enroll again until the next annual enrollment period.

Important

FSA elections **do not** roll over from one year to the next, so you must enroll and select a new annual contribution amount each year if you want to continue to contribute to an FSA.

- If you are a new employee. You are eligible to participate in the HCFSA and the DCFSA on your date of hire. In order to participate in either FSA, you must complete the applicable enrollment information and indicate how much you want to contribute to each account. FSA contributions begin on the first day of the payroll period following the date of your election and continue through the last pay period of the calendar year.
- Keep in mind, changes due to a new enrollment (or qualifying life event) will not be permitted after the last pay period during the calendar year has been run.
- If you are rehired after a break in service. If the break in service is 30 days or less and you are rehired in the same calendar year, your previous flexible spending account elections will be reinstated as of your rehire date. Contributions will be recalculated to deduct the full amount of your election by the end of the plan year.

  If the break in service is longer than 30 days or if you are rehired in a new calendar year, you will make new FSA elections which will become effective as of your rehire date.
- **Annual enrollment**. You have a new opportunity to enroll in the HCFSA and the DCFSA each year. During the annual enrollment period, you decide whether you want to participate in one or both FSAs and how much you want to contribute. Your participation status and the amount you contribute can change from one year to the next.

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

Electing direct deposit reimbursement

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

Life event guide – FSA

Under current federal tax rules, your ability to change your HCFSA and DCFSA elections is limited.

You may change your enrollment once each year during the annual enrollment period. You will be notified in advance of the annual enrollment dates. Coverage changes will take effect the following January 1. You must check your enrollment confirmation for any errors. If you do not correct any errors within the enrollment period or, with the permission of Stryker, after the end of the enrollment period but before January 1, you will not be permitted to make any changes unless you subsequently have a qualifying life event or qualify for HIPAA special enrollment rights as described next.

In most cases, you cannot change your HCFSA or DCFSA election during the year. However, mid-year election changes may be permitted if you experience a qualifying life event as provided in the following chart. Keep in mind, changes due to a new enrollment or qualifying life event will not be permitted after the last pay period during the calendar year has been run.

Not all healthcare change events permit FSA changes

You are not permitted to change your health FSA elections because of a reduction in hours of service or because you intend to enroll in a plan offered through the public Marketplace.

Qualifying life event	Healthcare Flexible Spending Account (HCFSA)	Day Care (child and adult) Flexible Spending Account (DCFSA)
Marriage, declaration or registration of a tax-dependent domestic partner, birth or adoption	You may enroll or increase your HCFSA election.	You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.
Death of tax dependent, divorce, annulment or termination of tax dependent domestic partnership **Note: Legal separation is not considered a qualifying life event**	▪ You may enroll or increase your HCFSA election if coverage is lost under another health plan (e.g., your spouse's plan). ▪ You may decrease your HCFSA in the event of a death of a tax dependent.	You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.
Change in the employment status of employee, spouse, dependent or tax dependent domestic partner (e.g., change in work hours, change between salaried and hourly, loss of employer sponsored coverage and leaves of absence)	You may enroll or increase your HCFSA election if eligibility under another employer health plan is affected. You may reduce your HCFSA election if your covered dependent becomes covered under another employer health plan.	You may enroll, increase or decrease your DCFSA election if the event affects your day care expenses and the change is consistent with the event.

Qualifying life event	Healthcare Flexible Spending Account (HCFSA)	Day Care (child and adult) Flexible Spending Account (DCFSA)
Change in residence or work site of employee, spouse, tax dependent domestic partner or dependent	N/A	You may enroll, increase or decrease your DCFSA election if the event affects day care expenses and the change is consistent with the event.
Employee or dependent becomes eligible or loses eligibility for Medicare or Medicaid	You may enroll or increase your HCFSA election if there has been a loss of Medicare or Medicaid. You may reduce your HCFSA election in the event of Medicare or Medicaid eligibility and enrollment.	N/A
Court issues order regarding medical coverage of child (qualified medical child support order or QMCSO)	You may enroll or increase your HCFSA election if you are required to provide coverage for a dependent not previously covered.	N/A
Change in amount charged by current day care provider	N/A	You may increase or decrease your DCFSA election based on whether your costs increase or decrease, but only if the change in cost is not imposed by a relative.
Change in day care provider	N/A	You may increase or decrease your DCFSA election, based on whether the change causes your costs to increase or decrease, regardless of whether the new provider is a relative.
Need for day care changes (e.g., child begins kindergarten)	N/A	You may enroll, increase or decrease your DCFSA election. The change must be consistent with the event.
Another employer's plan cancels or reduces FSA elections due to discrimination determination	You may enroll or increase your HCFSA election if you elected HCFSA under the other employer's plan for the same plan year.	You may enroll or increase your DCFSA election if you elected DCFSA under the other employer's plan for the same plan year.
Enrollment period for coverage under another employer's plan occurs while your elections are in effect	You may not change your HCFSA election.	You may decrease your DCFSA election if your spouse elects coverage under a DCFSA offered by his/her employer.

Changes to your healthcare and/or day care (child and adult) flexible spending account elections must be consistent with the qualifying life event. Your Benefits representative must approve benefit election changes. If you have a qualifying life event as shown in the previous chart, you must contact your Benefits representative and provide proof of the life event (if applicable) within 30 days of the event (including the date of the event) in order to change your healthcare and/or day care election. Additional elected amounts will be eligible for use on all services incurred on and after the effective date of the change.

Taking a family or medical leave of absence

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

Reporting qualifying life events

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

The importance of estimating carefully

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

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

Use it or lose it

Under IRS regulations, amounts remaining in an HCFSA following the March 31st claim-filing deadline must be forfeited and cannot be applied to the next year's expenses.

DCFSAs include a grace period of 2.5 months after the end of the current plan year for incurring expenses. Funds not used, with claims filed by the March 31st deadline, must be forfeited.

You can submit claims for expenses incurred and paid in a calendar year until March 31 of the following year. For example, you can submit expenses incurred in 2024 until March 31, 2025. UnitedHealthcare must receive claims no later than March 31.

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

DCFSA plans include a grace period. If you have unused contributions in your account at the end of the current plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31 of the following year. For example, if you have $1000 in unused contributions remaining at the end of the current plan year, you may use eligible expenses incurred through March 15 to deplete those funds, and submit the claims by March 31. Any expenses incurred after March 15 would count toward the current plan year account, if you have one. According to Internal Revenue Service regulations, after March 31 funds remaining in your account for the previous plan year will be forfeited.

Keeping you informed

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

When FSA participation ends

If you leave Stryker or stop contributing to an HCFSA for any reason, your participation will end on the date your employment ends or you stop contributions to either or both accounts. You may continue to submit claims for expenses incurred prior to the date your participation ended up to March 31 of the following year. If you are eligible, you may elect to continue participating in the

HCFSA after you leave Stryker through COBRA continuation. For details, see “COBRA: Continuing Healthcare Coverage” in the **Participating in healthcare benefits** section.

If you leave Stryker or stop contributing to a DCFSA for any reason, you may submit claims for the eligible expenses you have incurred until the earlier of the date your DCFSA balance at the time of termination is exhausted or the end of the plan year of your employment termination date. Any such claims must be submitted on or before March 31 of the next plan year.

Healthcare Flexible Spending Account (HCFSA)

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

How much you can contribute

When you enroll in the HCFSA, you select an annual calendar year contribution amount that will be prorated and deducted from each of your paychecks on a before-tax basis. Annual HCFSA contributions cannot exceed $3,050 as of 2024 The minimum annual HCFSA contribution is $100.

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

An example

Assume that you are hired in May and your HCFSA participation begins in June. If you elect to contribute the annual maximum and you are paid semi-monthly, your per-paycheck contribution would be $217.86, as shown in the following chart.

How much you can contribute to the HCFSA				
Annual Contribu-tion		**Remaining Pay Periods (June – December)**		**Per Paycheck Contribu-tion Amount**
$3,050	÷	14	=	$217.86

Eligible expenses

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

For more information

See the UnitedHealthcare website at **www.myuhc.com** for current detailed information regarding eligible HCFSA expenses or call UnitedHealthcare customer service toll free at 800 387 7508.

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

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

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

- Acupuncture services
- Auto equipment to assist the physically handicapped
- The difference in cost between Braille and non-Braille books and magazines
- Special schools for the mentally or physically handicapped
- Contact lenses, solutions and supplies
- Deductibles and amounts paid as coinsurance or copayments under medical, dental, vision and prescription drug plans
- Detoxification or substance abuse treatment to the extent that treatment is not covered by a medical plan
- Equipment installed in your home and certain home improvements, if the main purpose is medical care
- Expenses in excess of medical, dental or vision coverage limits

- Expenses for eye examinations, frames, lenses and tinting that are not covered under Stryker's vision benefits
- Guide dogs for the blind and deaf
- Hearing exams and hearing aids
- Medically necessary mattresses and bed boards
- Menstrual care products
- Nursing home care
- Orthopedic shoes (portion of the cost that exceeds the cost of a regular pair of shoes), only if used to treat or alleviate a specific condition
- Over-the-counter (OTC) drugs and medicines
- Oxygen equipment
- Preventive healthcare services not covered under a group medical plan
- Radial keratotomy and laser eye surgery
- Smoking cessation programs
- Special equipment for the handicapped
- Transportation expenses related to medical care
- Weight loss programs, but only if part of a treatment plan for a specific condition and prescribed by a physician

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

Expenses not covered

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

- Expenses for cosmetic surgery, medications or any other treatment or procedure directed at improving appearance that does not promote proper functioning of the body or prevent or treat illness or disease is excluded
- Claims for expenses that were not incurred during the current plan year or that were incurred prior to the date of mid-year election increase due to a qualifying event
- Expenses for items that are merely beneficial to general health, such as health/fitness club memberships or weight loss programs
- Claims for expenses incurred after your HCFSA plan participation stops
- Expenses that have been reimbursed, or are reimbursable, by another source such as a group medical plan
- Healthcare expenses (or the portion of healthcare expenses) that exceed your annual HCFSA contribution election
- Any expense, other than for non-prescription drugs, that could not be claimed as an income tax deduction under Section 213 of the Internal Revenue Code without regard to the 7.5% adjusted gross income threshold
- Insurance premiums

Failure to cash reimbursement checks

All reimbursement checks must be presented for payment within 12 months of issuance. After this period, replacement checks will not be issued, and uncashed checks shall be considered forfeitures.

Qualified reservist distribution

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

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

To receive a QRD of all or part of any unused HCFSA amounts, or additional details on how to

request a qualified distribution, contact your Benefits representative as soon as you receive your orders or are called to active duty.

HCFSA claim procedures

Submitting a claim for reimbursement

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

Important

Only expenses incurred while you are a participant in the HCFSA are reimbursable. In addition, expenses incurred during one plan year cannot be reimbursed during another plan year. An expense is considered incurred when services are provided, **not** when you are billed or when you pay for care.

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

HCFSA claims should be submitted to the following address:

Health Care Account Service Center
P.O. Box 981506
El Paso, TX 79998-1506

If you prefer, you can submit your claims via fax at 915 231 1709.

Only expenses incurred while you are a participant in the HCFSA are reimbursable. In addition, expenses incurred during one plan year cannot be reimbursed during another plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a claim form as often as you like. If you have established an HCFSA, your total annual calendar year contribution is available immediately. You can request reimbursement for eligible expenses up to your annual contribution amount as soon as eligible expenses are incurred.

HCFSA claims will be accepted until March 31 of the following year. Any claims submitted prior to March 31 and denied due to a lack of proper documentation will be reconsidered only if the appropriate documentation is submitted and received by UnitedHealthcare by April 30. In accordance with IRS regulations, amounts contributed to your HCFSA during the plan year but remaining in your account after March 31 of the following year cannot be returned to you or used to reimburse expenses incurred in a subsequent plan year. These amounts are forfeited.

Remember, you cannot be reimbursed for any expenses paid by an employer-sponsored medical or dental plan. Any expenses reimbursed by your HCFSA cannot be included as a deduction or credit on your income tax return.

Automatic reimbursement

If you enroll in a UnitedHealthcare Choice or Value PPO plan and elect to contribute to the HCFSA, your medical and prescription drug copayments and coinsurance amounts will automatically roll over to the HCFSA. Medical and prescription drug expenses that are not covered under your UnitedHealthcare Choice or Value PPO plans, including copayments and coinsurance amounts, are automatically submitted to your HCFSA for reimbursement. This automatic claim submission feature eliminates extra paperwork and makes it more convenient for you to use your HCFSA.

Important

Unless you use your Consumer Account Card, an HCFSA claim form must be submitted for any other types of expenses, such as dental or vision expenses that are not covered by the UnitedHealthcare Choice or Value PPO plans.

If you do not want to use the automatic submission feature, call UnitedHealthcare customer service at 800 387 7508 in order to request that it be discontinued. You can also discontinue automatic claim submission by visiting the UnitedHealthcare website at **www.myuhc.com**.

If you have medical coverage through another carrier, you cannot select the automatic claim submission feature. In addition, automatic submission cannot be selected for your spouse if

your spouse is not covered under Stryker's Health Plan.

Unless you use your Consumer Account Card, an HCFSA claim form must be submitted for any other types of expenses, such as dental or vision expenses that are not covered by a plan administered by UnitedHealthcare.

Initial claim determination

UnitedHealthcare will decide your claim no more than 30 days after it is received as long as all needed information was provided with the claim. This time period may be extended for an additional 15 days if additional information is needed to process the claim when necessary due to matters beyond the control of UnitedHealthcare or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period, and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information necessary to complete your claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the 45 days, your claim will be decided within 15 days after the information is received. If you do not provide the requested information within the prescribed timeframe, your claim will be denied. An adverse benefit determination notice will explain the reason for the adverse benefit determination, refer to the part of the plan on which the adverse benefit determination is based and explain claim appeal procedures.

If your claim is denied

If UnitedHealthcare sends you a notice of adverse benefit determination, whether that is for the entirety of your claim for a benefit or a part of the claim, you will receive a written notice that will provide:

- The specific reason or reasons for the adverse benefit determination
- Reference to specific plan provisions on which the determination was based
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary
- A description of the steps you must follow (including applicable time limits) if you want to appeal the adverse benefit determination, including, in the case of an adverse benefit determination on a claim for reimbursement under the HCFSA:
  - Your right to submit written comments and have them considered
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal
- If the claim administrator relied on an internal rule, guideline, protocol or other similar criterion in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request

Review of adverse benefit determination

If you have a question or concern about an adverse benefit determination, you may informally contact a UnitedHealthcare customer service representative before requesting a formal appeal. The customer service telephone number is 800 387 7508. If the customer service representative cannot resolve the issue to your satisfaction, you may request a formal appeal.

If you wish to request a formal appeal of an adverse benefit determination, you should contact customer service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid and any written information to support your appeal.

Your first level appeal request must be made in writing to the claim administrator within 180 days after you receive the written notice that your claim has been denied in whole or in part. If you

do not file your appeal within this time period, you will lose the right to appeal the denial.

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

UnitedHealthcare will review the first level appeal request and notify you of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted in writing to UnitedHealthcare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for a second level appeal.

UnitedHealthcare has the exclusive right to interpret and administer Stryker's healthcare spending account plan, and these decisions are conclusive and binding.

The review will take into account all comments, documents, records and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial adverse benefit determination. In addition, the individual who decides your appeal will not be the same individual who denied your initial claim and will not be that individual's subordinate.

Review of an appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the adverse benefit determination, you will receive a written explanation of the reasons and facts relating to the adverse benefit determination.

Filing a second appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UHC must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UHC's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim adverse benefit determination and appeals	
Type of claim or appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the adverse benefit determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Claim adverse benefit determination and appeals	
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

* UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

You will be notified in writing of the decision on appeal. If the decision upholds the initial adverse benefit determination, the notification will provide:

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

Designation of an authorized representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claim procedures to "you" is intended to include your authorized representative.

Adverse benefit determination of claims based on ineligibility to participate

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

Your written appeal should state that it is an appeal, set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate and describe the specific details of what happened to cause the issue resulting in ineligibility. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Submit your appeal to the following address:

Stryker Benefits Committee
Attn: Health Plan Administrator
Stryker
1901 Romence Road Parkway
Portage, MI 49002

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

Day Care (child and adult) Flexible Spending Account (DCFSA)

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

How much you can contribute

When you enroll in the DCFSA, you select an annual contribution amount that will be prorated and deducted from each of your paychecks on a before-tax basis. Annual DCFSA contributions cannot exceed $5,000 per year if you are married and filing jointly or if you are single. If you are married and file a separate tax return, your maximum annual contribution cannot exceed $2,500. The minimum annual DCFSA contribution is $100.

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

An example

Assume that you are hired in May and you make your election so that your DCFSA participation begins in June. If you elect to contribute the annual maximum, and you are paid semi-monthly, your per-paycheck contribution would be $357.14, as shown in the chart below.

How much you can contribute to the DCFSA				
Annual Contribution		**Remaining Pay Periods (June – December)**		**Per Paycheck Contribution Amount**
$5,000	÷	14	=	$357.14

Day care expenses that enable you and your spouse to work, look for work or attend school full-time are eligible for reimbursement under the DCFSA.

Eligible expenses

Eligible expenses under the DCFSA are determined according to current Internal Revenue Service guidelines. Generally, amounts you pay for the care of a qualifying dependent so that you (and your spouse, if you are married) can work, look for work or attend school full-time are eligible expenses. Qualifying dependents under the DCFSA include:

- A child younger than the age of 13 who lives with you more than 50% of the year. A non-custodial parent is not eligible even if that parent is responsible for paying child care expenses. The child must be your child, stepchild or eligible foster child.
- Your spouse who is physically or mentally incapable of caring for himself or herself and who resides with you for more than 50% of the year.
- An adult relative (including a child age 13 or over) who is physically or mentally incapable of caring for himself or herself and who resides with you for more than 50% of the year. If the individual is your adult relative, he or she must be able to qualify as your tax dependent except that the individual is not eligible if he or she had too much income, filed a joint return, or you, or your spouse if filing jointly, and could be claimed as a dependent on someone else's tax return. Please consult with a tax advisor for details.

For More Information

See the UnitedHealthcare website at **www.myuhc.com** for current detailed information regarding eligible DCFSA expenses or call UnitedHealthcare customer service toll free at 800 387 7508.

Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes, such as one of your older children. If the care is provided by a facility that cares for more than six individuals, the facility must be licensed and comply with state and local laws. Expenses for care outside your home for any individual age 13 or over are eligible only if the dependent regularly spends at least eight hours each day in your household.

Examples of eligible expenses include:

- Day care center charges, provided that the center complies with appropriate state and local regulations
- Babysitter charges for care inside or outside your home provided the charges allow you and your spouse to work or look for work (you must provide a Social Security number for your sitter to claim reimbursement from the DCFSA)
- Expenses paid to a preschool or kindergarten provided that charges related to education cannot be separated from the charges for the care of a qualifying dependent child
- Charges made by a relative who cares for your dependents, so long as the relative is not your dependent or is not your child under age 19 at the end of the calendar year, even if that child is no longer your dependent
- Charges for care of an elderly or incapacitated dependent, either in your home or outside your home (the dependent must spend at least eight hours each day in your home if you are seeking reimbursement for care provided outside your home)
- Charges for day care at a day camp during school vacations

Expenses not covered

Expenses that are not eligible for DCFSA reimbursement include:

- The cost of food, clothing and education
- The cost of transportation between your house and the place where day care services are provided, unless transportation is provided by your day care provider
- Medical and dental expenses for you or your eligible dependents
- Overnight camp expenses
- Nursing home expenses
- Any expenses you incur if your spouse is not employed, looking for work, disabled or a full-time student
- Any day care expenses that you have also claimed under the federal child and day care tax credit
- Care provided by the children's parent

Expenses that are eligible for reimbursement under the DCFSA are subject to IRS guidelines and may change from time to time. See the UnitedHealthcare website at **www.myuhc.com** for current detailed information regarding eligible DCFSA expenses or call customer service toll free at 800 387 7508. In addition, information is available online at **www.irs.gov** or by calling the IRS at 800 TAX FORM (800 829 3676) and requesting Publication #503: Child and Day care Expenses.

Failure to cash reimbursement checks

All reimbursement checks must be presented for payment within 12 months of issuance. After this period, replacement checks will not be issued, and uncashed checks shall be considered forfeitures.

The federal tax credit

A portion of your qualified day care expenses can also be applied as a credit when you complete your federal income tax return. However, expenses that have been reimbursed through the DCFSA cannot be applied toward the credit. In addition, all amounts reimbursed through the DCFSA reduce the maximum available tax credit on a dollar-for-dollar basis. Therefore, you should consider both options and decide which one produces the greater tax savings for you.

Eligible expenses under the tax credit are the same as those eligible for reimbursement through the DCFSA. Depending on your family's total gross income, your tax credit could be as much as 35% of your annual day care expenses, subject to certain maximums.

The maximum amount of day care expenses you can use to calculate the tax credit is $3,000 if you have one dependent or $6,000 if you have two or more.

The maximum available tax credit is $1,050 for one dependent or $2,100 for two or more. It's up to you to determine whether the federal dependent and child care tax credit or the DCFSA is more advantageous for you. In order to make this decision, you should consider:

- Your total annual day care expenses
- Your family's adjusted gross income (the amount you pay taxes on after you've claimed exemptions)
- The maximum available tax credit

You can obtain detailed information about the federal tax credit by calling UnitedHealthcare toll free at 800 387 7508 or by visiting the UnitedHealthcare website at **www.myuhc.com**. Information also is available directly from the Internal Revenue Service online at **www.irs.gov** or by calling toll free at 800 TAX FORM (800 829 3676) and requesting Publication #503: Child and Day care Expenses.

Other things you should know

- If your spouse does not work, you cannot use the DCFSA or the tax credit unless your spouse is looking for work, a full-time student or is disabled and incapable of self-care.
- The amount of work-related day care expenses that can be used to calculate the tax credit or submitted to the DCFSA cannot exceed the lower of your annual income or your spouse's annual earned income. For example, if you earn $30,000 annually, and your spouse earns $3,000, the most you can contribute to the DCFSA or apply toward the tax credit is $3,000—regardless of the actual amount of your expenses or the number of qualified dependents.
- If your spouse is a full-time student or is disabled, you may assume a minimum amount of earned income in order to determine the maximum allowable DCFSA contribution, or the maximum available tax credit. If you claim expenses for one dependent, your spouse's minimum earning assumption is $250 monthly. If you claim expenses for two or more dependents, your spouse is assumed to earn $500 per month.
- In order to use the DCFSA or the tax credit, you must report your day care provider's name, address and taxpayer identification number on your federal income tax return. If an individual instead of a day care center provides care, the taxpayer identification number is the individual's social security number.
- You must file a claim in order to be reimbursed for qualified day care expenses.

How to obtain DCFSA benefits

UnitedHealthcare processes DCFSA claims. You must submit a claim form and appropriate documentation in order to receive payment from the DCFSA. Examples of acceptable documentation include:

Documentation

Photocopies of canceled checks are **not** considered acceptable documentation.

- A receipt or itemized statement from a licensed day care center showing dates of service and the amount charged
- A canceled check showing the dates of service and the name of your day care provider (This is adequate documentation only if a relative provides services.)

Photocopies of canceled checks are not considered acceptable documentation.

Completed claim forms should be sent to:

Health Care Account Service Center
P.O. Box 981506
El Paso, Texas 79998-1506

If you prefer, you can submit your claims via fax at 915 231 1709.

When you enroll in the DCFSA, you may choose to have your claim reimbursements deposited directly to your bank account. If you elect the direct deposit option, you will receive a notice each time a claim is paid. The notice will indicate the amount of the reimbursement and the date it was deposited to your account.

DCFSA claims are processed every week. If your claim is in order, it will be processed promptly, and a reimbursement check (or direct deposit verification notice) will be sent to your home. However, you should be aware that claim processing might be delayed in the following circumstances:

- If your claim form is incomplete or if you have not provided necessary documentation, your claim form will be returned to you.
- If your claim exceeds your current DCFSA balance, claim payment will be based on the account balance amount. The remaining claim amount will be held until the next claim-processing period.
- If your claim includes amounts paid in advance, payment is based upon services

actually provided as of the claims processing date. Amounts paid for future services will be held until charges are incurred.

You can be reimbursed only for expenses incurred during the same year you put money in the DCFSA. For example, only day care expenses incurred during 2024 and filed with UnitedHealthcare by March 31, 2025 can be reimbursed from your 2024 DCFSA, with the exception of the grace period as noted below.

DCFSA plans include a grace period. If you have unused contributions in your account at the end of the current plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31 of the following year. For example, if you have $1000 in unused contributions remaining at the end of the current plan year, you may use eligible expenses incurred through March 15 to deplete those funds, and submit the claims by March 31. Any expenses incurred after March 15 would count toward the current plan year account, if you have one. According to Internal Revenue Service regulations, after March 31 funds remaining in your account for the previous plan year will be forfeited.

DCFSA claim forms are available from your Benefits representative, by calling UnitedHealthcare toll free at 800 387 7508 or at **www.myuhc.com**, the UnitedHealthcare website. You can elect to have DCFSA reimbursements deposited to your checking account by visiting the UnitedHealthcare website at **www.myuhc.com**.

If your claim is denied

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

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary
- A description of the steps you must follow (including applicable time limits) if you want to appeal the adverse benefit determination of your claim, including, in the case of an adverse benefit determination of a claim for reimbursement under the DCFSA:
    - Your right to submit written comments and have them considered
    - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
- If the claim administrator relied on an internal rule, guideline, protocol or other similar criterion in denying your claim, either:
    - A description of the specific rule, guideline, protocol or criterion relied on, or
    - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request

Review of denied claims

If you have a question or concern about a benefit determination, you may informally contact a UnitedHealthcare customer service representative before requesting a formal appeal. The customer service telephone number is 800 387 7508. If the customer service representative cannot resolve the issue to your satisfaction, you may request a formal appeal.

If you wish to request a formal appeal of a denied claim, you should contact customer service to obtain the UnitedHealthcare address where the appeal should be sent. Your appeal should be submitted in writing to that address and should include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid and any written information to support your appeal.

Your first level appeal request must be made in writing to the claim administrator within 180 days after you receive the written notice that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

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

records and other information relevant to the claim.

UnitedHealthcare will review the first level appeal request and notify you of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted in writing to UnitedHealthcare within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision in writing within 30 days from receipt of a request for a second level appeal.

UnitedHealthcare has the exclusive right to interpret and administer Stryker's day care (child and adult) flexible spending account plan, and these decisions are conclusive and binding.

The review will take into account all comments, documents, records and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

You will be notified in writing of the decision on appeal. If the decision upholds the initial adverse benefit determination of your claim, the notification will provide:

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records and other information relevant to your claim
- If an internal rule, guideline, protocol or other similar criterion was relied on in denying your claim, either:
  - A description of the specific rule, guideline, protocol or criterion relied on; or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request

Denials of claims based on ineligibility to participate

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

Your written appeal should state that it is an appeal, set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate and describe the specific details of what happened to cause the issue resulting in ineligibility. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

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