Stryker benefits summary



Stryker is pleased to provide you with this summary plan description ("SPD" or "benefits summary") describing the healthcare, welfare and retirement benefits available to eligible Stryker employees as of January 1, 2026.

When the unexpected occurs — a serious illness, a long absence from work, even death — we count on Stryker-sponsored healthcare and welfare benefits for financial protection. In addition, Stryker Corporation sponsors the Stryker Corporation 401(k) Savings and Retirement Plan so that you and other employees of Stryker and its participating subsidiaries (all referred to in this Summary as the "Company") may save for retirement on a "before-tax" basis. The benefits provided under the 401(k) Plan are in addition to Social Security.

To get the maximum value from your benefit plans, you need to understand how they work: what's covered, what's not, who is eligible and when. This Stryker benefits summary provides information about the plan provisions and guidelines governing your healthcare, welfare and retirement benefits.

The information presented in the benefits summary makes it easy to understand your benefits. Consider this handbook your first resource whenever you have a question about what is covered, how to file claims or your rights as a plan participant. The benefits described are summaries of the official plan documents and contracts, which govern the plans. They are written in plain language to help you understand how the plans work.

When you have questions that are not answered here, please refer to the section called **Contacts** on page 240. The information provided in the **Contacts** section includes toll-free phone numbers and web site addresses for Stryker's claims administrators and insurance carriers. Please contact the claim administrators or insurance carriers first when you have questions about coverage or claim status. As always, your Benefits representative is also available to assist you with complex questions or situations that require special handling.

For more information

Administrative details and procedures for Stryker's healthcare and welfare plans can be found in the **Your rights and responsibilities** section starting on page 228. (Administrative information about the 401(k) Savings and Retirement Plan is included within the **401(k) Retirement Plan** section starting on page 182.) See the **Contacts** section on page 240 for phone numbers and web addresses you can use for answers to your questions.

If you have questions about the information in this benefits summary, you can also contact your Benefits representative.

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About this summary

This benefits summary describes the main features of the Stryker healthcare benefits, flexible spending accounts, health savings account, life insurance and disability benefits, 401(k) Savings and Retirement Plan and additional benefits in non-technical language. These descriptions are part of the formal plan documents that govern plan operation; however, to the extent that the separate plan documents contain additional terms and conditions governing the plans' operation, the provisions in the plan document will govern.

The following benefits are described in this benefits summary:

- Healthcare benefits
  - Medical benefits
  - Prescription drug benefits
  - Dental benefits
  - Vision benefits
  - Location-based provisions (supplemental information about location-specific benefits)
- Flexible spending accounts
- Health savings account
- Life and AD&D insurance
- Disability benefits
- 401(k) Savings and Retirement Plan
- Additional benefits
  - Adoption assistance plan
  - Maven: Family building, parenting and midlife health
  - Employee assistance program
  - Strive for Wellbeing program

For more information

Administrative details and procedures for the healthcare and welfare benefits can be found in the **Your rights and responsibilities** section starting on page 228. (See the **401(k) Retirement Plan** section starting on page 182 for administrative information for those plans.)

If you have questions about the information in this benefits summary, you can also contact your Benefits representative.

Important note: For the healthcare and welfare benefits, the applicable sections of this benefits summary and applicable vendor contracts or certificates of coverage together constitute the summary plan description (SPD) for that benefit. The 401(k) Savings and Retirement Plan that applies to you is described in its entirety (including administrative details governing the plan) within the **401(k) Retirement Plan** section starting on page 182, with the appropriate section constituting the SPD for that plan. Notwithstanding any other provision in this SPD, Stryker intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, Stryker will modify this SPD accordingly and/or provide a Summary of Material Modifications.

An important note!

Stryker Corporation, as the plan administrator and plan sponsor, has the sole discretion to interpret the plan documents and the information set out in this summary. Except to the extent that the plan administrator has delegated such authority, no other person has the authority to interpret the plans or to make any representations about them. For example, the plan administrator may delegate to the claims administrator the authority to process benefit claims and administer the appeal procedure with respect to denied benefit claims. Further, any fully insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and for the payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurer is the exclusive source of payment for a fully insured benefit.

The information in this benefits summary has been prepared as accurately as possible. The information for all plans reflects provisions in effect as of January 1, 2026, unless noted otherwise.

All determinations and decisions of the plan administrator are final and conclusive for all parties. These determinations and decisions will not be overturned unless it is determined that they are arbitrary and capricious.

If there is any conflict between the information in this benefits summary and the official plan documents, the plan documents will always govern. In no event may any representations by any person change the terms of the plans.

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.

General information about other Stryker-sponsored benefits is also included for your reference.

Stryker reserves the right to terminate any plan or make changes to any plan at any time, for any reason. Your participation in these plans is not a contract of employment.

Updated information

As of January 1, 2026, this benefits summary replaces all earlier descriptions of Stryker healthcare benefits, flexible spending accounts, life insurance and disability benefits, 401(k) Savings and Retirement Plan and additional benefits.

If you have questions

If you have any questions about this benefits summary or any provision of the benefits provided by Stryker, see the **Contacts** section on page 240 for phone numbers and web addresses, or contact your Benefits representative.

If you need help understanding this summary

This benefits summary contains a summary of your rights and benefits under the plans described in it. If you have difficulty understanding any part of this summary, contact your Benefits representative.

Healthcare benefits



This Healthcare benefits section describes Stryker's healthcare benefits and includes the following information:

- **Participating in healthcare benefits**, starting on page 5
- **Medical benefits**, starting on page 31
- **Prescription drug benefits**, starting on page 98
- **Medical and Rx claims procedures**, starting on page 108
- **Vision benefits**, starting on page 119
- **Dental benefits**, starting on page 124
- **Location-based provisions**, starting on page 133

Because of the amount of claims and appeal information that is required in SPDs, this benefits summary includes a separate section on **Medical and Rx claims procedures**, starting on page 108. Claims filing information for dental and vision benefits, however, are explained within the Dental benefits and Vision benefits sections, respectively.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the medical claims administrator. For information on notification or prior authorization, contact the medical claims administrator.

Notice regarding post-mastectomy care

If you or a covered dependent receives benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Coverage will be subject to the same deductibles, coinsurance and/or co-payment applicable to other medical and surgical benefits provided under the plan.

Participating in healthcare benefits



The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides preventive care benefits to help keep you well.

This section includes information about who is eligible for healthcare benefits, how to enroll or make changes to your benefit elections, when coverage is effective and when it ends.

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Eligibility

Regular full-time and regular part-time employees

Important

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

In addition, see the **Your rights and responsibilities** section starting on page 228, in this Stryker benefits summary for more information regarding Qualified Medical Child Support Orders (QMCSOs).

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

Direct temporary employees expected to work 30 hours/week

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

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

Other employees

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

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

Ineligible individuals

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

Ongoing eligibility

Standard measurement period

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

2026 plan year, the standard measurement period will begin on October 4, 2024, and end on October 3, 2025.

If you are a regular part-time employee working at least 20 hours per week or a regular full-time employee working at least 40 hours per week, you will remain eligible for benefits as described under "Eligibility" on page 6 except as described below if your scheduled hours are reduced during the stability period.

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

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

Transfers and working hours changes

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

Breaks in service

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

Dependents

Eligible dependents include:

- Your legal spouse (if your spouse resides outside of the country, he or she may still be eligible for benefits)
- Your children through the last day of the month in which they turn age 26, regardless of their student, marital or employment status
- Your child of any age who relies on you for at least 51% of his or her support due to a physical or mental disability. Eligibility will continue if you provide proof of the disability within 30 days after the child reaches the age at which coverage would otherwise end. Coverage will then remain in effect as long as the disability continues, and you maintain dependent coverage under the Plan. If you are a newly hired employee with a child who relies on you for at least 51% of his or her support due to a physical or mental disability, you must attest that the dependent was disabled prior to having reached age 26.
- Your domestic partner. Note: registered domestic partnerships are not subject to any requirements for proof of relationship or waiting periods applied to domestic partnerships that are not also applied to marriages.
- For purposes of Stryker's benefit plans, a domestic partnership is defined as:
  - A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry, if applicable.

OR

- A domestic partnership in which both partners can attest to all of the following criteria:
  - We are at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
  - We are each other's sole domestic partner in a committed relationship, have been so for at least 12 months, and intend to remain so indefinitely.
  - We are not related in a way that would prohibit a legal marriage.
  - We are not legally married to anyone else, nor have another domestic partner.
  - We are currently residing together in the same principal residence, have done so for at least 12 months, and intend to do so indefinitely (although we may live apart for reasons of education, healthcare, work, or military service).
  - We are jointly responsible for each other's common welfare and financial obligations of the household.

For purposes of determining eligibility under the Stryker Corporation Welfare Benefits Plan, the term "child" means your (or your spouse's or domestic partner's) child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, a child placed for adoption, or a child for whom you have been appointed legal guardianship.

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

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

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

If satisfactory proof of eligibility is not provided within the applicable annual enrollment, new hire, or qualifying life event enrollment period, the dependent will not be eligible for coverage under the plan.

If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the **Medical and Rx claims procedures** section, starting on page 108, the **Dental benefits** section, starting on page 124, or the **Vision benefits** section, starting on page 119.

If both you and your spouse, domestic partner or dependent work for Stryker, you may not be covered under the plan both as an employee and a dependent, nor may you be covered under any other Stryker-sponsored plan as a dependent if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Eligibility requirements

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

- UnitedHealthcare Value PPO Plan, HSA plans and Surest Advantage Plan
- UnitedHealthcare Out-of-Area plan
- UnitedHealthcare/OptumRx prescription drug plan
- Delta Dental dental plan
- EyeMed vision plan

HMOs and other insured medical plans may have eligibility requirements which are different than those outlined in this booklet. If you are enrolled in a medical plan option other than the UnitedHealthcare Value PPO Plan, HSA plans, Surest Advantage Plan or Out-of-Area Plan, see the supplemental summary plan description for the applicable plan in the **Location-based provisions** section, starting on page 133, or contact your Benefits representative for specific information regarding eligibility requirements.

Enrollment

You must enroll in order to be covered for any of the benefits under the Stryker Corporation Welfare Benefits Plan.

You are required as a condition of enrollment to provide your Social Security number and the Social Security numbers of each family member for whom you are requesting coverage. You must enroll via the Benefits Enrollment Site at **https://enroll.stryker.com**, or by completing an enrollment form and returning it to your Benefits representative along with the required dependent documentation within 30 days of your hire date (including your date of hire) in order to complete the enrollment on a pre-tax basis.

Important

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

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

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

If you don't properly enroll and submit all of the requested documentation within 120 days of your date of hire (including your date of hire), you will not be enrolled in any of the healthcare coverages. You will not be able to enroll for medical, prescription drug, dental or vision coverage during the year unless you have a qualifying life event or qualify for a HIPAA special enrollment period.

If failure to enroll with all of the required documentation within the applicable timeframes is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the **Medical and Rx claims procedures** section, starting on page 108, the **Dental benefits** section, starting on page 124, or the **Vision benefits** section, starting on page 119.

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

In certain circumstances, you may also have the option to enroll in a Stryker medical plan not listed among your available options on the Benefits Enrollment Site. If you wish to enroll in a plan that's available in your area but not listed as

an option, you must contact your Benefits representative during the annual enrollment period (or within 30 days if you are newly hired or have a qualifying life event that permits a medical plan election) to request a change.

You must check your enrollment confirmation for any errors. If you do not correct any errors within the enrollment period, you will not be permitted to make any changes unless you subsequently have a qualifying life event or qualify for HIPAA special enrollment rights as described under "Making changes" starting on page 10.

Making changes

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

Qualifying life events

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

When changes take effect

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

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

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

If you need to change your healthcare benefit election due to one of these life events, your Benefits representative must approve any benefit election changes. See "Life event guide — healthcare" on page 13 for details about making benefit changes as a result of a qualifying life event.

Qualifying life event rules

Documentation required

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

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

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

If you are enrolled in a medical plan option other than the UnitedHealthcare Value PPO Plan, HSA plans, Surest Advantage Plan or Out-of-Area Plan, see the supplemental summary plan description for the applicable plan (provided in the **Location-based provisions** section, starting on page 133) or contact your Benefits representative for specific information regarding eligibility requirements. You will be asked to provide proof of the life event (for example, loss of coverage under another health plan) and dependent documentation, such as a marriage or birth certificate, of any qualifying life event. See "Life event guide — healthcare" on page 13 for further details on Qualifying Life Events.

HIPAA special enrollment rights

There are circumstances under which you will qualify for HIPAA special enrollment and other rights:

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

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

  If you don't enroll within 30 days, you may still enroll within the 120-day period described in "Eligibility" on page 6 and "Making changes" on page 10, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and will be payable retroactively to the date the child was acquired). If you don't enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

- **You or a dependent loses other coverage.** If you waived health coverage because you or your dependent had other medical coverage (including COBRA coverage), you may enroll yourself and your dependents if you or your dependents subsequently lose eligibility for that other coverage (or exhaust COBRA coverage) or if employer contributions for that coverage are terminated (this does not include the reduction or end of a COBRA subsidy).

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

  - A loss of coverage that results from termination of employment, reduction in hours of employment, divorce, termination of domestic partnership, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan);
  - In the case of HMO coverage, a loss of coverage that results when an individual no longer resides, lives or works in an HMO service area and there is no other benefit package available to the individual; and
  - A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part.

  Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis, voluntary termination or termination of coverage for cause (such as fraud) or loss of coverage with no qualifying life event. See "When coverage ends" on page 18 for more information about termination of coverage for cause.

- **You lose Medicaid/CHIP eligibility.** If you or an eligible family member loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (CHIP), you may have HIPAA special enrollment rights.

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

  If you don't enroll within 30 days, you may still enroll within the 120-day period described in "Eligibility" on page 6 and "Making changes" on page 10, but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and will be payable retroactively to the date eligibility was lost). If you don't enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

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

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

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

  If you don't enroll within the 60-day period, you may still enroll within the 120-day period but all contributions for coverage will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and will be payable retroactively to the qualifying life event). If you don't enroll within the 120-day period, you generally will not be permitted to enroll until the next annual enrollment period.

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

Life event guide — healthcare

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

Important note about life events…

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

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

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

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

If you are adding coverage and submit all of the requested documentation more than 30 days (including dependent documentation) but less than 120 days of the event, your change will be effective but all new contributions will be deducted from your paycheck on a post-tax basis for the remainder of the plan year in which you properly completed the enrollment (and payable retroactively to the date of the qualifying life event). However, you may not switch health plan options as specified in the following chart more than 30 days after your qualifying life event. If you don't properly change your enrollment and submit all of the requested documentation within 120 days of the event, you will have to wait until the next annual enrollment period to make any changes to your healthcare benefit election, unless you experience another qualifying life event that would permit an election change prior to that time. (Fully insured plans are administered by insurance carriers that do not always agree to the

extension of benefits. Please contact your Benefits representative for confirmation.)

If failure to enroll within this timeframe is due to circumstances beyond your control, please submit an appeal for further consideration as instructed in the **Medical and Rx claims procedures** section, starting on page 108, the **Dental benefits** section, starting on page 124, or the **Vision benefits** section, starting on page 119.

Life event guide	
Qualifying life event	**Permissible election change**
Marriage, declaration or registration of a domestic partner with any state or local government, birth, adoption, placement for adoption, appointment of legal guardianship, acquiring a stepchild or placement of a foster child	You may add your new spouse, new domestic partner or newly acquired dependent child to the medical and prescription drug, dental and/or vision coverage. You may also add any other eligible dependents who were not previously covered under this plan. If you previously declined coverage, you may enroll yourself, your spouse, your domestic partner and/or any eligible dependent child in the medical and prescription drug, dental and/or vision coverage. You may drop medical and prescription drug, dental and/or vision coverage if you become enrolled for similar coverage under your spouse's or domestic partner's plan. With a marriage, domestic partnership, birth, adoption or placement of adoption, you may change health plan options as applicable (e.g., from the UHC Basic HSA Plan to the UHC Value PPO Plan).
Death of dependent, divorce, annulment or termination of domestic partnership, termination of an adopted or foster child's placement or end of guardianship appointment **Note:** Legal separation is not considered a qualifying life event	You must drop the affected dependent's medical and prescription drug, dental and/or vision coverage. You may enroll yourself and any eligible dependents in similar coverage if the event causes a loss of coverage under your spouse or domestic partner's plan.
Change in the employment status of employee, spouse, domestic partner or dependent (e.g., change in work hours, change between salaried and hourly and leaves of absence)	You may enroll for medical and prescription drug, dental and/or vision coverage if the change in employment status results in a loss of eligibility for other similar coverage. If there is a change in employment status of your spouse, domestic or civil union partner or dependent that results in a loss of eligibility under their employer's plan, you may enroll them in similar coverage as well as other eligible dependents not previously covered. You may drop medical and prescription drug, dental and/or vision coverage if the change in employment status results in eligibility for other similar coverage and you are enrolled in another medical and prescription drug, dental and/or vision plan(s).
Dependent loses benefit eligibility under Stryker's plan (for example, the dependent reaches age 26)	You may drop the affected dependent's medical and prescription drug, dental and/or vision coverage.
Dependent newly satisfies eligibility requirement under Stryker's plan	You may add the newly eligible dependent that satisfies the plan eligibility requirement as well as other previously eligible dependents not covered under the plan.

Life event guide	
Qualifying life event	**Permissible election change**
Change in residence or work site	You may change to another similar plan option or drop coverage if the event results in loss of eligibility under your current plan option. However, you are not permitted to change your healthcare FSA election because of a change in residence.
Dependent moves to the United States from another country	You may enroll your dependent(s) for medical and prescription drug, dental and/or vision coverage. Your contributions for any coverage you elect will be made on an after-tax basis for the remainder of the plan year in which Stryker was notified.
Loss of other employer, government or educational institution sponsored medical coverage by employee, spouse, domestic partner or dependent	You may enroll yourself and/or your spouse, domestic partner or dependents in the medical and prescription drug, dental and/or vision plan(s) if other similar coverage is lost due to: ▪ Exhaustion of COBRA; ▪ Loss of eligibility; or ▪ Termination of employer contributions as an active employee only. You may add any other eligible dependents that were not previously covered under this plan. You may change health plan options (e.g., from an HMO to PPO).
Employee or dependent becomes entitled for or enrolled in (or loses entitlement for or enrollment in) Medicare or Medicaid	You may drop medical and prescription drug, dental and/or vision coverage for the affected individual upon entitlement to Medicare or Medicaid. You may enroll yourself and/or the affected individual for medical and prescription drug, dental and/or vision coverage upon loss of similar coverage through Medicare, Medicaid or CHIP eligibility, and if you are already covered under the Stryker Corporation Welfare Benefits Plan. You may also change health plan options (e.g., HMO to PPO).
Court issues order regarding medical coverage of child (qualified medical child support order (QMCSO)) or National Medical Support Notice (NMSN)	You may enroll your child in medical and prescription drug, dental and/or vision coverage. If you are not currently covered, you must also be added to the same plan(s). You may drop similar coverage for your child if another individual is ordered to provide medical and prescription drug, dental and/or vision coverage for the child under a QMCSO or NMSN and coverage is in fact provided.
Significant increase in cost or significant curtailment of coverage under an employer-sponsored plan	If the plan increase occurs mid-year under this plan and you have other plan options under this plan, you may elect similar coverage under this plan or you may drop coverage if you enroll in a similar plan with another employer. If no other plan options are available to you under this plan, you may drop coverage for the medical, dental or vision plan to which the cost increase is associated. If you are electing similar coverage, you may also add any other eligible dependents that were not previously covered under this plan.
Enrollment period for coverage under another employer's plan occurs while your elections are in effect	You may drop medical and prescription drug, dental and/or vision coverage if you become enrolled for similar coverage under another employer's plan. You may enroll for medical and prescription drug, dental and/or vision coverage if similar coverage under the other employer's plan was dropped during that plan's enrollment period.

Life event guide	
Qualifying life event	**Permissible election change**
Reduction in hours of service	You and your covered dependents may drop your group health plan coverage, even if you remain eligible for such coverage, if: ▪ You were reasonably expected to work 30 hours per week, and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week ▪ You enroll yourself and your covered dependents that are dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop Stryker health coverage.
Enrollment in a health plan offered through the public Marketplace	If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop Stryker group health plan coverage, even if you remain eligible for Stryker coverage. You (and any dependents whose coverage is dropped at this time) must enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under the Stryker Corporation Welfare Benefits Plan is dropped. IRS guidance also permits the employee to retain self-only coverage and to drop family coverage if at least one family member is eligible to enroll in Marketplace coverage during its special or annual enrollment periods AND if the family intends to enroll.

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

Your cost for healthcare benefits

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

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

Tobacco surcharge

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

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

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

Tobacco cessation program

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

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

Tobacco-use verification

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

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

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

Tobacco surcharge

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

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

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

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

Strive tobacco cessation journeys can be accessed by you and your spouse/domestic partner through the Strive program at **strive.stryker.com**.

Definition of a tobacco user

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

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

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

Non-grandfathered status

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

Questions regarding which protections apply, and which protections do not apply to a non-grandfathered health plan can be directed to the plan administrator (see the **Your rights and responsibilities** section starting on page 228). You may also contact the Employee Benefits and Security Administration, U.S. Department of Labor at 866 444 3272or **www.dol.gov/ebsa/healthreform**. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

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

When coverage begins

For you

If you enroll when you are first eligible, your coverage under the Stryker Corporation Welfare Benefits Plan begins immediately as of your date of hire or as of the date you become eligible for benefits. See "Eligibility" on page 6 for further details.

For your dependents

If you are covered, new dependents will be covered as of the event date if you enroll them within 30 days after they first become eligible, or within 120 days as described in "Eligibility" on page 6 and "Making changes" on page 10.

Any dependent child born while you are insured for medical insurance will become insured for medical insurance on the date of birth. If you do not wish to change your benefit election due to the birth of a newborn, the automatic coverage for the newborn will terminate immediately following day four after birth. You will need to wait until the next annual enrollment to change your election if coverage has not been selected within 30 days.

Newborn expenses are covered for the first four days after the birth. These expenses will be covered separate from the parent.

For re-hired employees and their dependents

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

When coverage ends

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

- The date you leave Stryker or fail to pay required coverage costs (unless you are on an approved leave and payments are made upon your return)
- The date you are no longer an eligible employee
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, on the December 31 following the annual enrollment period
- The date the plan is terminated
- The date the plan administrator terminates your coverage for reasons as described in the "Termination of Coverage for Cause" box that follows

In addition, dependent coverage also ends:

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

Termination of coverage for cause

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

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

When your coverage ends, claims will be paid for covered healthcare services that you received before your coverage ended. However, once your coverage ends, benefits are not provided for healthcare services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

If you are enrolled in a medical plan option other than the UnitedHealthcare Value PPO Plan, HSA plans, Surest Advantage Plan or Out-of-Area Plan, check the supplemental summary plan description for the applicable plan (provided in the **Location-based provisions** section, starting on page 133) or contact your Benefits representative for specific information regarding eligibility requirements. If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see "COBRA: continuing healthcare coverage" on page 19.

COBRA: continuing healthcare coverage

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

COBRA continuation coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying life event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose health plan coverage because of a qualifying life event. Depending on the type of qualifying life event, employees, spouses, domestic partners of employees and dependent children of employees may be qualified beneficiaries.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Stryker Corporation Welfare Benefits Plan, Health Care Flexible Spending Account and Employee Assistance Program because either one of the following qualifying life events happens:

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

Note: If you are enrolled in a medical plan option other than the UnitedHealthcare Value PPO Plan, HSA plans, Surest Advantage Plan or Out-of-Area Plan, see the supplemental summary plan description for the applicable plan (provided in the **Location-based provisions** section, starting on page 133) or contact your Benefits representative for specific information about eligibility for COBRA Continuation Coverage for your spouse or domestic partner and dependent children.

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

- Your spouse or domestic partner dies,
- Your spouse's or domestic partner's hours of employment are reduced or your spouse's or domestic partner's employment ends for any reason other than his or her gross misconduct,
- You become divorced from your spouse,
- Your domestic partnership is terminated, or
- Your spouse or domestic partner becomes enrolled in Medicare (Part A or Part B).

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

- The parent-employee dies,
- The parent-employee's hours of employment are reduced or the parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parents become divorced,
- The parent's domestic partnership is terminated,
- The child stops being eligible for coverage under the plan as a "dependent child," or
- The parent-employee becomes eligible for Medicare (Part A or Part B).

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

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

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

Duration of COBRA continuation coverage

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

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

Disability extension of 18-month period of continuation coverage

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

Second qualifying life event extension of 18-month period of continuation coverage

If your family experiences a second qualifying life event while receiving COBRA continuation coverage (either during the initial 18-month continuation period or during the following 11 months if there is an extension due to disability), the spouse, domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse, domestic partner and dependent children if the former employee dies, or gets divorced, legally separated or there is a termination of domestic partnership. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child. **In all of these cases, you must make sure that the plan administrator is notified of the second qualifying life event within 60 days of the second qualifying life event via your Benefits representative. This notice must be sent to the plan's COBRA administrator**. You will be required to supply documentation — such as a marriage or birth certificate — that a second qualifying life event has occurred.

Medicare entitlement prior to termination of employment or reduction in hours

If you enroll in Medicare (Part A, Part B or both) in the 18-month period immediately preceding your

termination of employment or reduction in hours, your spouse, domestic partner and dependent children can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the date you enrolled in Medicare.

Contacting the COBRA administrator

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

When COBRA coverage ends

COBRA continuation coverage will terminate on the earliest of the following dates:

- The end of the applicable maximum coverage period
- If any required premium is not paid on time, the last day of the period for which a timely payment was made
- The date, after the date of the COBRA election, that a qualified beneficiary first becomes covered under another group health plan
- The date after the date of the COBRA election, that a qualified beneficiary first enrolls in Medicare
- The last date on which the employer ceases to provide any group health plan for its employees
- In the case of the disability extension, the last day of the 11-month extension period

Continuation coverage may also be terminated for any reason the plan administrator would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

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

Electing COBRA continuation coverage

Each qualified beneficiary has an independent right to elect continuation coverage. For example, either you or your spouse or domestic partner may elect continuation coverage, or only one of you may choose to do so. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election form. Failure to do so will result in loss of the right to elect continuation coverage under the plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's or domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying life event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost of COBRA continuation coverage

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

Paying for COBRA continuation coverage

First payment for continuation coverage

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

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

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. If you make a periodic

payment on or before its due date, your coverage under the Stryker Corporation Welfare Benefits Plan will continue for that coverage period without any break. The plan will send an annual notice of payments due for these coverage periods.

Grace periods for periodic payments

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

COBRA coverage for domestic partners

Although not required by COBRA law, under the UnitedHealthcare plans provided through Stryker, a covered domestic partner has the same COBRA rights as a spouse. Termination of the domestic partner relationship is treated in the same manner as divorce.

Note: If you are enrolled in a medical plan option other than the UnitedHealthcare Value PPO Plan, HSA plans, Surest Advantage Plan or Out-of-Area Plan, see the supplemental summary plan description for the applicable plan (provided in the **Location-based provisions** section, starting on page 133) or contact your Benefits representative for specific information about eligibility for COBRA continuation coverage for your spouse or domestic partner and dependent children.

Coverage options besides COBRA continuation coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP)**, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA continuation coverage after group health plan coverage ends

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

Continuing healthcare coverage upon military leave

If you cease to be eligible for health coverage under the Stryker Corporation Welfare Benefits Plan due to service in the U.S. military, you and your eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). You and your dependents may also be entitled to elect to continue your health coverage under COBRA if you cease to be eligible for health coverage due to your military service.

Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA continuation coverage

You may elect to continue health coverage under the Stryker Corporation Welfare Benefits Plan for yourself and your eligible dependents for the period that is the lesser of:

- Twenty-four months, beginning with the first day you are absent from work to perform military service; or
- The period beginning on the first day you are absent from work to perform military service and ending with the date you fail to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA continuation coverage

If you give the Company advance notice of a period of military service that will be 30 days or less, the plan administrator will treat your notice as an election to continue your health coverage during your military service unless you specifically inform the Company, in writing, that you want to cancel your health coverage during your military leave. You will have to pay the required premiums for your health coverage, but you will not have to complete any additional forms or paperwork to continue your health coverage during your military service.

If you give the Company advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide you with a notice of your right to elect to continue health coverage pursuant to USERRA and a form for you to elect USERRA continuation coverage for yourself and your eligible dependents. Unlike COBRA, your dependents do not have a separate right to elect USERRA coverage. If you want USERRA continuation coverage for any member of your family, you must elect it for yourself and all eligible dependents who are enrolled in health coverage under the Stryker Corporation Welfare Benefits Plan when your military service begins.

If you choose USERRA continuation coverage, you must return the USERRA election form to the plan administrator within 60 days of the date it was provided to you. If you do not timely return the election form, USERRA continuation coverage will not be available to you and your eligible dependents.

A special rule applies if you do not give the Company advance notice of your military service. In that case, you and your eligible dependents will not be provided with USERRA continuation coverage during any portion of your military service, but you can elect to reinstate your coverage (and the coverage of your eligible dependents) retroactive to the first day you were absent from work for military service under the following circumstances:

- You are excused from providing advance notice of your military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for you to provide advance notice or the advance notice was precluded by military necessity),
- You affirmatively elect to reinstate the coverage, and
- You pay all unpaid premiums for the retroactive coverage.

Paying for USERRA continuation coverage

For the first 30 days of military service, your required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If your period of military service is more than 30 days, beginning on the 31st day of your military service your required contributions will be 102% of the cost of identical coverage for similarly-situated participants.

USERRA continuation coverage will be cancelled if you do not timely pay any required premiums for that coverage. If your USERRA continuation coverage is cancelled for non-payment of premiums it will not be reinstated.

The initial premium must be paid within 45 days after the date you elect USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after you initially elect USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of your USERRA continuation coverage.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting period, except for illnesses or injuries connected to the military service.

If you have other coverage

Due to coordination of benefits rules, the Stryker Corporation Welfare Benefits Plan may not pay benefits if you also are eligible for medical, prescription drug, dental and/or vision benefits from another plan.

Medical benefits

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

When does Coordination of Benefits apply?

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

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

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

What are the rules for determining the order of benefit payments?

Order of benefit determination rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

         a. The plan covering the custodial parent.

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

         c. The plan covering the non-custodial parent.

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

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

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

   d. (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan, and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or shorter length of coverage. The plan that covered the person the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.
7. The Stryker medical plan is primary to medical coverage provided under a personal vehicle insurance policy, unless state insurance law requires otherwise.

How are benefits paid when this plan is secondary?

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

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

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

How is the Allowable Expense determined when this Plan is secondary?

Determining the Allowable Expense If this Plan is secondary

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

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

What is different when You qualify for Medicare?

Determining which Plan is Primary when you qualify for Medicare

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

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

Determining the allowable expense when this Plan is secondary to Medicare

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

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

Medicare Crossover program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

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

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

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

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

Right to receive and release needed information

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

Does this Plan have the right of recovery?

Overpayment and underpayment of benefits

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

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

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

Refund of overpayments

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

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

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

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

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

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

Dental benefits

Coordination of benefits (COB) is used to pay dental expenses when you are covered by more than one plan. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

When you or your family members are covered by more than one plan, Delta Dental follows coordination of benefits rules established by Michigan law to decide which plan is primary and pays first, which plan is secondary and how much the secondary plan must pay. You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Delta Dental pays benefits for eligible care only when you follow its rules and procedures. If these rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Other important information

Bundled payments

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

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

Medical benefits



Stryker's medical benefits are designed to provide comprehensive coverage and freedom of choice while also controlling costs for you and for Stryker. You may use any licensed healthcare provider and receive benefits for medical services that are required for the care of a sickness or an accidental injury.

This section of the Stryker benefits summary describes the UnitedHealthcare (UHC) plans and Surest Advantage Plan available to most Stryker employees. In specific locations, HMO and other fully insured medical plans are offered as alternatives to the UHC or Surest Advantage plans. If you are enrolled in one of those medical plans, refer to the **Location-based provisions** section, starting on page 133, and the benefit summary or certificate of coverage provided by the insurance company or HMO for detailed information regarding your covered services and supplies. Additional information about your medical options is also available at **https://totalrewards.stryker.com**.

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Stryker's medical options

Stryker offers most employees a choice of two UnitedHealthcare HSA plans-the Basic HSA Plan and the Premium HSA Plan-the UnitedHealthcare Value PPO Plan or the Surest Advantage Plan. However, depending on where you live, you may have alternative options.

UnitedHealthcare manages the Choice Plus network that serves as the network for Stryker's Value PPO Plan, HSA plans and the Surest Advantage Plan. UnitedHealthcare is also the claims administrator for Stryker's HSA plans, Value PPO Plan and the Out-of-Area Plan. Surest is the claims administrator for the Surest Advantage Plan.

Your options are described below.

The UnitedHealthcare Value PPO Plan

A PPO (Preferred Provider Organization) is a managed care arrangement that allows you to choose in- or out-of-network care each time you need a medical service or supply. When you use in-network providers, the Value PPO Plan pays a higher percentage of covered charges.

If you enroll in the UHC Value PPO Plan, you are not eligible to contribute to a Health Savings Account (HSA).

The UnitedHealthcare Basic and Premium HSA plans

The Basic and Premium HSA Plans work much like a traditional PPO. You choose in- or out-of-network care each time you need a medical service or supply. When you use in-network providers, the HSA plans pay a higher percentage of covered charges.

The HSA plans offer a tax-advantaged health savings account (HSA), which gives you more control over how you spend and save your healthcare dollars. See the **Health Savings Account** section, starting on page 167, for more information. If you enroll in a Health Savings Account, you are not eligible to participate in a Healthcare FSA.

The Surest Advantage Plan

The Surest Advantage Plan through UnitedHealthcare provides the coverage you would expect from traditional health insurance, but with clear, upfront cost and coverage information, so you know in advance what's covered and what you'll pay. There are no deductibles or coinsurance. Instead, you pay copays when you need services.

You can look up the copays on the Surest app or member website before making an appointment. For office visits and many procedures, you see one price. By grouping services — such as combining the labs and X-rays that go along with a medical procedure or test into one price — Surest makes it easier for you to know what you'll pay in advance.

Surest evaluates providers and locations based on past claims data. Higher Care Ratings are given to high-value providers with a record of quality, safety, efficiency and effectiveness, such as lower rates of complications after surgeries and better use of resources. Providers with a higher Care Rating are assigned a lower copay.

If you enroll in the Surest Advantage Plan, you are not eligible to contribute to a Health Savings Account (HSA).

Other medical plan options

Other medical options

If you reside in an area offering an alternative medical option, see the **Location-based provisions** section, starting on page 133, for more information.

While the UnitedHealthcare Value PPO Plan, HSA plans and Surest Advantage Plan options are available to employees in most Stryker locations, in the following states, alternative medical plans are offered:

- **California**-The Kaiser Permanente HMO is offered as an alternative to the UnitedHealthcare and Surest options. If you select the HMO, your prescription drug benefits are provided through Kaiser Permanente, and you are not eligible to contribute a Health Savings Account (HSA).
- **Hawaii**-The HMSA plan is the only medical plan offered in Hawaii. The UnitedHealthcare Value PPO Plan, HSA plans and Surest Advantage Plan options are not available in Hawaii. If you enroll in the HMSA plan, your prescription drug benefits will be provided through HMSA, and you are not eligible to contribute to a Health Savings Account (HSA).

The Out-of-Area Plan

The UnitedHealthcare Value PPO Plan, HSA plans and the Surest Advantage Plan are available to employees in most Stryker locations. The Out-of-Area Plan is available if you live in a zip code where there is not satisfactory access to the UHC Choice Plus network. Benefits are payable for covered health services that are provided by or under the direction of a physician or other provider regardless of their network status. This plan does not provide a network benefit level or an out-of-network benefit level.

How the UnitedHealthcare and Surest Advantage plans work

The following explains information you need to know about how the UnitedHealthcare and Surest Advantage plans work, and how using participating or non-participating providers impacts your benefits. All of these plans cover the same broad range of services and offer access to the same UHC Choice Plus provider network.

Covered health services

The healthcare service, supply or pharmaceutical product is only a covered health service if it is considered Medically Necessary. See "Medical plan definitions" on page 87 to understand how the Plan defines a covered health service. The fact that a physician or other provider has performed or prescribed a procedure or treatment does not mean that it is a covered service under the Plan.

The UHC Basic and Premium HSA medical plans work similarly. However, there are differences in the employee costs, deductibles, co-insurance and out-of-pocket maximums. In addition, there are no co-pays with the HSA plans.

The UHC Value PPO Plan has higher employee paycheck costs than the HSA Plans, but a lower deductible and out-of-pocket maximum.

The Surest Advantage Plan through UnitedHealthcare provides coverage for the same broad range of services as the other UHC plans but with clear, upfront cost and coverage information, so you know in advance what's covered and what you'll pay. There are no deductibles or coinsurance. Instead, you pay copays when you need services. The Surest Advantage Plan has slightly higher employee paycheck costs than the Value PPO Plan.

Finding care with the Surest Advantage Plan

Surest gives you the ability to compare providers and their actual copays for services before you make an appointment. This can help you understand your potential costs in advance and plan accordingly.

You can find providers—including their copays and Care Ratings—using the Surest website (**benefits.surest.com**) or app, which is separate from the UHC website and app. When you search, you'll see a range of in-network options, including high-value, lower cost providers, as well as virtual care.

Surest evaluates providers and locations based on past claims data. Higher Care Ratings are given to high-value providers with a record of quality, safety, efficiency and effectiveness, such as lower rates of complications after surgeries and better use of resources. Providers with a higher Care Rating are assigned a lower copay. For more information and to look up costs of care before you enroll, visit surest.care/stryker.

You can search in different ways:

- Enter search terms like provider names or specialties, such as dermatology.
- Search for care by entering common words, symptoms or conditions, like "back pain" or "my head hurts" — and search results will show different provider types and treatment options.

Search results display providers and care options as well as your copay amount. No matter what you search for, all results shown are in-network.

Your choices for receiving care

Each time you need care, you choose between:

- In-network services received from participating providers
- Out-of-network services received from non-participating providers

The Plans pay benefits for covered services either way, but at a higher level for in-network care. In addition, participating providers file claims and handle in-network prior authorization requirements for you.

In-network benefits are based on negotiated fees paid to participating providers. When covered health services are received from out-of-network providers, eligible expenses are based on fees that are negotiated with the provider, a percentage of the published rates allowed by Medicare for the same or similar service, or in rare circumstances, 50% of the billed charge or a fee schedule that is determined at the time of service. When reasonable and customary fee guidelines apply, you are responsible for paying the provider for

any difference between the reasonable and customary fee and the provider's actual charge.

Emergency services provided by an out-of-network provider will be reimbursed as eligible expenses under the plan.

Covered services provided at certain in-network facilities by an out-of-network physician, when not emergency services, will be reimbursed as eligible expenses under the plan. For these covered services, "certain network facility" is limited to:

- a hospital (as defined in 1861(e) of the Social Security Act),
- a hospital outpatient department,
- a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act),
- an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and
- any other facility specified by the Secretary.

Air ambulance transport provided by an out-of-network provider will be reimbursed as described under "Eligible expenses" on page 36.

Out-of-network benefit exception

Most of the healthcare services you need are available within the network. However, if there is no in-network provider within a 20-mile radius of your home ZIP code, you may be eligible for in-network benefits in connection with specific covered health services. The claims administrator must approve any benefits that fall under this exception **prior to receipt of care**. These benefits are subject to any plan limitations or exclusions outlined in this benefits summary.

Participating providers

All participating providers are carefully selected according to objective requirements and standards. The criteria for doctors include professional credentials, education, medical training and experience and hospital admitting privileges. Whenever possible, doctors are either board certified or board-eligible in their areas. For hospitals, the criteria include accessibility, quality of care, community reputation, available services and cost efficiency. Network managers regularly re-evaluate participating providers to make sure they continue to meet requirements.

Network participation status changes from time to time, so it is important to verify that your doctor and/or facility participates in the UnitedHealthcare Choice Plus network before scheduling an appointment or procedure. Participating provider information is available through your plan:

- UHC Value PPO and HSA plans: On the UnitedHealthcare website (**www.myuhc.com**), the UHC app or by calling 800 387 7508 toll free, or
- Surest Advantage Plan: On the Surest website (**benefits.surest.com**), the Surest app or by calling 844 530 0139

If you receive a covered service from an out-of-network provider and were informed incorrectly prior to receipt that the provider was an in-network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for in-network benefits.

It is possible that you might not be able to obtain services from a particular in-network provider. The network of providers is subject to change. Or you might find that a particular in-network provider may not be accepting new patients. If a provider leaves the network or is otherwise not available to you, you must choose another in-network provider to get in-network benefits.

However, if you are currently receiving treatment for covered services from a provider whose network status changes from in-network to out-of-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the in-network benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your ID card.

If you are newly enrolling in the UHC Value PPO Plan, HSA Plans or Surest Advantage Plan and you are currently undergoing a course of treatment utilizing an out-of-network physician or health care facility, you may be eligible to receive transition of care benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions

regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care benefits, please contact UHC or Surest at the telephone number on your ID card.

Do not assume that an in-network provider's agreement includes all covered services. Some in-network providers participate in the UnitedHealthcare Choice Plus network to provide only certain covered services, but not others. Some in-network providers choose to be an in-network provider for only some products. Refer to your provider directory or contact UHC or Surest for assistance.

UnitedHealthcare's and Surest's credentialing process confirms public information about the provider's licenses and other credentials but does not assure the quality of the services provided.

Possible limitations on provider use

If UnitedHealthcare determines that you are using healthcare services in a harmful or abusive manner, you may be required to select a network physician to provide and coordinate all of your future covered health services.

Under the UnitedHealthcare plans, if you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single network physician for you. In the event that you do not use the selected network physician, benefits will not be paid.

UnitedHealth Premium℠ program

To help you make more informed choices about your healthcare under the UHC Value PPO Plan, HSA plans and Out-of-Area Plan, the UnitedHealth Premium® program recognizes network physicians who meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® program including how to locate a UnitedHealth Premium® Physician, log onto **www.myuhc.com** or call the number on your ID card.

Eligible expenses

Eligible expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in "Medical plan definitions" on page 87. For certain covered health services under the UHC HSA or Value PPO plans, the Plan will not pay these expenses until you have met your annual deductible.

Stryker has delegated to the claims administrator the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount the claims administrator determines that the Plan will pay for benefits.

- For designated in-network benefits and in-network benefits for covered health services provided by an in-network provider, except for your cost sharing obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.
- For out-of-network benefits **under the UnitedHealthcare plans**, except as described below, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount the claims administrator will pay for eligible expenses.
    - For covered health services that are **ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.
    - For covered health services that are **non-ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.

- For covered health services that are **emergency health services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible.
- For covered health services that are **Air Ambulance services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Eligible expenses are determined in accordance with UnitedHealthcare's or Surest's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated in-network providers and in-network benefits

Eligible expenses are based on the following:

- When covered health services are received from a designated in-network provider, Eligible expenses are the contracted fee(s) with that provider.
- When covered health services are received from an out-of-network provider as arranged by the claims administrator, including when there is no in-network provider who is reasonably accessible or available to provide covered services, eligible expenses are an amount negotiated by UnitedHealthcare, or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Out-of-network benefits

When covered health services are received from an out-of-network provider as described below, Eligible expenses are determined as follows:

- **For non-emergency covered health services received at certain in-network facilities from out-of-network physicians** when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the out-of-network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

  For the purpose of this provision, "certain in-network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Important note

For ancillary services, non-ancillary services provided without notice and consent and non-ancillary services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-network physician may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible.

- **For emergency health services provided by an out-of-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the out-of-network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

Important note

You are not responsible, and an out-of-network provider may not bill you for amounts in excess of your applicable copayment, coinsurance or deductible.

- **For air ambulance transportation provided by an out-of-network provider**, the eligible expense is based on one of the following in the order listed below as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the out-of-network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

Important note

You are not responsible, and an out-of-network provider may not bill you for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

When covered health services are received from an out-of-network provider, except as described above, eligible expenses are determined as follows:

- An amount negotiated by the claims administrator,
- A specific amount required by law (when required by law), or
- An amount the claims administrator has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the Plan.

The Plan will not pay excessive charges. You are responsible for paying, directly to the out-of-network provider, the applicable coinsurance, copayment or any deductible. Please contact the claims administrator if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible to access the Advocacy Services as described below.

Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the eligible expense (which includes your coinsurance, copayment, and deductible) is yours.

Advocacy services

The Plan has contracted with UnitedHealthcare and Surest to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expenses and how the claims administrator determined those amounts. Please call the number on your ID card to access these advocacy services, or if you are billed for amounts in excess of your applicable coinsurance or copayment.

In addition, if the claims administrator, or its designee, reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and the claims administrator, or its designee, determines that it would serve the best interests of the Plan and its employees (including interests in avoiding costs and expenses of disputes over payment of claims), the claims administrator, or its designee, may use its sole discretion to increase the eligible expense for that particular claim.

Important note

Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here. This includes non-Ancillary Services where notice and consent is satisfied as described under section 2799B-2(d) of the Public Health Service Act.

With the UHC Out-of-Area Plan

Eligible expenses are the amount UnitedHealthcare determines that the Plan will pay for benefits. For covered health services from out-of-network providers, except as described below, you are responsible for paying, directly to the out-of-network provider, any difference between the amount the provider bills you and the amount the Plan will pay.

- For covered health services that are **ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is

based on the recognized amount as defined in the SPD.

- For covered health services that are **non-ancillary services received at certain in-network facilities on a non-emergency basis from out-of-network physicians** who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.
- For covered health services that are **emergency health services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.
- For covered health services that are **air ambulance services provided by an out-of-network provider**, you are not responsible, and the out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law.

When covered health services are received from an out-of-network provider, eligible expenses are determined as follows:

- **For non-emergency covered health services received at certain in-network facilities from out-of-network physicians** when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the eligible expenses is based on:
  - The reimbursement rate as determined by applicable law or by an applicable state All Payer Model Agreement.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

  For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Important notice

For ancillary services, and for non-ancillary services provided without notice and consent, you are not responsible, and an out-of-network physician may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.

- **For emergency health services provided by an out-of-network provider**, the eligible expense is based on:
  - The reimbursement rate as determined by applicable state law or by an applicable state All Payer Model Agreement.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

Important notice

You are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance or deductible which is based on the recognized amount as defined in the SPD.

- **For air ambulance transportation provided by an out-of-network provider**, the eligible expense is based on:
  - The reimbursement rate as determined by applicable state law or by an applicable All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by UnitedHealthcare, or the amount subsequently agreed to by the out-of-network provider and UHC.
  - The amount determined by Independent Dispute Resolution (IDR).

Important notice

You are not responsible, and an out-of-network provider may not bill you for amounts in excess of your copayment, coinsurance or deductible which is based on the rates that would apply if the service was provided by an in-network provider.

Except as described above, eligible expenses are based on either of the following:

- When covered health services are received from an in-network provider, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered health services are received from an out-of-network provider as arranged by UnitedHealthcare, eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
- When covered health services are received from an out-of-network provider, eligible expenses are determined, based on:
  - Negotiated rates agreed to by the out-of-network provider and either UnitedHealthcare or one of their vendors, affiliates or subcontractors, at UHC's discretion.
  - If rates have not been negotiated, then one of the following amounts applies based on the claim type:
    - For covered health services other than pharmaceutical products, eligible expenses are determined based on available data resources of competitive fees in that geographic area.
    - When covered health services are pharmaceutical products, eligible expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

Important notice

Out-of-network providers may bill you for any difference between the provider's billed charges and the eligible expense described here. This includes non-Ancillary Services where notice and consent is satisfied as described under section 2799B-2(d) of the Public Health Service Act.

Your deductible

A deductible is money you must spend out-of-pocket for covered expenses or the recognized amount when applicable before the UHC HSA and Value PPO plans pay benefits. Your deductible is determined by the Plan you choose the number of people you cover and whether you use in-network or out-of-network providers. See the chart under "Your medical benefits" on page 43 for specific deductible amounts.

Note that the Surest Advantage Plan does not require a deductible.

With the UnitedHealthcare Value PPO Plan, the family deductible may be satisfied by any combination of covered expenses incurred by any covered family member. However, no one family member may contribute more than the individual deductible amount.

With the UnitedHealthcare HSA plans, the total family deductible must be met before the Plan covers any expenses. No one family member's expenses are capped at an individual deductible amount.

The deductible applies to all expenses except:

- Expenses that are subject to a flat dollar copayment, such as office visits and emergency room services under the Value PPO Plan (See "Your share in the cost of covered services" on page 39 for more information about copayments.)
- Covered preventive healthcare expenses
- Approved travel and lodging expenses
- Expenses that exceed the eligible expenses guidelines or the recognized amount, where applicable
- Your contributions toward the cost of medical coverage (your premium)
- The amounts of any penalty you incur by not obtaining prior authorization as required
- Except when required by law, only expenses incurred for in-network services apply toward the in-network deductible. Likewise, only expenses incurred for out-of-network services apply toward the out-of-network deductible.

Family deductible example

Assume that you enroll in the Value PPO Plan and have a family of four. When you use in-network doctors and facilities, the annual family deductible is $2,550 under the Value PPO Plan. Here is an example of how the family deductible might be satisfied:

Participant	Covered expenses
Employee:	$800
Spouse:	$600
Child #1:	$650
Child #2:	$500
Total:	$2,550

Assume that you enroll in the Basic HSA Plan and have a family of four. When you use in-network doctors and facilities, the annual family deductible is $5,000 under the Basic HSA plan. With the HSA plans, the total family deductible must be met before the Plan covers any expenses. No one family member's expenses are capped at an individual deductible amount.

Here is an example of how the family deductible might be satisfied:

Participant	Covered expenses
Employee:	$1,000
Spouse:	$2,750
Child #1:	$750
Child #2:	$500
Total:	$5,000

Your share in the cost of covered services – UHC Value PPO and HSA plans

The Plan pays a certain portion of covered medical expenses. The portion you must pay is your coinsurance percentage or a copayment, depending on the type of service provided:

- Coinsurance is a percentage of a covered expense or the recognized amount when applicable (for example, with the UHC Value PPO Plan, you pay 20% and the Plan pays 80%). You pay your coinsurance share after your deductible has been satisfied.

- A copayment is a fixed charge, like $25 or $40 for an office visit, under the UHC Value PPO Plan. When a flat dollar copayment is required, the covered expense is not subject to the annual deductible, when applicable. For example, with the UHC Value PPO Plan, you pay $25 for an office visit with a primary care physician and the Plan pays the balance. The annual deductible does not apply. There are no copays in the UHC Basic or Premium HSA plans.

Your coinsurance share or copayment requirement differs depending on the Plan you elect. If you are enrolled in the UnitedHealthcare Value PPO or HSA plans, your coinsurance share (and copayment, if applicable) requirements differ when you use in-network versus out-of-network providers. See the chart under "Your medical benefits" on page 43 for specific coinsurance and copayment amounts.

Your share in the cost of covered services – Surest Advantage Plan

With the Surest Advantage Plan through UnitedHealthcare (UHC), there is no coinsurance or deductibles, only copays, which you can look up on the Surest app or member website before making an appointment. Most copayments are listed as a range and are based on a provider or facility's Care Rating for the service. For office visits and many procedures, you see one price. By grouping services — such as combining the labs and x-rays that go along with a medical procedure or test into one price — Surest makes it easier for you to know what you'll pay in advance.

Surest evaluates providers and locations based on past claims data. Higher Care Ratings are given to high-value providers with a record of quality, safety, efficiency and effectiveness, such as lower rates of complications after surgeries and better use of resources. Providers with a higher Care Rating are assigned a lower copay. For current provider-specific copayment information, members should check the Surest mobile app or **benefits.surest.com** website or call Surest Member Services at the phone number on the back of your ID card.

Your out-of-pocket maximum

The out-of-pocket maximum limits the amount you pay towards the cost of covered medical expenses (including your medical and prescription drug copays, coinsurance and payments toward satisfying the annual deductible, as applicable) in a calendar year.

Under the UHC Value PPO Plan, your prescription drug copays will only count toward your in-network out-of-pocket maximum and not your deductible. Since there is no deductible under the Surest Advantage Plan, your prescription drug copays apply only towards your out-of-pocket maximum. With the UHC HSA plans, prescription costs count toward meeting your medical plan deductible and out-of-pocket maximum.

Your out-of-pocket maximum is based on the Plan you are enrolled in and the number of people you cover. If you are enrolled in the UHC Value PPO Plan, HSA plans or the Surest Advantage Plan, the out-of-pocket maximum is also determined by whether you use in-network or out-of-network providers. See the chart under "Your medical benefits" on page 43 for specific out-of-pocket maximums.

The individual out-of-pocket maximum is the most that will apply to any one family member, regardless of which medical plan you choose. Once you or a covered dependent reaches the individual out-of-pocket maximum, the Plan pays 100% of that person's eligible expenses for the rest of the calendar year. Once your family out-of-pocket maximum is reached, the Plan pays 100% of eligible expenses for the rest of the calendar year for you and all your covered dependents.

The family out-of-pocket limit may be satisfied by any combination of covered expenses incurred by any covered family member. **However, no one family member may contribute more than the individual out-of-pocket maximum.**

Family out-of-pocket maximum example

Assume that you enroll in the UHC Value PPO Plan and have a family of four. When you use in-network doctors and facilities, the annual family out-of-pocket maximum is $9,250 under the UHC Value PPO Plan. Here is an example of how the in-

network family out-of-pocket maximum might be satisfied:

Participant	Covered expenses
Employee:	$3,950
Spouse:	$3,000
Child #1:	$2,000
Child #2:	$300
Total:	$9,250

The out-of-pocket maximum includes your medical copays (including those for covered health services available in **Your Prescription Drug Benefits)**, your share of the coinsurance and payments toward satisfying the annual deductible (if applicable). It does not include:

- Your contributions toward the cost of medical coverage (your premium)
- Any amounts that exceed eligible expenses, or the recognized amount when applicable, as defined in "Medical plan definitions" on page 87.
- The amounts of any penalty you incur by not obtaining prior authorization as required
- Any amounts over plan limits for organ transplants

Out-of-pocket expenses incurred for in-network services apply toward the in-network out-of-pocket maximum only. Only out-of-pocket expenses incurred for out-of-network services apply toward the out-of-network out-of-pocket maximum.

Your medical benefits

The chart below provides highlights of the plan features that currently apply under the Surest Advantage Plan, UnitedHealthcare Value PPO Plan and the Out-of-Area Plan.

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific covered health services as described in the definition of "Recognized Amount" on page 95 in "Medical plan definitions."

Surest Advantage Plan, UHC Value PPO and Out-of-Area plans

	Surest Advantage Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Annual deductible					
Employee	None	None	$850	$1,700	$450
Employee + 1			$1,700	$3,400	$900
Family			$2,550	$5,100	$1,350
Your share in the cost of covered services-after any applicable deductible unless noted					
Office visit copayment-primary care	$10 to $65 copay	$195 copay	$25 copay; not subject to deductible	40%	20%
Non-routine lab & X-ray services - outpatient	$10 to $775 copay	$90 to $2,325 copay	20%	40%	20%
Office visit copayment-specialist	$10 to $65 copay	$195 copay	$40 copay; not subject to deductible	40%	20%
Preventive care					

	Surest Advantage Plan		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Office visits	$0 copay (Plan pays 100% of eligible expenses)	$100 copay	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)
Other covered services	$0 copay (Plan pays 100% of eligible expenses)	$100 copay	$0 (Plan pays 100% of eligible expenses)	40%; not subject to deductible	$0 (Plan pays 100% of eligible expenses)
Emergency room visits-after any applicable deductible unless noted					
Facility and physician charges	$375 copay	$375 copay	$150; not subject to deductible	$150; not subject to deductible	$150; not subject to deductible
Inpatient services – after any applicable deductible unless noted					
Inpatient hospital care (when admitted from ER)	$1,600 copay (ER copay waived when admitted from ER)	$1,600 copay (ER copay waived when admitted from ER)	20%	40%	20%
Inpatient hospital care	$200 - $2,500 copay	Up to $7,000 copay	20%	40%	20%
Inpatient mental health and substance-related and addictive disorder treatment	$1,200 copay	$3,600 copay	20%	40%	20%
Annual out-of-pocket maximum					
Employee	$4,000	$8,000	$4,250	$8,500	$2,950
Employee + 1	$8,000	$16,000	$8,500	$17,000	$5,900
Family	$8,000	$16,000	$9,250	$18,500	$6,250

* For out-of-network costs, see the Summaries of Benefits and Coverage on totalrewards.stryker.com/Resources. The allowed amount for an out-of-network claim is developed using reference-based methodology from Naviguard. Call the claims administrator, as it applies to you, to find out if Naviguard can assist you with negotiations and other billing assistance.

The chart below lists the deductibles, coinsurance (your share) and out-of-pocket maximums that apply under the UnitedHealthcare Basic and Premium HSA plans.

Deductibles, coinsurance and out-of-pocket maximums — UHC HSA plans

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Annual deductible				
Employee	$1,800	$3,600	$2,500	$5,000
Employee + 1	$3,600	$7,200	$5,000	$10,000

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Family	$3,600	$7,200	$5,000	$10,000
Your share in the cost of covered services-after deductible				
Office visit copayment-primary care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Office visit copayment-specialist	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Preventive care				
Office visits	$0 (Plan pays 100% of eligible expenses)	40% after deductible	$0 (Plan pays 100% of eligible expenses)	50% after deductible
Other covered services	$0 (Plan pays 100% of eligible expenses)	40% after deductible	$0 (Plan pays 100% of eligible expenses)	50% after deductible
Emergency room visits-after deductible				
Facility and physician charges	20% after deductible	20% after deductible	30% after deductible	30% after deductible
Inpatient services – after deductible				
Inpatient hospital care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Inpatient mental health and substance-related and addictive disorder treatment	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Annual out-of-pocket maximum				
Employee	$5,000	$10,000	$6,450	$12,900
Employee + 1	$10,000	$20,000	$12,900	$25,800
Family	$10,000	$20,000	$12,900	$25,800
2026 HSA contribution from Stryker**				
Employee	$600		$300	
Employee + 1	$1,200		$600	
Family	$1,200		$600	

* For out-of-network costs, see the Summaries of Benefits and Coverage on totalrewards.stryker.com/Resources. The allowed amount for an out-of-network claim is developed using reference-based methodology from Naviguard. Call the claims administrator, as it applies to you, to find out if Naviguard can assist you with negotiations and other billing assistance.

** Refer to the **Health Savings Account** section, starting on page 167, for additional details. Direct Temps and employees scheduled to work less than 20 hours who have measured as eligible for medical coverage during their measurement period are not eligible for the company contribution. Also, employees hired between December 2 and December 31 are not eligible to receive the company contribution. In addition, the company contribution is not guaranteed each year and will be reviewed on an annual basis.

Benefit maximums

There is no lifetime benefit maximum for covered individuals.

Emergency room care

With the UHC Value PPO Plan, when you need emergency care and use an emergency room, you pay a $150 copayment, and the Plan pays the balance of emergency room charges; no deductible applies. The emergency room copayment is waived if you are admitted to the hospital as an inpatient through the emergency room.

Eligible expenses for emergency health services provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 36.

With the UHC HSA plans, emergency room care is subject to the deductible and coinsurance.

Eligible expenses for emergency health services provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 36.

With the Surest Advantage Plan, you pay a $375 copayment, and the Plan pays the balance of emergency room charges. If you are admitted as an inpatient directly from the emergency room for the same condition, the emergency room services copayment will be waived, and you will be responsible for the inpatient hospital care (when admitted from ER) copayment.

If you are admitted to observation directly from the emergency room for the same condition, you will only be responsible for the emergency room services copayment.

Special services and procedures

To ensure you receive the appropriate care in the appropriate setting, the UnitedHealthcare Value PPO and HSA plans and the Surest Advantage Plan include a number of special services and requirements. This section describes what you need to know when you need medical care or services.

UHC Health Advantage and Surest 360

UHC Health Advantage (for members in the UHC Value PPO or HSA plans) and Surest 360 (for members in the Surest Advantage Plan) provide a special support team with your own "nurse in the family" approach, along with various health services and resources at your fingertips. In the event that you or a covered family member are diagnosed with a health condition that requires complex care, or requires follow-up care after a recent hospital stay, you and your family will receive support from a dedicated team of nurses, clinicians and other specialized professionals to help you improve your health.

UHC Health Advantage and Surest 360 provide specialized support for things such as:

- Managing a chronic condition, such as diabetes, coronary artery disease, asthma, COPD or heart failure,
- Those who have been diagnosed with a complex condition such as cancer or chronic kidney disease,
- Treatment of back pain and musculoskeletal conditions,
- Maternity support, and
- Any other health-related concern you may have.

UHC members: To learn more, contact UHC at 800 387 7508 or go to www.myuhc.com.

Surest members: To learn more, contact Surest at 844 530 0139 or go to **benefits.surest.com**.

Prior authorization requirements

Care management

When you seek prior authorization as required, the claims administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

Important note

Both UHC and Surest require prior authorization for certain covered health services. Your network primary physician and other in-network providers are responsible for obtaining prior authorization before they provide these network services to you. There are some out-of-network benefits, however, for which you are responsible for obtaining prior authorization as indicated in this SPD. Some prior-authorization requirements may vary between the UnitedHealthcare and Surest plans. Simply call the number on your ID card with questions.

It is recommended that you confirm with UHC or Surest (based on the plan you are enrolled in) that all covered health services listed below have been prior authorized as required. Before receiving these services from an in-network provider, you may want to contact the claims administrator to verify that the hospital, physician and other providers are in-network providers and that they have obtained the required prior authorization. Network facilities and in-network providers cannot bill you for services they fail to prior authorize as required. You can contact the plan for prior authorization by calling the number on your ID card.

When you choose to receive certain covered health services from out-of-network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-network provider intends to admit you to a network facility or refers you to other in-network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

In-network providers are responsible for obtaining from the claims administrator before they provide these services to you. There are some benefits, however, for which you are responsible for obtaining prior authorization from the claims administrator prior to receiving a service.

Certain services for which you are required to obtain prior authorization are identified in the benefit descriptions throughout this SPD. Please note that prior authorization timelines apply and requirements vary between the UnitedHealthcare and Surest plans. Refer to the applicable benefit description to determine how far in advance you must obtain prior authorization and any applicable penalties.

Contacting UnitedHealthcare or Surest for prior authorization is easy.

Prior-authorization requirements vary between the UnitedHealthcare and Surest plans. Simply call the number on your ID card.

Services that may require prior authorization include:

- Non-emergency air ambulance transportation;
- Clinical trials;
- Congenital heart disease surgeries;
- Diabetes services for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item);
- Durable medical equipment, including DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item);
- Gender dysphoria services, including both surgical treatment and non-surgical treatment;
- Home health care services;
- Hospice care (as described below);
- Hospital inpatient stays (as described below);
- Outpatient lab, X-ray and diagnostic services including genetic testing and sleep studies (with the exception of major diagnostic and imaging services);
- Mental health services, neurobiological disorders - autism spectrum disorder services, substance-related and addictive disorders services (as described under "Mental health,

substance-related and addictive disorder and neurobiological disorder services" on page 75;

- For out-of-network benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility and Partial Hospitalization/Day Treatment) you must obtain prior authorization five business days before admission or as soon as is reasonably possible for non-scheduled admissions.
- In addition, for out-of-network benefits you must obtain prior authorization before the following services are received:
  - Partial Hospitalization/Day Treatment;
  - Intensive Outpatient programs;
  - outpatient electro-convulsive treatment;
  - psychological testing;
  - transcranial magnetic stimulation;
  - extended outpatient treatment visits, with or without medication management;
  - Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

- Obesity surgery;
- Inpatient stay for the mother and/or newborn following delivery that will be more than 48 hours following a normal vaginal delivery, or more than 96 hours following a cesarean section delivery;
- Prosthetic devices that exceed $1,000 per device;
- Reconstructive procedures (as described below);
- Skilled nursing facility/inpatient rehabilitation facility services;
- Outpatient surgery for sleep apnea surgeries;
- Therapeutic treatments (outpatient), such as dialysis, IV infusion, intensity modulated radiation therapy, and MRI-guided focused ultrasound; and
- Transplantation services.

Prior authorization requirement for hospital inpatient stays

Please remember for out-of-network benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission you must provide notification as soon as is reasonably possible.

In addition, you must contact the claims administrator 24 hours before admission for a scheduled admission or as soon as reasonably possible for a non-scheduled admission.

With the UnitedHealthcare plans, if authorization is not obtained as required, or notification is not provided, benefits will be subject to a $400 penalty.

Prior authorization requirement for hospice care

For out-of-network benefits you must obtain prior authorization from the claims administrator five business days before admission for an inpatient stay in a hospice facility or as soon as is reasonably possible. With the UnitedHealthcare plans, if you fail to obtain prior authorization as required, benefits will be subject to a $400 penalty.

Prior authorization requirement for reconstructive services

For out-of-network benefits for:

- A scheduled reconstructive procedure, you must obtain prior authorization from the claims administrator five business days before a scheduled reconstructive procedure is performed.
- A non-scheduled reconstructive procedure, you must provide notification within one business day or as soon as is reasonably possible.

In addition, you must contact the claims administrator 24 hours before admission for a scheduled admission or as soon as reasonably possible for a non-scheduled admission.

If authorization is not obtained from UnitedHealthcare as required, or notification is

not provided, benefits will be subject to a $400 penalty under the UnitedHealthcare plans.

To continue treatment

If your doctor feels it is necessary for the confinement or treatment to continue longer than already approved, you, the physician or the hospital may request additional days by calling UHC or Surest. This request must be made no later than the last day that has already been approved. You must pay for continued treatment days that the reviewer determines are not covered.

UnitedHealthcare Penalties

With the UnitedHealthcare plans, a $400 penalty will apply if you do not obtain authorization as required. Any penalty amounts you pay will not count toward your deductible or out-of-pocket maximum.

Second surgical opinions

If your doctor recommends surgery that is covered under the Plan, you may want to get a second opinion. This is voluntary and will not affect your benefits. A second surgical opinion may include an exam, X-ray and lab work and a written report by the doctor. It must be performed by a doctor who is not associated or in practice with the physician who recommended the surgery, and who is certified by the American Board of Surgery or other specialty board.

If you are enrolled in the UnitedHealthcare Value PPO Plan and choose to get a second opinion from an in-network provider, you pay a $25 (or $40 for a specialist) office visit copayment and the Plan pays the balance. If you receive X-rays and/or lab work, you will also pay 20% of the eligible expense for those services after you have met your deductible. If you use an out-of-network provider for a second opinion, you pay 40% of the eligible expense, including any X-rays or lab work you receive. The annual deductible applies to second surgical expense consultations provided by out-of-network physicians.

If you are enrolled in the UnitedHealthcare HSA or Out-of-Area plans, you pay the applicable coinsurance for the eligible expense after you have met your deductible for a second surgical opinion consultation, including X-rays and lab work.

For the Surest plan, you pay the applicable copay for the services performed.

Second Opinions through Included Health

Employees enrolled in any of Stryker's medical plans can access Included Health for support with second opinions. Included Health can help employees and their families by providing remote second medical opinions from leading specialists and 24/7 access to expert medical advice. You can reach them online at **includedhealth.com/stryker** or by phone at 855 431 5551.

Clinical programs and resources

Stryker believes in giving you the tools you need to be an educated health care consumer. To that end, Stryker has made available several convenient educational and support services, accessible by phone and online, which can help you to:

- Take care of yourself and your family members;
- Manage a chronic health condition; and
- Navigate the complexities of the health care system.

Note

Information obtained through the services identified in this section is based on current medical literature and on physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare, Surest and Stryker are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer solutions and self-service tools

Decision support

In order to help you make informed decisions about your health care, the Decision Support program, available under the UHC and Surest plans, targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to accurate, objective and relevant health care information;
- Coaching by a nurse through decisions in your treatment and care;
- Expectations of treatment; and
- Information on high quality providers and programs.

Conditions for which this program is available include:

- Abnormal Uterine Bleeding
- Benign Prostatic Hyperplasia
- Breast Cancer
- Endometriosis
- Hip Pain
- Knee Pain
- Low Back Pain
- Overweight and Obesity
- Prostate Cancer
- Shoulder Pain
- Stable Angina
- Asthma
- Allergies (seasonal, pet, mold)
- Cardiac Imaging
- Gastro Esophageal Reflux Disease
- Hypertension
- Influenza
- Migraine Headache
- Osteoporosis
- Sinusitis
- Sleep Apnea
- Urinary Tract Infection
- Uterine Fibroids
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Osteoporosis Screening
- Prostate Cancer Screening

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

UHC's member website: www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- Receive personalized messages that are posted to your own website;
- Research a health condition and treatment options to get ready for a discussion with your physician;
- Search for in-network providers available in your plan through the online provider directory;
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- Use the hospital comparison tool to compare hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered on the UHC member website, simply go to **www.myuhc.com** and click on "Register Now." Have your ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims;
- Manage your health and track prior authorizations;
- View eligibility and plan benefit information, including copays and annual deductibles;
- View or print all of your Explanation of Benefits (EOBs) online; and
- Order a new or replacement ID card or print a temporary ID card.

Surest's member website: Benefits.Surest.com

Surest's member website provides access to what is covered, how much it costs, and where you can get care. You can also access this information by downloading the Surest mobile app.

With the Surest mobile app and the **Benefits.Surest.com** website, you can search for available care, cost and coverage options from any geographic location to choose the best option for you, or you can call Surest Member Services at 844 530 0139 for assistance with navigating coverage options.

Expert medical support

Expert medical opinion: Whether you need help finding the best physician in your area, information about a new diagnosis or treatment or support deciding if surgery is right for you, Included Health will give you expert medical advice, including second opinions from top doctors, for your individual medical needs. Included Health provides you and your family members with expert medical advice and support to help ensure that you receive the best care possible — at no cost to you. Use Included Health any time, but especially when:

- You need a checkup and don't have a regular doctor. Included Health finds the best physician in your area.
- You need an expert. Included Health can provide you with information about a new diagnosis, help you make tough decisions or get a second opinion from world-leading expert.

This service is available to all employees and their dependents enrolled in any of Stryker's U.S.-based medical plans.

Claims advocacy: If you are enrolled in the UHC Value PPO or HSA plans, Included Health offers 24/7 assistance with claims, appeals, personalized cost estimates and finding high quality providers. If you are enrolled in the Surest Advantage Plan, these services are available through Surest Member Services.

LGBTQ+ Health and Black Health: These programs offer support to help eligible employees and their families access high-quality, culturally inclusive care. All U.S. benefit-eligible employees and dependents can use these specialty services at no cost, even those not enrolled in one of Stryker's medical plans.

To access these benefits, call 855 431 5551 or activate your account at **https://includedhealth.com/microsite/stryker/** or by downloading the Included Health app on your mobile device.

Condition management services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions, you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and asthma programs are designed to support you. This means that you will receive free educational information and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- Access to educational and self-management resources on a consumer website;
- An opportunity for the disease management nurse to work with your physician to ensure that you are receiving the appropriate care; and
- Toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition;
  - medication management and compliance;
  - reinforcement of on-line behavior modification program goals;
  - preparation and support for upcoming physician visits;
  - review of psychosocial services and community resources;
  - caregiver status and in-home safety;

- use of mail-order pharmacy and in-network providers.

Participation is completely voluntary and without extra charge.

UHC Value PPO or HSA plan members: Get one-on-one support from a dedicated nurse through **UnitedHealthcare Health Advantage**.

Surest Advantage Plan members: Get one-on-one support from a dedicated nurse through **Surest 360**.

Cancer Resource Services (CRS)

The Plan pays benefits for oncology services provided by Designated Providers participating in the Cancer Resource Services (CRS) program. Designated providers are defined in "Medical plan definitions" on page 87.

For oncology services and supplies to be considered covered health services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered dependent has cancer, you may:

- Be referred to CRS by the UHC Health Advantage Program or Surest 360;
- Call CRS toll-free at 866 936 6002; or
- Visit **www.myoptumhealthcomplexmedical.com**.

To receive benefits for a cancer-related treatment, you are not required to visit a Designated Provider. If you receive oncology services from a facility that is not a Designated Provider, the Plan pays benefits as described for:

- Physician's office services -sickness and injury
- Physician fees for surgical and medical services
- Scopic procedures -outpatient diagnostic and therapeutic
- Hospital-inpatient stay
- Surgery -outpatient

Note: Services described for travel and lodging are covered health services only in connection with cancer-related services received at a Designated Provider.

To receive benefits under the CRS program, you must contact CRS prior to obtaining covered health services. The Plan will only pay benefits under the CRS program if CRS provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that network).

Cancer support program

UnitedHealthcare and Surest provide a program that identifies, assesses and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your physicians, as appropriate, to offer education on cancer and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program:

UHC Value PPO and HSA plan members: Learn more about the UnitedHealthcare Cancer Support Program at https://myuhc.com.

Surest Advantage Plan members: In the Surest app or website (benefits.surest.com), search for Cancer Support where you go to search for care. At the bottom of the search results, you will see a tile to learn more about the Cancer Support Program.

Congenital Heart Disease (CHD) resource services

UnitedHealthcare and Surest provides a program to its members that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call your claims administrator at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888 936 7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries, you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Kidney Resource Services (KRS)

Comprehensive Kidney Solution (CKS) Program

For Participants diagnosed with Kidney Disease, the UnitedHealthcare plan options offer the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) Stage 4/5 through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 866 561 7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the Travel and Lodging Assistance Program, refer to the provision below.

Musculoskeletal digital therapy with Kaia Health

UnitedHealthcare and Surest have partnered with Kaia Health to provide a mobile app for on-demand, personalized musculoskeletal support to help relieve pain and live healthier. This program offers tailored exercises, bite-sized lessons, one-on-one health coaching and strengthening exercises, all included as part of your health plan.

UHC Value PPO and HSA plan members: Access Kaia at no cost from myuhc.com.

Surest Advantage Plan members: Access Kaia at no cost from the Surest mobile app or on benefits.surest.com.

Maternity support program (available through Maven)

If you are pregnant, Maven's Maternity & Newborn Care program supports you and your partner in between doctor's visits as you navigate pregnancy, miscarriage/loss, postpartum, and returning to work. You can meet at any time with your Care Advocate and specialists like OB-GYNs, doulas, lactation consultants, sleep coaches, and

mental health specialists to help you through this exciting — and challenging — phase of life.

Maven family building, parenting and midlife health

Maven is your personal guide to family building, parenting and midlife health — available to you and your eligible dependents at no cost, regardless if you are enrolled in a Stryker medical plan.

Life is filled with so many incredible chapters, and Maven can help you through them all — from trying to expand your family and welcoming a little one to raising a child and navigating midlife health changes, like menopause or low testosterone. Get the support you and your loved ones deserve with access to hard-to-find specialists, articles, videos and more.

Maven is here for every symptom, feeling and health goal with expert answers you can trust.

Services include:

- **Video visits and messaging with top-rated specialists:** Get helpful guidance from award-winning family health specialists across 30+ specialties—all from the comfort of your home.
- **Answers, day or night:** Virtual support from a personalized Care Advocate who can offer advice and resources that can help, even at 2 a.m.
- **Expert articles, community forums, videos and on-demand classes:** Scroll clinically accurate resources that cover mental health, sleep, nutrition, wellness, symptom relief and more.

Get started today

Register at **mavenclinic.com/join/stryker** and download the Maven app. You will need your email address, date of birth and full name to get started.

Travel and lodging assistance program for complex medical conditions

Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the number on your ID card.

Travel and lodging expenses

The Plan covers expenses for travel and lodging for the covered member and a travel companion, provided he or she is not covered by Medicare as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider for care related to one of the programs listed below.
- The eligible expenses for lodging for the patient (while not a hospital inpatient) and one companion.
- If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides at least 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The claims administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the covered person is in the hospital.
- Per diem is limited to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

Examples of items that are not covered:

- Groceries

- Alcoholic beverages
- Personal or cleaning supplies
- Meals
- Over-the-counter dressings or medical supplies
- Deposits
- Utilities and furniture rental, when billed separate from the rent payment
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider
- Taxi fares (not including limos or car services)
- Economy or coach airfare
- Parking
- Trains
- Boat
- Bus
- Tolls

Covered medical expenses

The UnitedHealthcare Value PPO and HSA plans and the Surest Advantage Plan have no pre-existing condition limitation.

The following chart shows plan benefits for certain covered health service. Benefits are available only when all of the following conditions are met:

- Covered health services are provided while coverage is in effect.
- Covered health services are provided before the date your coverage under the Plan is terminated.
- The person who receives covered health services meets all the Plan's eligibility requirements.

Important to remember…

UnitedHealthcare and Surest do not have the ability to make enrollment changes, such as to add a newborn. All enrollment modifications must be directed to your Benefits representative.

Benefits for covered medical expenses – Surest Advantage, UHC Value PPO and Out-of-Area plans

The following table highlights the amount you pay for covered services (your share of the cost):

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific covered health services as described in the definition of "Recognized Amount" on page 95 in "Medical plan definitions."

Surest Advantage Plan: Refer to the Surest mobile app or **Benefits.Surest.com** website for complete coverage and copayment information or call Surest Member Services. Copayments may vary based on provider, location and treatment, test, or therapy.

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	Out-of-Area Plan*
Hospital charges: inpatient and outpatient services* after deductible unless noted**					
Room and board charges up to the semi-private room rate	$200 to $2,500 copay (inpatient hospital)	Up to $7,000 copay	20%	40%	20%
Intensive care unit	$1,600 copay	$4,800 copay	20%	40%	20%

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Services and supplies, including diagnostic testing, laboratory services and X-rays	Included in hospital stay copay	Included in hospital stay copay	20%	40%	20%
Surgery (inpatient and outpatient)	$15 to $2,500 copay	Up to $7,000 copay	20%	40%	20%
Outpatient hospital	$15 to $2,500 copay	Up to $7,000 copay	20%	40%	20%
Urgent and emergency treatment					
Emergency room	$375 copay	$375 copay	$150 copay	$150 copay	$150 copay
Urgent care/walk-in facility	$35 copay	$105 copay	$40 copay	40%	20%
Preventive care services (Coverage for preventive care office visits may vary from what is shown in this table. See the chart under " " on page for more information about your share of the cost for preventive care office visits.)					
Routine physical exam	$0	$100 copay	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible
Other preventive services, including children's immunizations, mammograms, PAP smears, X-rays and lab tests based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and Patient Protection Affordable Care Act (PPACA). Preventive testing services are limited to once per calendar year.	$0	$100 copay	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible
Doctors and healthcare professionals-after deductible unless noted (Primary care physicians, including general practitioners, internists and pediatricians. Gynecologists are also considered primary care physicians for preventive annual exams only.)					
Office visit - primary care physician	$10 to $65 copay	$195 copay	$25 copay	40%	20%

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Office visit - specialist	$10 to $65 copay	$195 copay	$40 copay	40%	20%
Virtual visit	$0 (primary and urgent care); $0 to $65 copay (specialty care); $10 to $40 copay (mental health and substance use disorder)	No coverage	$25 copay per visit	No coverage	20%
Physician lab and X-ray services Prior authorization is required for out-of-network before Genetic Testing and sleep studies are performed. Under UHC plans, benefits will be subject to a $400 penalty if prior authorization not obtained.	Imaging:$0 (routine), $75 to $950 copay (complex); Diagnostic tests: $0 (routine), $10 to $800 copay (non-routine)	Imaging: $0 to $2,850 copay; Diagnostic tests: $0 (routine), up to $2,400 copay (non-routine)	20%	40%	20%
Medical care	Copay varies by service	Copay varies by service	20%	40%	20%
Surgery (inpatient and outpatient)** (including Congenital Heart Disease surgery)	$15 to $2,500 copay	Up to $7,000	20%	40%	20%
Acupuncture services Limited to 30 visits per calendar year.	$30 copay	$90 copay	$40 copayment	40%	20%
Allergy testing and treatment	$70 copay	$210 copay	20%	40%	20%
Physical therapy Provided in all settings	$5 to $45 copay	$135 copay	20%	40%	20%
Occupational therapy	$10 to $65 copay	$185 copay	20%	40%	20%
Speech therapy	$10 to $65 copay	$185 copay	20%	40%	20%

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	Out-of-Area Plan*
Chiropractic treatment Medical necessity documentation required after 30 visits per calendar year. If visits exceed 30 in any calendar year, the claims administrator must review and approve additional benefits for chiropractic treatment.	$15 copay	$45 copay	$40 copay	40%	20%
Private duty nursing by an RN or LPN	$35 copay	$105 copay	20%	40%	20%
Podiatric treatment Covered only if for systematic disease (or diabetes for UHC plans).	$10 to $65 copay	$195 copay	$40 copay	40%	20%
Other services-after deductible unless noted					
Ground Ambulance*** Eligible expenses for emergency and non-emergency ground ambulance transport provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 36.	$225 copay	$225 copay	20%	20%	20%
Air Ambulance*** Eligible expenses for emergency and non-emergency air ambulance transport provided by an out-of-network provider will be determined as described under "Eligible expenses" on page 36.	$225 copay	$225 copay	20%	20%	20%

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Anesthetics and their administration	Included with procedure or visit copay	Included with procedure or visit copay	20%	40%	20%
Cellular and Gene Therapy Services must be received at a Designated Provider.	$1,700 copay	Not covered	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Not covered	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Durable medical equipment (DME)* **	$0 to $500 copay	$20 to $1,000 copay	20%	40%	20%
Gender Dysphoria Treatment*	$10 to $1,200 copay	$30 to $3,600 copay	20%	40%	20%
Fertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $15,000 lifetime maximum. Participants must work with a nurse consultant through the Fertility Solutions Plus (FS+) program to identify the best treatment options and facilitate care through one of UHC's/Surest's Centers of Excellence network clinics	$100 to $1,500 copay	Not covered	20%, up to lifetime maximums	Not covered	20%, up to lifetime maximums

	Surest Advantage Plan**		UHC Value PPO Plan		UHC Out-of-Area Plan
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**Out-of-Area Plan***
Prosthetic and orthotic devices* **	$0 to $500 copay	$2 to $1,000 copay	20%	40%	20%
Injectable drugs not intended for self administration	$20 to $2,000 copay (Cancer chemo: $10 to $550 copay)	$375 to $6,000 copay (Cancer chemo: $165 to $1,650 copay)	20%	40%	20%
Mental health and substance-related and addictive disorder treatment services-after deductible unless noted					
Inpatient* **	$1,200 copay	$3,600 copay	20%	40%	20%
Residential day care* **	$1,200 copay	$3,600 copay	20%	40%	20%
Outpatient* **	$10 copay (office visit); $10 to $75 copay (all other services)	$100 copay (office visit); $100 to $225 copay (all other services)	$100 copay (office visit); 20% (all other services)	40%	20%
Neurobiological Disorders - autism spectrum disorder, including intensive behavioral therapy	$10 copay (office visit); $10 to $75 copay (all other services)	$100 copay (office visit); $100 to $225 copay (all other services)	$25 copay (office visit); 20% (other services) Intensive behavioral therapy: 10% (no deductible applies)	40%	20%
Special facilities - after deductible as applicable, unless noted					
Birthing centers	$625 to $1,600 copay****	$4,800 copay****	20%	40%	20%
Home healthcare* **	$35 copay	$105 copay	20%	40%	20%
Hospice care-inpatient* ** and outpatient* (and home hospice visit under Surest)**	$35 to $1,600 copay	$105 to $4,800 copay	20%	40%	20%
Skilled nursing facility* **	$1,200 copay	$3,600 copay	20%	40%	20%
Reminder: The Employee Assistance Program (EAP) administered by Lyra provides free and confidential access to behavioral health professionals 24 hours a day, seven days a week. The EAP also provides up to 10 short-term counseling or coaching sessions per calendar year for you and your household members at no cost to you. Contact Lyra at 833 511 0159.					

* For out-of-network costs, see the Summaries of Benefits and Coverage on totalrewards.stryker.com/Resources. The allowed amount for an out-of-network claim is developed using reference-based methodology from Naviguard. Call the claims administrator, as it applies to you, to find out if Naviguard can assist you with negotiations and other billing assistance.

** For office visits and many procedures, Surest combines the labs and x-rays that go along with a procedure into one price. This table shows copays as a range because copays vary by provider, service and location. Providers or locations with higher Care Ratings have lower copays. For more information and to look up costs for care, visit surest.care/stryker.

*** Your network provider must obtain prior authorization from the claims administrator, as described in this SPD before you receive certain covered health services. With the UHC Out-of-Area Plan, however, you may be responsible for obtaining prior authorization from the claims administrator. Note that some prior-authorization requirements may vary between the UnitedHealthcare and Surest plans. Simply call the number on your ID card with questions.

**** There will be one copayment for all covered health services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copayment will apply to the baby's services. See Hospital Services section for benefits.

Plan benefits for covered medical expenses - UHC Premium and Basic HSA Plans

The following table highlights the amount you pay for covered services (your share of the cost):

Amounts which you are required to pay as shown below in the chart below are based on eligible expenses or, for specific Covered Health Services as described in the definition of "Recognized Amount" on page 95 in "Medical plan definitions."

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Hospital charges: inpatient and outpatient services-after deductible**				
Room and board charges up to the semi-private room rate	20%	40%	30%	50%
Intensive care unit	20%	40%	30%	50%
Services and supplies, including diagnostic testing, laboratory services and X-rays*	20%	40%	30%	50%
Surgery	20%	40%	30%	50%
Emergency treatment-after deductible				
Emergency room	20%	20%	30%	30%
Urgent care/walk-in facility	20%	40%	30%	50%
Preventive care services (Coverage for preventive care office visits may vary from what is shown in this table. See the chart under " " on page for more information about your share of the cost for preventive care office visits.)				
Routine physical exam	$0; not subject to deductible	40%; after deductible	$0; not subject to deductible	50%; after deductible

Medical benefits

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Other preventive services Includes children's immunizations, mammograms, PAP smears, X-rays and lab tests based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) and Patient Protection Affordable Care Act (PPACA). Preventive testing services are limited to once per calendar year.	$0; not subject to deductible	40%; not subject to deductible	$0; not subject to deductible	50%; not subject to deductible
Doctors and healthcare professionals-after deductible (Primary care physicians, including general practitioners, internists and pediatricians. Gynecologists are also considered primary care physicians for preventive annual exams only.)				
Office visit - primary care physician	20%	40%	30%	50%
Office visit - specialist	20%	40%	30%	50%
Physician Lab and X-ray services Prior authorization is required before out-of-network Genetic Testing and sleep studies is performed. Otherwise, under the UHC plans, benefits will be subject to a $400 penalty.	20%	40%	30%	50%
Medical care	20%	40%	30%	50%
Surgery**	20%	40%	30%	50%
Acupuncture services **Limited to 30 visits per calendar year.**	20%	40%	30%	50%
Allergy testing and treatment	20%	40%	30%	50%
Physical and occupational therapy	20%	40%	30%	50%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Speech therapy	20%	40%	30%	50%
Chiropractic treatment Medical necessity documentation required after 30 visits per calendar year. If visits exceed 30 in any calendar year, UnitedHealthcare must review and approve additional benefits for chiropractic treatment.	20%	40%	30%	50%
Private duty nursing by an RN or LPN	20%	40%	30%	50%
Podiatric treatment Covered only if for systematic disease or diabetes.	20%	40%	30%	50%
Other services-after deductible				
Ambulance** Eligible expenses for emergency and non-emergency ground and air ambulance transport provided by an out-of-network provider will be determined as described in "Eligible expenses" on page 36.	20%	20%	30%	30%
Anesthetics and their administration	20%	40%	30%	50%
Durable medical equipment (DME)**	20%	40%	30%	50%
Gender Dysphoria Treatment**	20%	40%	30%	50%

	UHC Premium HSA Plan		UHC Basic HSA Plan	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Fertility treatment Coverage for medical treatments up to a $25,000 lifetime maximum and prescription medication up to a $15,000 lifetime maximum. Participants must work with a nurse consultant through the Fertility Solutions Plus (FS+) program to identify the best treatment options and facilitate care through one of UHC's Centers of Excellence network clinics.	20%, up to lifetime maximums	Not covered	30%, up to lifetime maximums	Not covered
Prosthetic and orthotic devices**	20%	40%	30%	50%
Injectable drugs not intended for self administration	20%	40%	30%	50%
Mental health and substance-related and addictive disorder services-after deductible				
Inpatient**	20%	40%	30%	50%
Residential day care**	20%	40%	30%	50%
Outpatient including partial hospitalization/day treatment/high intensity outpatient/intensive outpatient programs and intensive behavioral therapy**	20%	40%	30%	50%
Special facilities-after deductible				
Birthing centers	20%	40%	30%	50%
Home healthcare**	20%	40%	30%	50%
Hospice care-inpatient and outpatient**	20%	40%	30%	50%
Skilled nursing facility**	20%	40%	30%	50%

* For out-of-network costs, see the Summaries of Benefits and Coverage on totalrewards.stryker.com/Resources. The allowed amount for an out-of-network claim is developed using reference-based methodology from Naviguard. Call the claims administrator, as it applies to you, to find out if Naviguard can assist you with negotiations and other billing assistance.

** Your network provider must obtain prior authorization from UnitedHealthcare, as described in this SPD before you receive certain covered health services. There are some network benefits, however, for which you are responsible for obtaining prior authorization from UnitedHealthcare.

Maternity benefits

Stryker's medical plan covers expenses for hospital stays or birthing centers and obstetrics provided by a doctor or certified nurse-midwife for pregnancy, childbirth or related complications. Newborn expenses are covered for the first four days after the birth. These expenses will be covered separate from the mother. See below for more information regarding how to add your child to the health plan.

Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

Pregnancy-related expenses of employees and dependents must be incurred while the person is covered under the Plan. If expenses are incurred after coverage ends or before coverage begins, no benefits will be paid. If there are benefits payable from a previous plan, these will be subtracted from benefits payable for the same expenses under this plan.

Expenses related to elective induced abortions and any complication related to an abortion are covered.

If you need to change your healthcare benefit election as the result of the birth of the baby, you must properly change your enrollment via the Benefits Enrollment Site at **https://enroll.stryker.com**, or by contacting your Benefits representative and completing an enrollment form, within 30 days of the child's date of birth (including the date of birth). You must also provide all of the required dependent documentation within 30 days as requested in order to change your elections on a pre-tax basis. See "Making changes" on page 10 in the **Participating in healthcare benefits** section, starting on page 5, for more information.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

It is important that you notify us regarding your pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

Benefits for outpatient rehabilitation services

Stryker's medical plan covers short-term outpatient rehabilitation services (including habilitative services) for:

- Physical therapy
- Occupational therapy
- Manipulative treatment (chiropractic and spinal manipulation)
- Speech therapy
- Post-cochlear implant aural therapy
- Vision therapy
- Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident
- Pulmonary rehabilitation therapy
- Cardiac rehabilitation therapy

For all rehabilitation services, a licensed therapy provider, under the direction of a physician (when required by state law), must perform the services. Benefits include rehabilitation services provided in a physician's office or on an outpatient basis at a hospital or alternate facility. Rehabilitative

services provided in a covered member's home by a home health agency are covered as home health care. Rehabilitative services provided in a covered member's home other than by a home health agency are provided as described in this section.

Benefits can be denied or shortened for covered member who is not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

Habilitative services

For the purpose of this benefit, "habilitative services" means medically necessary skilled healthcare services that help a person with a medical or behavioral disabling condition to learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain a covered member's current condition or to prevent or slow further decline.
- It is ordered by a physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not custodial care.

The claims administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a medical or behavioral disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for covered members with a medical or behavioral disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or physician.
- The initial or continued treatment must be proven and not experimental or investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial care, respite care, day care, therapeutic recreation, educational/vocational training and residential treatment are not habilitative services. A service or treatment plan that does not help the covered member to meet functional goals is not a habilitative service.

Limitations

The Plan may require that the following be provided: medical records and/or other necessary data to allow the Plan to prove medical treatment is needed. When the treating provider expects that continued treatment is or will be required to allow the covered member to achieve progress, the claims administrator may request additional medical records.

Benefits for durable medical equipment and prosthetic devices, when used as a component of habilitative services, are described under “Durable medical equipment (DME)” on page 69 and under “Prosthetic devices on page 78.

Preventive care services

One of the best ways to prevent illness is to take care of yourself. Regular check-ups and immunizations are important, so preventive care services provided in an outpatient setting are covered.

Eligible preventive care services are covered at 100% without deductibles or copayments. Routine tests and related lab and X-ray expenses are covered once per calendar year.

The Plan pays benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial

effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In general, the Plan pays preventive care benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a covered health service.

- Routine physical exam (one per year after age 3)
- Well child care through age 3
- Routine lipid profile
- Routine mammogram (including three-dimensional (3-D) breast cancer mammography)
- Routine PAP test
- Additional women's preventive care (per PPACA guidelines):
  - Gestational diabetes screening
  - HPV DNA testing for women age 30 and older
  - Screening for sexually transmitted infections
  - Screening and counseling for HIV
  - Screening and counseling for domestic violence
  - Counseling for and payment of generic FDA-approved contraception methods
  - Counseling for breastfeeding and payment of rental equipment and supplies
  - Pre-eclampsia screening (included in prenatal visit)
- Routine lab tests and X-rays related to covered preventive testing (facility and professional charges)
- Breast pumps:

  Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

  If more than one breast pump can meet your needs, benefits are available only for the most cost-effective pump. The claims administrator will determine the following:

  - Which pump is the most cost effective;
  - Whether the pump should be purchased or rented;
  - Duration of a rental;
  - Timing of an acquisition.

  Benefits are only available if breast pumps are obtained from a DME provider or physician.
- Immunizations:
  - Covered childhood immunizations generally include: Diptheria-tetanuspertussis (DTP), Oral poliovirus (OPV), Measles - mumps-rubella (MMR), Conjugate haemophilus influenza type B, Hepatitis B, Rotavirus vaccine, Varicella (Chicken Pox) and human papilloma virus (HPV) vaccine for ages 9-18.
  - The HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.
- Statins for prevention of cardiovascular disease for adults ages 40 - 75
- Adult latent tuberculosis screening
- Colorectal cancer fecal DNA test for adults ages 45 to 75

Preventive care benefits do not include:

- Services for the diagnosis or treatment of a disease, except for those women's preventive services noted above
- Medicines, drugs, appliances, equipment or supplies, except for those women's preventive services noted above
- Psychiatric, psychological or emotional testing or exams
- Exams related to employment
- Premarital exams
- Vision or dental exams

To confirm whether a service is covered as a preventive care benefit, contact UnitedHealthcare or Surest at the phone number on your ID card.

Acupuncture services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a hospital.

Covered health services include treatment of nausea as a result of:

- Chemotherapy.
- Pregnancy.
- Related to surgery.

Any combination of in-network Benefits and out-of-network benefits is limited to 30 treatments per calendar year.

Ambulance services

The Plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers emergency health services. Ambulance service by air is covered in an emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, the claims administrator may pay benefits for emergency air transportation to a hospital that is not the closest facility to provide emergency health services.

The Plan also covers non-emergency transportation provided by a licensed professional ambulance (either ground or air ambulance as the claims administrator determines appropriate) between facilities when the transport is:

- From an out-of-network hospital to an in-network hospital.
- To a hospital that provides a higher level of care that was not available at the original hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior authorization requirement

In most cases, the claims administrator will initiate and direct non-emergency ambulance transportation. For out-of-network benefits, if you are requesting non-emergency ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization as soon as possible before transport.

If you fail to obtain prior authorization under the UnitedHealthcare plans, benefits will be subject to a $400 penalty.

Cellular and gene therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

Benefits for CAR-T therapy for malignancies are provided under Transplantation Services.

Diabetes services

Diabetes self-management and training/diabetic eye exams/foot care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic self-management items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered as outpatient prescription drugs

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining any durable medical equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

Durable medical equipment (DME)

The Plan pays for durable medical equipment (DME) that is:

- Ordered or provided by a physician for outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of a sickness, injury or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home
- Is not implantable within the body

You must obtain the durable medical equipment or orthotic from a vendor UHC identifies, or from the prescribing in-network physician.

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen
- Standard wheelchairs
- Hospital beds
- Delivery pumps for tube feedings
- Burn garments
- Insulin pumps and all related necessary supplies
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Cranial helmets used to facilitate a successful post-surgical outcome are also covered as DME. **Note:** Only braces that are used to stabilize an injured body part or treat curvature of the spine are considered durable medical equipment and therefore covered under the Plan. Braces that straighten or change the shape of a body part (with the exception of cranial helmets) are considered orthotic devices and are not covered. Dental braces are also excluded from coverage.
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Ostomy supplies. Covered supplies are limited to:
  - Pouches, face plates and belts
  - Irrigation sleeves, bags and ostomy irrigation catheters
  - Skin barriers

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Note: DME is different from prosthetic devices- see “Prosthetic devices” on page 78.

Benefits are provided for the repair/replacement of a type of durable medical equipment once every three calendar years.

At UnitedHealthcare's or Surest’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the covered member's medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary equipment is only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be

made at any time and are not subject to the three-year timeline for replacement.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining any durable medical equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

Enteral nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a physician.

Fertility services and fertility solutions plus (FS+) program

Therapeutic services for the fertility treatment when provided by or under the direction of a physician. Benefits are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to in Vitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection - ICSI.
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, and ovarian cystoplasty.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Fertility Preservation for Medical Reasons - when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in Vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as described in the SPD. Benefits for diagnostic tests are covered as under Scopic Procedures - Outpatient Diagnostic and Therapeutic, Physician's Office Services — Sickness and Injury.

Enhanced benefit coverage

Embryo biopsy for Pre-implantation Genetic Screening (PGS) used to select embryos for transfer in order to increase the chance for conception.

Donor coverage — The plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The plan

will not pay for donor charges associated with compensation or administrative services.

Fertility preservation for medical reasons — when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Fertility preservation for non-medical reasons — when you would like to delay pregnancy for non-medical reasons. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

To be eligible for the fertility services benefit:

You do not need to have a diagnosis of infertility in order to be eligible to receive services described above.

- You are a female:
  - under age 44 and using own oocytes (eggs), or
  - under age 55 and using donor oocytes (eggs).

Note. For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Child Dependents are eligible for Infertility benefit. Child Dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical or non-medical reasons.

Any combination of in-network benefits and out-of-network benefits are limited to $25,000 for medical services and $15,000 for prescription drugs per covered person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include physician office visits for the treatment of infertility.

There are separate limits under the Plan for medical services and prescription drugs.

Charges for the following apply toward the fertility lifetime maximum:

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

Fertility Solutions Plus

Fertility Solutions Plus is an inclusive, comprehensive fertility and family-building support solution designed to help members navigate various paths to parenthood. By combining UnitedHealthcare's fertility support services with Maven's digital family health platform, Fertility Solutions Plus provides personalized support to help improve outcomes and member satisfaction while advancing diversity, health equity and inclusion.

To provide support throughout the process, Fertility Solutions Plus offers:

- Personalized engagement through 24/7 digital content, access to a dedicated fertility nurse and care advocate and support finding quality providers.
- Clinical and virtual support resources for help navigating coverage and getting referrals for in-person and virtual specialists.

For those seeking medical treatment related to fertility UnitedHealthcare provides education and counseling through individualized case management, utilization management and access to a high-quality Fertility Centers of Excellence (COE) network.

The Plan pays benefits for the fertility services described above when provided by Designated Providers participating in the Fertility Solutions Plus program.

Covered persons who do not live within a 60-mile radius of a Fertility Solutions Plus Designated Provider will need to contact a Fertility Solutions Plus case manager to determine an in-network provider prior to starting treatment.

For fertility services and supplies to be considered covered health services, you must contact Fertility Solutions Plus and enroll with a nurse consultant prior to receiving services.

You or a covered dependent may:

- Be referred to Fertility Solutions Plus by UHC or Surest.
- Call the telephone number on your ID card.
- Call Fertility Solutions Plus directly at 866 774 4626.

To take part in the Fertility Solutions program, call a nurse at 866 774 4626. The Plan will only pay benefits under the Fertility Solutions Plus program if Fertility Solutions Plus provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that network).

Gender dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a physician.

For the purpose of this benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Benefits for the treatment of gender dysphoria limited to the following services:

- Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses;
- Continuous hormone therapy administered by a medical provider (for example during an office visit);
- Continuous hormone therapy dispensed from a pharmacy (covered as per pharmacy benefits);
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting;
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy;
- Voice modification therapy;
- Surgery for the treatment for gender dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Breast augmentation with implants or fat transfer
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria
  - Metoidioplasty (creation of penis, using clitoris)
  - Nipple/areola reconstruction
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Revision of a reconstructed breast
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Tissue expander placements
  - Tracheal shave/reduction
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Voice modification surgery
  - Vulvectomy (removal of vulva)

Surgical treatment for gender dysphoria may be indicated for individuals who provide the following documentation:

- For breast surgery (mastectomy, breast reduction or breast augmentation), a written clinical assessment from at least one qualified healthcare professional experienced in treating gender dysphoria is required. The assessment must document that an individual meets all of the following criteria:
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age for breast augmentation
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges

  - For breast augmentation, continued gender dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required
- For thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords), a written clinical assessment from at least one qualified healthcare professional experienced in treating gender dysphoria is required. The assessment must document that an individual meets all of the following criteria:
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges
  - Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization
  - For voice modification surgery, documentation of presurgical voice lessons and/or therapy
- For genital surgery, a written clinical assessment from at least two qualified healthcare professionals experienced in treating gender dysphoria, who have independently assessed the individual, is required. The assessment must document that an individual meets all of the following criteria:
  - Persistent, well-documented gender dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age
  - Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges
  - Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender
  - Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender)
  - Treatment plan that includes ongoing follow-up and care by a qualified healthcare professional experienced in treating gender dysphoria

Prior authorization requirement for surgical treatment

For out-of-network benefits, you must obtain prior authorization as soon as the possibility of surgery arises and within 24 hours before admission for an inpatient stay.

If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

Prior authorization requirement for non-surgical treatment

Depending upon where the covered health service is provided, any applicable prior authorization requirements will be the same as those stated under each covered health service category in this section.

Hearing aids

The Plan pays benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound that may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a covered health service for which benefits are available under the applicable medical/surgical covered health services categories in this **Medical benefits** section, starting on page 31, and only for covered members who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

Home healthcare

Covered home healthcare expenses include charges by an approved home healthcare agency for the following services furnished as part of a home healthcare plan:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN), or services from a home health aide, up to the maximum of 120 visits per year
- Respiratory, occupational, speech and physical therapies provided by a home healthcare agency
- Medical supplies, appliances and equipment, drugs and medicines prescribed by a physician and provided by the home healthcare agency, if such items would have been covered under the Plan while hospital-confined
- Nutrition counseling or services, or special meals provided by or under the supervision of a registered dietitian or nutritionist

Home healthcare services provided by a social worker or a family member are not covered.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator five business days before receiving services including nutritional foods and private duty nursing or as soon as is reasonably possible. If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

Hospice Care

Hospice care is an integrated program recommended by a physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the covered person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Hyperhidrosis treatment

The Plan provides coverage for the following medical and surgical treatments for hyperhidrosis (excessive sweating) under the direction of a physician:

Medical treatments:

- Botulinum (botox) injections

Surgical treatments:

- Sympathectomy (scopic or open procedure) for the sympathetic nerve or sympathetic ganglion;
- Liposuction for the removal of axillary sweat glands; and
- Excision of axillary sweat glands.

Lab, X-ray and diagnostic - outpatient

Services for sickness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists
- Presumptive drug tests and definitive drug tests.

Genetic testing is covered when it is ordered by a physician, authorized in advance by the claims

administrator, follows genetic counseling and results in available medical treatment options.

Benefits for other physician services, such as physician fees for surgical and medical services. Lab, X-ray and diagnostic services for preventive care are covered as described in the appropriate sections of this SPD. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are also covered as described as outpatient services in this SPD.

Mental health, substance-related and addictive disorder and neurobiological disorder services

The mental health and substance-related and addictive disorder delegate (the delegate) administers benefits for mental health and substance-related and addictive disorder services. If you need assistance with coordination of care, locating a provider and confirmation that services you plan to received are covered health services, you can contact the Delegate (UnitedHealthcare) at 800 387 7508 or (Surest) at 844 530 0139.

Mental health and substance-related and addictive disorder services include those received on an inpatient or outpatient basis in a hospital, alternate facility or in a provider's office.

Covered neurobiological disorder services include behavioral services for autism spectrum disorder, including intensive behavioral therapies, such as applied behavior analysis (ABA) that are:

- Focused on the treatment of core deficits of Autism Spectrum Disorder;
- Provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their license; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

Note: The benefits described here are for the behavioral component of treatment for autism spectrum disorders only. Medical treatment of autism spectrum disorders is a covered health service for which benefits are available under the applicable medical covered health services categories.

Mental health, substance-related and addictive disorder and neurobiological disorder benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient treatment.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention
- Partial hospitalization/day treatment
- Inpatient treatment and residential treatment including room and board in a semi-private room (a room with two or more beds)
- Services for intensive outpatient programs.

The mental health or substance-related and addictive disorder administrator provides administrative services for all levels of care.

You are encouraged to contact the mental health or substance-related and addictive disorder administrator for assistance in locating a provider and for coordination of care.

Prior authorization requirement

For out-of-network benefits for a scheduled admission for mental health care and substance-related and addictive disorders services (including an admission for services at a residential treatment facility and neurobiological disorders - autism spectrum disorder services (including an admission for services at a residential treatment facility), you must obtain prior authorization five business days before admission or as soon as is reasonably possible for a non-scheduled admission.

In addition, for out-of-network benefits you must obtain prior authorization before the following services are received: partial hospitalization/day treatment/high intensity outpatient; intensive outpatient programs; psychological testing; transcranial magnetic stimulation; intensive behavioral therapy, including applied behavior analysis (ABA).

If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

Additional benefits available through the EAP

In addition to benefits available through the EAP program with Lyra, if your counseling or coaching sessions go beyond the annual limit and you participate in a UHC plan or the Surest Advantage Plan sponsored by Stryker, you can continue using the same Lyra provider using your medical plan's mental health benefits. Keep in mind that each medical plan has its own deductibles, coinsurance, copayments, annual maximum and limits on inpatient and outpatient care (as applicable), including number of visits/days of coverage. You will be responsible for the member cost share of these visits.

In addition, UHC and the Surest Advantage plans' participants have access to medication management services through Lyra. This includes a 90-minute consultation with a physician to discuss current medication or get insight into medications recommended by other providers. These visits are billed through the health plan and are subject to member cost share (deductibles, coinsurance and/or co-pays based on which plan you participate in).

Non-preventive nutritional counseling

The Plan covers non-preventive nutritional counseling services for mental health and substance-related and addictive disorders and medical diagnosis that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals.

Benefits for non-preventive nutritional counseling services for mental health and substance-related and addictive disorders will follow mental health and substance-related and addictive disorders services office visit.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under "Preventive care services" on page 66.

Obesity surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided all of the following is true:

- You have a minimum Body Mass Index (BMI) of 40 irrespective of comorbities, or greater than 35 with at least one comorbity directly related to, or exacerbated by morbid obesity:
  - Type 2 diabetes or pre-diabetes
  - Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension (systolic blood pressure greater than 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite pharmacotherapy)
  - History of coronary artery disease with a surgical intervention such as cardiopulmonary bypass or percutaneous transluminal coronary angioplasty
  - Cardiopulmonary problems (e.g., documented obstructive sleep apnea (OSA) confirmed on polysomnography with an AHI or RDI of >= 30 (as defined by AASM Task Force. Sleep.1999;22:667-89)
  - History of cardiomyopathy
  - High Cholesterol or Hyperlipidemia
  - Polycystic Ovarian Syndrome (PCOS)
- You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

- You have a 3-month physician supervised diet documented within the last 2 years.

Benefits for obesity surgery services are covered only if they meet the definition of a covered health service (see "Medical plan definitions" on page 87) and are not considered experimental, investigational or unproven. Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as the possibility of obesity surgery arises.

If you fail to obtain prior authorization as required under the UHC plans, benefits will be subject to a $400 penalty.

It is important that you provide notification regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Organ transplant benefits

UnitedHealthcare and Surest offer specialized case management services for individuals who have been recommended for an organ transplant, bone marrow transplant or tissue replacement, including CAR-T cell therapy for malignancies when ordered by a physician. The claims administrator must be notified regarding any of these procedures. During the notification process, the claims administrator may recommend that you receive transplant services at a facility that is nationally recognized as a center of excellence for specific organ transplant procedures.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization of a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Each case must meet specific criteria. If treatment at a Designated Provider is recommended, covered charges in connection with the transplant procedure will be covered at 80% of the in-network benefit level. Reasonable and customary fee limits will not apply. In addition, you may qualify for reimbursement of travel and lodging expenses.

If treatment at a Designated Provider is recommended **but** you decide to have the transplant procedure performed elsewhere, the Plan will pay 60% of covered charges in connection with the transplant procedure. The 60% benefit level will apply even when the facility is considered in-network for other non-transplant procedures.

Benefits are available to the donor and the recipient when the recipient is covered under this plan. The transplant must meet the definition of a "covered health service" and cannot be experimental or investigational, or unproven. Examples of transplants for which benefits are available include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/small bowel
- Pancreas
- Small bowel
- Cornea
- Bone marrow (either from you or from a compatible donor) including CAR-T cell therapy for malignancies, and peripheral stem cell transplants, with or without high dose chemotherapy (Not all bone marrow transplants meet the definition of a covered health service.)
- Transplantation of non-human organs is not covered.

Other transplant benefits

Charges for the following services are covered:

- Preparation, acquisition, transportation and storage of human organs, bone marrow or human tissue
- Approved travel and lodging expenses in connection with transportation of the organ recipient to the transplant procedure site as described in "Travel and lodging assistance program for complex medical conditions" on page 54.

Limitations

The Plan pays benefits for approved charges incurred by the organ donor and the transplant recipient when both are covered under Stryker's medical plan.

When the organ recipient is covered under Stryker's medical plan, but the donor is not, the Plan pays benefits for approved charges incurred by the organ donor to the extent that those charges are not covered by any other source.

When only the organ donor is covered under Stryker's medical plan, the Plan covers any charges related to donor services up to a maximum benefit of $5,000. This benefit is payable only when the transplant recipient's plan does not cover donor services.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Physician's office services - sickness and injury

Benefits are paid by the Plan for covered health services provided in a physician's office for the diagnosis and treatment of a sickness or injury. Benefits are provided regardless of whether the physician's office is freestanding, located in a clinic or located in a hospital. Benefits under this section include allergy injections and hearing exams in case of injury or sickness.

Covered health services include medical education services that are provided in a physician's office by appropriately licensed or registered healthcare professionals.

Covered health services include genetic counseling.

Benefits include allergy injections.

Benefits for preventive services are described under "Preventive care services" on page 66.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the physician's office, are described under "Lab, X-ray and diagnostic - outpatient" on page 74.

Prosthetic devices

At UnitedHealthcare's or Surest's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are more than the cost of replacement or when a change in the covered member's medical condition occurs sooner than the three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Benefits are limited to a single purchase (including repair/replacement) every three calendar years.

Prior authorization requirement

For out-of-network benefits you must obtain prior authorization from the claims administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required under the UHC plans, benefits will be subject to a $400 penalty.

Skilled nursing facility/ inpatient rehabilitation facility services

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are covered by the Plan. Benefits include:

- Non-physician services and supplies received during the inpatient stay
- Room and board in a semi-private room (a room with two or more beds)

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

Benefits for other physician services, including anesthesiologists, consulting physicians, pathologists and radiologists, are covered as defined by the Plan.

The claims administrator will determine if benefits are available by reviewing both the skilled nature of the service and the need for physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital; and
- You will receive skilled care services that are not primarily custodial care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- It is ordered by a physician;
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair;
- It requires clinical training in order to be delivered safely and effectively; and
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for covered members who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note:

- The Plan does not pay benefits for custodial care or domiciliary care, even if ordered by a physician, as defined in "Medical plan definitions" on page 87.
- Any combination of network benefits and out-of-network benefits is limited to 120 days per calendar year.

Prior authorization requirement

Please remember for out-of-network benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required under the UHC plans, or notification is not provided, benefits will be subject to a $400 penalty.

Specialty pharmacy

Specialty drugs are managed differently than everyday prescriptions. The claims administrator broadly define "specialty drugs" as:

- **Self-administered injectable drugs**. These are drugs that can be administered by the patient or a non-skilled caregiver. Self-administered injectable drugs are covered under the pharmacy benefit or may be excluded from coverage; a limited number of self-administered injectable drugs may also be covered under the medical benefit.
- **Injectable drugs** (not intended for self-administration). These are drugs that must be administered by a healthcare professional in a physician's office or other outpatient setting, usually by infusion or intra-muscular injection. This includes plasma or recombinant-derived products, such as factors to treat hemophilia or immune globulins. Chemotherapy agents are a significant component of this category. Injectable drugs are covered under the medical benefit with the deductible and coinsurance applied.
- **Biotech drugs. These are drugs manufactured through genetic engineering**. This includes oral, self-administered, injectable or infusion products given in an ambulatory setting.
- **Orphan drugs**. These are drugs that have been given a seven-year market exclusivity by the Orphan Drug Act.

Based on stipulations of the pharmaceutical manufacturers, certain specialty medications are only available through select specialty pharmacies.

Patient education materials are provided with specialty medications along with information on how to contact the appropriate specialty pharmacy, which differ by type of medication. Pharmacists are available 24 hours a day, seven days a week, to answer any questions and provide information about the medication, such as

administration, storage, general drug information and side effect management.

Certain medical conditions require specialty medications, such as anemia, asthma, cancer, cystic fibrosis, growth hormone deficiency, hemophilia, hepatitis C, HIV/AIDS, immune deficiencies, low white blood cells, multiple sclerosis, osteoporosis, psoriasis, pulmonary hypertension, rheumatoid arthritis and RSV prevention to name a few. Note that some drugs may be excluded from coverage under our plan. Please contact UnitedHealthcare (UHC) Customer Service at 800 387 7508 or Surest Member Services at 844 530 0139 for more information.

When a patient who needs a specialty medication is identified by the claims administrator, UHC's or Surest's specialty pharmacy contacts the physician to provide information, make initial transition plans and obtain a prescription(s). The specialty pharmacy then contacts the patient to answer any questions and inform him or her of the process. For more information contact UHC Customer Service at 800 387 7508 or Surest Member Services at 844 530 0139.

Pharmacy customer service centers are open 24 hours a day, seven days a week, except for Thanksgiving and Christmas days. Specialty pharmacies guarantee round-the-clock access to a pharmacist for any medication or administration-related questions.

Please note that there is a Coupon Adjustment Benefit Plan Protection program for prescriptions filled through the specialty pharmacy, OptumRx Specialty Services. Through this program, if a manufacturer drug coupon or manufacturer copay card is used, the drug manufacturer drug coupon or copay card dollar amount will not apply to your deductible and/ or out-of-pocket maximum amounts. Only your actual payment amount (after the coupon is applied) will apply to the deductible and out-of-pocket maximum amounts.

Therapeutic treatments - outpatient

The plan pays benefits for therapeutic treatments received on an outpatient basis at a hospital or Alternate facility (for all UHC medical plans) or in a physician's office (for the UHC Value PPO and Surest Advantage plans only), including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered health services include medical education services that are provided on an outpatient basis at a hospital or alternate facility by appropriately licensed or registered healthcare professionals.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists.

Travel and lodging

(For travel and lodging for complex medical conditions see "Travel and lodging assistance program for complex medical conditions" on page 54.)

The Plan provides a covered member with a travel and lodging allowance related to all covered health services, including mental health care and substance-related and addictive disorders services when such covered services are not available within 50 miles of your address.

Travel and lodging provides support for the covered person under the Plan. The Plan provides an allowance for reasonable travel and lodging expenses for a covered member and travel companion when the covered member must travel at least 50 miles from their address to receive the covered services.

This Plan provides an allowance for incurred reasonable travel and lodging expenses only and is independent of any existing medical coverage available for the covered person. An allowance of up to $4,000 per covered person per year and is further limited to a maximum allowance of $10,000 per covered person per lifetime, will be provided for travel and lodging expenses incurred as a part of the covered service. Lodging expenses are further limited to $50 per night for the covered person, or $100 per night for the covered person with a travel companion.

Please remember to save travel and lodging receipts to submit for reimbursement. If you would like additional information regarding travel and lodging, you may contact the telephone number on your ID card.

Urinary catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual care services

Virtual care for covered health services that include the diagnosis and treatment of less serious conditions. Virtual care services provide communication of medical information in real-time between the patient and a distant physician or health care specialist outside of a medical facility (for example, from home or from work).

In-network benefits are available only when services are delivered through a designated virtual network provider. You can find a designated virtual network provider by going to www.myuhc.com or benefits.surest.com or by calling the telephone number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency needs.

Please Note: Not all conditions can be appropriately treated through virtual care. The designated virtual network provider will identify any condition for which treatment by in-person physician contact is necessary.

Benefits do not include email, fax and standard telephone calls, or services that occur within medical facilities (CMS defined originating facilities).

Wigs

The Plan pays benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Any combination of in-network benefits and out-of-network benefits is limited to $500 per lifetime.

Expenses not covered

The following medical expenses are not covered under the Plan.

- Health services and supplies that do not meet the definition of a covered health service. (See “Medical plan definitions” on page 87.) Covered health services are those health services including services, supplies or pharmaceutical products, which the claims administrator determines to be all of the following:
  - Medically necessary.
  - Described as a covered health service in this SPD under "Covered medical expenses” on page 55.
  - Not otherwise excluded in this SPD.
- Health services related to a non-covered health service: When a service is not a covered health service, all services related to that non-covered health service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service.

  For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, which require hospitalization.
- Health care services from an out-of-network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-hospital facilities: alternate facility, freestanding facility, residential treatment facility, inpatient rehabilitation facility, and skilled nursing facility received outside of the covered member’s state of residence. For the purpose of this exclusion the "state of residence" is the state where the covered member is a legal resident, plus any geographically bordering adjacent state or, for a covered member who is a student, the state where they attend school during the school year.

  This exclusion does not apply in the case of an emergency or when there is no network provider who is reasonably accessible or available to provide covered health services.
- Health services provided in a foreign country, unless required as emergency health services.
- Services and supplies that are not necessary for the diagnosis, care or treatment of the disease or injury involved.
- Experimental or investigational services or unproven services, unless the Plan has agreed to cover them as defined in “Medical plan

definitions" on page 87. This exclusion applies even if experimental or investigational services or unproven services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

- Items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any covered member enrolled in the trial.
- Services or supplies that are experimental, investigational or unproven (However, this exclusion will not apply to services or supplies [other than drugs] received in connection with a disease if the claims administrator determines that the disease is expected to cause death within one year in the absence of effective treatment, and the service or supply is effective or shows promise of being effective for that disease. This exclusion will not apply to drugs that have been designated as an investigational new drug or are being studied at the Phase III level in a national clinical trial by the National Cancer Institute, if the claims administrator determines that the drug is effective or shows promise of being effective for the disease.). If you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for the treatment, the claims administrator may at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.
- Services, treatment, educational testing or training related to learning disabilities or developmental delays except for speech therapy services.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the member's disease or injury
- Treatment of covered healthcare providers who specialize in the mental healthcare field and who receive treatment as part of their training in that field
- Services of a resident physician or intern rendered in that capacity
- Expenses above the eligible expense fee limits set by the claims administrator
- Hospital or other facility expenses for custodial care
- Services and supplies furnished, paid for or for which benefits are provided or required because of a person's past or present service in the armed forces
- Services and supplies furnished, paid for or for which benefits are provided or required under any law of a government (This does not include a plan established by a government for its own employees or their dependents, or Medicaid.)
- Charges for eye refractions or vision examinations
- Charges for eyeglasses or contact lenses to correct refractive errors
- Eye surgery to eliminate refractive errors (such as radial keratotomy or LASIK)
- Services or supplies for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment
- Charges for plastic surgery, reconstructive surgery, cosmetic surgery, liposuction (except liposuction for lipedema paid as reconstructive procedure) or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will NOT apply if the service or supply is needed:
  - To improve the function of a body part (other than a tooth) that is malformed as a result of a severe birth defect or as a direct result of disease or surgery performed to treat a disease or injury
  - To repair an injury as long as surgery is performed in the calendar year of the accident which causes the injury or in the next calendar year

- For breast reduction surgery in which UHC determines is requested to treat a physiologic functional impairment, for coverage required by the Women's Health and Cancer Rights Act of 1998 or for treatment of gender dysphoria
- For medically necessary treatments for gender dysphoria

- Charges for therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- Charges for cosmetic procedures for gender dysphoria including:
  - Abdominoplasty
  - Blepharoplasty
  - Body contouring, such as lipoplasty. Removal of excessive skin and subcutaneous tissue, etc.
  - Brow reduction, augmentation and lift
  - Cheek implants and lipofilling
  - Chin reshaping
  - Injection of fillers or neurotoxins
  - Face lift, forehead lift, or neck tightening
  - Facial bone remodeling
  - Hair removal, except as part of a genital reconstruction procedure by the physician for the treatment of gender dysphoria
  - Hairline advancement and transplantation
  - Jaw reconstruction
  - Lip augmentation
  - Lip reduction
  - Lipofilling and Liposuction
  - Mastopexy
  - Penile transplants
  - Rhinoplasty
  - Skin resurfacing
  - Uterine transplants.
- The following fertility treatment-related services:
  - Cryo-preservation and other forms of preservation of reproductive materials except as described under "Fertility services and fertility solutions plus (FS+) program" on page 70. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which benefits are provided.
  - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
  - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- The following services related to a gestational carrier or surrogate:
  - Fees for the use of a gestational carrier or surrogate.
  - Insemination or InVitro fertilization procedures for surrogate or transfer of an embryo to gestational carrier.
  - Pregnancy services for a gestational carrier or surrogate who is not a covered person.
- Donor, gestational carrier or surrogate administration, agency fees or compensation.
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
  - Purchased egg donor (i.e., clinic or egg bank)—The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen.
  - Purchased donor sperm (i.e., clinic or sperm bank)—The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
- The reversal of voluntary sterilization.
- Fertility services not received from a Designated Provider (except for covered persons who do not live within a 60-mile radius of a Fertility Solutions Plus Designated Provider as determined by the Plan).

- Assisted reproductive technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Infertility treatment following unsuccessful reversal of voluntary sterilization.
- Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).
- Non-preventive nutritional counseling that is non-disease specific nutritional education such as general good eating habits. This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Services Task Force or to benefits provided described under "Non-preventive nutritional counseling" on page 76.
- Charges for food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which benefits are provided as described under Enteral Nutrition
- Charges for marriage, family, child, career, social adjustment, pastoral or financial counseling without a medical diagnosis
- Charges for acupressure, aromatherapy, hypnotism, massage therapy and rolfing
- Services provided by a close relative or anyone who resides in the patient's home (Close relatives include the patient's spouse, and any child, sibling or parent of the employee or spouse.)
- Travel or transportation expenses, even if ordered by a physician, associated with an organ transplant, as well as the expenses incurred by an organ donor whether or not the person is covered by the Plan, except as described under "Travel and lodging assistance program for complex medical conditions" on page 54.
- Health services for transplants involving animal organs or animal-assisted therapies.
- Charges for treatment of an injury or illness due to an act of war (declared or undeclared) or contracted while on duty with any military service for any country.
- Charges for treatment of obesity, unless the patient meets specific medical criteria as described under "Obesity surgery" on page 76
- Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under "Obesity surgery" on page 76.
- Charges for insulin syringes, lancets, insulin pen injectors and diabetic test strips (These expenses are covered under the prescription drug plan.)
- Services provided for comfort or convenience such as televisions, telephones, air conditioners, air purifiers, humidifiers, dehumidifiers, beauty or barbershop services or home remodeling to accommodate a health need.
- Prescribed or non-prescribed medical supplies.

  This exclusion does not apply to:
  - Medical foods for which benefits are provide (including medical foods to support enteral nutrition).
  - Diabetic supplies for which benefits are provided.
  - Ostomy supplies for which benefits are provided.
  - Urinary catheters for which benefits are provided.
  - Compression stockings.
  - Ace bandages.
  - Gauze and dressings.
- Dental services. This exclusion will not apply to anesthesia and associated hospital and facility charges that are not covered under the dental plan and are provided when, in the opinion of the treating dentist, any of the following criteria apply:
  - The related procedure involves extracting six or more teeth in various quadrants
  - Use of local anesthesia is considered ineffective because of acute infection, anatomic variation, or allergy
  - The procedure involves multiple extractions or restorations for a child under age four
  - There is a concurrent hazardous medical condition

- The procedure is intended to address extensive oral-facial and/or dental trauma and would be ineffective or compromised if performed using local anesthesia

  The benefits described here are covered only for anesthesia and related hospital and facility charges that are not covered by the dental insurance carrier.

- Prescription drugs and over-the-counter medications or supplies (These expenses may be covered under the prescription drug plan.)
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers contracted that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to covered individuals for self-administration.
- Routine foot care
  - Orthotic appliances and devices that straighten or re-shape a body part, except as covered under durable medical equipment (DME). This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.

  Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a covered person with diabetic foot disease.
- Non-powered exoskeleton devices are excluded. Intracellular micronutrient testing is excluded.
- Cranial molding helmets and cranial banding are excluded except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.
- Health services for organ and tissue transplants except as identified under "Organ transplant benefits" on page 77, unless the claims administrator determine the transplant to be appropriate according to their transplant guidelines
- Growth hormone therapy
- Domiciliary care
- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
- Liposuction
- Custodial care or maintenance care
- Private duty nursing inpatient
- Respite care.
  This exclusion does not apply to respite care for which benefits are provided as described under "Hospice Care" on page 74.
- Rest cures
- Services of personal care
- Independent living services
- Assisted living services
- Educational counseling, testing, and support services including tutoring, mentoring, tuition and school-based services for children and adolescents required to be provided by or paid for by the school under the Individual with Disabilities Education Act
- Vocational counseling, testing and support services including job training, placement services and work hardening programs (programs designed to return a person to work or to prepare a person for specific work)
- Transitional living services (including recovery residences)
- Over-the-counter hearing aids
- Psychosurgery
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Personal trainer
- Naturalist
- Holistic or homeopathic care

- Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to manipulative treatment and non-manipulative osteopathic care for which benefits are provided
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered when:
  - Required solely for purposes of career, education, sports or camp, travel employment insurance, marriage or adoption (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)
  - Related to judicial or administrative proceedings or orders unless medically necessary
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type (This exclusion does not include vaccines that are required by Stryker. If these vaccinations are required by your position the vaccinations are covered at 100%.)
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- In the event that an out-of-network provider waives copayments, coinsurance and/or the annual deductible for a particular health service (No benefits are provided for the health service for which the copayments, coinsurance and/or annual deductible are waived, not pursued, or not collected.)
- Charges in excess of any specified limitation
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), if the services are considered to be dental in nature, including oral appliances
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the actual charge (The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.)
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to, spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies
- Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which benefits are provided
- Habilitative services or therapies for the purpose of general well-being or condition in the absence of a medical or behavioral disabling condition. Any expenses you incur pursuing a claims appeal that you file.
- Certain new pharmaceutical products and/or new dosage forms until the date as determined by the claims administrator or their designee, but no later than December 31st of the following calendar year.

  This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening sickness or condition, under such circumstances, benefits may be available for the new pharmaceutical product to the extent provided under the Plan.

How to obtain medical benefits

You have no claims to file when you use in-network providers. If you are enrolled in the Out-of-Area plan or if you are enrolled in either PPO plan and use out-of-network services, you may be required to file a claim.

If you need to file a claim, contact your Benefits representative or the claims administrator for a claim form. You can also obtain a claim form online at the plan's web site (www.myuhc.com or benefits.surest.com). Read the claim form instructions carefully and fill out each section of the form that applies to you. Be sure to answer all questions and attach all materials specified to ensure complete processing of your claim.

Health statements

You will receive a Health Statement as an explanation of benefits (EOB) in the mail each month that the claims administrator processes at least one claim for you or a covered dependent. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered dependents online, you may do so at www.myuhc.com or benefits.surest.com. You may also elect to discontinue receipt of paper health statements by making the appropriate selection on this site.

If your claim for benefits is denied, you have the right to appeal the denial. If you wish to file an appeal, follow the instructions outlined in the **Medical and Rx claims procedures** section, starting on page 108.

How to reach UnitedHealthcare or Surest

UnitedHealthcare
Stryker Group #: 703997
P.O. Box 740800
Atlanta, GA 30374-0800
www.myuhc.com
800 387 7508

Surest
Stryker Group #: 78800874
P.O. Box 211758
Eagan, MN 55121
Benefits.Surest.com
844 530 0139

Medical plan definitions

Air Ambulance

Medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as defined in 42 CFR 414.605.

Ancillary Services

Items and services provided by out-of-network physicians at an in-network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by an out-of-network physician when no other in-network physician is available.

Annual deductible

The amount you must pay or the recognized amount when applicable, for covered services in a calendar year before the Plan begins paying benefits in that calendar year.

Assisted Reproductive Technology (ART)

The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism spectrum disorders

A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities, and as listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the

Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Care Rating (Surest Advantage Plan)

When you search on the Surest website or app, a Care Rating displays next to the provider or facility. Care Ratings are a simple way to help you navigate care options and potentially save you money. Surest evaluates providers and locations based on past claims data. Higher ratings are given to high-value providers with a record of quality, safety, efficiency and effectiveness, such as lower rates of complications after surgeries and better use of resources. Providers with a higher Care Rating are assigned a lower copay.

Cellular Therapy

Administration of living whole cells into a patient for the treatment of disease.

Claims administrator

UnitedHealthcare Value PPO and HSA plans:

UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates who provide certain claim administration services for the Plan (e.g., UnitedHealthcare is responsible for making claim payments according to the terms of the Plan).

Surest Advantage Plan:

Surest and its affiliates who provide certain claim administration services for the Plan (e.g., Surest is responsible for making claim payments according to the terms of the Plan).

Clinical Trials

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institute of Health (NIH). (Includes National Cancer Institute (NCI)
  - Centers for Disease Control and Prevention (CDC)
  - Agency for Healthcare Research and Quality (AHRQ)
  - Centers for Medicare and Medicaid Services (CMS)
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA)
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

Comparable to the system of peer review of studies and investigations used by the National Institute of Health, and

Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application
- The clinical trial must have written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Plan may, at any time, request documentation about the trial, or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the

definition of a covered health service and is not otherwise excluded under the Plan.

Coinsurance

The percentage of eligible expenses or the recognized amount when applicable, you are required to pay toward the cost of certain covered services.

Congenital anomaly

A physical developmental defect that is present at birth and is identified within the first twelve months after birth.

Copayment

The charge, stated as a set dollar amount, that you are required to pay for certain covered health services.

Please note that for covered health services, you are responsible for paying the lesser of the following:

- The applicable copayment.
- The eligible expense or the recognized amount when applicable.

Cosmetic procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is a good example of a cosmetic procedure because appearance would be improved, but there would be no improvement in physiological function, for example breathing.

Covered health services

Those health services, including services, supplies or pharmaceutical products, which the claims administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, Injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Described under "Covered medical expenses" on page 55
- Provided to a covered person who meets the Plan's eligibility requirements, as described in the SPD
- Not otherwise excluded in this SPD under "Expenses not covered" on page 81

Custodial care

Services that:

- Are non-health related, such as assistance in activities of daily living including, but not limited to, feeding, dressing, bathing, transferring and ambulating
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively

Definitive Drug Test

Test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Designated Dispensing Entity

A pharmacy, provider, or facility that has entered into an agreement with UHC, or with an organization contracting on UHC's behalf, to provide pharmaceutical products for the treatment of specified diseases or conditions. Not all in-network pharmacies, providers, or facilities are designated dispensing entities.

Designated Network Benefits

The description of how benefits are paid for the covered health services provided by a physician or other provider that has been identified as a designated provider.

Designated Provider

A provider and/or facility that:

- Has entered into an agreement with the claims administrator, or with an organization contracting on the claims administrator's behalf, to provide covered health services for the treatment of specific diseases or conditions; or
- The claims administrator has identified through their designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all in-network hospitals or physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at www.myuhc.com or Surest at Benefits.Surest.com or the telephone number on your ID card.

Durable medical equipment

Medical equipment that meets all of the following conditions:

- Can withstand repeated use
- Is not disposable
- Is used to serve a medical purpose with respect to treatment of a sickness or injury or their symptoms
- Is generally not useful to a person in the absence of a sickness or injury
- Is appropriate for use in the home
- Is not implantable within the body

Eligible expenses

For covered health services, incurred while the Plan is in effect, eligible expenses are determined by the claims administrator as stated below and as detailed in "Eligible expenses" on page 36.

Eligible expenses are determined in accordance with UnitedHealthcare's or Surest's reimbursement policy guidelines (which are based on industry standards) and are generally in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services

With respect to an Emergency:

- An appropriate medical screening examination (as required under section **1867 of the Social Security Act, 42 U.S.C. 1395dd** or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or an independent freestanding emergency department, as applicable, as are required under section **1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))**, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section **1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).**
- Emergency health services include items and services otherwise covered under the Plan when provided by an out-of-network provider or facility (regardless of the department of the hospital in which the items are services are provided) after the patient is stabilized and as

part of outpatient observation, or as a part of an inpatient stay or outpatient stay that is connected to the original emergency unless the following conditions are met:

- The attending emergency physician or treating provider determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
- The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
- The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
- Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Experimental or investigational services

Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
  - AHFS Drug Information (AHFS DI) under therapeutic uses section;
  - Elsevier Gold Standard's Clinical Pharmacology under the indications section;
  - DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III Clinical Trial as described in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are available as described under the definition of "Clinical Trials" above.
- If you are not a participant in a qualifying clinical trial as described above, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the claims administrator may, at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Fertility Solutions Plus (FS+)

A program administered by Optum Health (an affiliate of UnitedHealthcare). The FS+ program provides:

- Specialized clinical consulting services to covered employees and enrolled dependents to educate on fertility treatment options.
- Access to specialized network facilities and physicians for fertility services.

Gender Dysphoria

A disorder characterized by the diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Genetic Counseling

Counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about genetic testing; and
- Interpretation of the genetic testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.

Genetic Testing

Exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or provide information to guide the selection of treatment of certain diseases, including cancer.

Gene Therapy

Delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Gestational Carrier

A gestational carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Home health agency

A program or organization authorized by law to provide healthcare services in the home.

Hospital

An institution, operated as required by law, which meets both of the following conditions:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals (Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of physicians.)
- Has 24-hour nursing services

Independent Freestanding Emergency Department

A health care facility that:

- Is geographically separate and distinct and licensed separately from a hospital under applicable law; and
- Provides emergency health services.

Infertility

A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

Inpatient stay

An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

Intensive Behavioral Therapy (IBT)

Outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age-appropriate skills in people with autism spectrum disorders. Examples include applied behavioral analysis (ABA), The Denver Model and Relationship Development Intervention (RDI).

Intensive Outpatient Programs

A structured outpatient treatment program.

- For mental health services, the program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week.
- For substance-related and addictive disorders services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling

and education about addiction related and mental health problems.

Maximum Out-of-network Reimbursement (Naviguard)

This program establishes a benchmark for payment, including use of rates and methodologies established by Medicare to reimburse non-emergency claims. Stryker's Health and Welfare Plan pays based on 140% of these Medicare established fee limits.

Medically Necessary

Health care services that are all of the following as determined by the claims administrator or its designee, within UnitedHealthcare's or Surest's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The claims administrator reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's or Surest's sole discretion.

The claims administrator develops and maintains clinical policies that describe the **Generally Accepted Standards** of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the claims administrator and revised from time to time), are available to members, based on the plan you are enrolled in, on www.myuhc.com or Benefits.Surest.com or by calling the number on your ID card, and to physicians and other health care professionals on **www.UHCprovider.com** or www.uhcprovider.com/surest.

Medicare

Parts A, B, C and D of the insurance program established by Title XVIII of the United States Social Security Act, and as later amended.

Mental health and substance-related and addictive disorders delegate

The organization or individual designated by Stryker Corporation who provides or arranges mental health and substance-related and addictive disorders services.

Mental health services

Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment for the condition is a covered health service.

Mental illness

Those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment for the condition is a covered health service.

Neonatal Resource Services (NRS)

A program administered by UnitedHealthcare, Surest or its affiliates made available to you by Stryker. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

Network (also called in-network)

When used to describe a provider of healthcare services, this means a provider that has a participation agreement in effect with UnitedHealthcare, Surest or an affiliate to provide covered health services to covered members. The participation status of providers will change from time to time.

Network benefits

Benefits for covered health services that are provided by a network physician or other network provider.

Out-of-network benefits

Benefits for covered health services that are provided by an out-of-network physician or other out-of-network provider.

Partial hospitalization/day treatment/high intensity outpatient

A structured ambulatory program that may be a freestanding or hospital-based program and that provides services for at least 20 hours per week.

Personal Health Nurse

The primary nurse that the claims administrator may assign to you if you have a chronic or complex health condition. If a personal health nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s)

U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a covered health service by a physician.

Pharmaceutical Products (New)

A pharmaceutical product or new dosage form of a previously approved pharmaceutical product for the period of time starting on the date the pharmaceutical product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Physician

Any Doctor of Medicine, "M.D.," or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law. Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license is considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that benefits for services provided by that provider are available under the Plan.

Plan

The Stryker Corporation Welfare Benefits Plan.

Pregnancy

Includes all of the following:

- Prenatal care
- Postnatal care
- Childbirth
- Any complications associated with pregnancy

Presumptive Drug Test

Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing

Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- Services exceed the scope of intermittent care in the home.
- The service is provided to covered person by an independent nurse who is hired directly by the covered person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- The skilled care can be provided by a home health agency on a per visit basis for a specific purpose.

Qualified medical child support order (QMCSO)

Any judgment, order or decree issued by a court or state administrative agency that:

- Provides for child support with respect to a plan participant's child or directs the participant to provide coverage under a health benefits plan due to a state domestic relations law, or
- Enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan, and which satisfies the requirements to be a QMCSO set out in Section 609 of ERISA.

Recognized Amount

The amount which copayment, coinsurance and applicable deductible is based on for the below covered health services when provided by non-network providers:

- Non-network emergency health services.
- Non-emergency covered health services received at certain network facilities by non-network physicians, when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, "certain network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following:

- Applicable state law
- An All-Payer Model Agreement if adopted, or
- The qualifying payment amount as determined under applicable law.

Note: Covered health services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these covered health services were determined based upon an eligible expense.

Residential Treatment

A program of mental health services or substance-related and addictive disorders services that meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a physician.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

Residential treatment facility

A hospital or facility, licensed and operated as required by law, that provides residential treatment

Secretary

As that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

Sickness

Physical illness, disease or pregnancy. The term sickness as used in this SPD includes mental illness or substance-related and addictive disorders.

Skilled nursing facility

A hospital or nursing facility that is licensed and operated as required by law.

Specialty Pharmaceutical Product

Pharmaceutical products that are generally high-cost biotechnology drugs used to treat patients with certain illnesses.

Substance-related and addictive disorder services

Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment of the disorder is a covered health service.

Surrogate

A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. The surrogate provides the egg and is therefore biologically (genetically) related to the child.

Telehealth/Telemedicine

Live, interactive audio with visual transmissions, and/or transmissions through federally compliant secure messaging applications of a physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a covered person's home or place of work. Telehealth/telemedicine does not include virtual care services provided by a designated virtual network provider.

Therapeutic Donor Insemination (TDI)

Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living

Mental health services and substance-related and addictive disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery. Please note: these living arrangements are also known as supportive housing (including recovery residences).

UHC Health Advantage and Surest 360

Programs provided by the claims administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents.

UnitedHealth Premium Program

A program that identifies network physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions. To be designated as a UnitedHealth Premium provider, physicians and facilities must meet program criteria. The fact that a physician or facility is a network physician or facility does not mean that it is a UnitedHealth Premium Program physician or facility.

Surest Care Rating

Surest uses historical effectiveness and cost efficiency data from UHC to assign providers a Care Rating. Care Ratings are a simple way to help

you navigate care options and find high-quality providers with confidence. Providers with a higher Care Rating are assigned lower copays under the Surest Advantage plan.

Unproven services

Health services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are determined not to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-designed system reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case control studies cross-sectional studies and systematic reviews (with or without meta-analyses) of such studies.

The claims administrator has a process by which they compile and review clinical evidence with respect to certain health services. From time to time, The claims administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com (UHC plans) or Benefits.Surest.com (Surest Advantage Plan).

Please note:

- If you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), the claims administrator may, at their discretion, consider an otherwise unproven service to be a covered health service for that sickness or condition. Prior to such a consideration, the claims administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

The decision about whether such a service can be deemed a covered health service is solely at UnitedHealthcare's or Surest's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care

Care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center

An entity that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms.

Prescription drug benefits



Stryker's healthcare plan provides benefits for covered prescription drugs, including contraceptives, insulin and diabetic supplies. Benefits are paid for covered drugs that are medically necessary for treatment of a sickness or injury that is not job-related. Covered drugs must be prescribed by a licensed provider and dispensed by a registered pharmacist.

This section of the benefits summary describes the plans administered by UnitedHealthcare and Surest. If you are enrolled in an HMO or other insured medical plan that includes prescription drug benefits, please refer to your contract or benefit booklet for information regarding your prescription drug coverage.

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How prescription drug benefits work

When you enroll in a UnitedHealthcare or Surest medical plan, you automatically receive prescription drug coverage. You may purchase covered prescriptions through the pharmacy plan:

- At a participating retail pharmacy, including many chain and local pharmacies
- Through the mail from the convenient home delivery service (for long-term maintenance medications)

Benefits for covered prescription drugs are payable whether or not you use a pharmacy in the UnitedHealthcare Choice Plus network, although your out-of-pocket costs are lower when you use participating pharmacies.

If you are enrolled in the UHC Value PPO Plan or the Surest Advantage Plan, your prescription drug copays apply toward your in-network out-of-pocket maximum.

If you are enrolled in the UHC Basic or Premium HSA plans, you will pay the full cost of your non-preventive prescriptions until you meet the deductible, just like with the rest of your eligible medical expenses. Prescription costs count toward

meeting your plan deductible and out-of-pocket maximum.

Prescription drug list — for all UHC and Surest plans

The UnitedHealthcare/OptumRx™ program (also available with the Surest Advantage Plan) includes a prescription drug list (PDL) called the Advantage PDL. The PDL is a guide to help providers prescribe cost-effective medication. Use of the list is completely voluntary for you and your provider.

How prescription drug coverage works with the UHC Value PPO and Surest Advantage plans

The UHC Value PPO and Surest Advantage plans pay benefits at different levels for Tier-1, Tier-2 and Tier-3 prescription drugs. All prescription drugs covered by the plan are categorized into these three tiers on the prescription drug list (PDL). The tier status of a prescription drug can change periodically based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a prescription drug, depending on its tier assignment. Since the PDL may change periodically, UHC members can visit **www.myuhc.com** or call 800 387 7508; Surest members can visit Benefits.Surest.com or call 844 530 0139 for the most current information.

Each tier is assigned a copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your copay will also depend on whether or not you visit the pharmacy or use the mail order service.

Here's how the tier system works:

- Tier-1 is your lowest copay option. For the lowest out-of-pocket expense, you should consider Tier-1 drugs if you and your provider decide they are appropriate for your treatment.
- Tier-2 is your middle copay option. Consider a Tier-2 drug if no Tier-1 drug is available to treat your condition.
- Tier-3 is your highest copay option. The drugs in Tier-3 are usually more costly. Sometimes there are alternatives available in Tier-1 or Tier-2.

For prescription drug products at a retail in-network pharmacy, you are responsible for paying the lowest of the following:

- The applicable copayment and/or coinsurance.
- The network pharmacy's usual and customary charge for the prescription drug product.
- The prescription drug charge for that prescription drug product.

Your prescription drug benefits — UHC Value PPO Plan

The following table shows your prescription drug copays and the benefits available to you when you enroll in the UHC Value PPO Plan.

UnitedHealthcare network pharmacy or home delivery service	Non-network pharmacy
▪ At a retail pharmacy, you pay (up to 31-day supply): ▫ $10 copay for a Tier 1 drug ▫ $25 copay for a Tier 2 drug ▫ $50 copay for a Tier 3 drug ▪ At a retail pharmacy, you pay (up to 90-day supply): ▫ $30 copay for a Tier 1 drug ▫ $75 copay for a Tier 2 drug ▫ $150 copay for a Tier 3 drug ▪ Through home delivery, you pay (up to a 90-day supply; refills by phone or online): ▫ $25 copay for a Tier 1 drug ▫ $62.50 copay for a Tier 2 drug ▫ $125 copay for a Tier 3 drug ▪ No claim forms ▪	▪ You pay full cost of covered prescriptions at time of purchase ▪ Your reimbursement is equal to the amount you paid less the applicable copay (as shown in column on left) within 45 days of the purchase. ▪ If the reimbursement is submitted 46 days or later, your reimbursement will be equal to UnitedHealthcare's discounted drug costs, minus the appropriate copay. ▪ Claim forms required ▪ Up to a 31-day supply

Note: Copays apply to the in-network out-of-pocket maximum only.

Your prescription drug benefits — Surest Advantage Plan

The following table shows your prescription drug copays and the benefits available to you when you enroll in the Surest Advantage Plan.

Surest Advantage Plan retail pharmacy or mail-order pharmacy service
▪ At a pharmacy (in-network or out-of-network), you pay (up to a consecutive 31-day supply): ▫ $5 copay for a Tier 1 drug ▫ $40 copay for a Tier 2 drug ▫ $60 copay for a Tier 3 drug ▪ Through in-network retail or mail-order pharmacy, you pay (up to a 90-day supply; mail-order refills by phone or online): ▫ $12.50 copay for a Tier 1 drug ▫ $100 copay for a Tier 2 drug ▫ $150 copay for a Tier 3 drug ▪ No claim forms ▪ No out-of-network coverage with mail-order pharmacy service

How prescription drug coverage works with the Basic and Premium HSA Plans

If you are enrolled in the UHC Basic or Premium HSA plans, you will pay the full cost of your non-preventive prescriptions until you meet the deductible, just like with the rest of your eligible medical expenses. There are no prescription drug copays in the Basic and Premium HSA medical plans. So, keep in mind that if you choose one of the HSA medical plans, you will likely pay more at the pharmacy counter if you haven't met your deductible, but you can use your tax-free HSA funds to pay for your prescription drugs. Prescription costs count toward meeting your plan deductible and out-of-pocket maximum.

Your prescription drug benefits — Basic and Premium HSA Plans

The following table shows your prescription drug benefits available to you when you enroll in the Basic and Premium HSA medical plans.

Prescription costs and coinsurance	
If your deductible has not been met	**If your deductible has been met**
You pay the full cost of your prescription drugs until your plan deductible is met. ▪ Under the Affordable Care Act (ACA), some preventive medications are covered at 100% with no deductible requirement. ▪ In addition, Stryker will cover certain Core Plus Preventive Medications for the Basic and Premium HSA plans before the deductible is met with only the appropriate coinsurance applied. For an up-to-date Core Plus Preventive Drug List, visit **www.myuhc.com** or call UHC at 800 387 7508.	You pay the applicable coinsurance amount for your prescription drugs until your out-of-pocket maximum has been reached. The coinsurance amounts are: ▪ Premium HSA Medical Plan: You pay 20% in-network/40% out-of-network, after deductible. ▪ Basic HSA Medical Plan: You pay 30% in-network/50% out-of-network, after deductible.

Important terms

- Copay: The flat dollar amount you are required to pay per prescription.
- Coinsurance: The percentage of the cost that you are required to pay per prescription.

Certain prescription drug products or pharmaceutical products for which benefits are described in this benefits summary are limited to a certain amount of medication covered per copay or coinsurance or in a specific time period.

Expenses covered at 100% under all UHC Plans and the Surest Advantage Plan

UnitedHealthcare/OptumRx™ preventive care medications under the Patient Protection and Affordable Care Act (PPACA)

Certain over-the-counter (OTC) drugs and items that are classified for use in preventive care will be covered at 100% when they are:

- Prescribed by a health care professional
- Age and/or gender appropriate
- Filled at a network pharmacy

Most brands of eligible OTC medications are covered by the prescription drug benefit. For an up-to-date list of the covered OTC Preventive Care Medications, visit **www.myuhc.com**, Benefits.Surest.com or call the telephone number on your ID card.

Contraceptives for women

Certain contraceptives, prescription hormonal contraceptives, prescription emergency contraceptives, and prescription diaphragms are covered at 100% when they are:

- Prescribed by a health care professional
- Filled at a network pharmacy

Male contraceptives are not covered.

For an up-to-date list of covered contraceptives included in the Preventive Care Medication list, visit **www.myuhc.com**, Benefits.Surest.com or call the telephone number on your ID card.

Smoking cessation products

The prescription drug plan covers smoking cessation medications, which require a prescription by a physician (e.g., Chantix, bupropion). Certain over-the-counter (OTC) smoking cessation products (such as patches, lozenges and gum) are covered by the plan, when accompanied by a written (paper) prescription, covered at 100%. You will be eligible for coverage for up to two 90-day treatment cycles of medication each year.

Some prescription (non-OTC) smoking cessation prescription drugs are covered by the plan, at no cost-share. Examples are Bupropion sustained-release (generic Zyban), Nicotrol Inhaler, Nicotrol Nasal Spray and Chanitx Tablet.

For an up-to-date list of covered OTC and prescription drugs included in the Preventive Care Medication list, visit **www.myuhc.com,** Benefits.Surest.com or call the telephone number on your ID card.

Covered expenses for all UHC Plans and the Surest Advantage Plan

Generic drugs

One way that the plans manage costs for both you and Stryker is to use generic drugs when available. Only FDA "A" rated generic equivalent drugs are dispensed through both the network and home delivery pharmacies. "A" rated generics are subject to the same FDA regulations as brand-name drugs and considered to be equal in therapeutic effectiveness and safety when taken as prescribed. The main difference between generic and brand-name drugs is price; generics generally cost substantially less.

Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is medically necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by the claims administrator, benefits provided for the prescription drug product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information, please contact the telephone number on your ID card

Expenses not covered under all UHC Plans and the Surest Advantage Plan

The plan does not cover the following:

- Drugs or medicines lawfully obtainable without a prescription, except for covered OTC preventive care medications and supplements or OTC contraceptives
- Diagnostic kits and products including associated services.
- Injectable medication and chemotherapy agents administered by a physician or healthcare professional; these medications are generally covered under the medical plan (injectable medications that are commonly self-administered, like insulin, are covered under the prescription plan.)
- Over-the-counter smoking cessation products and smoking cessation medications not prescribed by a physician, or for dependents under age 18, or filled at a non-network pharmacy
- The following over-the-counter drugs and products:
  - Drugs or products available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the claims administrator has designated the over-the-counter drug or product as eligible for coverage as if it were a prescription drug product and it is obtained with a prescription order or refill from a physician.
  - Over-the-counter continuous glucose monitors.
- The following prescription drug products with over-the-counter alternatives:

- Prescription drug products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
- Certain prescription drug products that the claims administrator has determined are therapeutically equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

The claims administrator may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision.

- Prescription drug products prescribed by a provider who is on UnitedHealthcare's list of excluded providers due to fraud, waste, and/or abuse findings.
- Any drug considered to be experimental or investigational by the Food and Drug Administration (FDA) or medications used for experimental indications and/or dosage regimens considered to be experimental.
- Certain prescription drug products that are repackaged, relabeled or packaged as a unit dose or unit doses
- Certain new pharmaceutical products and/or new dosage forms until the date as determined by the claims administrator's designee, but no later than December 31st of the following calendar year.

  This exclusion does not apply if you have a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment).
- Durable medical equipment and prescribed and non-prescribed outpatient supplies other than disposable insulin syringes, insulin pen injectors, needles, insulin pump syringes/ needles, lancets and test strips prescribed with injectable insulin (see the **Medical benefits** section, starting on page 31, for durable medical equipment coverage).
- A pharmaceutical product for which benefits are provided in the medical portion of the Plan. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Immunization agents, biological sera, allergens, allergenic extracts (oral or injectable) and blood or blood plasma (generally covered under the medical plan).
- Any medication administered and entirely consumed in connection with direct patient care rendered in the home by licensed healthcare professionals (These medications are generally covered under the medical plan.)
- More than a 31-day supply of a covered drug from a retail pharmacy, or more than a 90-day supply of a covered maintenance drug from a retail pharmacy or the home delivery program
- Any medication consumed or administered at the place where the prescription is written, including medication taken or administered while the individual is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution
- Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's original order
- Prescription drug products used for cosmetic or convenience purposes without prior approval from the claims administrator
- Any product dispensed for the purpose of appetite suppression or weight loss. Certain drugs with an FDA-approved indication for weight loss (such as GLP-1 or dual GLP-1/GIP agonist) are not covered for any condition, including other FDA-approved indications (other than diabetes). This exclusion does not apply, however, to Wegovy when prescribed for cardiovascular conditions.
- Any charge for the administration of covered prescription drugs
- Any drug that may be covered under local, state or federal programs, including Workers' Compensation
- Any amounts over the allowable discounted drug cost
- General vitamins, except prenatal vitamins, vitamins with fluoride, vitamins provided at no cost as described under "Preventive Care

Medications," on page 101 and single entity vitamins that require a prescription

- Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product. Compound prescriptions over $50 are not covered unless prior authorization.
- A prescription drug product that contains an active ingredient available in a therapeutically equivalent to another prescription drug product. Such determinations may be made up to six times during a calendar year, and the claims administrator may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision.
- A prescription drug product that contains an active ingredient which is a modified version of and therapeutically equivalent to another prescription drug product. Such determinations may be made up to six times during a calendar year, and the claims administrator may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision.
- Prescription drugs with an OTC equivalent.
- Dental products, with the exception of prescription fluoride topicals in certain circumstances.
- Certain prescription drug products for which there are therapeutically equivalent alternatives available, unless otherwise required by law or approved by the claims administrator. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate benefits for a prescription drug product that was previously excluded under this provision.
- Certain unit dose packaging or repackages of prescription drug products.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a prescription drug product.

Medications may be excluded from coverage under your pharmacy benefit when it works the same or similar as another prescription medication or an over-the counter (OTC) medication. The UnitedHealthcare/OptumRx™ Advantage PDL provides a list of excluded medications. For an up-to-date Advantage PDL, visit **www.myuhc.com**, Benefits.Surest.com or call the telephone number on your ID card.

How to apply for an exception

If an excluded drug is prescribed for a specific medical condition, you may qualify for an exception. To request an exception, submit a letter to UHC or Surest from your doctor stating the medical condition that requires the non-covered drug and the length of projected use. The maximum time for which a letter can justify an exception is 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable copay or coinsurance amount.

How to obtain prescription drug benefits

Network pharmacies

If you use an in-network retail pharmacy for your covered prescriptions, you pay the appropriate copay (if you are enrolled in the UnitedHealthcare Value PPO or Surest Advantage plans), or the coinsurance (if you are enrolled in the UnitedHealthcare Basic or Premium HSA plan and you have met your deductible). When you present your medical plan ID card at a network pharmacy, there are no claims to file.

Vacation/travel overrides

If you are going to be away from home for an extended period of time, you may want to refill your prescription before you leave — even if you have not used up your current supply of medication. In these situations, contact UnitedHealthcare at 800 387 7508 or Surest at 844 530-0139 to request special authorization for the prescriptions you need to take with you on your trip. If you prefer, you can ask your pharmacy to call the claims administrator to make the request on your behalf.

Home delivery service

The home delivery service allows you to order up to a 90-day supply of maintenance medication through the mail. Maintenance medications are prescription drugs taken on a regular or long-term basis. Examples include oral contraceptives and blood pressure medication. Covered prescriptions are delivered directly to your home in unmarked, tamper-resistant packages by First Class mail or a national delivery service. For added convenience, you may order refills by phone or via the Internet.

You pay the appropriate copay (if you are enrolled in the UnitedHealthcare Value PPO Plan or Surest Advantage Plan), or the coinsurance (if you are enrolled in a UnitedHealthcare HSA plan and you have met your deductible).

Non-network pharmacies

If you use a pharmacy outside the network, you pay the full cost of the prescription at the time of purchase. You then must submit a claim form and itemized receipt to the claims administrator. Your reimbursement will be the amount you paid less the applicable copay, coinsurance or deductible within 45 days of the purchase. If the reimbursement claim is submitted 46 days or later, your reimbursement will be equal to UnitedHealthcare's or Surest's discounted drug costs, minus the applicable copay, coinsurance or deductible.

Prior authorization

Certain medications must be reviewed and approved by the claims administrator for medical necessity before your prescription is filled. Your doctor or your pharmacist can obtain prior authorization by calling UHC at 800 387 7508 or Surest at 844 530 0139. The prior authorization team will obtain information about your diagnosis and your doctor's drug therapy treatment plan, and determine whether the prescription is approved. Generally, prior authorizations are valid for one year.

Examples of drug and therapeutic classes that currently require prior authorization include but are not limited to:

- Avita-Penderm
- Avodart
- Compound medications- any compound over $50 requires prior authorization.
- Differin-Galderma
- Growth hormones
- Narcotic analgesics
- Regranex
- Retin-A
- Seizure medications (brand)
- Tracleer

This list may change from time to time, as determined by UnitedHealthcare.

Non-network pharmacy prior authorization

If you do not obtain prior authorization from the claims administrator before you fill a prescription at a non-network pharmacy, you can ask the Plan to consider reimbursement. You will be required to pay for the prescription drug at the pharmacy. You may seek reimbursement from the Plan by submitting a claim form. In such a case, you may be responsible for the full cost of the prescription.

If you submit a claim for a prescription filled at a non-network pharmacy with a prior authorization from the claims administrator, the amount you are reimbursed* will be the amount you paid less the applicable copay, coinsurance or deductible within

45 days of the purchase. If the reimbursement claim is submitted 46 days or later, your reimbursement* will be equal to UnitedHealthcare's discounted drug cost, minus the appropriate copay, coinsurance or deductible.

* Discounted Drug Cost — the amount the Plan will pay to reimburse you for a prescription drug product that is dispensed at a non-network pharmacy. The discounted drug cost for a particular prescription drug product dispensed at a non-network pharmacy includes a dispensing fee and any applicable sales tax.

Clinical programs

Specialty pharmacy

Some medications are covered as medical benefits rather than as prescription benefits. Please see "Specialty Pharmacy" in the **Medical benefits** section, starting on page 31, for further details.

Step therapy

Certain prescription drug products or pharmaceutical products for which benefits are described in this benefits summary are subject to step therapy requirements. This means that in order to receive benefits for such prescription drug products or pharmaceutical products, you are required to use a different prescription drug product(s) or pharmaceutical product(s) first.

You may determine whether a particular prescription drug product or pharmaceutical product is subject to step therapy requirements by visiting **www.myuhc.com** or Benefits.Surest.com or by calling the number on the back of your ID card.

Quantity level limits / quantity per duration

Certain prescription drug products or pharmaceutical products for which benefits are described in this benefits summary are limited to a certain amount of medication covered per copay or coinsurance or in a specific time period.

Rebates

The claims administrator receives rebates for certain brand-name medications included on the prescription drug list. A portion of these rebate payments are shared with Stryker and are used to offset the cost of Stryker's health plan. Neither UnitedHealthcare, Surest nor Stryker are required to pass on to you, and do not pass on to you, amounts payable under rebate or other discount programs.

Price Edge program

The Price Edge program is a pharmacy benefit program designed to help find the lowest price available on your generic medications: The Price Edge program works behind the scenes when you fill your prescription to compare cash discount card pricing for traditional generic drugs against pharmacy benefit plan pricing, helping to find the lowest prescription cost available at any in-network retail pharmacy, or home delivery. It also helps you save on over-the-counter items and other medications not covered by your benefit plan, if you have a prescription. This program is available within all UHC plans and the Surest Advantage Plan. If your plan has a copay and the Price Edge price is lower than your copay, you will pay the lower price.

Price Edge Cost List

The Price Edge Cost (PEC) List is a list of generic prescription drug products that will be covered at a price level that Optum establishes when a prescription drug product is obtained from a retail in-network pharmacy or a mail order network pharmacy. This list is subject to Optum's review and may change from time to time. When a generic prescription drug product is included on the PEC List and is dispensed by a retail network pharmacy or a mail order network pharmacy, the PEC List price will only apply when the PEC List price is the lowest cost option for the covered member. You may access the amount you will pay for prescription drug products to be dispensed by a retail network pharmacy or a mail order network pharmacy by contacting UnitedHealthcare at www.myuhc.com or Surest at Benefits.Surest.com or by calling the number on your ID card.

Smart fill program for specialty drugs

Certain specialty prescription drug products are included in the Smart Fill Program offered under the UHC and Surest plans. Find a complete list of these drugs through the internet at **www.myuhc.com** or Benefits.Surest.com or by calling the telephone number on your ID card.

Split fill

Certain specialty prescription drug products may be dispensed by the designated pharmacy in 15-day supplies up to 90 days and at a pro-rated copayment or coinsurance. The covered member will receive a 15-day supply of their specialty prescription drug product to determine if they will tolerate the specialty prescription drug product

prior to purchasing a full supply. The designated pharmacy will contact the covered member each time prior to dispensing the 15-day supply to confirm if the covered member is tolerating the specialty prescription drug product. You may find a list of specialty prescription drug products included in the Smart Fill Program – Split Fill, through the internet at **www.myuhc.com** or Benefits.Surest.com or by calling the telephone number on your ID card.

Specialty pharmacy coupon adjustment benefit plan protection

When you fill a prescription through the plan's specialty pharmacy or home delivery service, if a manufacturer drug coupon or manufacturer copay card is used, the amount of the coupon or copay card will not apply to your deductible and/ or out-of-pocket maximum amounts. Only your actual payment amount (after the manufacturer coupon is applied) will apply to the deductible and out-of-pocket maximum amounts.

Notice of Creditable Coverage

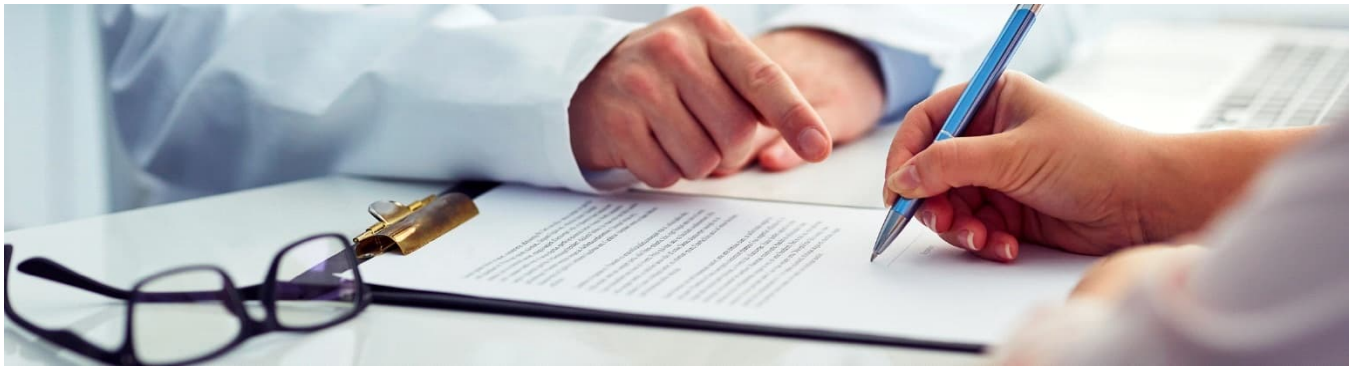
If you are approaching age 65, you will receive information before your 65th birthday about Medicare Part D, the government's prescription drug program, and how it will work with Stryker coverage.

How to reach UnitedHealthcare or Surest

UnitedHealthcare
Stryker Group #: 703997
P.O. Box 740800
Atlanta, GA 30374-0800
800 387 7508

Surest
Stryker Group #: 78800874
P.O. Box 211758
Eagan, MN 55121
Benefits.Surest.com
844 530 0139

Medical and Rx claims procedures



This section of the Stryker benefits summary describes the procedures for filing a claim for medical and prescription drug benefits and how to appeal an adverse benefit determination.

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Medical and Rx benefits

In-network providers

UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates are the claims administrators for medical and prescription drug benefits under the UHC Value PPO and HSA plans and pays **in-network providers** directly for your covered medications and health services. If an in-network provider bills you for any covered health service, contact UnitedHealthcare. However, you are responsible for paying copayments, your remaining deductible and your coinsurance share (as applicable) to an in-network provider at the time of service or when you receive a bill from the provider.

Surest and its affiliates are the claims administrators for medical and prescription drug benefits under the Surest Advantage Plan and pays **in-network providers** directly for your covered medications and health services. If an in-network provider bills you for any covered health service, contact Surest.

Out-of-network providers

When you receive covered health services from an **out-of-network provider**, you are responsible for filing a claim in order to obtain reimbursement for the cost of these services. You must file the claim in a format that contains all of the information required, as described in "Required information" on page 109.

- If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and you believe that the plan should have paid for it, you may submit a claim for reimbursement following the procedures for filing a post-service claim (see "Submitting medical or Rx benefit claims" on page 110). If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement,

again following the procedures outlined for filing a post-service claim.

- If a retail or mail order pharmacy fails to fill a prescription that you have presented because they believe it is not covered under the plan, you may contact the claims administrator to determine if it is a covered health service. In such a case, you can submit a claim for coverage following the procedures described for filing a pre-service claim (see "Submitting medical or Rx benefit claims" on page 110).

You must submit a request for payment of benefits within one year of the date of service. If you don't provide this information to the claims administrator within one year of the date of service, benefits for that health service or medication will be denied or reduced at the claims administrator's discretion. This time limit does not apply if you are legally incapacitated.

An individual is considered "legally incapacitated" for plan purposes if they are determined by a court of law to be lacking the capacity to make or communicate responsible personal decisions. A person may also be considered "legally incapacitated" if they exhibit an inability to meet their own personal needs for medical care, nutrition, clothing, shelter or safety. In such a case, a general guardian will be appointed.

If your claim relates to an inpatient hospital stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider; all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to you. The claims administrator will not reimburse third parties who have purchased or been assigned benefits by physicians or other providers.

Required information

When you request payment of benefits, you must provide the claims administrator with all of the following information:

- The employee's name and address
- The patient's name and age
- The group number stated on your ID card
- The name and address of the provider of the service(s)
- A diagnosis from the physician
- An itemized bill from your provider that includes the current procedural terminology (CPT) codes or a description of each charge
- The date the injury or sickness began
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program (If you are enrolled for other coverage, you must include the name of the other carrier(s).)

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

For medical benefits claims, the above information should be filed with the claims administrator at the address on your ID card. When filing a claim for outpatient prescription drug benefits, your claims should be submitted to:

OptumRx
ATTN: Claims Department
P.O. Box 29077
Hot Springs, AR 71903

Payment of benefits

You may not assign, transfer, or in any way convey your benefits under the Plan or any cause of action related to your benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, plan sponsor, or the claims administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for benefits.

The Plan will not recognize claims for benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a covered person or beneficiary, or derivatively, as an assignee of a covered person or beneficiary.

References to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a covered person, and where practicable for the claims administrator (as determined in its sole discretion), UHC may make payment of benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your benefits; and
- is NOT a waiver of the prohibition on assignment of benefits under the Plan; and
- shall NOT stop the Plan, plan sponsor or the claims administrator from asserting that any purported assignment of benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such benefits is extinguished by such payment. If any payment of your benefits is made to a provider as a convenience to you, the claims administrator will treat you, rather than the provider, as the beneficiary of your claim for benefits, and the Plan reserves the right to offset any benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), as described under Coordination of Benefits.

Eligible expenses to an out-of-network provider for covered services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260) are paid directly to the provider.

Submitting medical or Rx benefit claims

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the plan's procedures for filing claims. There are three types of claims for medical benefits, each of which is subject to different rules.

- An **urgent care claim** is a type of pre-service claim that, if the regular time periods for handling pre-service claims were followed:
  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that could not be adequately managed without the care or treatment that is subject to the claim.
- A **pre-service claim** is a claim for a benefit that requires prior approval or notification under the terms of the plan, such as inpatient admission notification.
- A **post-service claim** is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care, medications or supplies that have already been received.

If you have other healthcare coverage

If you have other healthcare coverage, see the **Participating in healthcare benefits**, starting on page 5, for information on how that coverage may impact your claims.

A pre-service claim is considered submitted when the claims administrator receives a request for prior approval. See the "Notification Requirement" section of the **Medical benefits** section, starting on page 31, or "Prior Authorization" in the **Prescription drug benefits** section, starting on page 98, of this benefits summary for the procedures for notification or approval.

If you filed a pre-service claim improperly, the claims administrator will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the claims administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension, not longer than 15 days, and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the claims administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, 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 provide the claim appeal procedures.

In-network providers will generally submit their claims for payment directly to the claims administrator. If you obtain services from an out-of-network provider, or if you are enrolled in the Out-of-Area plan, you must pay for the services and submit a claim for reimbursement.

A claim is considered submitted when the claims administrator receives it.

Initial claim determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

Urgent care claims

The table below describes the timeframes, which you and the claims administrator are required as follows:

Urgent request for benefits*	
Type of request for benefits or appeal	**Timing**
If your request for benefits is incomplete, the claims administrator must notify you within:	**24 hours**
You must then provide your completed request for benefits to the claims administrator within:	**48 hours** after receiving notice of additional information required
The claims administrator must notify you of the benefit determination within:	**72 hours**
If the claims administrator denies your request for benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The claims administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

* You do not need to submit urgent care appeals in writing. You should call the claims administrator as soon as possible to appeal an urgent care request for benefits.

Concurrent care claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for benefits as defined above, your request will be decided within 24 hours. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Pre-service claims

You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. If you filed a pre-service claim improperly, the claims administrator will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the claims administrator will notify you of the information needed within 15 days after the claim was received and may request a one-time extension not longer than 15 days and pend your claim until all information is received. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested 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 specified timeframe, your claim will be decided within 15 days after the information is received. If you do not provide the requested information within the specified timeframe, you will receive an adverse benefit determination. 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 provide the claim appeal procedures.

Previously approved medical treatments

If the claims administrator previously approved an ongoing course of medical treatment that was

to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension.

If the claim involves urgent care, you will be notified whether the extension of treatment has been approved or denied no more than 24 hours after your request for the extension of treatment is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims.

If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Post-service claims

If you receive an adverse benefit determination for a post-service claim, you will receive a written notice from the claims administrator within 30 days of receipt of the claim, 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. You will be advised in writing of the need for a one-time 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 needed to complete the 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 specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, you will receive an adverse benefit determination. A 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 provide the claim appeal procedures.

If you receive an adverse benefit determination

If your claim for a benefit is denied in whole or in part, 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 of your claim, including:
  - 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 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 rule, guideline, protocol or criterion will be provided free of charge upon request
- If the basis for the adverse benefit determination was a determination of

experimental or investigational treatment or similar exclusion or limit, either:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances
- A statement that such an explanation will be provided free of charge upon request

- In the case of an adverse benefit determination of an urgent care claim, a description of the expedited review process applicable to such claim.

Keep in mind, if you file an appeal, you are responsible for any expenses you incur pursuing the appeal. The plan does not cover appeal expenses.

Review of an adverse benefit determination: what to do first

If your question or concern is about a benefit determination, you may informally contact the claims administrator's customer service before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in "Initial claim determinations" on page 111, you may appeal it as described below, without first informally contacting customer service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address for the claims administrator.

If you are appealing an urgent care claim adverse benefit determination, please refer to "Urgent claim appeals that require immediate action" on page 113 and contact customer service immediately. The customer service telephone number is 800 387 7508 for UHC or 844 530 0139 for Surest. Customer service representatives are available to take your call during regular business hours, Monday through Friday.

How to appeal a claim decision

If you still disagree with a claim determination after contacting customer service, you can contact the claims administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of medical service(s)
- The provider's name
- The reason you disagree with the adverse benefit determination (that is, why you believe the claim should be paid)
- Any documentation or other written information to support your request for claim payment

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.

Depending on the medical plan you are enrolled in, submit your appeal to the claims administrator at the following address:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Surest
P.O. Box 211758
Eagan, MN 55121

Except in the case of urgent care claims, your claim appeal must be made in writing.

Urgent claim appeals that require immediate action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the claims administrator as soon as possible. The claims administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

For urgent claim appeals, Stryker has delegated to the claims administrator the exclusive right to interpret and administer the provisions of the plan. The claims administrator's decisions regarding these matters are conclusive and binding.

The table below describes the timeframes, which you and the claims administrator are required to follow.

Urgent request for benefits*	
Type of request for benefits or appeal	**Timing**
If your request for benefits is incomplete, the claims administrator must notify you within:	**24 hours**
You must then provide your completed request for benefits to the claims administrator within:	**48 hours** after receiving notice of additional information required
The claims administrator must notify you of the benefit determination within:	**72 hours**
If the claims administrator denies your request for benefits, you must appeal the adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The claims administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

* You do not need to submit urgent care appeals in writing. You should call the claims administrator as soon as possible to appeal an urgent care request for benefits.

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. Submit your appeal to the following address:

Health Plan Administrator
Stryker
1941 Stryker Way
Portage, MI 49002

Your 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.

Appeal process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The claims administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Determinations on appeal

Urgent care claims

For procedures associated with urgent claims, see "Urgent claim appeals that require immediate action" on page 113.

Adverse benefit determination of claims based on ineligibility to participate

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 claim 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.

Pre-service claims

For appeals of pre-service claims, you will be notified of the determination on first level appeal within a reasonable period of time but no longer than 15 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the decision, you have the right to file a second level appeal. Your second level appeal request must be submitted within 60 days of receipt of the first level appeal decision. The claims administrator will make a determination on your appeal no more than 15 days from receipt of a request for review of the first level appeal decision.

The table below describes the timeframes, which you and the claims administrator are required to follow.

Pre-service request for benefits*	
Type of request for benefits or appeal	**Timing**
If your request for benefits is filed improperly, the claims administrator must notify you within:	**5 days**
If your request for benefits is incomplete, the claims administrator must notify you within:	**15 days**
You must then provide completed request for benefits information to the claims administrator within:	**45 days**
The claims administrator must notify you of the benefit determination:	
▪ if the initial request for benefits is complete, within:	**15 days**
▪ after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The claims administrator must notify you of the first level appeal decision within:	**15 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
The claims administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

* The claims administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-service claims

The claims administrator will review and decide your appeal within a reasonable period of time but no longer than 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the decision, you have the right to file a second level appeal. Your second level appeal request must be submitted within 60 days of receipt of the first level appeal decision. The claims administrator will make a determination on your appeal no more than 30 days from receipt of a request for review of the first level appeal decision. For pre-service and post-service claim appeals, Stryker has delegated to the claims administrator the exclusive right to interpret and administer the provisions of the plan. The claims administrator's claim appeal decisions are conclusive and binding. The claims administrator's decision is based only on whether or not benefits are available for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

The table below describes the timeframes, which you and the claims administrator are required to follow.

Post-service claims Type of claim or appeal	Timing
If your claim is incomplete, the claims administrator must notify you within:	**30 days**
You must then provide completed claim information to the claims administrator within:	**45 days**
The claims administrator must notify you of the 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 an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The claims administrator 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
The claims administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Notification of the determination on appeal

Except in instances in which notice is provided under the expedited procedures for urgent care claims, you will be notified in writing of the decision at each level of appeal.

If the decision upholds the adverse benefit determination of your claim, 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 the adverse benefit determination was based on a determination of experimental or investigational treatment or similar exclusion or limit, either:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances
  - A statement that such an explanation will be provided free of charge upon request
- 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

External review program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the adverse benefit determination of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to

you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if the claims administrator fails to respond to your appeal within the timelines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor the claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four months of the date you receive the adverse benefit determination. You, your treating physician or an authorized designated representative may request an independent review by calling 800 387 7508 (the toll-free number on your ID card) or by sending a written request to the address on your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the plan. The independent review organization (IRO) has been contracted by the claims administrator and has no material affiliation or interest with the claims administrator or Stryker. The claims administrator will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of the claims administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the claims administrator in making a decision on the case; and
- All other information or evidence that you or your physician has already submitted to the claims administrator.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the claims administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the claims administrator with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the plan. If the final independent review decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the number on your ID card for more information regarding your external appeal rights and the independent review process.

Designation of an authorized representative

Under provisions of the plan, plan benefits are not subject to assignment by a participant, beneficiary or any other person except the Plan fiduciaries, and any attempt to do so shall be void. However, ERISA provides that in the case of persons with coverage under a state Medicaid program, automatic assignment of benefits to state Medicaid agencies is enforceable against the plan. Where benefits are paid directly to a doctor, hospital or other provider of care (other than to a state Medicaid agency), such direct payments are provided at the discretion of the Plan fiduciaries as a convenience to plan participants and do not imply an enforceable assignment of plan benefits or the right to receive such benefits.

An assignment to a healthcare provider for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other healthcare professional who is licensed, accredited or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claim procedures to "you" is intended to include your authorized representative. An assignment to a healthcare provider for purposes of payment does not constitute appointment of an authorized representative under these claim procedures. Notwithstanding this provision, plan benefits are not subject to assignment by participant, beneficiary or any other person except the Plan fiduciaries.

Employee incentive program

Because of the large volume of activity in hospitals' and doctors' billing offices, oversights and duplicate charges do occur. As an incentive to carefully review your bills, Stryker will pay you 50% of any overcharges that are recovered from a hospital or doctor up to a maximum of $2,000. Bills eligible for this program must be for you or your dependents for which Stryker's plan is primary.

Follow these procedures when reviewing your hospital or doctor bill:

- Before you leave the hospital or doctor's office, make sure you receive or will be sent an itemized bill, including the date and type of service performed and the corresponding charges.
- Check that each listed service was performed and contact the doctor's or hospital's billing office if you have any questions.
- Ask for an explanation of any charges you don't understand.
- If you find any errors, it is your responsibility to contact the hospital's or doctor's billing department to report the error and obtain a corrected bill within 90 days of discharge or the date of service. Have the hospital or doctor send the corrected bill, with the corrected items circled, to the claims administrator. Upon review of the corrected bill, the claims administrator will issue a corrected Explanation of Benefits (EOB) form.
- Present the original bills and the original and corrected EOBs to your Benefits Representative for review. You and the payroll department will then be notified of the incentive amount for which you are eligible. Please note that reimbursements under this program are considered income for tax purposes.

Vision benefits



Whether your vision is 20/20 or less than perfect, everyone needs regular vision care. That's why Stryker offers vision benefits as part of the Stryker Corporation Welfare Benefits Plan.

The plan provides for professional vision services as well as glasses and contact lenses. EyeMed administers vision benefits. When you purchase covered vision services and materials through EyeMed's provider network, your out-of-pocket expenses are limited to your copayments. Out-of-network services and materials are covered, too, but you pay a greater share of the cost.

While the definition of dependent child has been voluntarily amended to align with the medical and prescription benefit pursuant to the Affordable Care Act (ACA), the vision benefit is not otherwise subject to the ACA's market reform requirements.

A detailed vision plan summary is available at **http://www.stryker.com/spd/2026-vision-summary.pdf**.

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How vision benefits work

Stryker's vision benefits cover the cost of regular vision exams for you and your covered family members. Prescribed glasses and contact lenses are also covered.

When you use participating EyeMed providers

Examination benefit

The plan covers a comprehensive spectacle eye examination, including dilation, performed by a participating provider at no cost to you. Please note: there may be an additional charge from a provider for a contact lens exam.

Additionally, retinal imaging may be available at participating providers, but is not covered under the plan. Retinal imaging has been provided as an additional discount to your vision plan. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. As this is a discounted service, you would be required to pay up to $39 out of pocket for these services at an in-network provider.

Frame benefit

You are entitled to a $150 frame allowance every 12 months, with a $0 copay, when you purchase a frame with prescription lenses from a participating provider. If the frame you select costs more than $150, you pay 80% of the balance over $150.

Lens benefit

When you purchase lenses from a participating provider, you pay a $10 copay for single vision, bifocal, trifocal or lenticular lenses. You also pay the following fixed amounts for lens options:

Lens option	You pay
▪ Ultra violet coating	$15
▪ Tint (solid and gradient)	$15
▪ Standard scratch resistant	$15
▪ Standard polycarbonate	$40
▪ Standard progressives (add-on to bifocal)*	$75 (including the $20 bifocal copay)
▪ Standard anti-reflective	$45
▪ Other add-ons	20% discount

* Standard progressive lenses include, but are not limited to, the following trade names: Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.

Contact lens benefit

If you purchase contact lenses from a participating provider in lieu of spectacle lenses, you are entitled to a $150 contact lens allowance, with a $0 copay, every 12 months. If you purchase disposable contact lenses that cost more than $150, you pay 100% of the balance over $150. If you purchase non-disposable contact lenses that cost more than $150, you pay 85% of the balance over $150.

Laser vision benefit

You are entitled to a 15% discount off retail or a 5% discount on promotional pricing for LASIK and PRK treatments provided by a U.S. Laser Network provider. Discounts apply to the procedure itself as well as pre-operative and post-operative care, provided that the same participating provider performs the procedure and provides the pre-operative and post-operative care. For more information about laser vision benefits, call 877 552 7376.

Additional purchases

When you purchase vision supplies from a participating provider, you are entitled to a 20% discount off items not covered by the plan at network providers. The discount does not apply to professional services, disposable contact lenses or laser vision services and cannot be combined with any other discount or promotional offer.

Secondary purchase discount

If you purchase additional pairs of glasses (including prescription sunglasses) from a participating provider, you will receive a 40% discount off a complete pair of eyeglass purchases and a 15% discount off conventional lenses once the funded benefit has been used. Add $15 to these amounts if you live in California, Alaska, Hawaii, Oregon or Washington.

Additional promotions and discounts are also available through EyeMed. You can view more details by viewing the Special Offers platform when you log into **www.eyemed.com**.

How to locate participating providers

EyeMed's provider locator service is available seven days a week, 24 hours a day, via an interactive voice response system or the Internet. Call 866 723 0513 or visit **www.eyemed.com**. To speak with a customer service representative, call 866 723 0513. At the prompt, please choose the Access Network when using the provider tool on **www.eyemed.com**.

Online retail participating providers

Please note that **glasses.com** and **contactsdirect.com** are part of the participating provider network. Benefits will be applied in your shopping cart and free shipping is provided.

If you need adjustments for glasses that are ordered from **glasses.com**, you are welcome to take your frames into a retail partner (such as Lens Crafters, Sears Optical, or Target Optical) for adjustments.

Additional online participating providers include **lenscrafters.com**, **targetoptical.com** and **ray-ban.com**.

If you use non-participating providers

When you receive eye care services or materials from a non-participating provider, you pay the cost and then submit a claim for reimbursement. Your reimbursement is based on the type of service up to the following maximums:

Service/Material	Benefit amount
Exam	▪ $35
Lenses	
▪ Single vision	▪ $46
▪ Bifocal	▪ $60
▪ Trifocal or lenticular	▪ $80
Frames	▪ $45
Contact Lenses	
▪ Conventional	▪ $105
▪ Disposable	▪ $105

Benefit frequency

You are eligible for vision services and materials at the following intervals:

Service/Material	Frequency
Exam	Every 12 months, based on a calendar year
Lenses	Every 12 months, based on a calendar year
Frames	Every 12 months, based on a calendar year
Contact lenses	Every 12 months, based on a calendar year (in lieu of glasses)

Expenses not covered

Benefits are not provided for services or materials arising from:

- Orthoptic or vision training
- Subnormal vision aids and any associated supplemental testing
- Medical or surgical treatment of the eye, eyes or supporting structures (These services are generally covered under the medical plan.)
- Corrective eyewear required by an employer as a condition of employment and safety eyewear
- Any service or material that may be covered under any Workers' Compensation law
- Plano non-prescription lenses and non-prescription sunglasses, except for the 20% discount for materials purchased from participating providers
- Two pairs of glasses in lieu of bifocals
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim and Pro Design
- Services that are available without cost from any federal, state, county, city or other governmental organization

Benefits may not be combined with any discount, promotional offering or other group benefit plans. Allowances are one-time use benefits; no remaining balance may be used for additional pairs. Lost or broken materials are not covered.

How to obtain vision benefits

If you use participating providers

Once you've located a participating provider, schedule an appointment. Be sure to let the provider's office know that you are covered under an EyeMed vision plan. Your provider's office will collect your copays as well as any additional amounts you may owe for optional items such as designer frames or tinting. The provider's office also files claims for you.

Please note that the contact lens allowance is a one-time per calendar year benefit. If you purchase disposable contact lenses from a participating provider, be sure to purchase a sufficient quantity so that you use all of the $150 in-network benefit allowance. If you do not use all of the allowance for a single purchase, you won't have any remaining balance to use for future purchases in the same calendar year.

If you use non-participating providers

If you do not use a participating provider, you must pay for services and materials and then file a one-time claim for reimbursement of all services and materials. You will need to complete an out-of-network claim form and submit the form with itemized receipts for reimbursement to:

EyeMed Vision Care
Attention: OON Claims
P.O. Box 8504
Mason, OH 45040

You may also submit your claim via the EyeMed website (**www.eyemed.com**). If your eye exam is provided on a date that is different from the date you receive your glasses or contacts, don't file your claim for reimbursement until you have all of the necessary receipts.

If you purchase contact lenses from a non-participating provider, you must file a claim in order to obtain the $105 contact lens allowance. This is a one-time reimbursement, so you should wait to file your claim until you have all of the necessary receipts for your contact lens exam, fitting and the contact lenses themselves.

Time frames for processing out-of-network claims

Health claim processing activity	Time frame
Plan Initial Determination	
▪ Initial review decision	▪ 30 calendar days
▪ Extension period, including extension for missing information	▪ 14 calendar days
Plan Notice of Incomplete Claim	
▪ Missing information	▪ Included in extension period above
Claimant Time to Complete Claim	
▪ Provide additional information	▪ 45 calendar days
▪ Comply with required filing procedure	▪ 45 calendar days

Time frames for responding to appealed claims

Health claim processing activity	Time frame
Claimant Appeal of Adverse Determination (Denial or Reduction)	▪ 180 calendar days
Plan Decision or Appeal	▪ 60 calendar days

EyeMed Vision Care has been determined to belong to the post service claims category. If a claim for benefits is denied, EyeMed Vision Care will notify the member in writing of the specific reasons for the denial. The member may request a full review by EyeMed Vision Care within 180 days of the date of a denial. The member's written letter of appeal should include the following:

- The applicable claim number or a copy of the EyeMed Vision Care denial information or Explanation of Benefits, if applicable

- The item of your vision coverage that you feel was misinterpreted or inaccurately applied
- Additional information from your eye care provider that will assist EyeMed Vision Care in completing its review your appeal, such as documents, records, questions or comments

The appeal should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, Ohio 45040

EyeMed Vision Care will review your appeal for benefits and notify you in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member grievance procedure

If you are dissatisfied with the services provided by an EyeMed Vision Care Provider, you should either write to EyeMed at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at 866 723 0513.

The EyeMed Vision Care Member Services representative will log the telephone call and attempt to reach a resolution to the issues you raise. If a resolution cannot be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to communicate back with you within four (4) business days, with a decision or resolution to the issues or questions raised. If you are not satisfied with the resolution, you may file a formal appeal as set forth above related to a denial of benefits.

How to reach EyeMed

EyeMed Vision Care
Stryker Group # for Active Employees: 9706201
Stryker Group # for COBRA Participants: 9706219
4000 Luxottica Place
Mason, OH 45040
866 723 0513
www.eyemed.com

Dental benefits



Dental coverage under Stryker's healthcare plan helps pay dental bills for you and your family. It is designed to encourage good dental care. The plan covers preventive dental services and treatment for a disease, defect or accident that injures your teeth and is not job-related, as long as treatment meets accepted dental standards and is provided by a licensed dentist.

This section of the Stryker benefits summary describes Stryker's dental benefits administered by Delta Dental of Michigan. For additional information about the plan, see the Delta Dental PPO certificate available at **https://totalrewards.stryker.com/2026 Delta Dental Certificate.pdf**.

While the definition of dependent child has been voluntarily amended to align with the medical and prescription benefit pursuant to the Affordable Care Act (ACA), the dental benefit is not otherwise subject to the ACA's market reform requirements.

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How dental benefits work

Delta Dental of Michigan administers Stryker's dental benefits. Under the Delta Dental program, you may choose any licensed dentist. If you choose a dentist who participates in Delta Dental Premier or Delta Dental PPO networks, you will pay only your copayment for covered services. Participating dentists agree to accept Delta Dental's payment and your copayment as payment in full for covered services.

If you choose a dentist who does not participate in a Delta Dental program, you will still be covered. However, you may have to pay more than just the copayment amount. You will also be responsible for the difference, if any, between Delta Dental's allowed fee and the dentist's submitted fee.

Your deductible

A deductible is money you must spend on your own for covered services before the dental plan pays benefits. Your deductible is $50 per person per year, not to exceed $150 per family per year.

The deductible does not apply to Class I Benefits or to Class IV Benefits (see "Schedule of benefits" on page 125).

Before you have treatment

When you or a covered dependent expects to have any dental treatment that may cost more than $200, it is recommended that your dental provider submit a Pre-Treatment Estimate from Delta Dental. This lets you and the treating dentist know in advance what benefits are covered, how much the plan will pay and how much you will have to pay.

To file for Pre-Treatment Estimate, ask your dentist to complete a claim form describing the planned services and charges, and submit the form to Delta Dental before treatment begins.

Optional treatment

If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

While you are responsible for the difference in cost for any optional treatment, having a Pre-Treatment Estimate can help determine the amount you will have to pay toward the service before it is completed. Examples of services for which Delta Dental will provide an allowance for optional treatment include:

- Overdentures — Delta Dental will pay only the amount that it would pay for a conventional denture.
- Inlays, regardless of the material used — Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

If you lose coverage during treatment

If you or a covered dependent lose your dental coverage under Stryker's healthcare plan while receiving dental treatment, payment will be made only for those covered services actually received while coverage was in effect. However, crowns, jackets, bridges and dentures (full or partial) begun before the loss of eligibility will be covered if the work is completed within 60 days from the date coverage ends.

Schedule of benefits

Benefits under the plan are divided into four classes:

- **Class I Benefits** cover 100% of diagnostic and preventive services including X-rays.
- **Class II Benefits** cover basic dental services such as oral surgery, minor restorative services, periodontics and endodontics. Class II Benefits are paid at 80% after deductible.
- **Class III Benefits** cover prosthodontics and major restorative services. Benefits are paid at 50% after deductible.
- **Class IV Benefits** cover orthodontics . Orthodontics for plan participants may be covered if there is a medical necessity for the orthodontic treatment. Benefits are paid at 50%.

Benefit maximums

For Class I, Class II and Class III Benefits, the dental plan pays a combined maximum of $2,000 per person per year. For Class IV Benefits, the maximum is $2,000 per person per lifetime.

Covered dental expenses

The amounts you pay for covered services from a participating provider are shown in the chart below:

Covered service from a participating provider	Your share of cost
Class I Benefits: Diagnostic and Preventive Services (no deductible applies)	
Oral exams Limited to two in any calendar year.	$0
X-rays, full mouth (including bitewing) Limited to one set in any five-year period.	$0
X-rays, bitewing only Limited to once in any calendar year.	$0
Prophylaxis (cleaning, scaling and polishing) Limited to two in any calendar year, including periodontal prophylaxes. May be performed by a licensed dental hygienist.	$0
Fluoride treatments Limited to children under age 19. Limited to two in any consecutive 12-month period. May be performed by a licensed dental hygienist.	$0
Sealants Limited to occlusal (top biting) surface of first permanent molars for children under age 9 and second permanent molars for children under age 14. Covered once per tooth per lifetime.	$0
Emergency palliative treatment (to temporarily relieve pain)	$0
Class II Benefits: Basic Services (subject to deductible)	
Oral surgery	20%
Minor restorative services, including fillings, relines and repairs to bridges, dentures and partials Amalgam and resin restorations are payable once within a 24-month period regardless of the number or combination of restorations placed on a tooth surface. Benefits for reline or complete replacement of denture base material are payable once in any three-year period.	20%
Periodontics (treatment of the gums and supporting structures of the teeth) Benefits for root planing are payable once in any two-year period. Periodontal surgery, including subgingival curettage, is payable once in any three-year period.	$0 for cleaning; 20% for all other services
Endodontics (root canal therapy)	20%

Covered service from a participating provider	Your share of cost
Class III Benefits: Major Restorative Services (subject to deductible)	
Prosthodontics (treatment to replace missing natural teeth or other dental structures)	50%
Complete dentures Limit of one complete upper and one complete lower denture per person in any five-year period.	50%
Partial dentures, fixed bridges or removable partials Limit of one per person in any five-year period except where the loss of additional teeth requires the construction of a new appliance. Fixed bridges and removable cast partials are not covered for children under age 16.	50%
Major restorative services, including crowns, jackets and onlays Treatment per tooth is limited to once in any five-year period. Full porcelain, porcelain/resin processed to metal, full cast or 3/4 cast crowns are not covered for children under age 12.	50%
Endosteal implants An implant for any person can be covered once in any five-year period, per tooth.	50%
Class IV Benefits: Orthodontics (no deductible applies)	
If orthodontia treatment began before coverage under Stryker's healthcare plan became effective, benefits will be calculated based on the remaining months of treatment. If orthodontia treatment is terminated prior to completion, for any reason, benefit payment will end as of the date treatment is terminated.	50%
Benefit Maximums	
Class I, Class II and Class III combined	$2,000 per person per calendar year
Class IV	$2,000 per person lifetime maximum

Special Healthcare Needs Program

This program is offered to help members with special healthcare needs and/or physical disabilities who may need additional appointments or sedation to receive dental care. The program allows four cleanings per year instead of two and covers treatment delivery modifications at 100% in-network, such as anesthesia and nitrous oxide, or completing a cleaning or other procedure over multiple visits.

Expenses not covered

The plan does not pay for the following expenses:

- Services that are not necessary as determined by the standards of generally accepted dental practice
- Treatment by other than a licensed dentist, except for prophylaxis (cleaning and scaling of teeth) and topical application of fluoride performed by a licensed dental hygienist under the supervision and direction of a licensed dentist
- Cosmetic dentistry or dentistry to correct congenital malformations
- Services or appliances, including crowns and bridges, for which treatment began prior to the date the person became covered under the plan
- Prescription drugs, laboratory tests and/or exams, premedications and local anesthesia (These services may be covered under the medical plan.)
- Hospitalization
- General anesthesia and intravenous sedation for restorative dentistry or surgical procedures, unless a specific need is shown (e.g., on account of a child's age)
- Preventive control programs, including home care items
- Charges for completion of claim forms
- Missed dental appointments
- Appliances, surgical procedures or restorations whose primary purpose is to alter vertical dimension, restore occlusion or replace tooth structure loss resulting from attrition, abrasion or erosion
- Inlays
- Replacement, repair, relines or adjustments of occlusal guards (Occlusal guards are limited to one per five years.)
- Lost, missing or stolen appliances of any type, and replacement or repair of orthodontic appliances
- Services that are experimental in nature
- Services and supplies for which no charge is made, for which the patient is not legally obligated to pay or for which no charge would be made in the absence of Delta Dental coverage
- Services to treat a dental disease, defect or injury due to an act of war, declared or undeclared
- Services that are covered under the medical or prescription drug benefits provided under the Stryker Corporation Welfare Benefits Plan
- Services or appliances for the treatment of temporomandibular joint (TMJ) disorder (Note: These services are covered under the medical plan.)
- Services for injuries or conditions covered under Workers' Compensation or employers' liability laws
- Services that are available from any government agency, political subdivision, community agency, foundation or similar entity
- Services that are excluded by Delta Dental's processing policies

How to obtain dental benefits

If you use participating dentists

If you use a dentist who participates in Delta Dental Premier or Delta Dental PPO, the dentist will submit your claim and receive payment directly from Delta Dental. You will receive an explanation of benefits (EOB) showing the portion of the charges paid by Delta Dental and the amount you owe.

For participating dentists, claim payment is based on

If you have other dental coverage

If you have other dental coverage, see the **Participating in healthcare benefits**, starting on page 5, for information on how Coordination of Benefits with that coverage may impact your claims.

the Maximum Approved Fee for a covered service as determined by Delta Dental. Payment is based on the lesser of the fee charged or the Maximum Approved Fee. Participating dentists agree not to charge you for any difference between their actual fee and the Maximum Approved Fee.

If you use non-participating dentists

In most cases, when you use a non-participating dentist, you are responsible for paying the dentist directly and filing a claim for reimbursement. You will receive payment from Delta Dental along with an explanation of benefits (EOB) form.

For non-participating dentists, benefits are based on Delta Dental's non-participating dentist fee for a covered service. Payment is based on the lesser of the dentist's submitted fee or Delta Dental's non-participating dentist fee. You are responsible for the difference between the claim payment amount and actual charges.

Coordination of benefits

Coordination of Benefits (COB) is used to pay healthcare expenses when you are covered by more than one plan. See "If you have other coverage" in the **Participating in healthcare benefits**, starting on page 5, of this benefits summary for more information about COB provisions for the dental plan.

How payment is made

If the dentist is a PPO dentist and a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The PPO dentist schedule
- The Maximum Approved Fee

Delta Dental will send payment to the PPO dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the PPO dentist schedule or the Maximum Approved Fee for covered services. The subscriber will be responsible for the lesser of the PPO schedule amount, the Maximum Approved Fee, or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist is a PPO dentist but is not a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The PPO dentist schedule.

Delta Dental will send payment to the PPO dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the PPO dentist schedule for covered services. The subscriber will be responsible for the lesser of the PPO schedule amount or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist is not a PPO dentist but is a Premier dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The Maximum Approved Fee

Delta Dental will send payment to the Premier dentist, and the subscriber will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for covered services. The subscriber will be responsible for the lesser of the Maximum Approved Fee or the dentist's submitted amount for most commonly-performed noncovered services. For other noncovered services, the subscriber will be responsible for the dentist's submitted amount.

If the dentist does not participate in Delta Dental PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of:

- The submitted amount
- The non-participating dentist Fee

Delta Dental will usually send payment to the subscriber, who will be responsible for making payment to the dentist. The subscriber will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount.

For dental services rendered by an out-of-country dentist, Delta Dental will base payment on the lesser of:

- The submitted amount
- The out-of-country dentist fee

Delta Dental will usually send payment to the subscriber, who will be responsible for making payment to the dentist. The subscriber will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount.

Claims determinations

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you or your Dentist should contact Delta Dental's Customer Service department at their toll-free number, 800 524 0149, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 9089, Farmington Hills, Michigan 48333-9089. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Claims appeal procedure

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the claims appeal procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, the Dental Director will assess the information, including any additional information that you have provided, as if the Dental Director were deciding the claim for the first time.

The Dental Director will make a decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the

pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of the adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required claims appeal procedure or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

How to reach Delta Dental

Delta Dental Plan of Michigan
Stryker Group #: 5480
P.O. Box 9085
Farmington Hills, MI 48333-9085
800 524 0149
www.deltadentalmi.com

If you are using the dentist directory, select "Delta Dental Premier" or "Delta Dental PPO" for the product type.

Dental plan definitions

Dentist

A person licensed to practice dentistry in the state or country in which the dental services are provided.

Diagnostic and preventive services

Services and procedures used to evaluate existing conditions and/or to prevent the occurrence of dental abnormalities or disease. Such services include examinations, prophylaxis (cleaning) and topical application of fluoride solution.

Maximum Approved Fee

A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental participating dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The submitted amount
- The lowest fee regularly charged, offered, or received by an individual dentist for a dental service, irrespective of the dentist's contractual agreement with another dental benefits organization
- The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty, under normal circumstances

Delta Dental may also approve a fee under unusual circumstances. Participating dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the covered service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the covered service.

Non-participating dentist

A licensed dentist who has not signed an agreement with Delta Dental. Delta Dental's payment is sent to the employee, who is responsible for making full payment to the non-participating dentist.

Orthodontics

Services and treatment required for the correction of malpositioned teeth.

Participating dentist

A licensed dentist who has signed an agreement to participate in Delta Dental Premier or Delta Dental PPO. A participating dentist agrees to accept Delta Dental's payment and the patient's payment, if any, as payment in full. Delta Dental's payment is sent directly to the participating dentist.

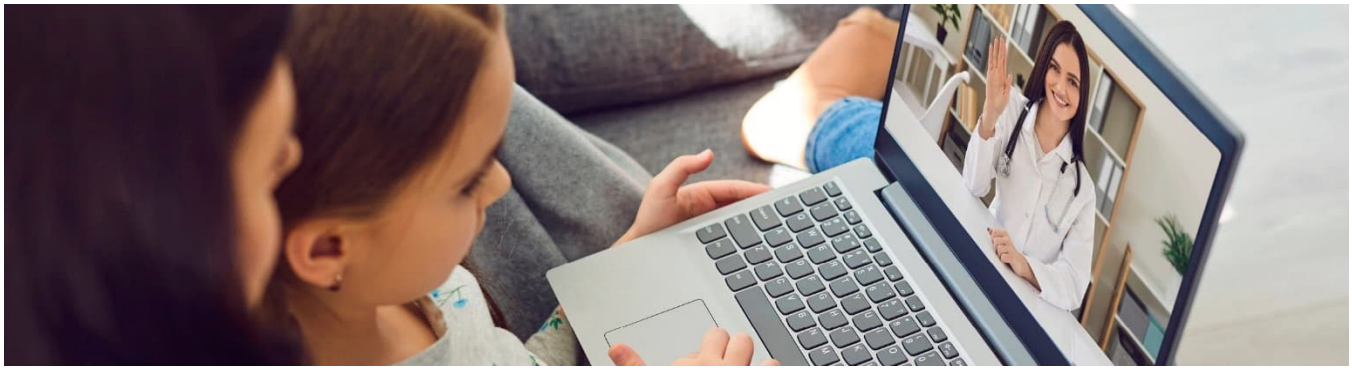
Pre-Treatment Estimate

A procedure in which the dentist submits a treatment plan and expected charges to Delta Dental before rendering services. Delta Dental reviews the treatment plan and notifies the patient and dentist of its determination regarding covered services and the amount of benefits payable. Payment for predetermined services is contingent on continued eligibility of the patient. Generally, a pre-treatment estimate is recommended for procedures that are expected to cost $200 or more, but Delta Dental will predetermine benefits for less expensive procedures.

Restorative services

Services to rebuild and repair natural tooth structure damaged by disease or injury. Minor restorative services include amalgam and resin fillings. Major restorative services include crowns, jackets and gold-related services when the teeth cannot be restored with another filling material.

Location-based provisions



This section includes location-specific supplemental benefit information for employees who live in:

- California
- Hawaii

Supplemental benefit information is also included in this section about Stryker's Medical Benefits Abroad plan available to global full-time and part-time Stryker employees and Board of Directors who are traveling on Stryker business outside their country of residence or permanent assignment.

Information is also included for employees who participate in the International Plan.

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California

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well.

Healthcare benefits

If you live or work in California, Stryker offers multiple medical carrier options for most ZIP codes. UnitedHealthcare (UHC) and Surest, as described earlier in this Stryker benefits summary, and the Kaiser Permanente HMO option. If you select Kaiser, your prescription drug benefits are provided through Kaiser Permanente. Direct Temporary employees, interns and co-ops will only be eligible for the Kaiser Permanent HMO option in California if they are not eligible for the UHC plans based on their zip code.

Important

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

If you are in an area where no satisfactory network is available, you will be offered the UnitedHealthcare (UHC) Out-of-Area plan.

This section of the Stryker benefits summary, together with other sections of the Stryker benefits summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Evidence of Coverage issued by Kaiser Permanente, constitute the Summary Plan Description for the Kaiser Permanente HMO option.

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

For more information

If you have questions or want additional information, refer to the Kaiser documents for your location as shown here:

- If you live in Northern California, your Evidence of Coverage is available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Kaiser North Certificate.pdf**
- If you live in Southern California, your Evidence of Coverage is available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Kaiser South Certificate.pdf**

Eligibility

Regular full-time and regular part-time employees

You are eligible to enroll in the Kaiser Permanente HMO option if you are:

- A full-time or part-time employee of Stryker who are regularly scheduled to work an average of at least 20 hours a week, and
- You live or work in the HMO's service area at the time you enroll.

"Full-time" means the employee is regularly scheduled to work at least 40 hours per week. "Part-time" means the employee is regularly scheduled to work at least 20 hours per week. Newly hired regular employees who meet these requirements become eligible on their date of hire. Note: only those regular full-time or part-time employees who both reside and perform their work in the United States are eligible to participate in the U.S. based Stryker Corporation Welfare Benefits Plan.

Direct temporary employees expected to work 30 hours/week

If you were hired as a direct temporary employee (which means a temporary employee directly hired by Stryker, including interns and co-op employees) and Stryker reasonably expects you to work an average of at least 30 hours per week at the time you start work, you will be eligible to enroll in the UHC Basic HSA Plan (with no Stryker HSA contribution).

This coverage becomes effective as of your 90th day of service. Your contribution rate for coverage will be based on whether you are full-time or part-time as described above.

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

Other employees

If you are a regular employee regularly scheduled to work less than 20 hours per week, a direct temporary employee who is reasonably expected to work less than 30 hours per week upon hire, a variable hours employee (where Stryker cannot reasonably determine whether you will work sufficient hours to otherwise be eligible) or a seasonal employee, you may become eligible for coverage under the Kaiser Permanente HMO option. You must complete an initial measurement period during which you are credited with an average of at least 30 hours of service per week.

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

Ineligible individuals

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

Ongoing eligibility

Standard measurement period

For each plan year (January 1 through December 31) there will be a 12-month standard measurement period before the year begins. The standard measurement period for each plan year will end on October 3 immediately preceding the first day of the plan year. For example, for the 2026 plan year, the standard measurement period will begin on October 4, 2024, and end on October 3, 2025.

If you are a regular part-time employee working at least 20 hours per week or a regular full-time employee working at least 40 hours per week, you will remain eligible for benefits as described in the **Participating in healthcare benefits**, starting on page 5, of this Stryker benefits summary except as described below if your scheduled hours are reduced during the stability period.

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

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

Transfers and working hours changes

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

Breaks in service

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

The applicable service area is described in the "Definitions" section of the Evidence of Coverage for your plan. Special rules apply if you live or move outside of the service area after you enroll as described in the "Premiums, Eligibility and Enrollment" section of the applicable Evidence of Coverage.

Dependents

Eligible dependents include:

- Your spouse
- Your domestic partner. Note: registered domestic partnerships are not subject to any requirements for proof of relationship or waiting periods applied to domestic partnerships that are not also applied to marriages. For purposes of Stryker's benefit plans, a domestic partnership is defined as:
  - A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry, if applicable.

  OR

  - A domestic partnership in which both partners can attest to all of the following criteria:
    - We are at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
    - We are each other’s sole domestic partner in a committed relationship, have been so for at least 12 months, and intend to remain so indefinitely.
    - Is not related to you in a way that would prohibit a legal marriage.
    - We are not legally married to anyone else, nor have another domestic partner.
    - We are currently residing together in the same principal residence, have done so for at least 12 months, and intend to do so indefinitely (although you may live apart for reasons of education, healthcare, work, or military service).
    - We are jointly responsible for each other's common welfare and financial obligations of the household.
- Your or your spouse's (or domestic partner's) children through the end of the month in which they turn age 26
- Other dependent persons (but not including foster children) who meet all of the following requirements:
  - They are under age 26
  - They receive all of their support and maintenance from you, your spouse or your domestic partner
  - They permanently reside with you
  - You or your spouse (or domestic partner) is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled dependent under your family coverage

Dependents who meet the dependent eligibility requirements except for the age limit may be eligible if they meet all the following requirements:

- They are incapable of self-sustaining employment because of a physically or mentally disabling injury, illness or condition that occurred prior to reaching the age limit for dependents;
- They receive 50% or more of their support and maintenance from you, your spouse or your domestic partner; and
- You provide proof of their incapacity and dependency within 60 days after such proof is requested.

For purposes of determining eligibility under the Kaiser HMO option, the term "child" includes your (or your spouse’s or domestic partner’s) biological child, legally adopted child, a child placed for

adoption, a stepchild or a child who is required to be covered under the Stryker Corporation Welfare Benefits Plan by a qualified medical child support order (QMCSO). See the **Your rights and responsibilities** section starting on page 228 in this Stryker benefits summary for more information regarding QMCSOs.

If both you and your spouse, domestic partner, or dependent work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the Kaiser HMO option. Other options may have other requirements. Please see "Dependents" on page 7 in the **Participating in healthcare benefits** section for those requirements.

When coverage begins

If you enroll when you are first eligible, your coverage under the plan begins immediately as of your date of hire. If you are re-hired after a break in service, coverage begins immediately on your date of hire.

A newly eligible child, spouse or domestic partner will be covered immediately if you contact your Benefits representative and complete necessary paperwork to enroll him or her within 30 days of the date of birth or marriage or the date the child joined the family.

For a newborn child, coverage is effective from the moment of birth. However, if you do not enroll the newborn child within 30 days, the newborn is covered for only 31 days (including the child's date of birth).

When coverage ends

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

- The date you leave Stryker, fail to pay required coverage contributions or otherwise become an ineligible employee.
- The date you drop coverage due to a qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, coverage ends on the December 31 following the annual enrollment period

Dependent coverage ends:

- On the date your coverage ends
- On the last day of the month in which the dependent child turns age 26
- On the date your dependent ceases to qualify as a dependent under the plan
- In the case of your spouse, the date of divorce
- In the case of your domestic partner, the date you submit an affidavit terminating the partnership

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary.

COBRA coverage for domestic partners

Although not required by COBRA law, under the Stryker Plan, a covered domestic partner has the same COBRA rights as a spouse under the Kaiser Permanente HMO option. Termination of the domestic partner relationship is treated in the same manner as divorce. For more information about COBRA coverage, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary.

Medical benefits

For specific and detailed information about the medical benefits offered under the Kaiser Permanente HMO option, refer to the Evidence of Coverage for your plan.

You may also refer to a Benefit Summary for an overview of your plan's benefits:

- If you live in Northern California, refer to the Benefit Summary for Kaiser Northern California, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/Kaiser-North-2026-SBC.pdf**

- If you live in Southern California, refer to the Benefit Summary for Kaiser Southern California, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/Kaiser-South-2026-SBC.pdf**

Prescription drug benefits

The Kaiser Permanente HMO option provides benefits for covered prescription drugs, including contraceptives, insulin and diabetic supplies. Specific information is set out in the "Outpatient Prescription Drugs, Supplies and Supplements" section of the Evidence of Coverage for your plan.

Claim procedures

Information about filing claims for benefits is set out in the "Requests for Payment or Services" section of the Evidence of Coverage for your plan. Kaiser Permanente is the fiduciary for purposes of deciding claims for benefits under this healthcare option.

Other information

Continuation of coverage after COBRA

Under certain circumstances, coverage may be continued after the maximum COBRA coverage period ends. For more information, see the "Continuation of Membership" section of the Evidence of Coverage for your plan.

Subrogation rights

If your illness or injury is caused by a third party's act or omission, the Kaiser Permanente may have subrogation rights. For more information, see the "Exclusions, Limitations, Coordination of Benefits and Reductions" section of the Evidence of Coverage for your plan.

Funding

HMO benefits are fully insured by Kaiser Permanente and disbursements are made pursuant to a contract between Kaiser Permanente and Stryker. Information regarding how to contact Kaiser Permanente may be found in the Evidence of Coverage.

Hawaii

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well.

Healthcare benefits

If you live in Hawaii, Stryker offers the HMSA plan.

This section of the Stryker benefits summary, together with other sections of the Stryker benefits summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Evidence of Coverage issued by HMSA, constitute the Summary Plan Description for the HMSA plan.

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

Important

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

For more information

If you have questions or want additional information about your medical benefits, refer to the plan Guide to Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 HMSA Medical Certificate.pdf**.

For information about the prescription and vision benefits, refer to the Plan Certificates available at:

- Prescription Drug: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 HMSA Prescription Drug Rider.pdf**

- Vision: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 HMSA Vision Care Rider.pdf**

Eligibility

Regular full-time and regular part-time employees

You are eligible to enroll in the HMSA plan if you are:

- A full-time or part-time employee of Stryker who are regularly scheduled to work an average of at least 20 hours a week, and
- You live or work in the HMSA plan's service area at the time you enroll.

"Full-time" means the employee is regularly scheduled to work at least 40 hours per week. "Part-time" means the employee is regularly scheduled to work at least 20 hours per week. Newly-hired regular employees who meet these requirements become eligible on their date of hire. Note: only those regular full-time or part-time employees who both reside and perform their work in the United States are eligible to participate in the U.S. based Stryker Corporation Welfare Benefits Plan.

Direct temporary employees expected to work 30 hours/week

If you were hired as a direct temporary employee (which means a temporary employee directly hired by Stryker, including interns and co-op employees) and Stryker reasonably expects you to work an average of at least 30 hours per week at the time you start work, you will be eligible to enroll in the HMSA plan after you complete 90 days of service. Your contribution rate for coverage will be based on whether you are full-time or part-time as described above.

Other employees

If you are a regular employee regularly scheduled to work less than 20 hours per week, a direct temporary employee who is reasonably expected to work less than 30 hours per week upon hire, a variable hours employee (where Stryker cannot reasonably determine whether you will work sufficient hours to otherwise be eligible) or a seasonal employee, you may become eligible for coverage under the HMSA plan. You must complete an initial measurement period during which you are credited with an average of at least 30 hours of service per week.

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

Ineligible individuals

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

Ongoing eligibility

Standard measurement period

For each plan year (January 1 through December 31) there will be a 12-month standard measurement period before the year begins. The standard measurement period for each plan year will end on October 3 immediately preceding the first day of the plan year. For example, for the 2026 plan year, the standard measurement period will begin on October 4, 2024, and end on October 3, 2025.

If you are a regular part-time employee working at least 20 hours per week or a regular full-time employee working at least 40 hours per week, you will remain eligible for benefits as described in the **Participating in healthcare benefits**, starting on page 5, of this Stryker benefits summary except as described below if your scheduled hours are reduced during the stability period.

If you are a regular employee working less than 20 hours and are credited with at least 30 hours per week during the standard measurement period, you will be eligible for medical and prescription coverage as a regular full-time

employee for the immediately following plan year and your cost will be based on part-time rates.

If you are a direct temporary employee, variable hours employee, or seasonal employee and are credited with an average of at least 30 hours per week during the standard measurement period, you will be eligible for medical and prescription drug coverage for the immediately following plan year, and your cost will be based upon part-time rates unless you are regularly scheduled to work 40 hours per week. If you satisfy the minimum hour requirement during the standard period measurement period, you will be notified after the measurement period ends and will be provided with the opportunity to enroll in coverage for the immediately following plan year.

Transfers and working hours changes

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

Breaks in service

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

The applicable service area is described in the "Definitions" section of the Evidence of Coverage for your plan. Special rules apply if you live or move outside of the service area after you enroll as described in the "Premiums, Eligibility and Enrollment" section of the applicable Evidence of Coverage.

Dependents

Eligible dependents include:

- Your spouse as the result of marriage who is recognized in the state of Hawaii.
- Your domestic partner. Note: registered domestic partnerships are not subject to any requirements for proof of relationship or waiting periods applied to domestic partnerships that are not also applied to marriages. For purposes of Stryker's benefit plans, a domestic partnership is defined as:
  - A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry, if applicable.

  OR

  - A domestic partnership in which both parties can attest to all of the following criteria:
    - We are at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
    - We are each other’s sole domestic partner in a committed relationship, have been so for at least 12 months and intend to remain so indefinitely.
    - We are not related to you in a way that would prohibit a legal marriage.
    - We are not legally married to anyone else, nor have another domestic partner.
    - We are currently residing together in the same principal residence, have done so for at least 12 months, and intend to do so indefinitely (although you may live apart for reasons of education, healthcare, work, or military service).
    - We are jointly responsible for each other's common welfare and financial obligations of the household.
- In general, you may enroll a child who meets the following requirements:
  - The child is your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child

defined as an individual who is placed with you by an authorized placement agency or by judgement, decree or other court order).

- Your domestic partner's children.
- The child is under 26 years of age.

- You may enroll your disabled child by providing documentation demonstrating that:
  - Your child is incapable of self-sustaining support because of a mental disability.
  - Your child's disability existed before the child turned age 26.
  - Your child relies primarily on you for support and maintenance as a result of the disability.
  - Your child is enrolled under this coverage or another HMSA plan and has had continuous health care coverage with HMSA since before the child's 26th birthday.

  The required documentation must be provided to HMSA within 31 days of the child's 26th birthday and subsequently at the plan's request, but not more frequently than annually.

See the **Your rights and responsibilities** section starting on page 228 in this Stryker benefits summary for more information regarding QMCSOs.

If both you and your spouse, domestic partner, or dependent work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the HMSA plan. Other options may have other requirements. Please see "Dependents" on page 7 in the **Participating in healthcare benefits** section for those requirements.

When coverage begins

If you enroll when you are first eligible, your coverage under the plan begins on your date of hire. If you are re-hired after a break in service, coverage begins on the date of rehire. If you are hired as a result of an acquisition, coverage will begin on the first day you become eligible for Stryker benefits.

A newly eligible child, spouse, or domestic partner will be covered immediately if you contact your Benefits representative and complete necessary paperwork to enroll him or her within 30 days of the date of birth or marriage or the date the child joined the family.

You may enroll a newborn or adopted child according to the following requirements:

- The birth date of a newborn, providing you comply with the usual enrollment process within 31 days of the birth.
- The date of adoption, providing you comply with the usual enrollment process within 31 days of adoption.
- The birth date of a newborn adopted child, if you provide notice of your intent to adopt the child within 31 days of the child's birth.
- The date the child is placed with you for adoption, if you provide notice of the placement within 31 days of the placement. Placement occurs when you assume a legal obligation for total or partial support of the child in anticipation of adoption.

When coverage ends

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

- The date on which your employment ends, you fail to pay required coverage contributions or otherwise become an ineligible employee. (NOTE: In compliance with the Hawaii Prepaid Health Care Act, if you live in Hawaii when you leave Stryker, your coverage ends on the date on which your employment ends.)
- The date of the qualifying life event
- If you elect to drop healthcare benefits during annual enrollment, coverage ends on the December 31 following the annual enrollment period

Dependent coverage ends:

- On the date your coverage ends
- On the last day of the month in which the dependent child turns age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support)

- On the date your dependent ceases to qualify as a dependent under the plan
- In the case of your spouse, on the date of divorce
- In the case of your domestic partner, on the date the domestic partnership terminates.

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage. For more information, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary.

COBRA coverage for dependents

COBRA continuation coverage can become available to you, your spouse and dependent children who are covered under the Stryker Corporation Welfare Benefits Plan when coverage might otherwise be lost. For more information, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary. However, keep in mind that the HMSA plan does not provide COBRA coverage for domestic partners.

Medical benefits

For specific and detailed information about the medical benefits offered under the HMSA plan, refer to the HMSA Summary of Benefits and Coverage, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 HMSA SBC.pdf**.

Claim procedures

Information about filing claims for benefits is set out in the "Requests for Payment or Services" section of the Evidence of Coverage for your plan.

Other information

Continuation of coverage after COBRA

Under certain circumstances, coverage may be continued after the maximum COBRA coverage period ends. For more information, see the "Continuation of Membership" section of the Evidence of Coverage for your plan.

Subrogation rights

If your illness or injury is caused by a third party's act or omission, HMSA may have subrogation rights. For more information, see the "Exclusions, Limitations, Coordination of Benefits and Reductions" section of the Evidence of Coverage for your plan.

Funding

Benefits are fully insured by HMSA and disbursements are made pursuant to a contract between HMSA and Stryker. Information regarding how to contact HMSA may be found in the Evidence of Coverage.

Medical Benefits Abroad

Stryker provides a Medical Benefits Abroad plan through Cigna Global Health Benefits to global full-time and part-time Stryker employees and Board of Directors that are traveling on business outside their country of residence or permanent assignment. In addition, spouse/domestic partner and dependent children traveling with the covered person outside of their home country of residence or permanent assignment will also be covered under the Medical Benefits Abroad plan. Spouse/domestic partner and dependent children will not be eligible for Accidental Death and Dismemberment coverage. Information about this benefit, including eligibility, can be found at **https://stryker.sharepoint.com/sites/totalrewards/SitePages/Medical-Benefits-Abroad.aspx**.

International Plan

The Stryker Corporation Welfare Benefits Plan provides medical, prescription drug, dental and vision benefits for you and your eligible dependents. The plan offers valuable financial protection against the high cost of illness and injury, and also provides certain preventive care benefits to help keep you well. The plan also provides life and accidental death and dismemberment (AD&D) insurance, as well as long-term disability insurance, at no cost to you. These plans offer you income protection for you and your dependents in the face of unforeseen events.

If you are a U.S. Expatriate employee, you and Stryker share in the cost of your health care benefits. You are not eligible for life and AD&D benefits under the International Plan. You are, however, eligible for life and AD&D insurance through the U.S. benefit plan. For more information on these benefits, see the **Life and AD&D insurance coverage** section, starting on page 176, in this Stryker benefits summary or refer to the Life and Accident Certificate of Insurance.

The following chart summarizes the benefits available to you.

Benefits at a glance

Medical coverage	▪ Comprehensive medical benefits for you and your covered dependents ▪ You must meet a small annual deductible before the plan begins to pay benefits ▪ Preventive care (as outlined in the benefit highlights) is free ▪ Most other services are 100% covered once you meet the annual deductible ▪ Includes coverage for prescription drugs purchased outside the U.S.
Prescription drug coverage	▪ Prescription drug benefits for you and your covered dependents ▪ You must meet an annual deductible before the plan begins to pay benefits ▪ You pay a set copayment for prescription drugs purchased through participating retail pharmacies (30-day or 90-day supply) or mail-order (90-day supply) ▪ Your cost depends on whether the medication is generic or brand-name
Dental coverage	▪ Comprehensive dental benefits for you and your covered dependents ▪ You must meet a small annual deductible before the plan begins to pay benefits ▪ Preventive care (as outlined in the benefit highlights) is free ▪ You pay a portion of the cost for basic and major services once you meet the annual deductible ▪ Orthodontia services are covered at 50%, up to $1,000, for dependents up to age 19
Vision coverage	▪ Vision benefits for you and your covered dependents ▪ Plan reimburses you for eligible eye care and eyewear expenses, up to certain amounts
Life Insurance	▪ Pays benefits to your beneficiary in the event of your death ▪ Coverage of two times your annual basic earnings, up to $500,000 ▪ Stryker provides this coverage automatically at no cost to you ▪ **U.S. Expatriate employees are excluded from this coverage and are eligible for the U.S. Life and AD&D benefits.**
(AD&D) Insurance	▪ Pays benefits to you for certain injuries or other conditions resulting from an accident, and benefits to your beneficiary in the event of your death ▪ Coverage of two times your annual basic earnings, up to $500,000 ▪ Stryker provides this coverage automatically at no cost to you ▪ **U.S. Expatriate employees are excluded from this coverage and are eligible for the U.S. Life and AD&D benefits.**

For more information

The Schedules of Benefits issued by Cigna and MetLife contain detailed information about the benefits for each plan offered under the International Plan. If you have questions or want additional information, refer to the Schedule of Benefits, available at:

- Health Care:
  - **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**
  - **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-mcc-rider.pdf**
  - **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-et-rider-stryker-corporation.pdf**
- Life/AD&D:
  - U.S. Expatriate: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/Stryker Life ADD Full Time EE 2026.pdf**
  - Inpatriate (a foreign national who works in the U.S. for more than 6 months of the year): **https://totalrewards.stryker.com/-medica/Mercer/Stryker/Documents/2026 MetLife LTD Expat_TCN_01-26.pdf**
  - Third Country National (a foreign national who works outside of the country for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife Life ADD TCN.pdf**
- LTD:
  - U.S. Expatriate: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Expat_TCN_01-26.pdf**
  - Inpatriate (a foreign national who works in the U.S. for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Inpat.pdf**
  - Third Country National (a foreign national who works outside of the country for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Expat_TCN_01-26.pdf**

Healthcare benefits

If you are on International Assignment and meet the eligibility requirements, Stryker offers you one medical option-the Cigna International Expatriate Benefits option provided through Cigna. The other carrier options, including the UnitedHealthcare plans, are not available.

Important

The information contained in this section is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

This section of the Stryker benefits summary, together with other sections of the Stryker benefits summary that pertain to the Stryker Corporation Welfare Benefits Plan and the Schedule of Benefits issued by Cigna, constitute the Summary Plan Description for the Cigna option. It is intended to supplement the information contained elsewhere in the Stryker benefits summary. Except for the provisions described in this section, the description of the terms and conditions regarding medical coverage set out in other sections of the Stryker benefits summary will apply.

Eligibility

Employees

You are eligible to enroll in the Cigna health care option if you are a full-time employee of Stryker, or part-time employee of Stryker who works 20 or more hours per week, and who is on International Assignment and meets all other eligibility requirements as outlined in the Certificate, available at:

- Health Care:
  - **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

- **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-mcc-rider.pdf**
- **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-et-rider-stryker-corporation.pdf**

Note: If you are transferring from one Stryker global location to another Stryker location (in another country), you will be allowed to remain enrolled in Cigna healthcare option until you become active in the destination country payroll system and you are covered by the destination country benefits package.

Employees not currently enrolled in Cigna healthcare option can be enrolled:

- while they are waiting for active status in their destination country payroll system and/or the destination country benefits package, or
- when his or her benefit plan on the home country plan would not provide similar or adequate coverage when the employee is located in the destination country and/or the day coverage is lost.
- Life/AD&D:
  - U.S. Expatriate: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/Stryker Life ADD Full Time EE 2026.pdf**
  - Inpatriate (a foreign national who works in the U.S. for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife Life ADD Inpat Certificate-_01-26.pdf**
  - Third Country National (a foreign national who works outside of the country for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife Life ADD TCN.pdf**
- LTD:
  - U.S. Expatriate: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Expat_TCN_01-26.pdf**
  - Inpatriate (a foreign national who works in the U.S. for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Inpat.pdf**
  - Third Country National (a foreign national who works outside of the country for more than 6 months of the year): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 MetLife LTD Expat_TCN_01-26.pdf**

Dependents

Eligible dependents include:

- Your legal spouse
- Your domestic partner. Note: registered domestic partnerships are not subject to any requirements for proof of relationship or waiting periods applied to domestic partnerships that are not also applied to marriages. For purposes of Stryker's benefit plans, a domestic partnership is defined as:
  - A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry, if applicable.

  OR

  - A domestic partnership that meets all of the following requirements for the immediately preceding 12 months:
    - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
    - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely.
    - Has not had another domestic partner within the prior 12 months.
    - Has not been a party to a divorce or annulment proceeding in at least 12 months.
    - Is not related to you in a way that would prohibit a legal marriage.
    - Is not legally married to anyone else, and any prior marriages have been dissolved through death, divorce or nullity.
    - Shares a household with you that is the primary residence of both of you

(although you may live apart for reasons of education, healthcare, work, or military service).

- Shares joint responsibility with you for each other's basic living expenses incurred during the domestic partnership.

- Your child under age 26
- A disabled child, who is not able to support himself because of a physical or mental disability that existed before age 26 and who relies primarily on you for support, provided the child has had continuous coverage with Cigna since the child's 26th birthday

The term "child" means:

- A natural child
- A stepchild or domestic partner's child
- A foster child
- A legally adopted child
- A child placed for adoption.

"Child" also includes a child who is required to be covered under the Stryker Corporation Welfare Benefits Plan by a qualified medical child support order (QMCSO). See the **Your rights and responsibilities** section starting on page 228 in this Stryker benefits summary for more information regarding QMCSOs.

If both you and your spouse, domestic partner, or dependent work for Stryker, you may not be covered under the plan both as an employee and a dependent nor may you be covered under any other Stryker-sponsored plan if you are enrolled in this plan. Any eligible children of two Stryker employees may be covered as dependents by only one parent.

Note: The dependent eligibility requirements and age limitations discussed here apply only to the Cigna option. Other options may have other requirements. Please see "Dependents" on page 7 in the **Participating in healthcare benefits** section for those requirements.

When coverage begins

If you enroll when you are first eligible, your coverage under the plan begins immediately as of your date of hire. If you are re-hired after a break in service, coverage begins immediately on your date of re-hire.

A newly eligible child, spouse or domestic partner will be covered immediately if you contact your Benefits representative and complete the necessary paperwork to enroll him or her within 30 days of the date of birth, marriage or domestic partnership, or the date the child joined the family.

Effective date of dependent insurance

Insurance for your dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for dependent insurance. All of your dependents as defined will be included.

If you are a late entrant for dependent insurance, the insurance for each of your dependents will not become effective until Cigna agrees to insure that dependent. Your dependent will not be denied enrollment for medical insurance due to health status. Your dependents will be insured only if you are insured.

Late entrant - dependent

You are a late entrant for dependent insurance if:

- You elect that insurance more than 30 days after you become eligible for it
- You again elect it after you cancel your payroll deduction.

Exception for newborns

Any dependent child born while you are insured for medical insurance will become insured for medical insurance on the date of his birth if you elect dependent medical insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception to late entrant definition

A person will not be considered a late entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; Employer contributions toward the other coverage have been terminated; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted: and he enrolls for this

coverage within 30 days after losing or exhausting prior coverage. In addition, a dependent spouse, domestic partner or minor child enrolled within 30 days following a court order of such coverage will not be considered a late entrant.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective on the date of marriage, birth, adoption, or placement for adoption.

When coverage ends

Coverage for you and your dependents under the Stryker Corporation Welfare Benefits Plan ends on the date on which any of the following take place:

- You leave Stryker or fail to pay required coverage contributions
- You are no longer an eligible employee
- You drop coverage due to a qualifying life event

If you elect to drop healthcare benefits during annual enrollment, coverage ends on the December 31 following the annual enrollment period.

Dependent coverage ends:

- On the date your coverage ends
- On the last day of the calendar month in which your dependent child reaches age 26
- On the date your dependent child ceases to qualify as a dependent under the plan
- In the case of a spouse, the date of divorce
- In the case of a domestic partner, the date of the termination of domestic partnership

If coverage under the plan ends, you or your dependents may be able to choose COBRA continuation coverage.

For more information, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary.

COBRA coverage for domestic partners

Although not required by COBRA law, under the Stryker Plan, when you elect COBRA coverage, your covered domestic partner and their covered dependents may also be eligible to continue coverage under COBRA. However, your domestic partner and their dependents will not be considered a qualified beneficiary for purposes of COBRA unless you (as the employee) cover the domestic partner under your COBRA plan. For more information about COBRA coverage, see "COBRA: continuing healthcare coverage" on page 19 in the **Participating in healthcare benefits** section of this Stryker benefits summary.

Medical benefits

For specific information about the medical benefits offered under the Cigna option, refer to the Schedule of Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Prescription drug benefits

The Cigna option provides benefits for covered prescription drugs purchased inside the United States, including contraceptives, insulin and diabetic supplies. Specific information is set out in the "Prescription Drug Insurance" section of the , available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Dental benefits

The Cigna plan provides dental benefits for basic, restorative, and major services, as well as orthodontia for dependents up to age 19. Preventive care is covered at 100%. Plan details are outlined in the "Traditional Dental Insurance" section of the Schedule of Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Vision benefits

The Cigna plan offers vision care insurance, which provides benefits for eye exams and eyewear every 12 months. For details, refer to the "Vision Care Insurance" section of the Schedule of Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Claim procedures

Information about filing claims for benefits, as well as appealing a reduction or denial of benefits,

is set out in the Schedule of Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Cigna is the fiduciary for purposes of deciding claims for benefits under this healthcare option.

Other information

Subrogation rights

If your illness or injury is caused by a third party's act or omission, Cigna may have subrogation rights. For more information, see the "Expenses for Which a Third Party May Be Liable" section of the Schedule of Benefits, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026 Cigna Medical Certificate.pdf**

Funding

Benefits under the Cigna option are fully insured. Medical, prescription drug, dental and vision benefit disbursements are made pursuant to a contract between Cigna Health and Life Insurance Company and Stryker. Life, AD&D and disability benefit disbursements are made pursuant to a contract between Life Insurance Company of North America and Stryker. Information regarding how to contact both Cigna Health and Life Insurance Company and MetLife may be found in the Summary of Benefits.

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.

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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 and participate in an HSA, due to IRS regulations.**

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 155 and "Day Care (child and adult) Flexible Spending Account (DCFSA)" on page 161.

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

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.

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.

- 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.

- If you enroll in the FSA mid-year, your contribution election may be limited based on the number of payroll cycles left in the year, or if it is not administratively possible to complete a deduction prior to the end of the 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.
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 entitled for or enrolled in (or loses entitlement for or enrollment in) 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.

Qualifying life event	Healthcare Flexible Spending Account (HCFSA)	Day Care (child and adult) Flexible Spending Account (DCFSA)
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 2026 until March 31, 2027. 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**.

If you are enrolled in the Surest Advantage Plan, login to benefits.surest.com and navigate to the Plan Resources page. There, you'll find a section asking, "Do you have an FSA with UHC?" Click the Visit Website link to be redirected to www.myuhc.com. You will log in using the same HealthSafe ID credentials as Surest to view your FSA details. Alternatively, you can go directly to www.myuhc.com and log in using your HealthSafe ID to view your FSA details.

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" on page 19 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 $3,300 as of 2026. 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 $235.71, as shown in the following chart.

How much you can contribute to the HCFSA				
Annual Contribution		**Remaining Pay Periods (June – December)**		**Per Paycheck Contribution Amount**
$3,300	÷	14	=	$235.71

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 (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, which 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 the UnitedHealthcare Value PPO Plan or the Surest Advantage Plan and elect to contribute to the HCFSA, your medical and prescription drug copayments and coinsurance amounts, as applicable, will automatically roll over to the HCFSA. Medical and prescription drug expenses that are not covered under the UnitedHealthcare Value PPO Plan or the Surest Advantage Plan, 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 Value PPO plan.

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 the Stryker Corporation Welfare Benefits 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 the claims administrator.

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
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
1941 Stryker Way
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

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:

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.

- 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.

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.

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

Documentation

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

of acceptable documentation include:

- 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 2026 and filed with UnitedHealthcare by March 31, 2027, can be reimbursed from your 2026 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.

Submit your appeal to the following address:

Stryker Benefits Committee
Attn: Health Plan Administrator
Stryker
1941 Stryker Way
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 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.

Health Savings Account



The Health Savings Account (HSA) is a triple tax-advantaged savings account available to employees enrolled in either the UnitedHealthcare (UHC) Basic HSA or Premium HSA medical plans (the "high deductible health plans"). The Basic HSA and Premium HSA plans include two components:

- Medical plan coverage through a high deductible health plan; and
- The opportunity to participate in a separate Health Savings Account (HSA) that can be used to pay for certain qualified medical expenses on a pre-tax basis.

This section of the Stryker benefits summary describes some key features of the HSA that you can establish to complement the UHC Basic and Premium HSA medical plans. Please refer to the **Medical benefits** section, starting on page 31, of your Stryker benefits summary for information about the UHC Basic and Premium HSA medical plans (the high deductible health plans).

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Highlights of the HSA

The HSA, administered by UnitedHealthcare (UHC) through Optum Bank, offers a way to save for your out-of-pocket medical expenses, such as expenses incurred before the medical plan deductible is met, or your share of covered medical expenses.

- You contribute to the Health Savings Account with before-tax deductions from each paycheck (lowering your taxable income).
- Funds can be withdrawn tax-free to pay for eligible healthcare expenses and money in the account rolls over from year to year.
- The money in your account grows with tax-free interest.

- Once you reach a balance of $2,100, you have the option to invest some of your balance and potentially grow your account with tax-free earnings.

Keep in mind that IRS rules prohibit you from participating in both an HSA and a health care flexible spending account (HCFSA). Therefore, you are not eligible to participate in the HCFSA if you are enrolled in the UnitedHealthcare Basic HSA or Premium HSA plans and participate in an HSA. You can, however, participate in the day care (child and adult) flexible spending account (DCFSA).

The Health Savings Account is not governed by the Employee Retirement Income Security Act of 1974 (ERISA). For example, ERISA requirements such as providing a Summary Plan Description, filing an annual report (Form 5500 Series), or making a summary annual report available do not apply to Health Savings Account (HSA) participation

You gain choice and control over your health care decisions and spending when you establish your HSA to complement the high deductible health plan coverage provided through the UHC Basic HSA or Premium HSA plan described in the **Medical benefits** section, starting on page 31, of your Stryker benefits summary.

The HSA can help you cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as deductibles, copayments or coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses; however, these amounts are subject to income tax and may be subject to a 20% penalty if withdrawn before age 65.

What is an HSA?

An HSA is a tax-advantaged account that you can use to pay for qualified health expenses that you or your eligible dependents incur. HSA contributions:

- Accumulate over time with interest or investment earnings (if applicable).
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for any other expense on a taxable basis.

Eligibility

Eligibility to participate in the UHC Basic HSA or UHC Premium HSA medical plan is described in the **Medical benefits** section, starting on page 31. You must be covered under the UHC Basic or Premium HSA medical plan in order to participate in the HSA. If you enroll in a high deductible health plan (UHC Basic or Premium plan) and you wish to opt out of the HSA component, you must contact your Benefits Team immediately upon enrollment. In addition, in order to be eligible for a Health Savings Account you:

Must not be covered by any medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)

- Must not, as an employee of Stryker, be enrolled in Medicare or Tricare.
- Must not be claimed as a dependent on another person's tax return.
- Must not have coverage by an HRA or health care FSA that does not limit reimbursements to permitted limited scope (dental and vision), preventive or post-deductible expenses, which disqualifies a person from making or receiving tax-free HSA contributions. This rule applies even if the HRA or health care FSA coverage is provided to the HSA owner's spouse or other family member.

You can obtain additional information on your HSA online at **www.irs.gov**. You may also contact your tax advisor. Please note that additional rules may apply to a spouse's (who is an eligible individual) intent to opening an HSA.

Enrolling in an HSA

To participate in a Health Savings Account, you must enroll for coverage in the UHC Basic HSA medical plan or UHC Premium HSA medical plan. Please see the **Participating in healthcare benefits**, starting on page 5, for the enrollment rules for these plans.

You must elect the amount that you would like to contribute to your Health Savings Account each plan year. You may change your election at any time.

In order to open a Health Saving Account, you must be eligible for a U.S. bank account and have

a physical mailing address (not a P.O. Box). If Optum Bank needs any additional information to verify your eligibility for the account, they will reach out to you directly via U.S. mail.

In the event that Optum Bank is unable to open your Health Savings Account within 60 days of the date that you initially elected to open it, Stryker's contributions made on your behalf and your contributions will be returned to Stryker. If this occurs, you will not be eligible to receive the Stryker employer funding, and your employee contributions will be returned to you via your paycheck and taxed appropriately. You may elect to open the account again but only payroll contributions that are elected after the account has been opened will be deposited and you will not be eligible to receive the Stryker employer contribution.

Once your Health Savings Account is opened, any monthly maintenance fee charged by Optum Bank will automatically be paid by Stryker while you are an active participant in one of the Stryker HSA medical plans. Once you are no longer enrolled in a Stryker HSA medical plan, the monthly maintenance fee will become your responsibility and will be deducted from your account. Any questions regarding this fee should be directed to Optum Bank.

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 HSA participation will continue while you are away from work. If you are receiving any pay from Stryker while on FMLA leave, 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. In addition, any missed deductions may be taken from your paycheck when you return to work if you return in the same calendar year.

Keeping you informed

Regularly, you will receive an HSA 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 contributions begin

Once your account has been opened, contributions for a taxable year can be made any time within that year and up until the tax filing deadline for the following year, which is typically April 15.

When HSA contributions stop

You can change your HSA employee contributions at any time throughout the year (provided that the last payroll has not been processed for the calendar year). The change to your contributions will be prospective.

If you leave Stryker or if coverage under the UHC Basic or Premium HSA medical plan (the high-deductible health plans) ends, no further contributions may be made through a Stryker paycheck to the HSA and you will not be eligible for any employer contributions on or after the date of your termination. The account with Optum Bank will remain open and any amounts contributed to your HSA belong to you. Health Savings Account balances are non-forfeitable and are always fully vested.

How HSAs work

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

HSA contributions

In 2026, Stryker will make a contribution to your HSA upon enrollment and activation of your account provided you are an eligible employee. The Stryker contribution amount will vary based on the medical plan you choose, and your coverage tier as follows:

2026 HSA contribution from Stryker		
	UHC Premium HSA Medical Plan (High Deductible Plan)	UHC Basic HSA Medical Plan (High Deductible Plan)
Employee	$600	$300
Employee + 1	$1,200	$600
Family	$1,200	$600

The Stryker contribution will be deposited as soon as administratively possible and is typically made after the first payroll following the effective date of your enrollment in a qualifying medical plan.

The following employees are not eligible for the Stryker employer contributions:

- Direct Temporary Employees
- Interns
- Part-time employees scheduled to work less than 20 hours
- Terminated employees

There are limits on how much you and Stryker, together, can contribute to your account. The limits for 2026 are:

- $4,400 annually for individual coverage.
- $8,750 annually if you cover dependents.
- An additional $1,000 per year as a catch-up contribution, if you are age 55 or older.

All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Contributions for mid-year enrollees

The amount that you can contribute in a calendar year is dependent on whether or not you will remain eligible for an HSA and enrolled in HSA-compatible plan for the 13 months measured from the December for the year in which the election is made through the end of the following December.

- You are eligible to contribute the full IRS maximum (set by federal regulations based on the coverage tier you elect) for the current tax year if you are enrolled by December 1 and remain eligible for HSA contributions for the next 13 months. This means you have to remain covered by an HSA-compatible plan for the next 13 months or you will be subject to tax implications and an additional tax of 10%. If you become ineligible during the 13-month period (e.g., enroll in a non HSA-compatible health plan), the pro-rated portion of the contributions that you made for the months that you were not covered by a qualified HSA-compatible plan will become taxable and you may be subject to an additional penalty tax.
- If you will not be enrolled in an HSA-compatible plan for the 13 months following December 1 of a given year, you will be eligible to contribute to your HSA on a pro-rated basis for the months that you are eligible to contribute within the current tax year. For example, if you are hired on April 15, 2026 and are enrolled in employee-only coverage in the Basic or Premium HSA medical plan, you are eligible to contribute beginning May 1, 2026, which means you are eligible for 8 months if you remain eligible through the remainder of 2026. The maximum you can contribute is calculated by taking the IRS maximum annual contribution for your coverage tier and dividing by 12 ($4,400 for employee-only coverage ÷ 12 = $366.66 per month). Next, multiply the monthly contribution amount by the number of months you are eligible in the tax year ($366.66 × 8 = $2,933.28). Remember that this pro-rated maximum includes both the Stryker contribution and your personal contribution.
- Eligible individuals enrolling in an HSA-compatible plan between December 2 and December 31 are not eligible to make HSA contributions on a tax-advantaged basis for the current tax year. Employees hired between December 2 and December 31 are not eligible for the company contribution for the plan year in which they are hired.

Eligible expenses include those that occur on or after the date your HSA is established (when it is funded), which occurs after the first of the month following your enrollment in an HSA compatible plan and the first deposit is made into the account. For Stryker, an HSA compatible plan includes the Basic HSA medical plan (high deductible health plan) and the Premium HSA medical plan (high deductible health plan). For example, if you are hired on April 15, 2026, and enroll in one of the high deductible plans, the date of service for the eligible claims must be on or after May 1, 2026 — provided that the account has been appropriately opened on May 1, 2026.

If Optum Bank is unable to establish the Health Savings Account for you, they will notify you of the additional information that is required to open your account. If the account is not successfully opened after approximately 60 days from the date you originally elected the account, the employer

funding will be returned to Stryker and you will no longer be eligible to receive it. In addition, any future payroll deductions will be stopped. If you miss this deadline but still wish to establish an account, you can restart the deductions via **https://enroll.stryker.com** after you have fully established the account; however, Stryker will not deposit any employer funding for the current plan year.

For more information, visit **www.irs.gov** and see Publication 969 or contact your Benefits Team.

Eligible expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the high deductible health plan, including annual deductibles, copayments and coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses".

For more information

See the UnitedHealthcare website at **www.myuhc.com** for current detailed information regarding eligible HSA expenses or call UnitedHealthcare customer service toll free at 800 387 7508. You can also visit **www.irs.gov** and see Publication 502.

Please see the description of "Additional medical expense coverage available with your Health Savings Account" on page 172, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

The following are examples of qualified medical that are covered by IRC Sections 213 and 223:

- medical services provided by medical practitioners and that are not covered by another plan
- charges for medically necessary services not covered by another plan, including but not limited to the following:
  - deductibles
  - out-of-pocket expenses
  - coinsurance
  - charges exceeding reasonable and customary amounts
  - charges exceeding plan limits
  - prescription drug charges
  - other non-covered charges for qualified medical care
  - all medically necessary prescription drugs and certain other prescription drugs permitted by the IRS (e.g., contraceptives and pre-natal vitamins)
  - eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses, lubricant eye drops, eye patches and reading glasses
  - LASIK eye surgery
  - dental implants
  - dental treatment, routine dental care (cleaning, X-rays, fillings, etc.), and over-the-counter products such as toothache relief, temporary filling, denture adhesive
  - orthodontia (braces)
  - mouth guards
  - hearing exams, hearing aids
  - cost differences between semi-private and private hospital rooms
  - costs for special medical equipment installed in your home, or for home improvements for purposes of medical care, e.g., ramps, support bars, railings, etc.
  - fees for special schools on the recommendation of a physician, including schools for the mentally impaired, physically disabled or individuals with severe learning disabilities

  - transportation (amounts paid for travel primarily for, and essential to, medical care)
  - personal use items if primarily used to prevent or alleviate a physical or mental defect or illness, e.g., wigs, Braille books, hearing aids
  - nursing services in hospital, nursing home or your home
  - smoking cessation programs
  - weight loss programs (if you have a letter from your treating physician indicating medical necessity)
  - alternative medicine
  - Christian Science practitioners
  - long-term care insurance premiums (Note: the tax-free reimbursement cannot exceed the annually adjusted "eligible long-term care premiums" in the Internal Revenue Code. This amount is based on age.)
  - COBRA premiums
  - Medicare premiums
  - health premiums while you are receiving unemployment insurance
  - retiree medical plan premiums other than for Medigap insurance.
- periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- routine prenatal and well-child care
- flu shots (if not covered by your medical plan)
- vaccinations
- child and adult immunizations
- screenings for conditions such as:
  - cancer
  - heart and vascular diseases
  - infectious diseases
  - mental health conditions
  - substance abuse
  - metabolic, nutritional, and endocrine conditions
  - musculoskeletal disorders
  - obstetric and gynecological conditions
  - pediatric conditions
  - vision and hearing disorders
- preventive over-the-counter expenses, such as:
  - home diagnostic tests or kits for blood pressure, cholesterol screening, diabetes (e.g., over-the-counter glucose monitor), colorectal, HIV
  - smoking-cessation relief, such as patches and gum
  - pre-natal vitamins (with doctor's note of medical necessity)
  - iron pills (with doctor's note of medical necessity)

Additional medical expense coverage available with your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services that are not covered under your medical plan and you have funds in your HSA, you may use the funds in your HSA to pay for the eligible medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not covered health services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your annual deductible or out-of-pocket maximum.

Using the HSA for non-qualified expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception

applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance, including Medicare Supplemental insurance, without incurring a tax except you may use your HSA to pay for COBRA premiums and Medicare Parts A, B or D premiums (but only if the account holder and Medicare enrollee are age 65 or older).

The following are examples of expenses that would not qualify for a tax-free withdrawal from your Health Savings Account:

- contributions to other employer-sponsored dental, vision or medical plans, including plans sponsored by your spouse's employer (contributions to the Company's dental, vision and medical plans are already made on a before-tax basis)

  Exceptions: COBRA premiums, Medicare premiums, health premiums while you are receiving unemployment insurance, retiree medical plan premiums other than for Medigap insurance and certain long-term care insurance premium amounts are considered qualified expenses.
- costs you deduct as qualified medical expenses on your federal income tax return
- expenses not eligible to be deducted under federal tax law
- expenses reimbursed by any other health plan
- health club membership dues
- cosmetic surgery: electrolysis, hair removal or transplants, liposuction, etc.
- vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary
- medications purchased merely to maintain you or your family's health
- prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine)
- cosmetic dental work (including bleaching, bonding and veneers)
- undocumented travel to or from your physician's office or other medical facility
- weight loss programs (unless you have a letter from your treating physician indicating medical necessity)

Portability feature

If you do not use all of the funds in your HSA during the calendar year, you do not lose the balance remaining in your HSA. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in this benefits summary. COBRA does not apply to the HSA because the benefit is not an ERISA plan.

However, if you elect COBRA, your remaining HSA funds can be used to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Keep your receipts

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. Stryker and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. Stryker and UnitedHealthcare/Optum Bank are not responsible or liable for the misuse by employees of HSA funds by, or for the use by employees of HSA funds for non-qualified health expenses.

HSA withdrawals

Optum Bank℠ Health Savings Account Debit MasterCard®

You can use your Optum Bank Health Savings Account Debit MasterCard for direct payment at a doctor's office, pharmacy or any health care facility that accepts MasterCard. In most cases, the card can also be used to pay a bill from a doctor's office or health care facility, provided they accept MasterCard.

You will receive your card in the mail seven to ten days after opening an HSA. Be sure to activate your card so you can start using it for your qualified medical expenses. You can activate your card using the included toll-free number and you may obtain your PIN at that time. With your PIN you can use your Debit MasterCard to withdraw funds at any ATM displaying the MasterCard brand name. So, for example, if you go to the doctor and pay for your services out of your own pocket, you can then withdraw money at the ATM to reimburse yourself.

Optum Bank will charge a per transaction fee for ATM withdrawals. Fees may also be charged by the ATM owner.

If you would like an additional debit card, download a request form at **http://www.irs.gov/** and follow the directions. Remember that your HSA Debit MasterCard acts like any other debit card and could incur charges not made by you. Protect yourself against fraudulent charges by routinely checking your HSA statement.

Paying online

When using your Optum Bank Debit MasterCard to pay for qualified medical expenses online, you receive additional protection of your personal information by using the MasterCard SecureCode™.

A SecureCode, known only to you, validates your identity as the cardholder for online transactions with participating retailers. Here's how it works:

- Each time you make an online purchase with a participating retailer, a window pops up, asking for your SecureCode.
- Correctly enter your SecureCode. This confirms you are the authorized cardholder and your purchase is completed.

Online retailers cannot see your SecureCode, adding another layer of protection.

Obtaining a SecureCode

The next time you use your Optum Bank Debit MasterCard for an online purchase, you will be prompted to register for a SecureCode. Choose your password, briefly provide other requested information identifying yourself, and continue to complete your purchase.

When making future online purchases, you will be asked to enter that same SecureCode to complete the transaction.

SecureCodes are required for all your HSA online debit card purchases at participating retailers.

Online banking and bill payment

Log in to **www.myuhc.com** and enjoy the convenience of online banking with Optum Bank. You can view recent account activity, link to your investment account, if you have one, and view and download your monthly statements. You can also pay bills for qualified medical expenses directly to your doctor or other health care providers. With online bill payment, you can set up the names and addresses of your providers to make future payments a snap.

At time of application, you agree to receive electronic monthly statements. You can, if you choose, request to have monthly statements mailed to your home. You can opt out of electronic statements by completing and returning a statement delivery change request form, available at **www.optumbank.com**.

Paying with checks

You may also request HSA checks to use when paying your medical bills. Checks are issued for a fee of $10 for a book of 25. Refer to the fee schedule for a list of fees that apply to your HSA.

Reimbursing yourself

You may choose to pay for some or all of your medical expenses out of pocket, saving receipts to track your qualified expenditures.

Then, at some point in the future, you may reimburse yourself for those expenses. Go to **www.myuhc.com**, log in to your HSA and select "Reimburse Yourself." You'll be able to choose to set up an electronic funds transfer (EFT) from Optum Bank to your savings or checking account at another bank. Or you can ask Optum Bank to send you a check by mail. You may also use paper checks, if you have purchased them, or withdraw money with your debit card from an ATM to reimburse yourself.

When you reimburse yourself is completely up to you. It can be weeks, months or even years after you've paid for the qualified medical expenses. You must, however, have retained the receipts for the qualified medical expenses in the event the IRS inquires, and the expenses must have been incurred after the date when you established your HSA.

Disbursement limits

Optum Bank℠ limits your ATM withdrawals to $300 within a 24-hour period. There is also a $10,000 limit on disbursements at a point of service, such as a health care facility, in a 24–hour period.

Investment options

Investment options are available to those with account balances in excess of $2,100.

You can learn about available investment options by calling Optum Bank customer service at 800 387 7508 or by visiting the UnitedHealthcare website at **www.myuhc.com**.

Additional information about the HSA

It is important for you to know the amount in your HSA prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify Optum Bank and the financial institution in writing.

You can obtain additional information on your HSA online at **www.irs.gov**. You may also contact your tax advisor. Please note that additional rules may apply to a spouse's (who is an eligible individual) intent to opening an HSA.

Life and AD&D insurance coverage



Life and accidental death and dismemberment (AD&D) insurance offers you and your eligible dependents financial support and peace of mind in the face of unforeseen events.

- Stryker provides basic life and AD&D insurance coverage through Unum at no cost to you.
- You also have the opportunity to purchase additional life insurance coverage for yourself and your covered dependents, through Unum.

Important

Certain plan provisions may vary depending on your state of residence. For details, refer to the Certificate of Insurance.

This section of the Stryker benefits summary provides an overview of your life and AD&D benefits. For more detailed information about these benefits and eligibility rules, refer to the Life and Accidental Death & Dismemberment Certificate of Insurance, available at the links below.

- For full-time employees: **https://totalrewards.stryker.com/us-full-time-group-life-and-acc-group-1-2026.pdf**
- For part-time employees: **https://totalrewards.stryker.com/us-part-time-group-life-and-acc-group-2-2026.pdf**
- For Howmedica retirees (a closed group): **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/howmedica-group-life-and-add-group-5-2026.pdf**

Together, this section of the Stryker benefits summary and the Certificate of Insurance issued by Unum constitute the Summary Plan Description for this plan.

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Rehires

If your coverage ends because you no longer work for Stryker or you are no longer in an eligible class, and you are later rehired or return to your eligible class within 30 days (and within the same plan year), coverage for you and your covered dependents may be reinstated. Evidence of Insurability will not be required as long as you return within 30 days. The reinstated coverage will be the same election that was in force when coverage ended; the amount of coverage may change if you are rehired in a new plan year.

Definition of domestic partner

For purposes of Stryker's benefit plans, a domestic partnership is defined as:

- A same-sex or different-sex couple who has registered with any state or local governmental domestic partner registry.

  OR

- A domestic partnership that meets all of the following requirements for the immediately preceding 12 months:
  - Is at least age 18 and mentally competent to enter into a legal contract when the domestic partnership began.
  - Is your sole domestic partner in a committed relationship and intends to remain so indefinitely.
  - Has not had another domestic partner within the prior 12 months.
  - Has not been a party to a divorce or annulment proceeding in at least 12 months.
  - Is not related to you in a way that would prohibit a legal marriage.
  - Is not legally married to anyone else, and any prior marriages have been dissolved through death, divorce or nullity.
  - Shares a household with you that is the primary residence of both of you (although you may live apart for reasons of education, healthcare, work, or military service).
  - Shares joint responsibility with you for each other's basic living expenses incurred during the domestic partnership.

Employees on International Assignment

If you are a U.S. Expatriate employee, you are eligible for life and AD&D insurance through the U.S. benefit plan.

Employees of Stryker Puerto Rico, Inc.

If you are an eligible full-time, active employee of Stryker Puerto Rico, Inc., you receive basic life and accidental death and dismemberment (AD&D) insurance coverage through Unum at no cost to you. You also have the opportunity to purchase additional life insurance coverage for yourself and your covered dependents, through Unum.

For detailed information about these benefits and the eligibility rules, refer to the Life and Accidental Death & Dismemberment Certificates of Insurance, available at the following links:

- For full-time employees: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-add-life-pr-ft-ees.pdf**.
- For part-time employees: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-add-life-pr-pt-ees.pdf**.

Coverage at a glance

Basic Life Insurance for you	▪ Pays benefits to your beneficiary in the event of your death ▪ Coverage of one times your eligible annual earnings, up to $500,000 ▪ Provided automatically at no cost to you
Basic AD&D Insurance for you	▪ Pays benefits to you for certain injuries or other conditions resulting from an accident, and benefits to your beneficiary in the event of your death ▪ Coverage of one times your eligible annual earnings, up to $500,000 ▪ Provided automatically at no cost to you
Supplemental Life Insurance for you	▪ Pays benefits to your beneficiary in the event of your death ▪ You may purchase additional coverage for yourself in any of the following amounts, up to $1,500,000: ▫ 1 × your eligible annual earnings ▫ 2 × your eligible annual earnings ▫ 3 × your eligible annual earnings ▫ 4 × your eligible annual earnings ▫ 5 × your eligible annual earnings ▪ Evidence of Insurability may be required
Dependent Life for your spouse/domestic partner	▪ Pays benefits to you in the event of your spouse/domestic partner's death ▪ You may purchase coverage for your spouse/domestic partner in increments of $10,000, up to $100,000 ▪ Evidence of Insurability may be required
Dependent Life for your child(ren)	▪ Pays benefits to your dependent child(ren)'s beneficiary(ies) in the event of their death ▪ You may purchase coverage for your dependent child(ren) equal to $10,000.

Disability coverage



Stryker provides short-term disability (STD) and long-term disability (LTD) coverage through Unum. Disability coverage offers you income protection in case a sickness, injury, or pregnancy, leaves you unable to work.

This section of the Stryker benefits summary provides an overview of your short-term and long-term disability benefits.

- For more information about the STD plan, refer to the benefits booklet for exempt and non-exempt employees, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/unum-us-short-term-disability.pdf**.
- For more information on the LTD plan, all eligible employees should refer to the LTD Certificate of Insurance, available at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/unum-us-long-term-disability-2026.pdf**.

Together, this section of the Stryker benefits summary and the STD booklets and LTD Certificate of Insurance issued by Unum constitute the Summary Plan Description for these plans.

Employees of Stryker Puerto Rico, Inc.

For information on the LTD plan for eligible employees of Stryker Puerto Rico, Inc., refer to the LTD Certificate of Insurance, available at:

- For part-time employees: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-add-ltd-pr-pt-ees.pdf**.
- For full-time employees: **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/2026-add-ltd-pr-ft-ees.pdf**

STD benefits and employment status

Your STD benefits are based on whether you are an exempt or non-exempt employee. Generally, you are considered:

- Exempt if you are not eligible for and do not receive overtime pay
- Non-exempt if you are entitled to receive overtime pay

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Coverage at a glance

STD coverage

Eligibility	▪ Active full-time employees scheduled to work 40 hours per week ▪ Active part-time employees scheduled to work 20 hours per week
Cost for coverage	▪ Stryker pays the full cost of your STD coverage. You do not contribute toward the cost of STD coverage
Enrollment	▪ Eligible employees are automatically enrolled for STD coverage as of their date of hire
When coverage ends	▪ Generally, coverage under the STD plan ends on the earliest of the following: ▫ The date you leave Stryker. Qualifying disabilities, which occur prior to separation, will remain covered by the plan ▫ The date you're no longer actively employed ▫ The date the plan is terminated
Weekly benefit	▪ Exempt employees: Weekly benefit equal to 100% of your eligible earnings ▪ Non-exempt employees: Weekly benefit equal to 60% to 100% of your eligible earnings: ▫ For the first 56 days of disability: 100% of your eligible earnings ▫ For days 57 to 180: 60% of your eligible earnings ▪ Benefits are reduced by the amount of any other income benefits, such as state disability or workers' compensation
When benefits are payable	▪ Benefits are payable beginning on the: ▫ Eighth day of your total disability due to sickness ▫ First day of total disability due to an accident, outpatient surgery, or a hospital stay
How long benefits last	▪ Generally, benefits are payable for up to: ▫ 173 days if disability is due to sickness ▫ 180 days if disability is due to an accident

LTD coverage

Eligibility	▪ Active full-time employees scheduled to work 40 hours per week
Cost for coverage	▪ Stryker pays the full cost of your LTD coverage. You do not contribute toward the cost of LTD coverage
Enrollment	▪ Eligible employees are automatically enrolled for LTD coverage as of their date of hire
When coverage ends	▪ Generally, coverage under the LTD plan ends on the earliest of the following: ▫ The date you leave Stryker. Qualifying disabilities, which occur prior to separation, will remain covered by the plan ▫ The date you're no longer actively employed (including temporary layoff or leave of absence) or become otherwise ineligible ▫ The date the plan is terminated
Monthly benefit	▪ Disability income equal to 60% of your monthly pre-disability earnings, up to $15,000 a month as defined by the plan rules ▪ Benefits are reduced by the amount of any other income benefits, such as worker's compensation, no fault disability insurance, Social Security disability, veteran's benefits, and state disability
When benefits are payable	▪ Benefits are payable beginning on the 181st day of your total disability, provided you are under the regular care of a physician and have an approved disability
How long benefits last	▪ Generally, benefits are payable up to the earlier of the date: ▫ You are no longer totally disabled as defined by the plan ▫ Your current pay exceeds 80% of your indexed pre-disability earnings ▫ You reach your normal retirement age (rules vary if you are age 64 or older when you become totally disabled) ▫ You die

401(k) Retirement Plan



Stryker sponsors the Stryker Corporation 401(k) Savings and Retirement Plan (the "Plan") so that you and other employees of Stryker and its participating subsidiaries (all referred to in this summary as the "Company") may save for retirement on a before-tax basis. The benefits provided under the Plan are in addition to Social Security.

The Plan provides different benefits for sales representatives and eligible employees other than sales representatives. To help each participant understand the Plan without confusion, the benefits are described separately, in two summary plan descriptions (SPDs):

- **401(k) Plan (Non-Sales Rep Employees)**, starting on page 183
- **401(k) Plan (Sales Reps)**, starting on page 203

The SPD's purpose is to explain your rights under the overall Plan. Note that each version of the SPD contains all the information required to be a complete SPD for the Plan. You do not need to read any other sections of the Stryker Benefits Summary to obtain the information you need for this Plan.

You are urged to read the SPD that applies to you carefully and to acquaint your family or beneficiaries with the Plan. You should retain a copy of the SPD for future reference.

As of January 1, 2026, this benefits summary replaces all earlier descriptions of the Stryker Healthcare Benefits, Spending Accounts, 401(k) Savings and Retirement Plans and Additional Benefits. The summary plan descriptions outline the Plans, which are complex and technical legal documents. In the event of any difference between the summary plan descriptions and the Plan document, the terms of the Plan document will control.

401(k) Plan (Non-Sales Rep Employees)

The Stryker Corporation 401(k) Savings and Retirement Plan (the “Plan”) gives participants a way to save for their future financial needs.

Important

This summary plan description (SPD) describes the main features of the Plan that apply to Stryker employees who are not sales employees (different Plan features for employees who are sales employees are described in a separate SPD). As used in this SPD, "sales employee" means an employee who has a classification of "Direct Sales" in the Job Family segment within the Company's or other Participating Employer’s human resources management system. If an employee's status changes from a sales employee to a non-sales position or vice versa, the features described in this SPD apply only with respect to the period of employment in a non-sales employee position.

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Overview of the Plan

The Plan is a type of profit-sharing retirement plan known as a "401(k)" plan. This means that you may elect to defer part of your compensation and have the Company contribute the deferred amount to the Plan instead of receiving it in your paychecks. The Company may also make discretionary contributions and will make matching contributions, as explained in "Contributions to the Plan" on page 185.

Your accounts

Your pay deferrals, Roth pay deferrals, and the other Company contributions made for you are placed in accounts in your name. Your accounts are invested together with the other participants' accounts in certain investment funds. The investment earnings are allocated to the accounts.

Your benefits

Your benefits from the Plan are the vested amounts in your accounts. When you leave the Company and become eligible for benefit payments, the Trustee will make the payments in the form you choose until you have received the full amount owed to you from your accounts. The amount in your accounts will largely depend on the amount of your deferrals, the amount of Company discretionary and matching contributions, and the investment performance of the funds in which you are invested.

Tax deferral

You will not be taxed on the contributions to the Plan (except for contributions that are Roth pay deferrals), or on the investment earnings credited to your accounts, until these amounts are actually distributed to you from your accounts. If you receive a "qualified" distribution from your Roth accounts, as explained in "Tax consequences of Roth distributions" on page 195, you will not be

taxed on the investment earnings credited to your Roth accounts.

Contacting Vanguard

Plan records are administered by The Vanguard Group located in Valley Forge, Pennsylvania. You can access information about the Plan and your accounts (including information on your investment performance, account balance, loan information, current investment elections and your recent activity) by

- Calling Vanguard's VOICE Network automated phone service (at 800 523 1188), which is available 24 hours a day,
- Accessing your account through the Vanguard web site (**www.vanguard.com/retirementplans**), or
- Speaking directly to a Participant Service Associate ("PSA") during business hours (at 800 523 1188).

You can also use any of these methods to make or cancel a pay deferral election or Roth pay deferral election, change your pay deferrals or Roth deferrals, change how your existing account balance is invested, change the investment mix of future contributions or your current account balance, and change your Personal Identification Number.

Eligibility

You will become a participant in the Plan on the date you become an eligible employee of the Company (but not before your 18th birthday).

You are **not** eligible to participate in the Plan if:

- You are a temporary employee (that is, you were hired for a position that is not permanent and is not expected to continue for more than one year), unless and until you complete 1,000 hours of service during the first 12 months of your employment or during any Plan Year thereafter;
- You are a "leased" employee;
- You are a union employee (unless your collective bargaining agreement provides for participation in the Plan);
- You are employed by one of the Company's foreign branches;
- You actively participate in another 401(k) or similar plan to which the Company or an affiliate of the Company contributes;
- You are not on the Company's payroll, or you are classified as an independent contractor (even if an agency or court later determines that your relationship to the Company was that of a common law employee); or
- You actively participate in a non-U.S. retirement plan or government retirement system to which the Company or an affiliate of the Company contributes.

If you terminate employment with the Company after you have become a participant, and you later become reemployed, you will resume participation in the Plan on your reemployment date.

Contributions to the Plan

The Plan has five types of contributions:

- Company Discretionary Contributions
- Pay Deferral Contributions
- Roth Pay Deferral Contributions
- Catch-Up Contributions
- Company Matching Contributions

Company discretionary contributions

At the end of each Plan Year, the Company will decide on the amount of its discretionary contribution for that year. The Company is not required to make a discretionary contribution.

Who is eligible

After you become a participant, you will share in the Company's discretionary contribution, if one is made, for a Plan Year if:

- You are employed on the last day of the Plan Year and have at least 1,000 hours of service during the Plan Year; or
- You terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

An hour of service is each hour for which you are paid or entitled to be paid by the Company or an affiliate of the Company.

Contribution amount

Your share of the Company's discretionary contribution will be a percentage of your compensation while you are a participant during the Plan Year. If the Company contributes less than 7% of the total compensation of all participants during the Plan Year, a cap will apply to the amount of compensation qualifying for the maximum discretionary contribution percentage.

Example 1

Assume the Company makes a 7% discretionary contribution for a Plan Year in which your compensation is $30,000. Your share of the Company discretionary contribution is $2,100, and it will be credited to your "discretionary contribution account."

Example 2

Assume that your Plan Year compensation is $125,000, and that the Company makes a 7% discretionary contribution for compensation capped at $110,000. Your share of the discretionary contribution is $7,700.

Example 3

Assume that your Plan Year compensation is $125,000, and that the Company makes a discretionary contribution of 7% of compensation up to $110,000 and 1% of compensation above $110,000. Your share of the discretionary contribution is $7,850.

Pay deferral contributions and Roth pay deferral contributions

You may contribute to the Plan by deferring a portion of your compensation as either pay deferral contributions, Roth pay deferral contributions, or a combination of both.

How to make pay deferral contributions or Roth pay deferral contributions

You may elect to defer a portion of your compensation and have the Company contribute your deferred compensation to the Plan on your behalf. When taken on a pre-tax basis, these contributions are called "pay deferrals" and are credited to your "pay deferral account." When taken on an after-tax basis, these contributions are called "Roth pay deferrals" and are credited to your "Roth pay deferral account." Contact Vanguard (see "Contacting Vanguard" on page 185) to make a pay deferral election and/or Roth pay deferral election.

Your pay deferrals and Roth pay deferrals may be any whole percentage up to a combined total of 75% of your compensation during a Plan Year. However, your total pay deferrals plus Roth pay deferrals may not exceed the dollar limit described in "Dollar Limit," and the Company may limit pay deferrals for highly paid employees to ensure that IRS nondiscrimination tests are met.

Automatic enrollment

If, upon becoming eligible to participate in the Plan, you fail to make an election either to make pay deferral contributions or Roth pay deferral contributions, or to opt out, you will automatically be treated as having made a pay deferral election. Your automatic election will start at 3%* of your compensation and will increase by 1% each year until it reaches 8% (15% if you became eligible to participate in the Plan on or after July 1, 2017). This automatic election will cease to apply, however, if and when you make your own pay deferral election or Roth pay deferral election or elect not to make pay deferral contributions or Roth pay deferral contributions. Amounts contributed to your account under automatic enrollment will **not** be treated as Roth pay deferrals.

* If you enrolled prior to April 1, 2015, your automatic pay deferral elections will start at 2% of your compensation.

Changing, stopping, resuming contributions

You may change your pay deferral (or Roth pay deferral) percentage or stop or resume your pay deferrals (or Roth pay deferrals) at any time by contacting Vanguard (see "Contacting Vanguard" on page 185). Your instructions will be implemented as soon as administratively feasible.

If you think there is a discrepancy between the classification of pay you elected to defer as a pay deferral vs Roth pay deferral and the classification of amounts actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise, you will be deemed to have elected the classification that is actually being contributed.

Discrepancies

If you think there is a discrepancy between the percentage of pay you elected to defer (or the automatic enrollment percentage, if applicable) and the percentage actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise, you will be deemed to have elected the percentage that is actually being contributed.

Benefits of deferring compensation

There are four benefits of deferring compensation under the Plan.

- First, any amounts contributed to the Plan as a result of your pay deferral election are not subject to current income taxes. As a result, your current taxable income will be reduced. Note that this is not true for Roth pay deferral elections because they are taken on an after-tax basis.
- Second, the amount contributed to the Plan as pay deferrals is invested on a tax-deferred basis. This means you will not pay income tax on the investment earnings that are allocated to your accounts. You will pay income taxes only when you receive your benefits from the Plan. As a result, this tax deferral permits a much more rapid accumulation of funds for your retirement. Unlike pay deferrals, however, your Roth pay deferrals will be taxed at the time you contribute them to the Plan, but these contributions and the related earnings will generally not be taxed when you receive a qualified distribution from the Plan. See "Tax consequences of Roth distributions" on page 195 for more information on the tax treatment of distributions of Roth pay deferrals.
- Third, under current provisions of the tax law, you may be ineligible to make deductible contributions to a traditional individual retirement account ("IRA"). Pay deferrals under the Plan allow you to save for retirement on a before-tax basis.
- Fourth, the Company will contribute 50¢ for each $1 that is contributed to the Plan as a result of your pay deferrals and/or Roth pay deferrals (up to a maximum match equal to 4% of your compensation). The portion of your matching contribution that does not exceed 2% of your compensation will be invested in the Stryker Stock Fund. Matching contributions above 2% of compensation will be invested according to your investment election. See "Company matching contributions" on page 188 for a discussion of "matching" contributions.

Example

Here is an example of how these benefits can affect you:

If you earn $30,000 per year and you defer 10% of your compensation as pay deferrals, your total deferral for the year is $3,000. The Company contributes your deferral of $3,000 to the Plan for you, along with a $1,200 matching contribution, of which $600 is invested in the Stryker Stock Fund.

In addition, the $4,200 contribution in your name is increased by any discretionary contribution that the Company makes for you and will reflect any change in value of the investment funds in which your accounts are invested. You will not pay income tax on your $3,000 pay deferral, the $1,200 match, any discretionary Company contribution, or any change in investment value until you eventually receive the amount in your accounts after terminating employment (or as a hardship withdrawal or other withdrawal).

Dollar limit

Federal law limits the amount of your total pay deferrals (including Roth pay deferrals) in a calendar year to $24,500, subject to adjustments for inflation after 2026 (the "dollar limit").

If your total pay deferrals and Roth pay deferrals under all 401(k) plans or other qualified plans in which you participate during a calendar year exceed the dollar limit for that calendar year (January 1 through December 31), the excess amount of pay deferrals will be included in your taxable income for the year of the deferral. The excess amount will also be taxed again in the year it is distributed to you if it is not withdrawn by April 15 of the following year. To receive a distribution of the excess amount before April 15, your request for distribution must be made to the Plan Administrator by March 1.

The Company will attempt to make sure that your pay deferral contributions and Roth pay deferral contributions to the Plan do not exceed the dollar limit. However, if you participate in another employer's 401(k) plan or a pay deferral simplified employee plan (SEP) during the same calendar year, the dollar limit applies to the total deferral

contributions to both plans. Also, if you participate in a tax-sheltered annuity plan of another employer, there is an increased combined limit that applies to deferrals to the Plan and the tax-sheltered annuity. You should monitor your pay deferral contributions and Roth pay deferral contributions so that you do not exceed the dollar limit.

Catch-Up contributions

If you will be at least 50 years old by the end of the Plan Year and you make the maximum amount of pay deferral contributions and Roth pay deferral contributions allowed under the Plan, you are eligible to make "catch-up" contributions in addition to your pay deferral contributions and Roth pay deferral contributions. The law allows up to $8,000 in catch-up contributions. Note if you are age 60 – 63, you are allowed up to $11,250 in catch-up contributions – or 150% of the catch-up limit – whichever is greater. Pay deferral catch-up contributions will be allocated to your pay deferral account, and Roth pay deferral catch-up contributions will be allocated to your Roth pay deferral account.

Company matching contributions

To give you an incentive to defer a portion of your compensation, the Company will make "matching" contributions based upon the amount of your pay deferrals and/or Roth pay deferrals. The Company will contribute 50¢ for each $1 of your pay deferrals and Roth pay deferrals, up to a maximum matching contribution equal to 4% of your compensation.

The matching contributions are made as of the end of each Plan Year. To receive a matching contribution, you must be employed on the last day of the Plan Year and must have at least 1,000 hours of service during the Plan Year. You will also be eligible for a matching contribution if you terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

These matching contributions made for you are credited to your "matching contribution account" as soon as administratively feasible following the end of the Plan Year. The portion of your matching contributions that does not exceed 2% of your compensation will be credited to a "2% subaccount" within your matching contribution account and will be initially invested in the Stryker Stock Fund. Any additional matching contributions are invested in accordance with your election.

Example

Here is an example of how matching contributions work:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral is $3,000. Your pay deferrals and/or Roth pay deferrals up to 8% of your compensation ($2,400) qualify for a matching contribution at the rate of 50¢ for each $1 of deferrals, for a total matching contribution of $1,200. Of that total matching contribution, $600 (2% of your compensation) will be invested in the Stryker Stock Fund. The remainder of your matching contribution will be invested in accordance with your election.

Roth in-Plan conversions

You may elect, in accordance with procedures established by the Plan Administrator, to have a portion of your vested Accounts (other than amounts in your Roth pay deferral or Roth rollover accounts) directly transferred to a Roth In-Plan Conversion account. You may elect to make such an in-plan conversion even if the vested amounts are not otherwise distributable to you. The benefit of making a Roth In-Plan Conversion is that the converted amount, along with any earnings on the converted amount, will not be taxed upon your receipt of such amounts in a "qualified" distribution (see "Tax consequences of Roth distributions" on page 195 for information on qualified Roth distributions).

A Roth In-Plan Conversion generally will be treated as a distribution for tax purposes, which means that in the year of the conversion, you will owe ordinary income taxes on any tax-deferred money in your Accounts, and any earnings in your Accounts, which are converted to Roth under the Plan in a Roth In-Plan Conversion.

A Roth In-Plan Conversion will not trigger any early distribution penalty tax (as discussed in "Excise tax on certain early distributions" on page 195), but the penalty may apply later if the converted amount is not held in the designated Roth account for the 5-year period required for Roth distributions to be tax-free.

Roth In-Plan Conversions are not subject to mandatory or optional tax withholdings. Therefore, if you decide to make a Roth In-Plan Conversion, you may need to increase your

withholding or make estimated tax payments outside the Plan to avoid any underpayment penalties that may result from the conversion.

If you wish to complete a Roth In-Plan Conversion, contact Vanguard (see "Contacting Vanguard" on page 185).

Important: Because the tax rules on Roth In-Plan Conversions can be complicated, you should consult with your professional tax advisor before deciding whether or not to complete a Roth In-Plan Conversion. Once a Roth In-Plan Conversion is made, it is irrevocable and cannot be undone or re-characterized in any way.

Any amounts transferred to a Roth In-Plan Conversion account will remain subject to any distribution restrictions that were applicable prior to the transfer.

Compensation

The compensation used in calculating the amount of the Company's contributions (including pay deferral contributions and Roth pay deferral contributions) on your behalf consists of the following (unless listed under "Items Excluded"):

- Wages, salary, and other taxable amounts received for services to the Company;
- Commissions and bonuses;
- Pay deferral contributions and Roth pay deferral contributions to this Plan;
- Pay reduction contributions to a "cafeteria" plan or qualified transportation fringe benefit program;
- Differential wage payments (wage amounts paid by the Company during any period in which you are performing active military service for at least 30 days) that would have been paid had you been actively employed by the Company during that period; and
- Unused vacation or sick pay that is paid to you in accordance with the Company's vacation cashout program, even if the payment is made after your termination of employment.

Items excluded

The following items are excluded from compensation for Plan purposes:

- Amounts paid to you before you met the requirements for participating in the Plan;
- Pay reduction amounts or other contributions to a nonqualified deferred compensation plan;
- Distributions from a nonqualified or qualified deferred compensation plan;
- Income from the exercise of a stock option;
- Income from restricted property that becomes taxable under Section 83 of the Internal Revenue Code when the restrictions lapse;
- Income realized on the sale of stock acquired under a statutory stock option;
- Amounts subject to special tax benefits which are not includible in income;
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits; and
- Severance pay.

Federal law requires the Plan to limit to $360,000 the amount of an employee's compensation during a Plan Year that may be used in figuring the amount of contributions on behalf of an employee under the Plan for the Plan Year. The IRS may increase the $360,000 limit in future years for inflation.

Rollovers

The Plan includes rollover provisions, as follows.

Rollovers from eligible employer plans

If you receive an "eligible rollover distribution" from an eligible retirement plan of a prior employer, you may be eligible to roll over that distribution to the Plan. An eligible retirement plan means any of the following types of plans:

- A qualified defined contribution or defined benefit plan (other than non-Roth after-tax contributions);
- A Section 403(b) tax-sheltered annuity (other than Roth or other after-tax contributions); or
- A Section 457 plan maintained by a governmental employer.

Such a distribution may be rolled over in either of two ways. The distribution may either be paid directly to the Plan by the other plan in a "direct rollover," or the other plan may pay the distribution to you (subject to any applicable withholding tax), and you will have 60 days after you receive it to contribute it to the Plan.

If you wish to make a rollover into the separate after-tax Roth rollover account, the funds must come from another Roth elective deferral account under another tax-qualified retirement plan.

Rollovers from IRAs

You may also roll over to the Plan the portion of a distribution from a Section 408 individual retirement account or annuity (IRA) that would otherwise be taxable to you and that is eligible to be rolled over.

More information regarding rollovers is available from Vanguard. Any amount you roll over is placed in your "rollover account."

Vesting

The term “vested” refers to the amount in your accounts that cannot be taken away from you regardless of the reason or time that you leave the Company.

Vested interest in your accounts

The following rules are used to determine if you are “vested”:

- Amounts in your pay deferral account, Roth pay deferral account, rollover account and Roth rollover account are always 100% vested.
- Amounts in your discretionary contribution account and matching contribution account are 100% vested if you attain age 65, become totally disabled, or die while employed by the Company.

  You are “totally disabled” if you have a mental or physical condition that makes you eligible to receive Social Security disability benefits. However, total disability does not include disability resulting from:

  - Military service
  - Criminal activity
  - Alcoholism
  - Drug abuse
  - Intentional self-inflicted injury
- Amounts in your discretionary contribution account and matching contribution account are 100% vested if you have at least five “years of vested service.”

If you leave the Company (for a reason other than retirement after age 65, total disability, or death) before completing five “years of vested service,” all or a portion of the amounts in your discretionary contribution account and your matching contribution account will be forfeited. You will receive only your vested percentage of your discretionary contribution account and your matching contribution account. Your vested percentage is determined as follows:

Years of Vested Service	Vested percentage
Less than 2	0%
2	20%
3	40%
4	60%
5 or more	100%

Year of Vested Service

You will receive a “year of vested service” for each Plan Year in which you are credited with at least 1,000 hours of service. The Company does not keep a record of individual hours worked by salaried employees. Salaried employees are credited with 45 hours of service for each week during which the employee would otherwise be credited with an hour of service.

Forfeitures

The portion of your discretionary contribution account and matching contribution account in which you are not vested is “forfeited.” The forfeiture will occur on the date you receive a distribution of your vested benefits (or the end of the Plan Year in which you have five consecutive breaks in service, if earlier). Any forfeitures from your accounts will be used to pay Plan expenses or to reduce the amount of the Company’s contributions.

Vesting rules upon reemployment

If you leave the Company and are later reemployed by the Company, the following rules apply to you:

- For information on your eligibility to join the plan after you are rehired, see “Eligibility” on page 185.
- Your former years of vested service will be restored if your Plan account was partially or fully vested before you terminated employment or if you have fewer than five consecutive vesting breaks in service. You must perform a

year of vested service after being reemployed in order for your prior service to be credited.

- The amount you forfeited will be restored if you have fewer than five consecutive vesting breaks in service and you repay the vested amount previously distributed to you (if any) within five years after being reemployed.
- If you have five or more consecutive vesting breaks in service and you left the vested portion of the discretionary contribution account or matching contribution account in the Plan, when you are reemployed, you will have two subaccounts. The first subaccount, consisting of the vested portion of the discretionary contribution and matching contribution accounts, will be 100% vested. The second subaccount, consisting of amounts added to the discretionary contribution and matching contribution accounts after you are rehired, will vest under the Plan's normal vesting schedule, based on your years of vested service after the break in service plus your years of vested service before the break in service that are restored under the above rules.

Vesting breaks in service

A "vesting break in service" is a Plan Year during which you have not completed more than 500 hours of service. Solely for determining whether a vesting break in service has occurred, if you are absent from work for maternity or paternity reasons you will receive credit for hours of service (but not more than 501) that would have been credited except for the absence. An absence from work for maternity or paternity reasons means an absence caused by pregnancy or childbirth, placement or adoption of a child, or child care immediately following birth or adoption.

If you have performed at least 500 hours of service in the Plan Year in which your absence for maternity or paternity reasons begins, then solely for purposes of preventing a break in service for the Plan Year subsequent to the Plan Year in which such leave begins, you will receive service credit of up to 500 hours for your absence during that Plan Year.

For example, if you take maternity leave in October and have more than 500 hours of service, there is no break in service that year. In addition, in order to avoid a break in service the following year, you will be credited with up to 500 hours of service.

Plan investments

The Plan offers you a choice of funds to invest the money in your accounts.

Investment of your accounts

You may direct the investment of contributions to your accounts in different investment funds made available by the Trustee. Information regarding these funds, including prospectuses, may be obtained by contacting Vanguard (see "Contacting Vanguard" on page 185).

If you do not make an investment election, contributions to your accounts (other than the 2% subaccount that is invested in the Stryker Stock Fund) will be invested in the age-appropriate Vanguard Target Retirement fund.

You may change your investment election at any time by contacting Vanguard (see "Contacting Vanguard" on page 185). Your change in investment election may apply to future contributions, amounts already invested, or both.

Amounts in the Roth In-Plan Conversion account may not be invested in the Stryker Stock Fund.

You may transfer at any time all or a portion of your 2% subaccount that is invested in the Stryker Stock Fund to any of the other investment funds available under the Plan, and all or a portion of your 2% subaccount that is invested in other investment funds back into the Stryker Stock Fund. However, you may not transfer any portion of your accounts other than the 2% subaccount into the Stryker Stock Fund.

The Plan is intended to meet the requirement of ERISA Section 404(c) and its regulations. Under these rules, plan fiduciaries may be relieved of liability for losses that are a direct and necessary result of participants' and beneficiaries' investment instructions.

Valuation and adjustment of your accounts

The Trustee will calculate the value of your accounts as of each business day ("valuation date"). The value of your accounts is the total of your investments in the Stryker Stock Fund and each of the other investment funds. Other than the various types of contributions that are credited to

your accounts, the following events will also change the value of your accounts:

- **Distributions.** If you receive a distribution or withdrawal, the account or accounts from which it is made are reduced by the amount of the distribution.
- **Investment results.** As of each valuation date, the Trustee will calculate the value of the investment funds. You should note that the value may increase or decrease, and your accounts will be adjusted accordingly. You will receive a quarterly statement that will state both the value of your interest in each investment fund and the total value of your accounts.
- **Expenses.** Investment management fees are paid by the investment funds to which they relate. In addition, accounts are charged with their share of Plan administration expenses that are paid by the Plan. Administrative expenses deducted from your accounts will appear on your quarterly statements.
- **Loans.** If you receive a loan, the account or accounts from which it is made will be reduced by the amount of the loan. Your account or accounts will be increased as you make payments of principal and interest on the loan.
- **Forfeitures.** If you resign or are dismissed before you are fully vested, you will not receive the full amount in your accounts. The portion of your accounts in which you are not vested is "forfeited" and used to reduce the Company's matching or discretionary contributions.

When your active participation in the Plan ends, you will no longer share in the Company's matching or discretionary contributions. However, as long as you have not yet received the full amount in your accounts, your accounts will still be adjusted for expenses, investment earnings, gains and losses as well as for distributions.

Distributions from the Plan

This section describes when you may receive a distribution from the Plan.

When benefits are distributed

You may request payment of your benefits at any time after you stop working for the Company, after you reach age 65 (even if you are still working), or upon total disability. Once you retire, federal law requires that your benefit payments begin no later than the April 1 after the calendar year in which you attain age 72 (age 73 if you were born after December 31, 1950), or the April 1 after the calendar year in which you retire, if later.

Severance from employment for a reason other than death

You are entitled to the vested amount in your accounts if you leave the Company for any reason. (See "Vesting" on page 190 for more information.)

If your vested account balance (other than your rollover account) exceeds $5,000, you have the option of requesting a distribution of benefits or maintaining your accounts in the Plan. Your benefits will be paid as soon as administratively feasible after you request the distribution.

If your vested account balance (other than your rollover account) does not exceed $5,000, you do not have the option of maintaining your accounts in the Plan. Your benefits will be distributed to you in a lump sum payment (subject to the Automatic Rollover discussed below) as soon as administratively feasible following your severance from employment.

Whether or not your vested account balance exceeds $5,000, you may elect to have your lump sum distribution transferred to an eligible retirement plan in a "direct rollover."

Automatic rollovers

If the value of your account exceeds $1,000 but does not exceed $5,000, and after receiving all required notices you do not affirmatively elect to receive your distribution directly or to have it rolled over, the vested amount in your accounts will be automatically rolled over by the Plan to an IRA with The Vanguard Group. Your account will be automatically invested in Vanguard Prime Money Market Fund, a fund designed to preserve principal, provide a reasonable rate of return, and maintain liquidity. You will be responsible for paying all fees and expenses assessed against your automatic rollover IRA. The fees and expenses will be comparable to the fees and expenses charged by Vanguard for other IRAs. For additional information on the Plan's automatic rollover rules, a Vanguard IRA, and the fees and expenses associated with a Vanguard IRA, call Vanguard at 800 523 1188.

If you receive a distribution before age 59½, the distribution may be subject to a 10% excise tax in addition to being considered taxable income in the year it is distributed to you.

Forms of distribution of benefits

If your vested account balance (other than your rollover account) exceeds $5,000, you may elect whichever of the following forms of payment you prefer:

- **A lump sum payment.** This payment will be made in cash, unless you elect to receive shares of stock for your vested 2% subaccount invested in the Stryker Stock Fund, provided that such vested portion is at least $1,000 in value (see "Election to receive distribution of Stryker stock" on page 195 for details on this election).
- **Cash payments** in roughly equal annual, quarterly, or monthly installments for a specific number of years. The specific number of years for which the payments will last cannot exceed either your life expectancy or the joint life expectancy of you and your beneficiary.
- **A combination** of a single sum cash payment and cash payments in roughly equal annual, quarterly or monthly installments.
- **A partial distribution** (of at least $500) from your vested account. (Limited to one per calendar quarter.)

If you elect installments, you may at any time elect to shorten the period over which the installments are being paid or receive a lump-sum distribution of your remaining balance.

Distribution of benefits upon death

Death before receiving benefits

If you die before you have begun receiving your benefits, the Trustee will pay your vested account balance to your beneficiary in the form (lump sum, installments, or a combination) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described in "Forms of distribution of benefits" on page 193.

Payments to your surviving spouse are required to begin by December 31 of the year following the year of your death or by December 31 of the year in which you would have attained age 72 (or age 73 if you were born after December 31, 1950), if later. Payments to an "eligible" designated beneficiary other than your spouse are required to begin by December 31 of the year following the year of your death unless you or your beneficiary elects by December 31 of the year following the year of your death to apply the "ten-year rule." If the ten-year rule is elected, your entire vested account balance must be distributed no later than December 31 of the year containing the tenth anniversary of your death. An "eligible" designated beneficiary is your spouse, your child under age 21, a disabled or chronically ill individual, or any other individual who is not more than ten years younger than you. Generally, payments to a designated beneficiary who is not an "eligible" designated beneficiary must be completed no later than the end of the calendar year that includes the tenth anniversary of your death.

Death while receiving benefits

If you die while receiving your benefits in the form of installment payments, payments will continue to your beneficiary according to the same schedule of installment payments until the amount in your accounts has been completely distributed. Your beneficiary may instead choose to receive the remaining benefits in a lump sum payment.

Beneficiary

If you are married at the time of your death, your spouse will be the beneficiary of the death benefit unless you elect otherwise. If you wish to designate a beneficiary other than, or in addition to, your spouse, your spouse must consent to waive the right to receive the entire death benefit. Your spouse's consent must be in writing and be witnessed by a notary or Plan representative.

You may appoint one or more beneficiaries by completing and submitting a beneficiary designation form online via the Vanguard website. You may change your beneficiary at any time before your death by completing and submitting a new beneficiary designation form online via the Vanguard website. If you have not named a beneficiary or your beneficiary predeceases you, payment will be made to your surviving spouse, if any. If you have not named a beneficiary or your beneficiary predeceases you, and you do not have

a surviving spouse at the time of your death, payment will be made to your estate.

If you have more than one beneficiary and a beneficiary dies before benefit payments are completed, the share payable to the deceased beneficiary will be paid to the beneficiaries who are still living in proportion to the shares otherwise payable to the living beneficiaries.

To be entitled to receive any undistributed vested portion of your accounts, any person or persons designated as a beneficiary must be alive and any entity designated as a beneficiary must be in existence at the time of your death. If the order of the deaths of you and your primary beneficiary cannot be determined or have occurred within 120 hours of each other, you will be deemed to have survived your beneficiary.

If you designate your spouse as your beneficiary and later become divorced, that designation will be deemed revoked, effective as of the date the Plan Administrator receives evidence of the divorce and will no longer be valid. However, if you wish to keep your former spouse as your beneficiary, you may re-designate your former spouse as a non-spouse beneficiary after your divorce is finalized.

If your death, or the death of your beneficiary, is the result of a formally charged criminal act involving any other beneficiary, any claim involving the charged beneficiary will be suspended, and any distribution to such beneficiary will be held, until the resolution of the criminal charge. If the beneficiary is convicted of this criminal act, the beneficiary may not receive any undistributed amounts from your vested account balance.

Inherited accounts opened for minor beneficiaries will be controlled by the minor's authorized representative. The authorized representative must demonstrate to the Plan Administrator's satisfaction to be authorized to act on behalf of the minor.

Income tax withholding/direct rollovers

Direct rollovers

Distributions and withdrawals from the Plan are generally "eligible rollover distributions." This means that all or a portion of the distributions can be rolled over in a "direct rollover" to an eligible retirement plan (which may be a qualified plan, a Section 408 individual retirement account or annuity (IRA), a Section 403(a) annuity, a Section 403(b) tax-sheltered annuity, a Section 457 governmental plan, or a Roth IRA) that accepts rollovers. If you choose a direct rollover, the Plan will issue a check directly to the eligible retirement plan, and you will not be taxed until you later take it out of the eligible retirement plan (unless the direct rollover is to a Roth IRA, in which case you will be taxed at the time of the rollover).

If you are making a rollover from your Roth pay deferral account or Roth rollover account, the rollover may be made to another Roth account under a tax-qualified retirement plan or to a Roth IRA.

Required withholding

If you receive an eligible rollover distribution from the Plan and do not choose a direct rollover, the Plan is required by law to withhold Federal income taxes of 20% of that amount. The amount of the distribution will be subject to tax in that year unless, within 60 days, you roll it over to an eligible retirement plan that accepts rollovers.

Other distributions

A distribution or withdrawal from the Plan is not an eligible rollover distribution, and is not subject to the above rules, if:

- It is paid in installments over a period of 10 years or more;
- It is paid in installments over your life expectancy (or joint life expectancy of you and your beneficiary); or
- It is a hardship withdrawal.

In addition, beginning in the year you reach 72 (age 73 if you were born after December 31, 1950) or retire (whichever is later), a certain portion of your payment cannot be rolled over because it is a "required minimum payment" that must be paid to you.

A payment from the Plan that is not an eligible rollover distribution is not subject to the direct rollover and mandatory withholding rules described above. If any portion of your distribution is not an eligible rollover distribution, you may elect not to have withholding apply to that portion.

Excise tax on certain early distributions

All distributions from the Plan (other than those from your Roth pay deferral account, Roth rollover account, and Roth In-Plan Conversion account) that are not rolled over to an IRA or another plan are taxable income. Further, if you receive a distribution from the Plan before age 59½, federal law imposes an excise tax equal to 10% of the amount of the distribution in addition to regular income tax. The 10% excise tax is imposed unless one of the following exceptions applies:

More information

Before receiving a distribution from the Plan, you will receive a Special Notice Regarding Plan Payments that provides more detailed information regarding the above rules as well as special tax rules that may apply.

- The distribution is made as a result of your termination of employment during or after the year you attain age 55;
- The distribution is made as a result of your death or disability;
- The distribution does not exceed your deductible medical expenses (medical expenses which exceed 7.5% of your adjusted gross income);
- The distribution is made under a qualified domestic relations order;
- The distribution consists of excess pay deferral amounts; or
- The distribution is part of a series of substantially equal payments over your life expectancy or over the joint life expectancy of you and your spouse.

Tax consequences of Roth distributions

When you or your beneficiary receives distributions from your Roth pay deferral account, you will generally not owe income taxes on the contributions or the earnings, to the extent that the distribution is "qualified." A Roth pay deferral distribution is qualified if it is made after a five-tax-year period of participation and is made on or after the date on which you attain age 59½, die, or become disabled. Your five-tax-year period of participation begins on the first day of your tax year for which you first elected to make Roth pay deferrals to the Plan or a Roth In-Plan Conversion, and ends when five consecutive tax years have been completed (but also may include certain periods attributable to amounts rolled over to your Roth pay deferral account). The Plan administrator will keep track of your five-tax-year period of participation, and you can find information about whether you have met the requirement by contacting Vanguard (see "Contacting Vanguard" on page 185 for more information).

Election to receive distribution of Stryker stock

If you take a lump sum distribution from the Plan you may elect to have your vested 2% subaccount that is invested in the Stryker Stock Fund distributed in shares of stock instead of in cash. To qualify for the election, the value of the Stryker common stock in your vested 2% subaccount must be at least $1,000. Fractional shares of Stryker common stock, and the part of your vested 2% subaccount that is not invested in Stryker common stock, will be distributed in cash. Hardship withdrawals and withdrawals after age 59½ while you are still an employee do not qualify for the election.

Special tax rule for net unrealized appreciation

If you make the election to receive shares of Stryker common stock as part of your lump sum distribution, you may have the option of not paying tax on the "net unrealized appreciation" of the stock until you sell it. Net unrealized appreciation generally is the increase in the value of the Stryker common stock while it was held by the Plan. If, for example, Stryker common stock was contributed to your account when it was

worth $1,000, but the stock is worth $1,200 when you receive it, you would not have to pay tax on the $200 increase in value until you later sell the stock.

Opting out of the special tax rule

You may instead elect not to use the special net unrealized appreciation rule. In that case the net unrealized appreciation will be taxed in the year you receive the stock unless you roll over the stock.

Effect on withholding

If you receive a distribution of both cash and Stryker common stock in a payment that can be rolled over, the 20% withholding will be based on the entire taxable amount paid to you (including the value of the Stryker common stock determined by excluding the net unrealized appreciation). However, the amount withheld will be taken from (and limited to) the cash part of the distribution.

More information

Before receiving a distribution from the Plan, you will receive a Special Notice Regarding Plan Payments that provides more detailed information regarding the above rules as well as special tax rules that may apply.

Loans and withdrawals

The following describes situations when you may be allowed to request a loan or distribution from your Plan account.

Loans

Prior to May 1, 2025, hardship loans (to alleviate demonstrated financial hardship) were offered under the Plan. Effective May 1, 2025, the Plan has been amended to offer general-purpose loans to participants.

Eligibility

To qualify for a loan, you must be an active employee of the Company or an affiliate of the Company.

Minimum amount

The minimum amount you may borrow is $1,000.

Maximum amount

The maximum amount you may borrow is whichever of following amounts is the smallest:

- The sum of the balances in your pay deferral account, Roth pay deferral account, rollover account, and your Roth rollover account
- One-half your vested account balance
- $50,000 (reduced, if you have had a loan outstanding at any time during the past 12 months, by the highest balance of that loan during that 12-month period)

Number of loans

You may not have more than one loan outstanding at any time. Not more than one loan will be approved in any 12-month period.

Collateral

Your loan will be secured by 50% of your vested account balance (measured as of the time you take out the loan).

Interest

The interest rate charged on your loan will be one percentage point above the prime rate in effect on the first business day of the month in which you apply for the loan.

Repayments

The maximum period of repayment for any loan is 54 months. In the case of a hardship loan taken before May 1, 2025, if the loan is for the purpose of paying the costs (excluding mortgage payments) directly related to the purchase of your principal residence, the maximum period of repayment is 174 months. A loan account will be set up in your name under the Plan. Your repayments of principal on the loan, together with interest, are made through payroll deductions. The amount of each principal repayment reduces the amount in your loan account and is invested, along with the interest you pay, in the Plan's investment funds in accordance with your investment election for new Plan contributions.

The amount of your loan may be prepaid in full at any time without penalty. Partial prepayments are not allowed.

If your employment terminates, any outstanding balance on your loan will become due and payable, unless you elect to continue making the required installment payments as permitted under

loan procedures adopted by the Plan Administrator. If your loan is not repaid by the earlier of:

- the end of the calendar quarter following the calendar quarter in which your employment termination occurs,
- the end of the calendar quarter following the calendar quarter in which your most recent unpaid payment was due, or
- the valuation date used to determine the amount of your distribution from the Plan.

Your vested account will be used to repay your loan, unless you elect to continue making the required installment payments following your termination from employment.

If a loan is not repaid in accordance with the terms of the promissory note and there is a default, the Plan may use your vested account to repay your loan. (However, amounts in your pay deferral account or Roth pay deferral account will not be used for this purpose until the time they could otherwise be distributed to you.)

Processing charge

You may be charged a processing fee for the cost of processing your loan as well as an annual loan maintenance fee.

Hardship withdrawals

If you have a "hardship," you may be eligible to receive a hardship withdrawal from the Plan. Additional information on hardship withdrawals will be provided at the time you request a withdrawal application. A "hardship" is defined as an immediate and heavy need resulting from one of the following:

- Expenses for medical care for you, your spouse, or your dependents;
- Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
- Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents;
- Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence; or.
- Expenses or losses you incur because of a federally-declared disaster if you live or work in the disaster area.

Eligibility

To qualify for a hardship withdrawal, you must be an employee of the Company or an affiliate of the Company.

Hardship proof and certification

You must demonstrate that a hardship (as defined above) exists, and that your hardship cannot reasonably be relieved by any of the following actions (except to the extent those actions would increase the amount of your need):

- Reimbursement or compensation through insurance or otherwise
- Liquidation of your assets
- Discontinuing your pay deferrals and Roth pay deferrals
- Plan distributions (or distributions from other plans)
- Borrowing from commercial sources on reasonable commercial terms

Amount available

The maximum amount you may receive as a hardship withdrawal is whichever of the following amounts is the smallest:

- The sum of the balances in your pay deferral account, Roth pay deferral account, rollover account, and Roth rollover account
- The amount which you certify is necessary to relieve your hardship (including any amounts necessary to pay any Federal, state, or local income tax or penalties expected to result from the hardship withdrawal)

Frequency limit

You may make only one hardship withdrawal during any 12-month period.

Qualified reservist distributions

If you are a uniformed services participant in the Plan, you may request an in-service distribution from your pay deferral account, or Roth pay deferral account, or from any Roth contribution subaccount of an account transferred to the Plan on your behalf as part of an acquisition. This distribution will not be subject to the otherwise applicable 10% excise tax if (i) you are a member of a reserve component who is ordered or called to active duty for either an indefinite period or a period in excess of 179 days and (ii) the distribution is made during the period beginning on the date of your order or call to active duty and ending at the close of the active duty period.

Withdrawals after age 59½

You may request a withdrawal of all or part of your pay deferral account or Roth pay deferral account at any time after you reach age 59½.

Rollover account withdrawals

You may request a withdrawal of all or part of your rollover account or Roth rollover account at any time.

CARES Act

The Coronavirus Aid, Relief and Economic Security Act (the "CARES Act") provided temporary additional loan and/or withdrawal options to certain qualified participants. If you have questions about any of the relief previously available under the CARES Act, including questions about the repayment of a CARES Act distribution, you should contact Vanguard (see "Contacting Vanguard" on page 185).

Other important Plan information

The following describes additional information you should know about the Plan.

Top-heavy status of the Plan

Federal law imposes certain requirements on "top-heavy" plans. The Plan is top-heavy if more than 60% of the balance in all accounts belongs to certain officers and shareholders of the Company. The Plan is not top-heavy and is not likely to become top-heavy.

If the Plan is top-heavy at the end of the Plan Year, a minimum contribution may be required to the Plan. You will be notified if the Plan is top-heavy, and this new requirement applies.

Distributions under Qualified Domestic Relations Orders

Generally, plan benefits may be paid only to you or possibly your beneficiaries or survivors. However, an exception to this may be made as a result of a qualified domestic relations order.

A domestic relations order is a court-ordered payment of benefits in connection with a support order, divorce, legal separation, or custody case. This means the Plan may be obligated to pay part of your account to someone else — for example, your former spouse, children or other dependents — to comply with such an order.

There are specific legal requirements a domestic relations order must meet to be recognized by the Plan Administrator. If you are affected by such an order, you will be notified by the Plan Administrator. You may obtain from the Plan Administrator, without charge, a copy of the procedures applicable to domestic relations orders.

Benefits are not insured

The benefit provisions under the Plan are not covered by the Pension Benefit Guaranty Corporation insurance provisions, because the benefits are determined solely by the amount in your accounts.

Claims and appeals

If you disagree about a benefit, the Plan allows you to file a written application for review of the issue with the Plan Administrator.

If a claim for benefits is denied in whole or in part, the Plan Administrator will give you written notice within 90 days after the Plan Administrator receives your claim, unless special circumstances outside the control of the Plan Administrator require an extension of the time limit. (The Plan Administrator will notify you of the need and reasons for any such extension, and the date by which the Plan expects to render a decision, before the end of the 90-day period.) The written notice will set forth:

- The specific reasons for denial of the claim;

- Reference to the particular provisions of the Plan on which denial of the claim is based;
- A statement as to any additional facts or information necessary to perfect the claim and an explanation as to why the same is required; and
- A reference to the procedures (described below) for review of the denial of the claim, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of a claim.

If your claim for benefits under the Plan is denied in whole or in part by the Plan Administrator, you have the right to request a review of such denial. The review will be granted upon written request, filed by you with the Plan Administrator within 60 days following receipt of written notice of the denial. A full and fair review will be conducted by the Company's Retirement Plan Committee. You will be permitted to submit written comments, records and other information relating to the claim and provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. The Retirement Plan Committee will consider all comments, documents and other information you submitted, without regard to whether that information was submitted or considered in the initial determination.

At any hearing by the Retirement Plan Committee, you will have reasonable notice and an opportunity to be present and be heard in person or by a duly authorized representative. The Retirement Plan Committee will decide the matter with reasonable promptness and in any event within 60 days following receipt of a request for review unless special circumstances exist which require an extension of such time limit. The Retirement Plan Committee will notify you of the need and reasons for such extension, and the date by which the Plan expects to render a decision, prior to the end of the 60-day period. Its decision will be provided to you in writing and will set forth its reasons for the decision; the provisions of the Plan on which the decision is based; a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The above appeal procedure applies not only to you but also to a beneficiary or other person who disagrees about a benefit.

If you wish to bring a civil action against the Plan following a denial of your claim on appeal, you must do so within one year of the Retirement Plan Committee's final decision on your claim.

Termination or amendment of the Plan

Although the Company intends to continue the Plan from year to year, it reserves the right to amend or terminate the Plan at any time. However, because the Plan was established for the exclusive benefit of the Company's employees and their beneficiaries, termination or amendment cannot subtract from your accounts as they exist when the amendment or termination occurs.

If the Plan is terminated, you will have a 100% vested right to your accounts regardless of your years of vested service. After paying the expenses of terminating the Plan, the remaining amounts in the Plan will be distributed to you and the other participants in lump sum payments.

Your rights as a participant

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

Receive information about your Plan and benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan (the Plan document and trust agreement), and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator 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 all documents governing the operation of the Plan (the Plan document and trust agreement), and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The Plan Administrator will 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.)

Prudent actions by Plan fiduciaries

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

Enforce your rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a 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 (these rights are described in "Claims and appeals" on page 198 of this summary plan description).

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 Plan Administrator. If you have a claim for benefits which 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, 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. Any suit must be files within the time frames discussed in the "Claims and appeals" section on page 198.

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.

Additional information

Name of Plan

Stryker Corporation 401(k) Savings and Retirement Plan

Name, address and telephone number of the Company

Stryker Corporation
1941 Stryker Way
Portage, MI 49002
269 389 2600

Company's identification number

38-1239739

Plan number

002

Type of plan

Section 401(k) Plan

Type of administration

Self-Administered

Plan Administrator

Stryker Corporation is the Plan Administrator.

Name and address of Agent for Service of Legal Process

Stryker Corporation
1941 Stryker Way
Portage, MI 49002

Service of legal process may also be made on the Plan Administrator or the Trustee.

Name and address of Trustee

Vanguard Fiduciary Trust Company
Vanguard Financial Center
P.O. Box 2900
Valley Forge, PA 19482

Plan year

January 1 through December 31

Names and employer identification numbers of participating employers

Company	Emp. Id. No.
Stryker Corporation 1941 Stryker Way Portage, MI 49002	38-1239739
Howmedica Osteonics Corp 325 Corporate Drive Mahwah, NJ 07430	22-2183590
Stryker Communications Inc. 1410 Lakeside Parkway #100 Flower Mound, TX 75028	20-1962228
Stryker Sales, LLC 1941 Stryker Way Portage, MI 49002	38-2902424
Stryker Sustainability Solutions 1810 West Drake Drive Tempe, AZ 85283	86-0898793
Stryker Performance Solutions LLC	46-1634423
Stryker Customs Brokers, LLC	20-8420912
Stryker Employment Company LLC	83-1484034

Special provisions applicable to eTrauma participants

The following special rules apply to you if you were employed by eTrauma.com Corp. ("eTrauma") at the time it became a Stryker company or are a former participant in the eTrauma.com Corp. 401(k) Retirement Plan (the "eTrauma Plan") whose account balance was transferred to the Plan as of September 30, 2005.

Prior eligibility service credit

You will be credited for eligibility purposes of the Plan with your service with eTrauma, including service credited to you under the eTrauma Plan, as if you had been an employee of the Company when that service was performed.

Accounts

You will have the following additional account in the Plan:

- **eTrauma matching contribution account.** A separate account reflecting your matching contributions to the eTrauma Plan through September 30, 2005, and any other amounts allocable to or chargeable to that account. This account will be subject to the vesting rules described in "Vesting" on page 190.

Total disability

You will be considered to have suffered a total disability for purposes of the Plan if your condition meets either the Plan's definition of "total disability" (see "Vesting" on page 190) or the following definition of "disability" (which is based on the eTrauma Plan).

- "Disability" means that the Participant is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

In-service withdrawals

In addition, your other withdrawal rights under the Plan, you have the following in-service withdrawal rights:

- **Withdrawals after age 59½.** You may request a withdrawal of all or a portion of your eTrauma Matching Contribution Account at any time after you have attained age 59½.

Special provision applicable to PlasmaSol participants

The following special rule applies to you if you were employed by PlasmaSol Corp. ("PlasmaSol") at the time it became a Stryker company.

Prior service credit

You will be credited for all purposes of the Plan with your service with PlasmaSol as if you had been an employee of the Company when that service was performed.

Special provision applicable to Porex Surgical, Inc. participants

The following special rule applies to you if you were employed by Porex Surgical, Inc. or its affiliate ("Porex") and you became an employee of the Company upon Stryker's acquisition of Porex.

Prior service credit

You will be credited for all purposes of the Plan with your service with Porex as if you had been an employee of the Company when that service was performed.

Special provision applicable to Boston Scientific Corporation participants

The following special rule applies to you if you were employed by Boston Scientific Corporation, or its affiliate ("Boston Scientific") and you became an employee of the Company upon Stryker's acquisition of Boston's neurovascular unit.

Prior service credit

You will be credited for all purposes of the Plan with your service with Boston Scientific as if you had been an employee of the Company when that service was performed.

Special Provision applicable to Gaymar Industries, Inc. participants

The following special rule applies to you if you were employed by Gaymar Industries, Inc. ("Gaymar") at the time it became a Stryker company.

Prior service credit

You will be credited for all purposes of the Plan with your service with Gaymar as if you had been an employee of the Company when that service was performed.

Special provisions applicable to divested Biotech participants

The following special rules apply to you if you were employed by Stryker Biotech L.L.C. and ceased to be an employee as a result of the sale of the OP-1 portion of Stryker Biotech L.L.C. (the "OP-1 Divestiture") on the date of the OP-1 Divestiture.

Waiver of certain contribution eligibility requirements

You will be deemed to have satisfied the Plan's eligibility requirements to receive a discretionary contribution and matching contribution for the 2010 Plan Year.

Full vesting

Your discretionary contribution account and matching contribution account will be fully vested and nonforfeitable as of the date you ceased to be an employee.

Acquisitions after September 30, 2012

If you were employed on the acquisition date by a company that Stryker acquires after September 30, 2012, and as a consequence become employed by Stryker at that time, you will be credited for all purposes of the Plan with your service with that acquired company as if you had been an employee of the Company when that service was performed. Special terms may apply to participants who were employed on an acquisition date by a company that Stryker acquired after September 30, 2012. Contact myHR for more information.

401(k) Plan (Sales Reps)

The Stryker Corporation 401(k) Savings and Retirement Plan (the "Plan") gives participants a way to save for their future financial needs.

Important

Effective September 30, 2012, the former Stryker Corporation 401(k) Savings and Retirement Plan for Sales Employees was merged into the Stryker Corporation 401(k) Savings and Retirement Plan (the "Plan").

This summary plan description (SPD) describes the main features of the Plan that apply to Stryker sales employees (different Plan features for employees who are sales employees are described in a separate SPD). As used in this SPD, "sales employee" means an employee who has a classification of "Direct Sales" in the Job Family segment within the Company's or other Participating Employer's human resources management system. If an employee's status changes from a sales employee to a non-sales position or vice versa, the features described in this SPD apply only with respect to the period of employment as a sales employee.

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Overview of the Plan

The Plan is a type of profit-sharing retirement plan known as a "401(k)" plan. This means that you may elect to defer part of your compensation and have the Company contribute the deferred amount to the Plan instead of receiving it in your paychecks. The Company will make matching contributions, as explained in "Contributions to the Plan" on page 185.

Your accounts

Your pay deferrals, Roth pay deferrals, and the Company matching contributions made for you are placed in accounts in your name. Your accounts are invested together with the other participants' accounts in certain investment funds. The investment earnings are allocated to the accounts.

Your benefits

Your benefits from the Plan are the vested amounts in your accounts. When you leave the Company and become eligible for benefit payments, the Trustee will make the payments in the form you choose until you have received the full amount owed to you from your accounts. The amount in your accounts will largely depend on the amount of your deferrals, the amount of matching contributions, and the investment performance of the funds in which you are invested.

Tax deferral

You will not be taxed on the contributions to the Plan (except for contributions that are Roth pay deferrals), or on the investment earnings credited to your accounts, until these amounts are actually distributed to you from your accounts. If you receive a "qualified" distribution from your Roth accounts, as explained in "Tax consequences of Roth distributions" on page 195, you will not be

taxed on the investment earnings credited to your Roth accounts.

Contacting Vanguard

Plan records are administered by The Vanguard Group located in Valley Forge, Pennsylvania. You can access information about the Plan and your accounts (including information on your investment performance, account balance, loan information, current investment elections and your recent activity) by

- Calling Vanguard's VOICE Network automated phone service (at 800 523 1188), which is available 24 hours a day,
- Accessing your account through the Vanguard web site (**www.vanguard.com/retirementplans**), or
- Speaking directly to a Participant Service Associate ("PSA") during business hours (at 800 523 1188).

You can also use any of these methods to make or cancel a pay deferral election or Roth pay deferral election, change your pay deferrals or Roth deferrals, change how your existing account balance is invested, change the investment mix of future contributions or your current account balance, and change your Personal Identification Number.

Eligibility

You will become a participant in the Plan on the date you become an eligible employee of the Company (but not before your 18th birthday).

You are **not** eligible to participate in the Plan if:

- You are a temporary employee (that is, you were hired for a position that is not permanent and is not expected to continue for more than one year), unless and until you complete 1,000 hours of service during the first 12 months of your employment or during any Plan Year thereafter;
- You are a "leased" employee;
- You are a union employee (unless your collective bargaining agreement provides for participation in the Plan);
- You are employed by one of the Company's foreign branches;
- You actively participate in another 401(k) or similar plan to which the Company or an affiliate of the Company contributes;
- You are not on the Company's payroll, or you are classified as an independent contractor (even if an agency or court later determines that your relationship to the Company was that of a common law employee); or
- You actively participate in a non-U.S. retirement plan or government retirement system to which the Company or an affiliate of the Company contributes.

If you terminate employment with the Company after you have become a participant, and you later become reemployed, you will resume participation in the Plan on your reemployment date.

Contributions to the Plan

The Plan has four types of contributions:

- Pay Deferral Contributions
- Roth Pay Deferral Contributions
- Catch-Up Contributions
- Company Matching Contributions

Pay deferral contributions and Roth pay deferral contributions

You may contribute to the Plan by deferring a portion of your compensation as either pay deferral contributions, Roth pay deferral contributions, or a combination of both.

How to make pay deferral contributions or Roth pay deferral contributions

You may elect to defer a portion of your compensation and have the Company contribute your deferred compensation to the Plan on your behalf. When taken on a pre-tax basis, these contributions are called "pay deferrals" and are credited to your "pay deferral account." When taken on an after-tax basis, these contributions are called "Roth pay deferrals" and are credited to your "Roth pay deferral account." Contact Vanguard (see "Contacting Vanguard" on page 185) to make a pay deferral election and/or Roth pay deferral election.

Your pay deferrals and Roth pay deferrals may be any whole percentage up to a combined total of 75% of your compensation during a Plan Year. However, your total pay deferrals plus Roth pay

deferrals may not exceed the dollar limit described in "Dollar Limit," and the Company may limit pay deferrals for highly paid employees to ensure that IRS nondiscrimination tests are met.

Automatic enrollment

If, upon becoming eligible to participate in the Plan, you fail to make an election either to make pay deferral contributions or Roth pay deferral contributions, or to opt out, you will automatically be treated as having made a pay deferral election. Your automatic election will start at 3%* of your compensation and will increase by 1% each year until it reaches 8% (15% if you became eligible to participate in the Plan on or after July 1, 2017). This automatic election will cease to apply, however, if and when you make your own pay deferral election or Roth pay deferral election or elect not to make pay deferral contributions or Roth pay deferral contributions. Amounts contributed to your account under automatic enrollment will **not** be treated as Roth pay deferrals.

* If you enrolled prior to April 1, 2015, your automatic pay deferral elections will start at 2% of your compensation.

Changing, stopping, resuming contributions

You may change your pay deferral (or Roth pay deferral) percentage or stop or resume your pay deferrals (or Roth pay deferrals) at any time by contacting Vanguard (see "Contacting Vanguard" on page 185). Your instructions will be implemented as soon as administratively feasible.

If you think there is a discrepancy between the classification of pay you elected to defer as a pay deferral vs Roth pay deferral and the classification of amounts actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise, you will be deemed to have elected the classification that is actually being contributed.

Discrepancies

If you think there is a discrepancy between the percentage of pay you elected to defer (or the automatic enrollment percentage, if applicable) and the percentage actually being taken out of your compensation, you should report that discrepancy right away, and in any case by the end of the calendar quarter following the quarter in which discrepancy occurred. Otherwise, you will be deemed to have elected the percentage that is actually being contributed.

Benefits of deferring compensation

There are four benefits of deferring compensation under the Plan.

- First, any amounts contributed to the Plan as a result of your pay deferral election are not subject to current income taxes. As a result, your current taxable income will be reduced. Note that this is not true for Roth pay deferral elections because they are taken on an after-tax basis.
- Second, the amount contributed to the Plan as pay deferrals is invested on a tax-deferred basis. This means you will not pay income tax on the investment earnings that are allocated to your accounts. You will pay income taxes only when you receive your benefits from the Plan. As a result, this tax deferral permits a much more rapid accumulation of funds for your retirement. Unlike pay deferrals, however, your Roth pay deferrals will be taxed at the time you contribute them to the Plan, but these contributions and the related earnings will generally not be taxed when you receive a qualified distribution from the Plan. See "Tax consequences of Roth distributions" on page 195 for more information on the tax treatment of distributions of Roth pay deferrals.
- Third, under current provisions of the tax law, you may be ineligible to make deductible contributions to a traditional individual retirement account ("IRA"). Pay deferrals under the Plan allow you to save for retirement on a before-tax basis.
- Fourth, the Company will contribute 50¢ for each $1 that is contributed to the Plan as a result of your pay deferrals and/or Roth pay deferrals (up to a maximum match equal to 4% of your compensation). The portion of your matching contribution that does not exceed 2% of your compensation will be invested in the Stryker Stock Fund. Matching contributions above 2% of compensation will be invested according to your investment election. See "Company matching contributions" on page 188 for a discussion of "matching" contributions.

Example

Here is an example of how these benefits can affect you:

If you earn $30,000 per year and you defer 10% of your compensation as pay deferrals, your total deferral for the year is $3,000. The Company contributes your deferral of $3,000 to the Plan for you, along with a $1,200 matching contribution, of which $600 is invested in the Stryker Stock Fund.

In addition, the $4,200 contribution in your name will reflect any change in value of the investment funds in which your accounts are invested. You will not pay income tax on your $3,000 pay deferral, the $1,200 match, or any change in investment value until you eventually receive the amount in your accounts after terminating employment (or as a hardship withdrawal or other withdrawal).

Dollar limit

Federal law limits the amount of your total pay deferrals (including Roth pay deferrals) in a calendar year to $24,500, subject to adjustments for inflation after 2026 (the "dollar limit").

If your total pay deferrals and Roth pay deferrals under all 401(k) plans or other qualified plans in which you participate during a calendar year exceed the dollar limit for that calendar year (January 1 through December 31), the excess amount of pay deferrals will be included in your taxable income for the year of the deferral. The excess amount will also be taxed again in the year it is distributed to you if it is not withdrawn by April 15 of the following year. To receive a distribution of the excess amount before April 15, your request for distribution must be made to the Plan Administrator by March 1.

The Company will attempt to make sure that your pay deferral contributions and Roth pay deferral contributions to the Plan do not exceed the dollar limit. However, if you participate in another employer's 401(k) plan or a pay deferral simplified employee plan (SEP) during the same calendar year, the dollar limit applies to the total deferral contributions to both plans. Also, if you participate in a tax-sheltered annuity plan of another employer, there is an increased combined limit that applies to deferrals to the Plan and the tax-sheltered annuity. You should monitor your pay deferral contributions and Roth pay deferral contributions so that you do not exceed the dollar limit.

Catch-Up contributions

If you will be at least 50 years old by the end of the Plan Year and you make the maximum amount of pay deferral contributions and Roth pay deferral contributions allowed under the Plan, you are eligible to make "catch-up" contributions in addition to your pay deferral contributions and Roth pay deferral contributions. The law allows up to $8,000 in catch-up contributions. Note if you are age 60 – 63, you are allowed up to $11,250 in catch-up contributions – or 150% of the catch-up limit – whichever is greater. Pay deferral catch-up contributions will be allocated to your pay deferral account, and Roth pay deferral catch-up contributions will be allocated to your Roth pay deferral account.

Company matching contributions

To give you an incentive to defer a portion of your compensation, the Company will make "matching" contributions based upon the amount of your pay deferrals and/or Roth pay deferrals. The Company will contribute 50¢ for each $1 of your pay deferrals and Roth pay deferrals, up to a maximum matching contribution equal to 4% of your compensation.

The matching contributions are made as of the end of each Plan Year. To receive a matching contribution, you must be employed on the last day of the Plan Year and must have at least 1,000 hours of service during the Plan Year. You will also be eligible for a matching contribution if you terminate employment during the Plan Year as a result of your retirement after reaching age 65, total disability, or death.

These matching contributions made for you are credited to your "matching contribution account" as soon as administratively feasible following the end of the Plan Year. The portion of your matching contributions that does not exceed 2% of your compensation will be credited to a "2% subaccount" within your matching contribution account and will be initially invested in the Stryker Stock Fund. Any additional matching contributions are invested in accordance with your election.

Example

Here is an example of how matching contributions work:

If you earn $30,000 per year and you defer 10% of your compensation, your total deferral is $3,000.

Your pay deferrals and/or Roth pay deferrals up to 8% of your compensation ($2,400) qualify for a matching contribution at the rate of 50¢ for each $1 of deferrals, for a total matching contribution of $1,200. Of that total matching contribution, $600 (2% of your compensation) will be invested in the Stryker Stock Fund. The remainder of your matching contribution will be invested in accordance with your election.

Roth in-Plan conversions

You may elect, in accordance with procedures established by the Plan Administrator, to have a portion of your vested Accounts (other than amounts in your Roth pay deferral or Roth rollover accounts) directly transferred to a Roth In-Plan Conversion account. You may elect to make such an in-plan conversion even if the vested amounts are not otherwise distributable to you. The benefit of making a Roth In-Plan Conversion is that the converted amount, along with any earnings on the converted amount, will not be taxed upon your receipt of such amounts in a "qualified" distribution (see "Tax consequences of Roth distributions" on page 195 for information on qualified Roth distributions).

A Roth In-Plan Conversion generally will be treated as a distribution for tax purposes, which means that in the year of the conversion, you will owe ordinary income taxes on any tax-deferred money in your Accounts, and any earnings in your Accounts, which are converted to Roth under the Plan in a Roth In-Plan Conversion.

A Roth In-Plan Conversion will not trigger any early distribution penalty tax (as discussed in "Excise tax on certain early distributions" on page 195), but the penalty may apply later if the converted amount is not held in the designated Roth account for the 5-year period required for Roth distributions to be tax-free.

Roth In-Plan Conversions are not subject to mandatory or optional tax withholdings. Therefore, if you decide to make a Roth In-Plan Conversion, you may need to increase your withholding or make estimated tax payments outside the Plan to avoid any underpayment penalties that may result from the conversion.

If you wish to complete a Roth In-Plan Conversion, contact Vanguard (see "Contacting Vanguard" on page 185).

Important: Because the tax rules on Roth In-Plan Conversions can be complicated, you should consult with your professional tax advisor before deciding whether or not to complete a Roth In-Plan Conversion. Once a Roth In-Plan Conversion is made, it is irrevocable and cannot be undone or re-characterized in any way.

Any amounts transferred to a Roth In-Plan Conversion account will remain subject to any distribution restrictions that were applicable prior to the transfer.

Compensation

The compensation used in calculating the amount of the Company's contributions (including pay deferral contributions and Roth pay deferral contributions) on your behalf consists of the following (unless listed under "Items Excluded"):

- Wages, salary, and other taxable amounts received for services to the Company;
- Commissions and bonuses;
- Pay deferral contributions and Roth pay deferral contributions to this Plan;
- Pay reduction contributions to a "cafeteria" plan or qualified transportation fringe benefit program;
- Differential wage payments (wage amounts paid by the Company during any period in which you are performing active military service for at least 30 days) that would have been paid had you been actively employed by the Company during that period; and
- Unused vacation or sick pay that is paid to you in accordance with the Company's vacation cashout program, even if the payment is made after your termination of employment.

Items excluded

The following items are excluded from compensation for Plan purposes:

- Amounts paid to you before you met the requirements for participating in the Plan;
- Pay reduction amounts or other contributions to a nonqualified deferred compensation plan;
- Distributions from a nonqualified or qualified deferred compensation plan;
- Income from the exercise of a stock option;
- Income from restricted property that becomes taxable under Section 83 of the Internal Revenue Code when the restrictions lapse;

- Income realized on the sale of stock acquired under a statutory stock option;
- Amounts subject to special tax benefits which are not includible in income;
- Reimbursements or other expense allowances, fringe benefits, moving expenses, deferred compensation, and welfare benefits; and
- Severance pay.

Federal law requires the Plan to limit to $360,000 the amount of an employee's compensation during a Plan Year that may be used in figuring the amount of contributions on behalf of an employee under the Plan for the Plan Year. The IRS may increase the $360,000 limit in future years for inflation.

Rollovers

The Plan includes rollover provisions, as follows.

Rollovers from eligible employer plans

If you receive an "eligible rollover distribution" from an eligible retirement plan of a prior employer, you may be eligible to roll over that distribution to the Plan. An eligible retirement plan means any of the following types of plans:

- A qualified defined contribution or defined benefit plan (other than non-Roth after-tax contributions);
- A Section 403(b) tax-sheltered annuity (other than Roth or other after-tax contributions); or
- A Section 457 plan maintained by a governmental employer.

Such a distribution may be rolled over in either of two ways. The distribution may either be paid directly to the Plan by the other plan in a "direct rollover," or the other plan may pay the distribution to you (subject to any applicable withholding tax), and you will have 60 days after you receive it to contribute it to the Plan.

If you wish to make a rollover into the separate after-tax Roth rollover account, the funds must come from another Roth elective deferral account under another tax-qualified retirement plan.

Rollovers from IRAs

You may also roll over to the Plan the portion of a distribution from a Section 408 individual retirement account or annuity (IRA) that would otherwise be taxable to you and that is eligible to be rolled over.

More information regarding rollovers is available from Vanguard. Any amount you roll over is placed in your "rollover account."

Vesting

The term "vested" refers to the amount in your accounts that cannot be taken away from you regardless of the reason or time that you leave the Company.

Vested interest in your accounts

The following rules are used to determine if you are "vested":

- Amounts in your pay deferral account, Roth pay deferral account, rollover account and Roth rollover account are always 100% vested.
- Amounts in your matching contribution account are 100% vested if you attain age 65, become totally disabled, or die while employed by the Company.

  You are "totally disabled" if you have a mental or physical condition that makes you eligible to receive Social Security disability benefits. However, total disability does not include disability resulting from:

  - Military service
  - Criminal activity
  - Alcoholism
  - Drug abuse
  - Intentional self-inflicted injury
- Amounts in your matching contribution account are 100% vested if you have at least five "years of vested service."

If you leave the Company (for a reason other than retirement after age 65, total disability, or death) before completing five "years of vested service," all or a portion of the amounts in your matching contribution account will be forfeited. You will receive only your vested percentage of your

matching contribution account. Your vested percentage is determined as follows:

Years of Vested Service	Vested percentage
Less than 2	0%
2	20%
3	40%
4	60%
5 or more	100%

Year of Vested Service

You will receive a "year of vested service" for each Plan Year in which you are credited with at least 1,000 hours of service. The Company does not keep a record of individual hours worked by salaried employees. Salaried employees are credited with 45 hours of service for each week during which the employee would otherwise be credited with an hour of service.

Forfeitures

The portion of your matching contribution account in which you are not vested is "forfeited." The forfeiture will occur on the date you receive a distribution of your vested benefits (or the end of the Plan Year in which you have five consecutive breaks in service, if earlier). Any forfeitures from your accounts will be used to pay Plan expenses or to reduce the amount of the Company's contributions.

Vesting rules upon reemployment

If you leave the Company and are later reemployed by the Company, the following rules apply to you:

- For information on your eligibility to join the plan after you are rehired, see "Eligibility" on page 185.
- Your former years of vested service will be restored if your Plan account was partially or fully vested before you terminated employment or if you have fewer than five consecutive vesting breaks in service. You must perform a year of vested service after being reemployed in order for your prior service to be credited.
- The amount you forfeited will be restored if you have fewer than five consecutive vesting breaks in service and you repay the vested amount previously distributed to you (if any) within five years after being reemployed.
- If you have five or more consecutive vesting breaks in service and you left the vested portion of the matching contribution account in the Plan, when you are reemployed, you will have two subaccounts. The first subaccount, consisting of the vested portion of the matching contribution account, will be 100% vested. The second subaccount, consisting of amounts added to the matching contribution account after you are rehired, will vest under the Plan's normal vesting schedule, based on your years of vested service after the break in service plus your years of vested service before the break in service that are restored under the above rules.

Vesting breaks in service

A "vesting break in service" is a Plan Year during which you have not completed more than 500 hours of service. Solely for determining whether a vesting break in service has occurred, if you are absent from work for maternity or paternity reasons you will receive credit for hours of service (but not more than 501) that would have been credited except for the absence. An absence from work for maternity or paternity reasons means an absence caused by pregnancy or childbirth, placement or adoption of a child, or child care immediately following birth or adoption.

If you have performed at least 500 hours of service in the Plan Year in which your absence for maternity or paternity reasons begins, then solely for purposes of preventing a break in service for the Plan Year subsequent to the Plan Year in which such leave begins, you will receive service credit of up to 500 hours for your absence during that Plan Year.

For example, if you take maternity leave in October and have more than 500 hours of service, there is no break in service that year. In addition, in order to avoid a break in service the following year, you will be credited with up to 500 hours of service.

Plan investments

The Plan offers you a choice of funds to invest the money in your accounts.

Investment of your accounts

You may direct the investment of contributions to your accounts in different investment funds made available by the Trustee. Information regarding these funds, including prospectuses, may be obtained by contacting Vanguard (see "Contacting Vanguard" on page 185).

If you do not make an investment election, contributions to your accounts (other than the 2% subaccount that is invested in the Stryker Stock Fund) will be invested in the age-appropriate Vanguard Target Retirement fund.

You may change your investment election at any time by contacting Vanguard (see "Contacting Vanguard" on page 185). Your change in investment election may apply to future contributions, amounts already invested, or both.

Amounts in the Roth In-Plan Conversion account may not be invested in the Stryker Stock Fund.

You may transfer at any time all or a portion of your 2% subaccount that is invested in the Stryker Stock Fund to any of the other investment funds available under the Plan, and all or a portion of your 2% subaccount that is invested in other investment funds back into the Stryker Stock Fund. However, you may not transfer any portion of your accounts other than the 2% subaccount into the Stryker Stock Fund.

The Plan is intended to meet the requirement of ERISA Section 404(c) and its regulations. Under these rules, plan fiduciaries may be relieved of liability for losses that are a direct and necessary result of participants' and beneficiaries' investment instructions.

Valuation and adjustment of your accounts

The Trustee will calculate the value of your accounts as of each business day ("valuation date"). The value of your accounts is the total of your investments in the Stryker Stock Fund and each of the other investment funds. Other than the various types of contributions that are credited to your accounts, the following events will also change the value of your accounts:

- **Distributions.** If you receive a distribution or withdrawal, the account or accounts from which it is made are reduced by the amount of the distribution.
- **Investment results.** As of each valuation date, the Trustee will calculate the value of the investment funds. You should note that the value may increase or decrease, and your accounts will be adjusted accordingly. You will receive a quarterly statement that will state both the value of your interest in each investment fund and the total value of your accounts.
- **Expenses.** Investment management fees are paid by the investment funds to which they relate. In addition, accounts are charged with their share of Plan administration expenses that are paid by the Plan. Administrative expenses deducted from your accounts will appear on your quarterly statements.
- **Loans.** If you receive a loan, the account or accounts from which it is made will be reduced by the amount of the loan. Your account or accounts will be increased as you make payments of principal and interest on the loan.
- **Forfeitures.** If you resign or are dismissed before you are fully vested, you will not receive the full amount in your accounts. The portion of your accounts in which you are not vested is "forfeited" and used to reduce the Company's matching contributions.

When your active participation in the Plan ends, you will no longer share in the Company's matching contributions. However, as long as you have not yet received the full amount in your accounts, your accounts will still be adjusted for expenses, investment earnings, gains and losses as well as for distributions.

Distributions from the Plan

This section describes when you may receive a distribution from the Plan.

When benefits are distributed

You may request payment of your benefits at any time after you stop working for the Company, after you reach age 65 (even if you are still working), or upon total disability. Once you retire, federal law requires that your benefit payments

begin no later than the April 1 after the calendar year in which you attain age 72 (age 73 if you were born after December 31, 1950), or the April 1 after the calendar year in which you retire, if later.

Severance from employment for a reason other than death

You are entitled to the vested amount in your accounts if you leave the Company for any reason. (See "Vesting" on page 190 for more information.)

If your vested account balance (other than your rollover account and any money attributable to the Plan's pre-1988 money purchase plan feature) exceeds $5,000, you have the option of requesting a distribution of benefits or maintaining your accounts in the Plan. Your benefits will be paid as soon as administratively feasible after you request the distribution.

If your vested account balance (other than your rollover account) does not exceed $5,000, you do not have the option of maintaining your accounts in the Plan. Your benefits will be distributed to you in a lump sum payment (subject to the Automatic Rollover discussed below) as soon as administratively feasible following your severance from employment.

Whether or not your vested account balance exceeds $5,000, you may elect to have your lump sum distribution transferred to an eligible retirement plan in a "direct rollover."

Automatic rollovers

If the value of your account exceeds $1,000 but does not exceed $5,000, and after receiving all required notices you do not affirmatively elect to receive your distribution directly or to have it rolled over, the vested amount in your accounts will be automatically rolled over by the Plan to an IRA with The Vanguard Group. Your account will be automatically invested in Vanguard Prime Money Market Fund, a fund designed to preserve principal, provide a reasonable rate of return, and maintain liquidity. You will be responsible for paying all fees and expenses assessed against your automatic rollover IRA. The fees and expenses will be comparable to the fees and expenses charged by Vanguard for other IRAs. For additional information on the Plan's automatic rollover rules, a Vanguard IRA, and the fees and expenses associated with a Vanguard IRA, call Vanguard at 800 523 1188.

If you receive a distribution before age 59½, the distribution may be subject to a 10% excise tax in addition to being considered taxable income in the year it is distributed to you.

Forms of distribution of benefits

If your vested account balance (other than your rollover account) exceeds $5,000, you may elect whichever of the following forms of payment you prefer:

- **A lump sum payment.** This payment will be made in cash, unless you elect to receive shares of stock for your vested 2% subaccount invested in the Stryker Stock Fund, provided that such vested portion is at least $1,000 in value (see "Election to receive distribution of Stryker stock" on page 195 for details on this election).
- **Cash payments** in roughly equal annual, quarterly, or monthly installments for a specific number of years. The specific number of years for which the payments will last cannot exceed either your life expectancy or the joint life expectancy of you and your beneficiary.
- **A combination** of a single sum cash payment and cash payments in roughly equal annual, quarterly or monthly installments.
- **A partial distribution** (of at least $500) from your vested account. (Limited to one per calendar quarter.)

Automatic forms of distribution for participants with Pre-1988 benefits

The Plan provides automatic forms of distribution for certain participants with "Pre-1988 Benefits" as described below. A "Pre-1988 Benefit" means the amount of your account balance attributable to the value of your account on December 31, 1987, as determined under the terms of the Plan in effect on December 31, 1987.

If you have a Pre-1988 Benefit, the plan provides for the following "automatic" forms of distribution of your vested account balance unless you elect an alternative form of payment:

- **Married participants.** If you are married when your benefits begin, your vested benefits will be used to purchase a "joint and survivor annuity" that pays a monthly benefit to you for your life, and after your death, a 50% monthly benefit to your surviving spouse for his or her

life (for example, monthly payments of $1,500 during your lifetime, and, if your spouse survives you, monthly payments of $750 for the rest of your surviving spouse's life). Please note that under a joint and survivor annuity:

  - If your spouse dies before you, your monthly payments will continue at their previous level ($1,500 in the above example).
  - If your spouse survives you, your spouse does not have the option of converting the survivor benefit ($750 per month in the above example) to any other form of payment such as a lump sum.

- **Unmarried participants.** If you are unmarried when benefits begin, the vested amount in your accounts will be used to purchase a "single life annuity," that is, an annuity that pays a monthly benefit to you for your life. No benefits are paid after your death.

The Plan will purchase your single life annuity or joint and survivor annuity from an insurance company using the vested Pre-1988 Benefit amount in your accounts. The amount of the monthly benefit paid under the annuity will depend on market conditions for annuity contracts at the time payments under the annuity begin. The monthly benefit will also depend on your age and (in the case of a joint and survivor annuity) your spouse's age.

Waiving the automatic form

If you have a Pre-1988 Benefit, you may waive the "automatic" form of distribution and elect one of the alternative forms of benefit payment described below in "Alternative Forms of Distribution." This waiver cannot be made more than 90 days before your benefits begin, and, if you are married, your election of an alternative form is effective only if your spouse consents in writing to the waiver of the joint and survivor annuity within that 90-day period. Your spouse's consent must be witnessed by a Plan representative or by a notary public.

Alternative forms of distribution

If you (and your spouse, if you are married) waive the automatic form of payment, you may elect the alternative form of payment you prefer. The alternative forms of payment are as follows:

- **A lump sum payment.** This payment will be made in cash, unless you elect to receive shares of stock for your vested 2% subaccount invested in the Stryker Stock Fund, provided that such vested portion is at least $1,000 in value (see "Election to receive distribution of Stryker stock" on page 195 for details on this election).
- **Cash payments** in roughly equal annual, quarterly, or monthly installments for a specific number of years. The specific number of years for which the payments will last cannot exceed either your life expectancy or the joint life expectancy of you and your beneficiary.
- **A combination** of a single sum cash payment and cash payments in roughly equal annual, quarterly or monthly installments.
- **A partial distribution** (of at least $500) from your vested account. (Limited to one per calendar quarter.)
- **If you are married,** a single life annuity immediately payable over your life.

If you elect installments, you may at any time elect to shorten the period over which the installments are being paid or receive a lump-sum distribution of your remaining balance.

Distribution of benefits upon death

Death before receiving benefits

If you have a Pre-1988 Benefit and you die before you have begun receiving your benefits, the amount in your accounts will be distributed to your designated beneficiary under one of the following methods:

- **Annuity.** If you are married, under the first method of payment the Trustee will use the amount in your accounts to purchase (from an insurance company) a preretirement survivor annuity for your surviving spouse. The annuity will pay a monthly benefit to your spouse until his or her death. The amount of the monthly benefit paid under the annuity will depend on market conditions for annuity contracts at the time the annuity contract is purchased. This form of death benefit is automatic unless you and your spouse waive it.
- **Waiver of annuity form.** You may waive the annuity form of death benefit any time after the beginning of the Plan Year in which you reach age 35. In order for your waiver to be valid, it must also be signed by your spouse. Your spouse's signature must be witnessed by

a Plan representative or by a notary public. You may revoke this waiver at any time.

- In addition, your spouse may waive the annuity form of death benefit after your death. In that case, your spouse would receive the amount in your accounts in the form elected in writing by your spouse from the optional methods of payment described above.

If you and your spouse waive the annuity form of death benefit, or if you are not married at the time of your death, the beneficiary you have named will receive the type of death benefit described in "Payments to beneficiary" on page 214**.** You may appoint one or more beneficiaries by completing and submitting a beneficiary designation form online via the Vanguard website. You may change your beneficiary at any time before your death by completing and submitting a new beneficiary designation online via the Vanguard website. If you have not named a beneficiary or your beneficiary predeceases you, payment will be made to your surviving spouse, if any. If you have not named a beneficiary or your beneficiary predeceases you, and you do not have a surviving spouse at the time of your death, payment will be made to your estate.

If you have more than one beneficiary and a beneficiary dies before benefit payments are completed, the share payable to the deceased beneficiary will be paid to the beneficiaries who are still living in proportion to the shares otherwise payable to the living beneficiaries.

To be entitled to receive any undistributed vested portion of your accounts, any person or persons designated as a beneficiary must be alive and any entity designated as a beneficiary must be in existence at the time of your death. If the order of the deaths of you and your primary beneficiary cannot be determined or have occurred within 120 hours of each other, you will be deemed to have survived your beneficiary.

If you designate your spouse as your beneficiary and later become divorced, that designation will be deemed revoked, effective as of the date the Plan Administrator receives evidence of the divorce and will no longer be valid. However, if you wish to keep your former spouse as your beneficiary, you may re-designate your former spouse as a non-spouse beneficiary after your divorce is finalized.

If your death, or the death of your beneficiary, is the result of a formally charged criminal act involving any other beneficiary, any claim involving the charged beneficiary will be suspended, and any distribution to such beneficiary will be held, until the resolution of the criminal charge. If the beneficiary is convicted of this criminal act, the beneficiary may not receive any undistributed amounts from your vested account balance.

Inherited accounts opened for minor beneficiaries will be controlled by the minor's authorized representative. The authorized representative must demonstrate to the Plan Administrator's satisfaction to be authorized to act on behalf of the minor.

Payments to beneficiary

Under the alternative method of payment, the Trustee will pay the amount in your accounts to the beneficiary you have named if either:

- You have no surviving spouse; or
- You have a Pre-1988 Benefit and you and your spouse waive the annuity form of death benefit.

The distribution will be made in the form (lump sum, installments, etc.) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described above.

If you die before you have begun receiving your benefits, the Trustee will pay your vested account balance to your beneficiary in the form (lump sum, installments, or a combination) that you elected in writing before your death. If you made no written election, the form of distribution will be elected by your beneficiary in writing from the optional methods of payment described above.

Payments to your surviving spouse are required to begin by December 31 of the year following the year of your death or by December 31 of the year in which you would have attained age 72 (or age 73 if you were born after December 31, 1950), if later. Payments to an "eligible" designated beneficiary other than your spouse are required to begin by December 31 of the year following the year of your death unless you or your beneficiary elects by December 31 of the year following the year of your death to apply the "ten-year rule." If the ten-year rule is elected, your entire vested account balance must be distributed no later than December 31 of the year containing the tenth anniversary of your death. An "eligible" designated

beneficiary is generally your spouse, your child under age 21, a disabled or chronically ill individual, or any other individual who is not more than 10 years younger than you. Generally, payments to a designated beneficiary who is not an "eligible" designated beneficiary must be completed no later than the end of the calendar year that includes the tenth anniversary of your death.

Death while receiving benefits

If you die while receiving your benefits in the form of installment payments, payments will continue to your beneficiary according to the same schedule of installment payments until the amount in your accounts has been completely distributed. Your beneficiary may instead choose to receive the remaining benefits in a lump sum payment.

Income tax withholding/direct rollovers

Direct rollovers

Distributions and withdrawals from the Plan are generally "eligible rollover distributions." This means that all or a portion of the distributions can be rolled over in a "direct rollover" to an eligible retirement plan (which may be a qualified plan, a Section 408 individual retirement account or annuity (IRA), a Section 403(a) annuity, a Section 403(b) tax-sheltered annuity, a Section 457 governmental plan, or a Roth IRA) that accepts rollovers. If you choose a direct rollover, the Plan will issue a check directly to the eligible retirement plan, and you will not be taxed until you later take it out of the eligible retirement plan (unless the direct rollover is to a Roth IRA, in which case you will be taxed at the time of the rollover).

If you are making a rollover from your Roth pay deferral account or Roth rollover account, the rollover may be made to another Roth account under a tax-qualified retirement plan or to a Roth IRA.

Required withholding

If you receive an eligible rollover distribution from the Plan and do not choose a direct rollover, the Plan is required by law to withhold Federal income taxes of 20% of that amount. The amount of the distribution will be subject to tax in that year unless, within 60 days, you roll it over to an eligible retirement plan that accepts rollovers.

Other distributions

A distribution or withdrawal from the Plan is not an eligible rollover distribution, and is not subject to the above rules, if:

- It is paid in the form of a joint and survivor annuity or single life annuity;
- It is paid in installments over a period of 10 years or more;
- It is paid in installments over your life expectancy (or joint life expectancy of you and your beneficiary); or
- It is a hardship withdrawal.

In addition, beginning in the year you reach 72 (age 73 if you were born after December 31, 1950) or retire (whichever is later), a certain portion of your payment cannot be rolled over because it is a "required minimum payment" that must be paid to you.

A payment from the Plan that is not an eligible rollover distribution is not subject to the direct rollover and mandatory withholding rules described above. If any portion of your distribution is not an eligible rollover distribution, you may elect not to have withholding apply to that portion.

Excise tax on certain early distributions

All distributions from the Plan (other than those from your Roth pay deferral account, Roth rollover account, and Roth In-Plan Conversion account) that are not rolled over to an IRA or another plan are taxable income. Further, if you receive a distribution from the Plan before age 59½, federal law imposes an excise tax equal to 10% of the amount of the distribution in addition to regular income tax. The

More information

Before receiving a distribution from the Plan, you will receive a Special Notice Regarding Plan Payments that provides more detailed information regarding the above rules as well as special tax rules that may apply.

10% excise tax is imposed unless one of the following exceptions applies:

- The distribution is made as a result of your termination of employment during or after the year you attain age 55;
- The distribution is made as a result of your death or disability;
- The distribution does not exceed your deductible medical expenses (medical expenses which exceed 7.5% of your adjusted gross income);
- The distribution is made under a qualified domestic relations order;
- The distribution consists of excess pay deferral amounts; or
- The distribution is part of a series of substantially equal payments over your life expectancy or over the joint life expectancy of you and your spouse.

Tax consequences of Roth distributions

When you or your beneficiary receives distributions from your Roth pay deferral account, you will generally not owe income taxes on the contributions or the earnings, to the extent that the distribution is "qualified." A Roth pay deferral distribution is qualified if it is made after a five-tax-year period of participation and is made on or after the date on which you attain age 59½, die, or become disabled. Your five-tax-year period of participation begins on the first day of your tax year for which you first elected to make Roth pay deferrals to the Plan or a Roth In-Plan Conversion, and ends when five consecutive tax years have been completed (but also may include certain periods attributable to amounts rolled over to your Roth pay deferral account). The Plan administrator will keep track of your five-tax-year period of participation, and you can find information about whether you have met the requirement by contacting Vanguard (see "Contacting Vanguard" on page 185 for more information).

Election to receive distribution of Stryker stock

If you take a lump sum distribution from the Plan you may elect to have your vested 2% subaccount that is invested in the Stryker Stock Fund distributed in shares of stock instead of in cash. To qualify for the election, the value of the Stryker common stock in your vested 2% subaccount must be at least $1,000. Fractional shares of Stryker common stock, and the part of your vested 2% subaccount that is not invested in Stryker common stock, will be distributed in cash. Hardship withdrawals and withdrawals after age 59½ while you are still an employee do not qualify for the election.

Special tax rule for net unrealized appreciation

If you make the election to receive shares of Stryker common stock as part of your lump sum distribution, you may have the option of not paying tax on the "net unrealized appreciation" of the stock until you sell it. Net unrealized appreciation generally is the increase in the value of the Stryker common stock while it was held by the Plan. If, for example, Stryker common stock was contributed to your account when it was worth $1,000, but the stock is worth $1,200 when you receive it, you would not have to pay tax on the $200 increase in value until you later sell the stock.

Opting out of the special tax rule

You may instead elect not to use the special net unrealized appreciation rule. In that case the net unrealized appreciation will be taxed in the year you receive the stock unless you roll over the stock.

Effect on withholding

If you receive a distribution of both cash and Stryker common stock in a payment that can be rolled over, the 20% withholding will be based on the entire taxable amount paid to you (including the value of the Stryker common stock determined by excluding the net unrealized appreciation). However, the amount withheld will be taken from (and limited to) the cash part of the distribution.

More information

Before receiving a distribution from the Plan, you will receive a Special Notice Regarding Plan Payments that provides more detailed information regarding the above rules as well as special tax rules that may apply.

Loans and withdrawals

The following describes situations when you may be allowed to request a loan or distribution from your Plan account.

Loans

Prior to May 1, 2025, hardship loans (to alleviate demonstrated financial hardship) were offered under the Plan. Effective May 1, 2025, the Plan has been amended to offer general-purpose loans to participants.

Eligibility

To qualify for a loan, you must be an active employee of the Company or an affiliate of the Company.

Minimum amount

The minimum amount you may borrow is $1,000.

Maximum amount

The maximum amount you may borrow is whichever of following amounts is the smallest:

- The sum of the balances in your pay deferral account, Roth pay deferral account, rollover account, and your Roth rollover account
- One-half your vested account balance
- $50,000 (reduced, if you have had a loan outstanding at any time during the past 12 months, by the highest balance of that loan during that 12-month period)

Number of loans

You may not have more than one loan outstanding at any time. Not more than one loan will be approved in any 12-month period.

Collateral

Your loan will be secured by 50% of your vested account balance (measured as of the time you take out the loan).

Interest

The interest rate charged on your loan will be one percentage point above the prime rate in effect on the first business day of the month in which you apply for the loan.

Repayments

The maximum period of repayment for any loan is 54 months. In the case of a hardship loan taken before May 1, 2025, if the loan is for the purpose of paying the costs (excluding mortgage payments) directly related to the purchase of your principal residence, the maximum period of repayment is 174 months. A loan account will be set up in your name under the Plan. Your repayments of principal on the loan, together with interest, are made through payroll deductions. The amount of each principal repayment reduces the amount in your loan account and is invested, along with the interest you pay, in the Plan's investment funds in accordance with your investment election for new Plan contributions.

The amount of your loan may be prepaid in full at any time without penalty. Partial prepayments are not allowed.

If your employment terminates, any outstanding balance on your loan will become due and payable, unless you elect to continue making the required installment payments as permitted under loan procedures adopted by the Plan Administrator. If your loan is not repaid by the earlier of:

- the end of the calendar quarter following the calendar quarter in which your employment termination occurs,
- the end of the calendar quarter following the calendar quarter in which your most recent unpaid payment was due, or
- the valuation date used to determine the amount of your distribution from the Plan.

Your vested account will be used to repay your loan, unless you elect to continue making the required installment payments following your termination from employment.

If a loan is not repaid in accordance with the terms of the promissory note and there is a default, the Plan may use your vested account to repay your loan. (However, amounts in your pay deferral account or Roth pay deferral account will not be used for this purpose until the time they could otherwise be distributed to you.)

Processing charge

You may be charged a processing fee for the cost of processing your loan as well as an annual loan maintenance fee.

Hardship withdrawals

If you have a "hardship," you may be eligible to receive a hardship withdrawal from the Plan. Additional information on hardship withdrawals will be provided at the time you request a withdrawal application. A "hardship" is defined as an immediate and heavy need resulting from one of the following:

- Expenses for medical care for you, your spouse, or your dependents;
- Costs (excluding mortgage payments) directly related to the purchase of your principal residence;
- Payment of tuition, related educational fees, and room and board expenses for up to the next 12 months of post-secondary education for you or your spouse, children or dependents;
- Payments necessary to prevent eviction from your principal residence or to prevent foreclosure on the mortgage on your principal residence;
- Payments for burial or funeral expenses for your deceased spouse, parent, children or dependents;
- Expenses (of the type that would qualify for a casualty loss tax deduction) for the repair of damage to your principal residence; or.
- Expenses or losses you incur because of a federally-declared disaster if you live or work in the disaster area.

Eligibility

To qualify for a hardship withdrawal, you must be an employee of the Company or an affiliate of the Company.

Hardship proof and certification

You must demonstrate that a hardship (as defined above) exists, and that your hardship cannot reasonably be relieved by any of the following actions (except to the extent those actions would increase the amount of your need):

- Reimbursement or compensation through insurance or otherwise
- Liquidation of your assets
- Discontinuing your pay deferrals and Roth pay deferrals
- Plan distributions (or distributions from other plans)
- Borrowing from commercial sources on reasonable commercial terms

Amount available

The maximum amount you may receive as a hardship withdrawal is whichever of the following amounts is the smallest:

- The sum of the balances in your pay deferral account, Roth pay deferral account, rollover account, and Roth rollover account
- The amount which you certify is necessary to relieve your hardship (including any amounts necessary to pay any Federal, state, or local income tax or penalties expected to result from the hardship withdrawal)

Frequency limit

You may make only one hardship withdrawal during any 12-month period.

Annuity waiver

If you have a Pre-1988 Benefit (defined in "Automatic forms of distribution for participants with Pre-1988 benefits" on page 212), to obtain a hardship withdrawal you must waive the joint and survivor form of distribution for the amount to be withdrawn and, if you are married, obtain your spouse's written consent (witnessed by a Plan representative or notary public) to the withdrawal.

Qualified reservist distributions

If you are a uniformed services participant in the Plan, you may request an in-service distribution from your pay deferral account, or Roth pay deferral account, or from any Roth contribution subaccount of an account transferred to the Plan on your behalf as part of an acquisition. This distribution will not be subject to the otherwise applicable 10% excise tax if (i) you are a member of a reserve component who is ordered or called to active duty for either an indefinite period or a period in excess of 179 days and (ii) the distribution is made during the period beginning on the date of your order or call to active duty and ending at the close of the active duty period.

Withdrawals after age 59½

You may request a withdrawal of all or part of your pay deferral account or Roth pay deferral account at any time after you reach age 59½. To receive a single-sum cash withdrawal, you must waive the joint and survivor form of distribution for the withdrawn amount and, if you are married, obtain your spouse's written consent (witnessed by a Plan representative or notary public) to the withdrawal.

Rollover account withdrawals

You may request a withdrawal of all or part of your rollover account or Roth rollover account at any time. To receive a single-sum cash withdrawal, you must waive the joint and survivor form of distribution for the withdrawn amount and, if you are married, obtain your spouse's written consent (witnessed by a Plan representative or notary public) to the withdrawal.

CARES Act

The Coronavirus Aid, Relief and Economic Security Act (the "CARES Act") provided temporary additional loan and/or withdrawal options to certain qualified participants. If you have questions about any of the relief previously available under the CARES Act, including questions about the repayment of a CARES Act distribution, you should contact Vanguard (see "Contacting Vanguard" on page 185).

Other important Plan information

The following describes additional information you should know about the Plan.

Top-heavy status of the Plan

Federal law imposes certain requirements on "top-heavy" plans. The Plan is top-heavy if more than 60% of the balance in all accounts belongs to certain officers and shareholders of the Company. The Plan is not top-heavy and is not likely to become top-heavy.

If the Plan is top-heavy at the end of the Plan Year, a minimum contribution may be required to the Plan. You will be notified if the Plan is top-heavy, and this new requirement applies.

Distributions under Qualified Domestic Relations Orders

Generally, plan benefits may be paid only to you or possibly your beneficiaries or survivors. However, an exception to this may be made as a result of a qualified domestic relations order.

A domestic relations order is a court-ordered payment of benefits in connection with a support order, divorce, legal separation, or custody case. This means the Plan may be obligated to pay part of your account to someone else — for example, your former spouse, children or other dependents — to comply with such an order.

There are specific legal requirements a domestic relations order must meet to be recognized by the Plan Administrator. If you are affected by such an order, you will be notified by the Plan Administrator. You may obtain from the Plan Administrator, without charge, a copy of the procedures applicable to domestic relations orders.

Benefits are not insured

The benefit provisions under the Plan are not covered by the Pension Benefit Guaranty Corporation insurance provisions, because the benefits are determined solely by the amount in your accounts.

Claims and appeals

If you disagree about a benefit, the Plan allows you to file a written application for review of the issue with the Plan Administrator.

If a claim for benefits is denied in whole or in part, the Plan Administrator will give you written notice within 90 days after the Plan Administrator receives your claim, unless special circumstances outside the control of the Plan Administrator require an extension of the time limit. (The Plan Administrator will notify you of the need and reasons for any such extension, and the date by which the Plan expects to render a decision, before the end of the 90-day period.) The written notice will set forth:

- The specific reasons for denial of the claim;
- Reference to the particular provisions of the Plan on which denial of the claim is based;
- A statement as to any additional facts or information necessary to perfect the claim and

an explanation as to why the same is required; and

- A reference to the procedures (described below) for review of the denial of the claim, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial of a claim.

If your claim for benefits under the Plan is denied in whole or in part by the Plan Administrator, you have the right to request a review of such denial. The review will be granted upon written request, filed by you with the Plan Administrator within 60 days following receipt of written notice of the denial. A full and fair review will be conducted by the Company's Retirement Plan Committee. You will be permitted to submit written comments, records and other information relating to the claim and provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. The Retirement Plan Committee will consider all comments, documents and other information you submitted, without regard to whether that information was submitted or considered in the initial determination.

At any hearing by the Retirement Plan Committee, you will have reasonable notice and an opportunity to be present and be heard in person or by a duly authorized representative. The Retirement Plan Committee will decide the matter with reasonable promptness and in any event within 60 days following receipt of a request for review unless special circumstances exist which require an extension of such time limit. The Retirement Plan Committee will notify you of the need and reasons for such extension, and the date by which the Plan expects to render a decision, prior to the end of the 60-day period. Its decision will be provided to you in writing and will set forth its reasons for the decision; the provisions of the Plan on which the decision is based; a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The above appeal procedure applies not only to you but also to a beneficiary or other person who disagrees about a benefit.

If you wish to bring a civil action against the Plan following a denial of your claim on appeal, you must do so within one year of the Retirement Plan Committee's final decision on your claim.

Termination or amendment of the Plan

Although the Company intends to continue the Plan from year to year, it reserves the right to amend or terminate the Plan at any time. However, because the Plan was established for the exclusive benefit of the Company's employees and their beneficiaries, termination or amendment cannot subtract from your accounts as they exist when the amendment or termination occurs.

If the Plan is terminated, you will have a 100% vested right to your accounts regardless of your years of vested service. After paying the expenses of terminating the Plan, the remaining amounts in the Plan will be distributed to you and the other participants in lump sum payments.

Your rights as a participant

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants are entitled to:

Receive information about your Plan and benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plan (the Plan document and trust agreement), and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator 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 all documents governing the operation of the Plan (the Plan document and trust agreement), and copies of the latest annual report (Form 5500 Series) and updated summary plan description (The Plan Administrator will 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.)

Prudent actions by Plan fiduciaries

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

Enforce your rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a 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 (these rights are described in "Claims and appeals" on page 198 of this summary plan description).

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 Plan Administrator. If you have a claim for benefits which 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, 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. Any suit must be files within the time frames discussed in the "Claims and appeals" section on page 198.

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.

Additional information

Name of Plan

Stryker Corporation 401(k) Savings and Retirement Plan

Name, address and telephone number of the Company

Stryker Corporation
1941 Stryker Way
Portage, MI 49002
269 389 2600

Company's identification number

38-1239739

Plan number

002

Type of plan

Section 401(k) Plan

Type of administration

Self-Administered

Plan Administrator

Stryker Corporation is the Plan Administrator.

Name and address of Agent for Service of Legal Process

Stryker Corporation
1941 Stryker Way
Portage, MI 49002

Service of legal process may also be made on the Plan Administrator or the Trustee.

Name and address of Trustee

Vanguard Fiduciary Trust Company
Vanguard Financial Center
P.O. Box 2900
Valley Forge, PA 19482

Plan year

January 1 through December 31

Names and employer identification numbers of participating employers

Company	Emp. Id. No.
Stryker Corporation 1941 Stryker Way Portage, MI 49002	38-1239739
Howmedica Osteonics Corp 325 Corporate Drive Mahwah, NJ 07430	22-2183590
Stryker Communications Inc. 1410 Lakeside Parkway #100 Flower Mound, TX 75028	20-1962228
Stryker Sales, LLC 1941 Stryker Way Portage, MI 49002	38-2902424
Stryker Sustainability Solutions 1810 West Drake Drive Tempe, AZ 85283	86-0898793
Stryker Performance Solutions LLC	46-1634423
Stryker Customs Brokers, LLC	20-8420912
Stryker Employment Company LLC	83-1484034

Special provisions applicable to eTrauma participants

The following special rules apply to you if you were employed by eTrauma.com Corp. ("eTrauma") at the time it became a Stryker company or are a former participant in the eTrauma.com Corp. 401(k) Retirement Plan (the "eTrauma Plan") whose account balance was transferred to the Plan as of September 30, 2005.

Prior eligibility service credit

You will be credited for eligibility purposes of the Plan with your service with eTrauma, including service credited to you under the eTrauma Plan, as if you had been an employee of the Company when that service was performed.

Accounts

You will have the following additional account in the Plan:

- **eTrauma matching contribution account.** A separate account reflecting your matching contributions to the eTrauma Plan through September 30, 2005, and any other amounts allocable to or chargeable to that account. This account will be subject to the vesting rules described in "Vesting" on page 190.

Total disability

You will be considered to have suffered a total disability for purposes of the Plan if your condition meets either the Plan's definition of "total disability" (see "Vesting" on page 190) or the following definition of "disability" (which is based on the eTrauma Plan).

- "Disability" means that the Participant is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

In-service withdrawals

In addition, your other withdrawal rights under the Plan, you have the following in-service withdrawal rights:

- **Withdrawals after age 59½.** You may request a withdrawal of all or a portion of your eTrauma Matching Contribution Account at any time after you have attained age 59½.

Special provision applicable to PlasmaSol participants

The following special rule applies to you if you were employed by PlasmaSol Corp. ("PlasmaSol") at the time it became a Stryker company.

Prior service credit

You will be credited for all purposes of the Plan with your service with PlasmaSol as if you had been an employee of the Company when that service was performed.

Special provision applicable to Porex Surgical, Inc. participants

The following special rule applies to you if you were employed by Porex Surgical, Inc. or its affiliate ("Porex") and you became an employee of the Company upon Stryker's acquisition of Porex.

Prior service credit

You will be credited for all purposes of the Plan with your service with Porex as if you had been an employee of the Company when that service was performed.

Special provision applicable to Boston Scientific Corporation participants

The following special rule applies to you if you were employed by Boston Scientific Corporation, or its affiliate ("Boston Scientific") and you became an employee of the Company upon Stryker's acquisition of Boston's neurovascular unit.

Prior service credit

You will be credited for all purposes of the Plan with your service with Boston Scientific as if you had been an employee of the Company when that service was performed.

Special Provision applicable to Gaymar Industries, Inc. participants

The following special rule applies to you if you were employed by Gaymar Industries, Inc. ("Gaymar") at the time it became a Stryker company.

Prior service credit

You will be credited for all purposes of the Plan with your service with Gaymar as if you had been an employee of the Company when that service was performed.

Special provisions applicable to divested Biotech participants

The following special rules apply to you if you were employed by Stryker Biotech L.L.C. and ceased to be an employee as a result of the sale of the OP-1 portion of Stryker Biotech L.L.C. (the "OP-1 Divestiture") on the date of the OP-1 Divestiture.

Waiver of certain contribution eligibility requirements

You will be deemed to have satisfied the Plan's eligibility requirements to receive a matching contribution for the 2010 Plan Year.

Full vesting

Your matching contribution account will be fully vested and nonforfeitable as of the date you ceased to be an employee.

Acquisitions after September 30, 2012

If you were employed on the acquisition date by a company that Stryker acquires after September 30, 2012, and as a consequence become employed by Stryker at that time, you will be credited for all purposes of the Plan with your service with that acquired company as if you had been an employee of the Company when that service was performed. Special terms may apply to participants who were employed on an acquisition date by a company that Stryker acquired after September 30, 2012. Contact myHR for more information.

Additional benefits



In addition to the healthcare, flexible spending account and retirement benefits described elsewhere in this benefits summary, Stryker offers the following additional benefits to eligible employees:

- Adoption Assistance Plan
- Maven: Family building, parenting and midlife health
- Mental health and Employee Assistance Program (EAP)
- Strive for Wellbeing program

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Adoption Assistance Plan

Stryker's Adoption Assistance Plan reimburses you for legal fees and certain other costs associated with adopting a child.

For additional details, see the document at **https://totalrewards.stryker.com/-/media/Mercer/Stryker/Documents/adoption-assitance-plan-doc-2019.pdf**.

How adoption assistance benefits work

The plan reimburses you-up to $5,000 per adoption-for necessary fees and expenses related to the legal adoption of an eligible child. The plan defines an eligible child as an individual who is either:

- A child under the age of 18; or
- Any disabled person who is unable to care for himself/herself due to a physical or mental disability.

Eligibility

You are eligible for adoption assistance benefits on your date of hire if you are a full-time employee regularly scheduled to work at least 40 hours each week, or you are a part-time employee regularly scheduled to work at least 20 hours each week.

Eligible expenses

Eligible expenses include:

- Court costs;
- Attorney fees;
- Adoption agency fees; and
- Charges for immigration services, including immunizations and translation fees.

Important to Remember

If you are married to another Stryker employee and are seeking to adopt a child, the two of you are subject to the same dollar and lifetime maximum benefits as an individual employee.

Eligible expenses must meet all of the following requirements:

- They are directly related to your legal adoption of an eligible child.
- They are incurred after you become eligible for adoption assistance benefits.
- They are filed while you are employed by the Company.

Benefit maximums

The maximum plan reimbursement is $5,000 per adoption. The plan pays benefits for up to two adoptions per employee per lifetime. If you are attempting two adoptions at the same time, you must provide adequate documentation of both adoption attempts in order to qualify for benefits in excess of $5,000. If you are married to another Stryker employee and are seeking to adopt a child, the two of you are subject to the same dollar and lifetime maximum benefits as an individual employee.

Special tax treatment

All amounts paid by the Adoption Assistance Plan are subject to Social Security and Medicare taxes (FICA) as well as federal unemployment tax (FUTA). Federal and state income taxes are also withheld from adoption assistance benefit payments.

Under current tax law, and depending on your circumstances, adoption assistance benefits may qualify for federal income tax exclusion. You may also be able to claim an adoption tax credit on your federal income tax return for any adoption expenses you incur in excess of $5,000. You should consult a tax advisor to determine the ultimate taxation of the benefits paid to you under this plan.

Expenses not covered

The Adoption Assistance Plan does not provide reimbursement for the following:

- Expenses related to a surrogate parenting arrangement;
- Expenses incurred in violation of a federal or state law;
- Expenses that have been reimbursed through another plan or any state, local or federal program;
- Expenses incurred in connection with travel;
- Expenses incurred in connection with the adoption of your spouse's child;
- Expenses incurred and/or filed for reimbursement before you were eligible for adoption assistance benefits;
- Expenses incurred and/or filed for reimbursement after your employment terminates; or
- Expenses that you claim as a credit or deduction on your federal income tax.

Claim forms for adoption assistance benefits are available from your Benefits representative.

How to obtain adoption assistance benefits

During the adoption process, be sure to keep itemized receipts for all of the expenses you incur. File your claim only after the adoption is final and you have incurred all of your expenses. Complete a claim form, attach all of the itemized receipts and submit the claim to your Benefits representative.

Your claim must be submitted before December 1 of the year following the year in which adoption expenses were incurred. For example, you have until December 1, 2026, to file a claim for expenses incurred at any time in 2025.

In most cases, your claim will be paid within 60 days or less. The total approved reimbursement amount will be added to your paycheck, less applicable FICA, FUTA and income taxes.

Maven: Family building, parenting and midlife health

Maven is your personal guide to family building, parenting and midlife health — available to you and your eligible dependents at no cost, regardless if you are enrolled in other Stryker benefits.

Life is filled with so many incredible chapters, and Maven can help you through them all — from trying to expand your family and welcoming a little one to raising a child and navigating midlife health changes, like menopause or low testosterone. Get the support you and your loved ones deserve with access to hard-to-find specialists, articles, videos and more.

Maven is here for every symptom, feeling and health goal with expert answers you can trust.

Services include:

- **Video visits and messaging with top-rated specialists:** Get helpful guidance from award-winning family health specialists across 30+ specialties — all from the comfort of your home.
- **Answers, day or night:** Virtual support from a personalized Care Advocate who can offer advice and resources that can help, even at 2 a.m.
- **Expert articles, community forums, videos and on-demand classes:** Scroll clinically accurate resources that cover mental health, sleep, nutrition, wellness, symptom relief and more.

Get started today

Join Maven today to access top-rated specialists and daily resources.

- Register at **mavenclinic.com/join/stryker**. You will need your email address, date of birth and full name to get started.

Mental health and Employee Assistance Program (EAP)

Stryker's mental health and Employee Assistance Program provides you and members of your household with professional confidential help in dealing with everyday issues. The program is administered by Lyra.

Services include:

- Professional confidential counseling, customized searches, self-guided care programs and referrals for life or family problems, work problems or emotional or substance abuse disorders;
- Up to ten short-term counseling or coaching sessions (per calendar year) available to you and members of your household at no cost;
- Child care and elder care research and referral services.

You and household family members are eligible for Lyra services on your date of hire. Enrollment in Stryker's medical plan is not required. The issues you bring to Lyra are held in strict confidence and are not shared with anyone at Stryker. All Lyra services are available by calling (833) 511 0159 seven days a week, 24 hours per day. You also can log on to **stryker.lyrahealth.com**.

For UHC plan participants under a Stryker-sponsored plan

If your counseling or coaching sessions go beyond the annual limit and you participate in a UHC plan sponsored by Stryker, you can continue using the same Lyra provider using your medical plan's mental health benefits. Keep in mind that each medical plan has its own deductibles, coinsurance, copayments, annual maximum and limits on inpatient and outpatient care, including number of visits/days of coverage. You will be responsible for the member cost share of these visits.

In addition, UHC plan participants have access to medication management services through Lyra. This includes a 90-minute consultation with a physician to discuss current medication or get insight into medications recommended by other providers. These visits are billed through the health plan and are subject to member cost share (deductibles, coinsurance and/or co-pays based on which plan you participate in).

Strive for Wellbeing program

All full-time and regular part-time employees, spouses and domestic partners are eligible to participate in the Strive for Wellbeing program, which is designed to help you live your best life. Strive offers fun activities that you can join on-demand throughout the year. You and your spouse/domestic partner can earn incentives throughout the year for participating in this program.

Complete health care is about making the right decisions for you and your family and taking action to manage your health year-round. Your health and wellbeing are important to Stryker, and we are focused on building and maintaining a healthy workforce. That means offering benefit programs that encourage you to get and stay healthy and giving you the tools and resources you need to better manage your health care expenses. The Strive program allows you to:

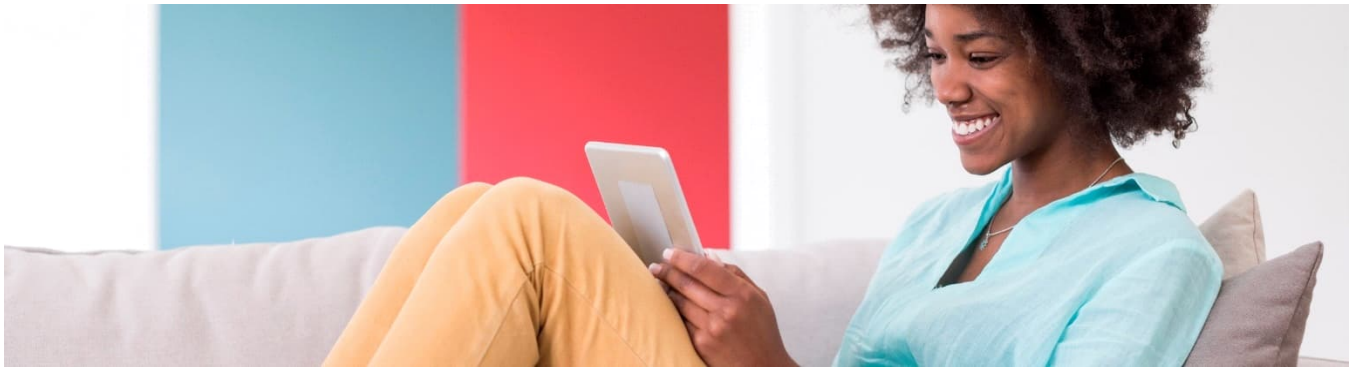
- Take a wellbeing assessment to gain a clearer picture of your health.
- Get motivated by participating in fun, friendly wellbeing challenges.
- Access tools and support to help you make healthier choices every day.
- Earn great incentives, including gift cards and Strive gear!

The Strive program is administered by Personify Health.

Not an ERISA plan

The Strive for Wellbeing program is not governed by the Employee Retirement Income Security Act of 1974 (ERISA). For example, ERISA requirements such as providing a Summary Plan Description, filing an annual report (Form 5500 Series), or making a summary annual report available do not apply.

Your rights and responsibilities



This benefits summary is the summary plan description (SPD), effective January 1, 2026, for:

- The Stryker Corporation Welfare Benefits Plan (which includes Stryker's medical, prescription drug, dental, vision, life insurance, short-term disability, long-term disability, and healthcare 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 the **Participating in healthcare benefits**, starting on page 5, 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 starting on page 182, with that section constituting the SPD for that plan. See the **401(k) Retirement Plan** section starting on page 182, for all details about your 401(k) plan.

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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. If Stryker elects, you may be required to 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.

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 from your Stryker paycheck.

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 the covered child otherwise ceases to qualify as a dependent under the Plan; or
- The date another individual is ordered to provide medical and prescription drug, dental and/or vision coverage for the child under a QMCSO or NMSN and coverage is in fact provided.

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 31 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.

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.

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.

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. For additional information regarding discretionary authority under the plan and/or standards of review for suits brought for plan benefits, please see the Stryker Corporation Welfare Benefits Plan document.

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 or Surest'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 or Surest 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 235.

The plan administrator will pay Benefits to you unless:

- The provider submits a claim form to the plan administrator 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 or Surest 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 Plan** section starting on page 182.

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, healthcare flexible spending account 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, short-term disability 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 Day Care Flexible Spending Account are 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 Value PPO Plan, Basic and Premium HSA plans, Out-of-Area Plan, Surest Advantage Plan and prescription drug plans; the Delta Dental plan; the EyeMed vision plan; flexible spending accounts; Maven 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
1941 Stryker Way
Portage, 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
1941 Stryker Way
Portage, 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 LLC	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 Employment Company LLC	83-1484034
Stryker Puerto Rico, LLC	(66-0955512)
Stryker Puerto Rico Sales, LLC	(66-0951462)

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 plans offered to employees in California and Hawaii 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.

Basic Life, Accidental Death and Dismemberment (AD&D) and Long-Term Disability coverage for employees is funded directly by Stryker from its general assets. Supplemental and dependent life insurance coverage are funded entirely by employee contributions made through after-tax salary deductions. Life, AD&D and Long-Term Disability are fully 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:

Privacy Officer
Stryker
1941 Stryker Way
Portage, 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.

Contacts

This section gives you telephone numbers, web site addresses and other important information about your benefits.

For information about	Use these resources	Important details
UnitedHealthcare plans Print temporary ID cards online Claim status, order ID cards, etc. Estimated treatment costs; information about a proposed surgery or a newly diagnosed health condition Virtual visits are available for an additional fee via the **www.myuhc.com** website	800 387 7508; follow prompts Customer service hours: Monday – Friday, 8am – 8pm (based on caller time zone) **www.myuhc.com**	You must register on the **www.myuhc.com** web site in order to access your claim status and eligibility information. To register, go to **www.myuhc.com** and click on Register Now. Medical plans group number: 703997
Surest Advantage Plan Print temporary ID cards online Claim status, order ID cards, etc. Estimated treatment costs; information about a proposed surgery or a newly diagnosed health condition Virtual visits are available via the **Benefits.Surest.com** website	**Surest Plan and Retail Pharmacy Questions:** Surest Member Services Team 844 530 0139 Monday – Friday, 6am to 9pm Central Time **Benefits.Surest.com**	Once enrolled, visit **Benefits.Surest.com**. You can also access this information by downloading the Surest mobile app. With the Surest mobile app and the Benefits.Surest.com website, participants can search for available care, cost, and coverage options from any geographic location. Medical plan group number: 78800874
Substance Use Disorder Helpline (Optum)	Substance Use Treatment Helpline: 855 780 5955 Helpline licensed clinicians available: 7 days a week, 24 hours a day **www.Liveandworkwell.com**	Speak with a licensed clinician for a substance use disorder evaluation and treatment support, including help finding a trusted provider.

For information about	Use these resources	Important details
Participating UnitedHealthcare plan providers **Participating UnitedHealthcare OptumRx pharmacies** Generic medication alternatives or costs for equivalent medications Ordering home-delivery prescription medication	800 387 7508; follow prompts Customer service hours: Monday – Friday, 8am – 8pm (based on caller time zone) www.myuhc.com	Registration is not required to view this provider site. Network — Choice Plus You must register on the www.myuhc.com web site to access the pharmacy locator service.
Kaiser Permanente — California	800 464 4000 Customer service hours: 24 hours a day/7 days a week for most services, except major holidays **kp.org**	Kaiser HMO includes prescription drug coverage. Kaiser North group number: 17181 Kaiser South group number: 118506
HMSA — Hawaii	800 948 6111 (Oahu) 800 776 4672 (Neighbor Islands) Monday – Friday, 8am – 5pm Hawaii Standard Time **www.hmsa.com**	HMSA includes prescription drug coverage. Group number: 32908-1-4
Cigna International	800 441 2668 (US/Canada), 302 797 3100 (call collect) **www.cignaenvoy.com** Customer service hours: 24 hours a day/7 days a week	Stryker Policy Number: 03509A
Cigna Medical Benefits Abroad	1 800 243 1348 or 001 302 797 3535 (collect calls accepted) **www.cignaenvoy.com**	For employees that are traveling on business internationally Stryker Policy Number: 03509B
Delta Dental	800 524 0149 Customer service hours: Monday – Friday, 8:30am – 7:55pm Eastern Time **www.deltadentalmi.com**	Registration not required to view this site. Group number: 5480

Contacts

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EyeMed Vision Care	866 723 0513 Customer service hours: Available 362 days each year: Mon. to Fri.: 7:30am – 11pm Eastern Time, Sat.: 8am – 11pm & Sun.: 11am – 8pm Eastern Time **www.eyemed.com**	Web site registration required. To locate participating providers, log on to **www.eyemed.com** **Group number: 9706201**
Health Savings Accounts (HSAs) (Optum Bank)	800 387 7508 Customer service hours: Monday – Friday, 8am – 8pm (based on caller time zone) **www.myuhc.com**	Group Number:703997
UnitedHealthcare Flexible Spending Accounts Healthcare flexible spending account Day care (child and adult) flexible spending account	800 387 7508; follow prompts Customer service hours: Monday – Friday, 8am – 8pm Eastern Time **www.myuhc.com**	Web site registration and Group number 703998 required.
Included Health	855 431 5551 Customer service hours: Monday – Friday, 8am – 8pm Eastern Time **https://includedhealth.com/microsite/stryker/**	
Unum Life and AD&D insurance	800 421 0344; follow prompts Customer service hours: Monday – Friday, 8am – 8pm Eastern Time **www.unum.com**	Group number: 940919
Unum Short-term disability Long-term disability	888 673 9940; follow prompts Customer service hours: Monday – Friday, 8am – 8pm Eastern Time **www.unum.com**	Group number: 940918 (STD) Group number: 940915 (LTD)
Lyra Mental health and Employee Assistance Program (EAP)	833 511 0159 Customer service hours: 24 hours a day, seven days a week **www.stryker.lyrahealth.com**	
Maven Support for family building, parenting and midlife health	Register at **mavenclinic.com/join/stryker** and download the Maven app.	You will need your email address, date of birth and full name to get started.
401(k) Savings and Retirement Plan	800 523 1188 Customer service hours: Monday – Friday, 8:30am – 9pm Eastern Time **www.vanguard.com/retirementplans**	Web site registration and plan number required. Plan Number: 090081

For information about	Use these resources	Important details
Personify Health Administrator of Strive for Wellbeing Program	833 643 0408 Email: **support@personifyhealth.com** Customer service hours: Monday – Friday 7am – 7pm Eastern Time	