Your Rights and Responsibilities

This Benefits Summary is the summary plan description (SPD), effective January 1, 2011, for:

- The Stryker Corporation Welfare Benefits Plan (which includes Stryker's medical, prescription drug, dental and vision plans and flexible spending accounts)
- The Stryker Adoption Assistance Plan

It also is the SPD for the 401(k) Savings and Retirement Plans, effective April 1, 2011.

These plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

This section contains legal and administrative information for the healthcare, welfare and adoption assistance plans described in this Benefits Summary, which you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if, for example, you want to know:

- How to contact the plan sponsor and administrator
- Time limits that apply to filing and appealing claims
- Your rights under ERISA

For More Information

This section describes administrative information and details applicable to the Stryker Healthcare Benefits, Flexible Spending Accounts and Additional Benefits only. See the *401(k) Retirement Plans* section for administrative information for that plan.

Also, see *Participating in Healthcare Benefits* for information about COBRA continuation of coverage, HIPPA certificates and what happens if you have healthcare coverage in addition to the benefits provided by Stryker.

Important Note

For the healthcare, welfare and adoption assistance plan benefits, the applicable sections of this Benefits Summary describing each benefit, along with this Your Rights and Responsibilities section and applicable vendor contracts or certificates of coverage together constitute the SPD for that benefit.

The 401(k) Savings and Retirement Plan that applies to you is described in its entirety (including administrative details governing that plan) within the *401(k) Retirement Plans* section, with that section constituting the SPD for that plan. See the *401(k) Retirement Plans* section for all details about your 401(k) plan.

The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a federal law enacted in 1993 that provides for an unpaid leave of absence for up to 12 weeks each year if you experience one of these events:

- The birth or adoption of a child, or placement of a foster child in your home
- A serious health condition affecting your child, spouse or parent (this does not include parents-in-law)
- A serious health condition that makes you unable to perform your job

To be eligible for an FMLA leave, you must have completed 1,250 hours of active work during the 12 consecutive month period before your leave is scheduled to begin. Any paid or unpaid leave time taken during the year is counted against your annual FMLA allowance. You must provide 30 days notice when the need for an FMLA leave is foreseeable. When the need for a leave comes up unexpectedly, you must provide as much advance notice as possible. Medical certification regarding your or a family member's serious health condition may be required.

While you are away from work on an FMLA leave, your coverage under the Stryker Corporation Welfare Benefits Plan will continue for the duration of your approved leave period. You must make arrangements to pay required healthcare benefit contributions on a regular basis while you are away from work.

If your coverage contributions have not been paid for 30 days, your health coverage may be canceled. You will be notified of a potential coverage cancellation. If Stryker elects to pay your contributions while you are on leave, you will reimburse the Company through payroll deduction when you return to work. If you do not return to work, you must repay the Company for the cost of Company-paid health coverage provided during your leave, unless you are not able to return to work due to the continuation, recurrence or onset of a serious health condition, or other circumstances beyond your control.

If you return to work when your leave ends, Stryker must restore you to your former position or an equal position with equal pay, benefits and terms and conditions of employment.

For full details on FMLA provisions in your state and how they affect your coverage under the plan, contact your Benefits Representative or Benefits Service Center.

Qualified Medical Child Support Orders

You may be required to enroll your child for coverage in the healthcare plan in accordance with the terms of a qualified medical child support order (QMCSO), even if you have not previously enrolled the child for coverage. If the plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, Stryker may withhold any contributions required for such coverage.

A QMCSO is a judgment, decree or order issued by a court or an authorized government agency that:

- Provides for child support and/or health benefit coverage for your child
- Is made according to a state domestic relations law that relates to group health benefits under the Stryker Corporation Welfare Benefits Plan; or enforces a law relating to medical child support described in Section 1396g of Title XIX of the Social Security Act
- Creates or recognizes the existence of the child's right to receive the healthcare benefits for which you are eligible under the Stryker Corporation Welfare Benefits Plan
- Meets the following requirements:
  - Clearly specifies your name and last known mailing address and the name and mailing address of each child covered by the order
  - Clearly specifies a reasonable description of the type of coverage to be provided to each child
  - Does not require the Stryker Corporation Welfare Benefit Plan to provide any type or form of benefit or any option not otherwise provided, except to the extent necessary to meet requirements relating to medical child support described in Section 1396g of Title XIX of the Social Security Act

Coverage for a child who is eligible under a QMCSO becomes effective on the latest of the following dates:

- The first day of the month specified in the order
- The first day of the month following the date the plan administrator determines that the order is qualified
- The effective date of a court order requiring Stryker to withhold coverage contributions for dependent health coverage from your earnings

If the plan administrator receives a judgment, decree or order that relates to the provision of healthcare benefits for your child, the plan administrator will notify you, the child's custodial parent and/or the appropriate governmental agency of the plan's procedures for determining whether the judgment, decree or order is "qualified." You can obtain, without charge, a copy of the procedures from the plan administrator. Within a reasonable period of time, the plan administrator will determine whether the order is a qualified medical child support order. You and the child's custodial parent or representative will be notified of the decision.

Patient Protection Notices

The claims administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the claims administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the claims administrator for your medical plan at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the claims administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the claims administrator's network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the claims administrator at the number on the back of your ID card.

Time Limits for Claims Filings

Medical and Dental Claims

Claims related to a period of illness or treatment of an injury must be filed within one year of the date you first become ill or injured and require covered medical or dental services. All other claims must be filed within one year of the date covered charges were incurred. If you are not able to meet this claim-filing deadline through no fault of your own, your claim will be accepted if you file the claim as soon as possible. Unless you are legally incapacitated, claims will not be accepted if they are filed more than two years after the claim-filing deadline.

Prescription Drug Claims

Claims must be filed within one year following the date the prescription is filled.

Vision Claims

Claims must be filed within one year following the date covered services or materials are provided.

Flexible Spending Accounts Claims

Claims must be received by March 31st following the end of the plan year during which you participated in the FSA and incurred eligible expenses.

Adoption Assistance Claims

Claims must be filed by December 1 of the year following the year in which eligible adoption expenses were incurred.

Legal Action

If legal action is to be brought against the plans, it must be done no later than two years from the date a claim is required.

Subrogation Rights

Medical and Prescription Drug Benefits

Important

The third parties and persons or entities referred to in the "Subrogation Rights" section are collectively referred to as "third parties."

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the plan will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the plan provided to covered persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by the Stryker Corporation Welfare Benefits Plan, the plan will also have an independent right to be reimbursed by covered persons for the reasonable value of any services and benefits the plan provides from any or all of the following listed below.

- Third parties, including any person alleged to have caused a covered person to suffer injuries or damages
- Any person or entity who is or may be obligated to provide benefits or payments to a covered person, including benefits or payments for under insured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators

Covered persons agree as follows:

- That a covered person will cooperate with the plan in a timely manner in protecting the plan's legal and equitable rights to subrogation and reimbursement, including but not limited to:
  - Providing any relevant information requested by the plan
  - Signing and/or delivering documents the plan or its agents may reasonably request to secure the subrogation and reimbursement claim

  - Responding to requests for information about any accident or injuries
  - Appearing at depositions in court
  - Obtaining the consent of the plan or its agents before releasing any party from liability or payment of medical expenses
- That failure to cooperate in this manner will be deemed a breach of contract and may result in the termination of health benefits and/or the institution of legal action against a covered person
- That the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated in this summary plan description
- That no court costs or attorney's fees may be deducted from the plan's recovery without the plan's express written consent; any so-called "fund doctrine" or "common fund doctrine" or "attorney's fund doctrine" will not defeat this right and the plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a covered person to pursue his or her damage/personal injury claim
- That, regardless of whether a covered person has been fully compensated or made whole, the plan may collect from covered persons the proceeds of any full or partial recovery that a covered person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection will include, but not be limited to, any and all amounts earmarked as a non-economic damage settlement or judgment
- That benefits paid by the plan may also be considered to be benefits advanced
- That covered persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness (either before or after any determination of liability), whether by settlement or judgment, the covered person will serve as a constructive trustee over the funds and failure to hold such funds will be deemed as a breach of the covered person's duties under the plan
- That covered persons or an authorized agent, such as the covered person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the plan separately and alone; and failure to hold such funds will be deemed a breach of contract and may result in the termination of health benefits or the institution of legal action against the covered person
- That the plan will be entitled to recover reasonable attorney's fees from covered persons incurred in collecting from the covered person any funds held by the covered person that he or she recovered from any third party
- That the plan may set off from any future benefits otherwise allowed by the plan the value of benefits paid or advanced under this section to the extent not recovered by the plan
- That covered persons will neither accept any settlement that does not fully compensate or reimburse the plan without the plan's written approval, nor will the covered person do anything to prejudice the plan's rights under this section
- That covered persons will assign to the plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits the plan provided, plus reasonable costs of collection
- That the plan's rights will be considered as the first priority claim against third parties, including tortfeasors for whom covered persons are seeking recovery, to be paid before any other of the covered person's claims are paid
- That the plan's rights will not be reduced due to the covered person's own negligence
- That the plan may, at its option, take necessary and appropriate action to reserve its rights under these subrogation provisions, including filing suit in the covered person's name, which does not obligate the plan in any way to pay the covered person part of any recovery the plan might obtain
- That the plan will not be obligated in any way to pursue this right independently or on behalf of the covered person
- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a plan beneficiary, this section applies to the personal representative of the deceased plan beneficiary

Assignment of Benefits

When completing a healthcare claim form, you may choose to have payment made directly to the provider. To do so, complete the "Assignment" section of the claim form. If you do not want payment made directly to the provider, leave this section of the form blank and any payment due will be sent to you.

Incorrect Claim Payments

If a claim is not paid correctly for any reason, an adjustment will be made. For instance, if a claim is underpaid, the additional benefit amount will be paid directly to you or the provider of service. If a claim is overpaid, the claims administrator has the right to recover the overpayment amount from you. Overpayments may be repaid directly to the claim administrator or deducted from future benefit payments.

Other Information

Name of Plans

- Stryker Corporation Welfare Benefits Plan
- Stryker Adoption Assistance Plan
- Stryker Corporation 401(k) Savings and Retirement Plan
- Stryker Corporation 401(k) Savings and Retirement Plan for Sales Employees

Note

The remaining portion of this section pertains to the Stryker Corporation Welfare Benefits Plan and the Stryker Corporation Adoption Assistance Plan. All information in this SPD concerning the 401(k) Savings and Retirement Plans is set forth in the *401(k) Retirement Plans* section.

Types of Plans

The Stryker Corporation Welfare Benefits Plan is an employee benefit welfare plan as defined by ERISA. The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental, vision, flexible spending accounts and employee assistance benefits which are further described in this summary plan description. In addition, the Stryker Corporation Welfare Benefits Plan provides life insurance and long-term disability insurance benefits through insurance policies. Employees participating in those benefits will receive a certificate of coverage from the insurer describing those fully-insured benefits. The Stryker Adoption Assistance Plan is a fringe benefit plan under the Internal Revenue Code and is not subject to ERISA.

Plan Documents

This summary plan description is intended to give a simple explanation of the following components of the Stryker Corporation Welfare Benefits Plan: the UnitedHealthcare PPO, Out-of-Area and prescription drug plans; the Delta Dental plan; the EyeMed vision plan, flexible spending accounts and the employee assistance benefit. HMO plans are described in separate documents. The booklet also explains the Stryker Adoption Assistance Plan. Note that the plans are set out and operate under the terms of plan documents and related contracts. If there is any conflict between this booklet and the plan documents and contracts, the plan documents and contracts will govern.

You or your beneficiary may examine any or all plan documents at the principal office of the plan administrator or available from your Benefits Representative or Benefits Service Center. Upon written request to the plan administrator, a copy of a plan document will be sent to any participant or beneficiary.

Future of the Plans

Stryker Corporation presently intends to continue these plans for employees. However, Stryker Corporation has the right to amend or terminate the plans at any time. If the plans were terminated, the rights of covered persons to benefits are limited to claims incurred and due up to the date of termination. The benefits under these plans are not vested.

Plan Administrator

These benefit plans are sponsored and administered by Stryker Corporation (also referred to as Stryker or the Company). Stryker Corporation has appointed people who are responsible for the plans' day-to-day operations. You may contact the plan administrator at:

Stryker
Attention: Corporate Benefits
2825 Airview Boulevard
Kalamazoo, MI 49002
269 389 2600

Agent for Service of Legal Process

If legal papers are to be served concerning any aspect of the plans, the designated agent is Stryker's General Counsel at:

Stryker Attention: General Counsel
2825 Airview Boulevard
Kalamazoo, MI 49002
269 389 2600

Plan Year

The plan year for the Stryker Corporation Welfare Benefits Plan and Adoption Assistance Plan begins on January 1 and ends on December 31 each year.

Identification

The plans cover eligible employees of Stryker Corporation, the plan sponsor and plan administrator, as well as eligible employees of its participating subsidiaries. The IRS has assigned the following employer ID numbers for the Company and its participating subsidiaries:

▪ Stryker Corporation	38-1239739
▪ Stryker Sales Corporation	38-2902424
▪ Howmedica Osteonics Corp	22-2183590
▪ Stryker Communications Inc.	20-1962228
▪ Stryker Biotech LLC	20-0470801

Stryker must use these numbers when corresponding with the IRS and the U.S. Department of Labor on any matters related to any of its employee benefit plans. By law, Stryker must also assign plan numbers to each of its ERISA plans. The plan number for the Stryker Corporation Welfare Benefits Plan is 501. When referring to this plan in claim appeals or other correspondence, you will receive help more quickly if you identify it fully and accurately. Use the full plan name and number.

Funding

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

HMO plans and Blue Cross Blue Shield plans offered to employees in Alabama, California, Connecticut, Hawaii, Maine, Massachusetts, New Hampshire, Vermont and Rhode Island are fully insured.

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

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

Examinations

Through its claims administrators, Stryker will have the right and opportunity to examine any person when and so often as it may reasonably require while a healthcare claim is pending.

Adjustment Rule

Stryker may change the level of benefits provided under the plans at any time. If a change is made, benefits for claims incurred after the date the adjustment takes effect will be paid according to the revised plan provisions. In other words, once an adjustment is made, there are no vested rights to benefits based on earlier plan provisions.

Notice About HIPAA Privacy

The Health Insurance Portability and Accountability Act (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of your privacy rights is found in the Notice of Privacy Practices that has been distributed to you.

The plan and those administering it will use and disclose health information only as allowed by law. If you have a complaint, questions, concerns or need a copy of the Notice of Privacy Practices, you may contact:

HIPAA Privacy Officer
Stryker
2825 Airview Boulevard
Kalamazoo, MI 49002

Your Rights Under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to the benefits subject to ERISA. All benefits under the Stryker Corporation Welfare Benefits Plan are subject to ERISA with the exception of the day care (child and adult) flexible spending account. The Adoption Assistant Plan is also not subject to ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and copies of all documents filed by the plan, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The administrator may make a reasonable charge for the copies.)
- Receive a summary of the plan's annual financial report (The plan administrator is required by law to furnish each participant with a copy of this summary annual report.)

Continue Group Health Plan Coverage

In addition, if you are a participant in a group health plan, you have the right to:

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage (Review this summary plan description and the documents governing the plan for information regarding your COBRA continuation coverage rights.)
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer—when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases and you may request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the summary plan description. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C.20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.