Your Rights and Responsibilities

This Benefits Summary is the summary plan description (SPD), effective January 1, 2019, for:

- The Stryker Corporation Welfare Benefits Plan (which includes Stryker's medical, prescription drug, dental, vision, life insurance, long-term disability, and flexible spending account plans)
- The 401(k) Savings and Retirement Plans

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 *Participating in Healthcare Benefits* for information about COBRA continuation of coverage, 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 Plan* section, with that section constituting the SPD for that plan. See the *401(k) Retirement Plan* section for all details about your 401(k) plan.

The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees to take up to 12 workweeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons, or for any "qualifying exigency" arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation. The FMLA also allows eligible employees to take up to 26 workweeks of job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

To be eligible for an FMLA leave, you must have worked 1,250 hours 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 of 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 will 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 Stryker Corporation Welfare Benefits Plan, contact your Benefits Representative.

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; and
  - 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.

Coverage for a child who is eligible under a QMCSO ends on the earliest of the following:

- The date, if any, specified in the order as the last day of coverage;
- The day prior to the covered child's 26th birthday; or
- The date the covered child otherwise ceases to qualify as a dependent under the Plan.

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

No lawsuit to recover benefits and/or premiums under the Plan may be brought more than one year after the final denial issue date of the claim under the Plan's appeal procedures.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which any third party is considered responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you receive for that sickness or injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Company in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured 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.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan benefits provided on behalf of the covered person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the benefits the Plan has paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to you, your dependents or the employee, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year deductible.
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

Assignment of Benefits

Under provisions of the Stryker Corporation Welfare Benefits Plan, Plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Trustees, and any attempt to do so shall be void.

Payment of Benefits

When you assign your benefits under the Plan to an out-of-network provider with UnitedHealthcare's consent, and the out-of-network provider submits a claim for payment, you and the out-of-network provider represent and warrant that the covered health services were actually provided and were medically appropriate.

To be recognized as a valid assignment of benefits under the Plan, the assignment must reflect the covered person's agreement that the out-of-network provider will be entitled to all their rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning their benefits, and that the covered person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If benefits are assigned or payment to an out-of-network provider is made, the Plan reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes the Plan as described in "Overpayment and Underpayment of Benefits" on page 209.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign benefits directly to that provider.
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned benefits to that third party.

Form of Payment of Benefits

Payment of benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

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 Stryker medical 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-sponsored 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 Stryker pays for benefits for expenses incurred on account of a covered member, that covered member, or any other person or organization that was paid, must make a refund to Stryker if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the covered member, but all or some of the expenses were not paid by the covered member or did not legally have to be paid by the covered member.
- 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, the covered member agrees to help the Plan get the refund when requested.

If the refund is due from the covered member and the covered member, , does 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 the covered member that are payable under the Plan. If the refund is due from a person or organization other than the covered member, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future benefits that are payable in connection with services provided to other covered members under the Plan.

The reallocated payment amount will 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.

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 eligible 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, Part B and DME carrier have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the claims administrator 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 go on to file claims for these expenses.
- For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

Other Information

Name of Plans

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

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 and accidental death and dismemberment (AD&D) insurance and long-term disability insurance benefits through insurance policies and administrative service agreements. Those benefits are described briefly in this summary plan description. 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. The Health Savings Account and short-term disability plan are also not governed by 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 PPOs, Basic and Premium HSA medical plans, Out-of-Area plan and prescription drug plans; the Delta Dental plan; the EyeMed vision plan; flexible spending accounts; and the employee assistance benefit.

HMO plans, as well as life and AD&D insurance and short-term and long-term disability insurance are described briefly here and detailed 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. 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 members 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 Sustainability Solutions	86-0898793
▪ Stryker Performance Solutions LLC	46-1634423
▪ Stryker Customs Brokers LLC	20-8420912

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. The UnitedHealthcare, Delta Dental and EyeMed plans are not insured. The administrators perform claim administrative functions only.

The HMO plans, the Cigna plan and Blue Cross Blue Shield plans offered to employees in Alabama, California, and Hawaii, are fully insured. Long-term disability is also 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.

Basic Life and Accidental Death and Dismemberment (AD&D) coverage for employees is funded directly by Stryker from its general assets. Supplemental and dependent life insurance coverage for are funded entirely by employee contributions made through after-tax salary deductions. Life, short-term disability and accident coverage is not insured.

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 as 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 and the health savings account (HSA). 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 life event. Stryker is not required to offer continuation of healthcare coverage to a domestic partner or children of a domestic partner. However, Stryker has chosen to offer coverage in the same manner as other dependents. 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

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 health or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health or 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.