HACKLEY HOSPITAL

RETIREE HEALTH REIMBURSEMENT PLAN SUMMARY PLAN DESCRIPTION

Effective January 1, 2019
# Table of Contents

**ARTICLE I.** INTRODUCTION ................................................................................................................................. 1

**ARTICLE II.** BASIC INFORMATION .......................................................................................................................... 2  
  2.1 Plan .................................................................................................................................................. 2  
  2.2 Employer and Plan Sponsor .................................................................................................................. 2  
  2.3 Plan Administrator ................................................................................................................................. 2  
  2.4 Third-Party Plan Administrator .......................................................................................................... 2  
  2.5 Third-Party COBRA Administrator ...................................................................................................... 2  
  2.6 Agent for Service of Legal Process ...................................................................................................... 3  
  2.7 Plan Year ......................................................................................................................................... 3  
  2.8 Original Effective Date ........................................................................................................................ 3  

**ARTICLE III.** ELIGIBILITY AND PARTICIPATION ........................................................................................................... 4  
  3.1 Eligibility ........................................................................................................................................ 4  
  3.2 Participation .................................................................................................................................... 4  
  3.3 Cessation ....................................................................................................................................... 4  
  3.4 Retiree Participant .............................................................................................................................. 4  
  3.5 Dependent ...................................................................................................................................... 4  
  3.6 Medical Child Support Orders ......................................................................................................... 5  
  3.7 COBRA Continuation Coverage ....................................................................................................... 5  
  3.8 Other Extensions of Participation ..................................................................................................... 8  

**ARTICLE IV.** CONTRIBUTIONS ....................................................................................................................................... 9  
  4.1 Participant Contributions ..................................................................................................................... 9  
  4.2 Employer Contributions ....................................................................................................................... 9  

**ARTICLE V.** VESTING AND BENEFITS .......................................................................................................................... 11  
  5.1 Vesting and Forfeiture ........................................................................................................................ 11  
  5.2 Health Care Reimbursement ............................................................................................................. 11  

**ARTICLE VI.** CLAIMS PROCEDURES .......................................................................................................................... 13  
  6.1 Claims for Benefits ............................................................................................................................. 13  
  6.2 Other Claims .................................................................................................................................. 13  
  6.3 Claims Notification ............................................................................................................................ 13  
  6.4 Appeals ........................................................................................................................................ 14
ARTICLE I

INTRODUCTION

This document is a summary plan description ("Summary") prepared in compliance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This Summary provides a general explanation of the Hackley Hospital Retiree Health Reimbursement Plan ("Plan"). The Plan is intended to constitute an "employee welfare benefit plan," as defined in ERISA. While we have tried to describe the Plan as completely and accurately as possible, due to the relatively brief nature of this Summary and the complexity of the Plan document, some details may not have been described or have been described only briefly.

We strongly urge you to read this Summary in its entirety. If you have further questions, or if you would like to review the entire Plan document, copies are available from your Employer and the Plan Administrator for inspection during normal business hours.

ARTICLE II

BASIC INFORMATION

2.1 Plan.
(a) Name: Hackley Hospital Retiree Health Reimbursement Plan
(b) Plan Number: 530
(c) Type: The Plan is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (“Code”), and the Treasury Regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and will be interpreted accordingly. The medical expenses reimbursed under the Plan are intended to be eligible for exclusion from a participant’s gross income under Code Section 105(b).
(d) Collective Bargaining Agreement: This Plan is established in part under the collective bargaining agreement between the Employer and the Michigan Nurses Association.

2.2 Employer and Plan Sponsor.
(a) Name: Mercy Health Partners, Hackley Campus (formerly Hackley Hospital and Medical Center)
(b) Address: 1700 Clinton Street Muskegon, Michigan 49442
(c) Phone: (231) 726-3511
(d) Employer Identification Number (EIN): 38-2589966

2.3 Plan Administrator: The Employer is the Plan Administrator and named fiduciary for purposes of ERISA.

2.4 Third-Party Plan Administrator: WageWorks, Inc. 877-924-3967 or https://www.wageworks.com

2.5 Third-Party COBRA Administrator: WageWorks, Inc. 877-502-6272 or https://www.wageworks.com
2.6 Agent for Service of Legal Process: The Plan Administrator

2.7 Plan Year: January 1 through December 31.

2.8 Original Effective Date: January 1, 2003
ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. If you are in Covered Employment or transfer to Covered Employment, you are eligible to participate in the Plan once you have completed your probationary period set forth in the collective bargaining agreement. “Covered Employment” is employment with the Employer as an employee that is covered by the collective bargaining agreement in Section 2.1(d) of this Summary. However, you are not in Covered Employment if you are a leased employee, a self-employed individual, a member of a collective bargaining unit that has not adopted this Plan, employed by a related employer to the Employer that has not adopted this Plan, or a person who is classified by the Employer as other than a regular or “common law” employee of the Employer, even if it is later determined for any purpose that the classification is incorrect.

3.2 Participation. Once you have completed the eligibility requirements in Section 3.1, above, you will become a “Participant” in the Plan on the next Entry Date. The “Entry Date” is the first day of the first payroll period after completion of the eligibility requirements. If you are a Participant in the Plan, a health reimbursement account (“HRA”) is established for you under the Plan. An HRA is a bookkeeping account established and maintained by the Plan Administrator for each Participant in the Plan that reflects the amount of Employer contributions, as set forth in Section 4.2(b), below, credited to the account, adjusted for earnings or losses in accordance with Section 8.1, and less the amount of Eligible Medical Expenses (as defined in Section 5.3(a) of this Summary) reimbursed from the account on behalf of the Participant or the Participant’s eligible Dependents.

3.3 Cessation. Your participation in and benefits under the Plan end when you have a Break in Continuous Employment unless you are a Retiree Participant (as defined in Section 3.4, below) or when you have exhausted your HRA balance. A “Break in Continuous Employment” occurs (and a new hire date shall be established if you are rehired by the Employer) upon your resignation or other termination from employment with the Employer, death, total and permanent disability, failure to return to employment with the Employer after the expiration of an approved leave of absence, FMLA leave or layoff from employment with the Employer without recall for at least one month. A Break in Continuous Employment will not occur if you transfer to employment with the Employer or one of its related employers that is not Covered Employment. A Participant who transfers to employment with the Employer or one of its related employers that is not Covered Employment remains a Participant until exhaustion or forfeiture of the Participant’s HRA balance.

3.4 Retiree Participant. You are a “Retiree Participant” for purposes of the Plan if you are a Participant and your employment with the Employer and its related employers terminates on or after you have reached age 55 and completed 10 years of Credited Service (determined in the manner set forth in Section 4.2(b) of this Summary).

3.5 Dependent. A “Dependent” of a Retiree Participant for purposes of the Plan is:

(a) One Eligible Adult. An “Eligible Adult” is the Retiree Participant’s legal spouse for federal tax purposes or a person who is not the Employee’s Dependent Child and satisfies the requirements to be Retiree Participant’s dependent for federal income
tax purposes under Internal Revenue Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B).

(b) The Retiree Participant’s Dependent Children until they reach age 26. The “Dependent Children” of a Retiree Participant are the Retiree Participant’s biological children, stepchildren, legally adopted children, eligible foster children (as defined in Code Section 152(f)(1)(C)) and children lawfully placed with the Retiree Participant for legal adoption by the Retiree Participant.

A Retiree Participant is required to provide proof of his or her Dependents’ eligibility at the request of the Plan Administrator. False or misrepresented eligibility information will cause both the Retiree Participant's and Dependents’ coverage under the Plan to be irrevocably terminated (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If a Retiree Participant's or Dependent's coverage is terminated retroactively due to fraud or misrepresentation, the Retiree Participant will forfeit any contributions made to his or her HRA by the Employer.

3.6 Medical Child Support Orders. A medical child support order is a court order directing the Plan Administrator to add coverage for your Dependent(s). The Plan Administrator shall only follow the directions of a medical child support order if it is qualified under federal law. The Plan Administrator shall promptly notify you and each alternate recipient named in a medical child support order of its determination. Additionally, you and/or your Dependents may request a copy of the Plan’s procedures governing qualified medical child support order ("QMCSO") determinations. The Plan Administrator will provide a copy of the procedures free of charge upon your request. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether the order is a QMCSO and shall notify you and each alternate recipient of its determination. If you or any affected alternate recipient objects to the determination of the Plan Administrator, the disagreeing party shall be treated as a claimant and the applicable claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

(a) Limitations. A QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law.

(b) Plan Must Recognize QMCSO. Upon the Plan’s determination that a court order is a QMCSO, the Plan shall provide benefits for the Participant's child as required by the order and to the extent otherwise provided under the Plan.

3.7 COBRA Continuation Coverage. The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). The right to COBRA Continuation Coverage is a temporary extension coverage under the Plan in certain instances where coverage under the Plan would otherwise end. This information is intended to provide notice and explain, in a summary fashion, COBRA Continuation Coverage, when it may become available to you and your family, what you must do to continue your coverage under the Plan, including what to do to protect the right to receive it. This information gives you only a summary of your COBRA Continuation Coverage
rights. Both you and your spouse, if any, should take the time to read this information carefully.

The Plan Administrator is responsible for administering COBRA Continuation Coverage. The Plan Administrator has contracted with the third-party COBRA administrator listed at the beginning of this Summary to assist with the Plan’s COBRA administration. The Plan Administrator may terminate or modify its contract with the third-party COBRA administrator at any time in its discretion.

COBRA Continuation Coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. COBRA Continuation Coverage must be offered to each person who is a “qualified beneficiary.” However, COBRA Continuation Coverage will only be offered if the Participant has an HRA balance at the time of the qualifying event. A qualified beneficiary is someone who was eligible to have his or her Eligible Medical Expenses (as defined in Section 5.3(a) of this Summary) paid or reimbursed from an HRA under the Plan on the day before a qualifying event and will lose eligibility to have his or her Eligible Medical Expenses paid or reimbursed from the HRA because of a qualifying event. Depending on the type of qualifying event, Retiree Participants and spouses and Dependent children of Retiree Participants may be qualified beneficiaries. However, the following individuals are not qualified beneficiaries: (a) a former employee whose employment with the Employer and its related employers terminated before he or she had reached age 55 and completed 10 years of Credited Service (determined in the manner set forth in Section 4.2(b); (b) an individual that receives benefits under the Plan only because of the election of COBRA Continuation Coverage by another individual, (c) an individual who does not elect COBRA Continuation Coverage during the applicable election period, or (d) and individual who does not properly and timely notify the Plan Administrator or third-party COBRA administrator of a qualifying event that is divorce or legal separation of the Retiree Participant and spouse or a Dependent child’s loss of eligibility for benefits under the Plan because he/she ceases to be the Retiree Participant’s Dependent. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay an administrative expense for COBRA Continuation Coverage with after-tax dollars. The first payment will be due within 45 days from the end of your COBRA election period. Subsequent payment will be due on the first day of each month following the due date of the initial payment.

If you are a Participant, you will become a qualified beneficiary only if you are a Retiree Participant, a proceeding in bankruptcy under Title 11 of the United States Code is filed with respect to the Employer, and that bankruptcy results in the loss of coverage under the Plan of any Retiree Participant. In this case, your Dependents will also be qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

If you are the spouse of a Retiree Participant, you will become a qualified beneficiary for any of the following reasons:

• The death of the Retiree Participant; or
• Divorce or legal separation from the Retiree Participant or otherwise ceasing to be the Retiree Participant’s spouse.
If you are the Dependent child of a Retiree Participant, you will become a qualified beneficiary for any of the following reasons:

- The death of the Retiree Participant;
- Parents’ divorce or legal separation (or a Retiree Participant’s spouse ceasing to be the Retiree Participant’s spouse); or
- You cease to be an eligible Dependent under the Plan.

Each qualified beneficiary eligible for COBRA Continuation Coverage is entitled to make a separate election. Thus, a Retiree Participant’s spouse or dependent child who is a qualified beneficiary is entitled to elect COBRA Continuation Coverage even if the Retiree Participant does not make that election. A Participant may elect COBRA Continuation Coverage on behalf of his or her spouse, and parents may elect COBRA Continuation Coverage on behalf of their children. Unless otherwise specified in a decree of divorce or legal separation, a Retiree Participant’s HRA balance shall be divided equally among the qualified beneficiaries upon an election of COBRA Continuation Coverage.

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Retiree Participant or commencement of a proceeding in bankruptcy with respect to the Employer, the Employer must notify the Plan Administrator of the qualifying event within 30 days of the event. Within 14 days of receipt of the notice from the Employer, the Plan Administrator (or third-party COBRA administrator on behalf of the Plan Administrator) will provide an election notice to each of the qualified beneficiaries. Notification to a qualified beneficiary who is the spouse of a Retiree Participant is treated as notification to all other qualified beneficiaries residing with that person at the time the notification is made.

For the other qualifying events (divorce or legal separation of the Retiree Participant and spouse, an individual ceasing to be a Retiree Participant’s spouse or a Dependent child’s loss of eligibility for coverage as a Dependent child), the Retiree Participant or other qualified beneficiary must notify the third-party COBRA administrator or Plan Administrator of the qualifying event within 60 days after the qualifying event occurs. This notice must be sent to the third-party COBRA administrator or Plan Administrator at the address listed at the beginning of this Summary. The notice must be in writing and must include: (1) the Plan name, (2) the name of the Retiree Participant and each qualified beneficiary impacted by the qualifying event, (3) the type of qualifying event, and (4) the date of the qualifying event. The notice to the third-party COBRA administrator or Plan Administrator can be provided by the Retiree Participant, the qualified beneficiary or any representative on behalf of the qualified beneficiary. Within 14 days of receipt of the notice from the Employer, the Plan Administrator (or third-party COBRA administrator on behalf of the Plan Administrator) will provide an election notice to each of the qualified beneficiaries. Notification to a qualified beneficiary who is the spouse of a Retiree Participant is treated as notification to all other qualified beneficiaries residing with that person at the time the notification is made.

Once the third-party plan administrator or Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who timely elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that Plan coverage would otherwise have been lost.
COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, the Participant's divorce or legal separation, an individual ceasing to be the Participant's spouse or a dependent child losing eligibility as an eligible dependent, COBRA Continuation Coverage lasts for up to 36 months. However, COBRA Continuation Coverage will end early for certain reasons, including if the qualified beneficiary exhausts his/her HRA balance or fails to timely pay a required premium.

In order to protect your family’s rights, you should keep the Plan Administrator and third-party plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or third-party plan administrator.

3.8 Other Extensions of Participation. If you transfer to employment with the Employer or one of its related entities that is not covered by the collective bargaining unit in Section 2.1(d) of this Summary or your employment with the Employer and its related entities terminates, you (or your spouse or Dependent children, if applicable) will retain your HRA balance until it is exhausted or forfeited.
ARTICLE IV

CONTRIBUTIONS

4.1 Participant Contributions. You will not make any contribution to the Plan.

4.2 Employer Contributions. If you are a Participant who is in Covered Employment at any time during a Plan Year and you complete at least 1,000 Hours of Service with the Employer during the Plan Year, the Employer will credit your HRA with an Employer contribution. You are in “Covered Employment” if you are covered under the collective bargaining agreement set forth in Section 2.1(d) of this Summary. “Hours of Service” are determined under the terms of the Retirement Plan for the Employees of Hackley Hospital through December 31, 2008, and in accordance with the terms of the Trinity Health Pension Plan on and after January 1, 2009. Even though benefit service in the Trinity Health Pension Plan was frozen, the Plan will continue to determine service under the benefit service definition in the Trinity Health Pension Plan beyond the date of the freeze of accruals under the Trinity Health Pension Plan.

The Employer contribution credited to your HRA for a Plan Year, if any, will depend upon your number of Points, your Considered Compensation for that Plan Year and the percentage determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Points</th>
<th>Percentage of Considered Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 – 29</td>
<td>.50%</td>
</tr>
<tr>
<td>30 – 39</td>
<td>.75%</td>
</tr>
<tr>
<td>40 – 49</td>
<td>1.00%</td>
</tr>
<tr>
<td>50 – 59</td>
<td>1.25%</td>
</tr>
<tr>
<td>60 – 69</td>
<td>1.50%</td>
</tr>
<tr>
<td>70 – 79</td>
<td>2.00%</td>
</tr>
<tr>
<td>80+</td>
<td>2.50%</td>
</tr>
</tbody>
</table>

Your “Considered Compensation” for a Plan Year generally means your W-2 wages from the Employer for the Plan Year paid for your services as an employee in Covered Employment before deduction of your Code Section 403(b) or 401(k) elective contributions, Code Section 457(b) elective contributions, if any, and any contributions you make to your Employer’s cafeteria and/or flexible benefit plan. Considered Compensation also includes short term disability benefits paid by the Employer through payroll. However, Considered Compensation does not include reimbursements or other expense allowances, fringe benefits (cash and noncash), severance pay benefits, moving expenses, contributions to or distributions from deferred compensation plans, including but not limited to SERP, restoration or similar executive supplemental plan benefits, welfare benefits, long term incentive pay, or similar benefits, subsidies or stipends. Considered Compensation for a Plan Year shall be limited to the Code Section 401(a)(17) limit for that Plan Year. The limit is $280,000 for 2019 and may be adjusted for inflation in future years. In addition, your Considered Compensation for purposes of the Plan does not include any compensation you earned before becoming a Participant in the Plan or while you are not in Covered Employment.
Your “Points” for a Plan Year are equal to the sum of your age (in whole years and completed months) and your years of Credited Service as of the last day of the prior Plan Year. Your years of “Credited Service” for purposes of determining your Points under the Plan are your years of Credited Service determined under the terms of the Retirement Plan for the Employees of Hackley Hospital through December 31, 2008, and your Benefit Service determined in accordance with the terms of the Trinity Health Pension Plan on and after January 1, 2009, with any Trinity Health entity.

The Employer contributions to be credited to HRAs under the Plan for a Plan Year will be made by the end of the first quarter of the following Plan Year.

**Example**

Sue is a Participant in the Plan, has at least one day of Covered Employment during the 2017 Plan Year (i.e., the Plan Year beginning January 1, 2017 and ending December 31, 2017), and completes at least 1,000 Hours of Service with the Employer during that Plan Year. As of December 31, 2016, Sue is age 50 and has 15 years of Credited Service so Sue has 65 Points for the 2017 Plan Year. Sue’s Considered Compensation for the 2017 Plan Year is $40,000. As a result, the Employer will credit $600 to Sue’s HRA for the 2017 Plan Year (1.50% x $40,000).
ARTICLE V

VESTING AND BENEFITS

5.1 Vesting and Forfeiture. You are vested in your HRA on the later of the date you attain age 55 and the date you complete 10 years of Credited Service. If you have a Break in Continuous Employment before becoming a Retiree Participant and before you are vested your HRA will be forfeited. Also, any vested amount in your HRA will be forfeited upon the death of the last survivor among the following individuals: you, your spouse, your other Dependent(s) and any individual who is a qualified beneficiary as a result of his or her relationship to you.

5.2 Health Care Reimbursement. If you are vested in your HRA, your employment with the Employer and its related employers has terminated and you are a Retiree Participant (as defined in Section 3.4 of this Summary), you may use your HRA for the reimbursement of Eligible Medical Expenses incurred by you and your Dependents after you became a Retiree Participant. An expense is “incurred” when the service or treatment giving rise to the expense has been performed or rendered and not in advance of the service or treatment or when billed or paid. Participants who are over age 65 and still working for the Employer or one of its related employers but collecting pension benefits are not Retiree Participants and, therefore, are not eligible to have their or their Dependent’s Eligible Medical Expenses reimbursed under the Plan.

(a) Eligible Medical Expenses. An “Eligible Medical Expense” is an expense for “medical care,” as defined by Code Section 213(d), that has not been reimbursed by any other source and for which you and your Dependent(s) will not seek reimbursement from any other source (e.g., another plan or Medicare). Whether an expense is for “medical care” is within the sole discretion of the Plan Administrator (or the third-party plan administrator). The Code generally defines “medical care” as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, prescription drugs and over-the-counter (“OTC”) drugs, products and devices. However, an OTC drug is not an Eligible Medical Expense unless it is prescribed (even if it is available without a prescription) or is insulin.

Not every health-related expense you and your Dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care,” as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible Dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Administrator (or the third-party plan administrator), be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Also, “stockpiling” of OTC drugs, products and devices is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs, devices and products could be used during the Plan Year (as determined by Plan Administrator or the third-party plan administrator).
Eligible Medical Expenses include amounts paid toward a deductible or copayment required under a health plan.

(b) Limitation. A Retiree Participant’s or COBRA qualified beneficiary’s right to reimbursement under the Plan is limited to the vested amount in his or her HRA.
ARTICLE VI

CLAIMS PROCEDURE

6.1 Claims for Benefits. To obtain reimbursement from your HRA for an Eligible Medical Expense incurred by you or your eligible Dependent, you must file a benefit claim form with the third-party plan administrator, together with a bill, receipt, or other satisfactory proof of the Eligible Medical Expense from an independent third party and any additional information required by the third-party plan administrator, including written certification that the expense has not been reimbursed or is not reimbursable under any other health plan coverage. The Plan Administrator and third-party plan administrator will have benefit claim forms available for your use. All claims for Eligible Medical Expenses incurred during a Plan Year must be filed no later than three (3) months after the end of the Plan Year in which the Eligible Medical Expenses were incurred. If a claim for an Eligible Medical Expense is not filed within this period, the Eligible Medical Expense will not be reimbursed under the Plan. Generally, your claim will either be paid or denied within 30 days of receipt of the claim by the third-party plan administrator. The review period may be extended for 15 days due to matters beyond the third-party plan administrator’s control if the third-party plan administrator notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the third-party plan administrator expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (a) the day you respond to the notice, or (b) at least 45 days from receipt of the notice requesting additional information. You will be required to repay any expense or cost incurred due to the payment of a benefit which should not have been reimbursed under the Plan.

6.2 Other Claims. If an individual has a claim under the Plan that is not a claim for benefits (e.g., an individual believes that he or she has been improperly excluded from being eligible to participate), the individual must file the claim in writing with the Plan Administrator. Generally, a decision on the claim will be made within 90 days of the Plan Administrator’s receipt of the claim. An extension of an additional 90 days is available if written notice is given to the claimant before the initial 90-day period ends.

6.3 Claims Notification. If your claim is wholly or partially denied, the third-party plan administrator or Plan Administrator, as applicable, will notify you of its decision in a written or electronic communication pursuant to Department of Labor Regulations Sections 2520.104b-1(c)(1), (iii) and (iv), which will contain: (a) the specific reason(s) for the claim’s denial, (b) specific reference to pertinent Plan provisions on which the decision is based, (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and (d) a description of the Plan’s review or appeal procedures and time limits applicable to such procedures, including a statement of your right to bring an action in federal court under Section 502(a) of ERISA with respect to any adverse benefit determination on review or appeal (i.e., after the Plan’s appeal procedures have been exhausted). In addition to the information above, if your claim is a benefit claim, the notice will also contain: (e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse benefit determination, either the specific rule, guideline, protocol or other criterion or a statement that a copy of such information will be provided free of charge upon request.
and (f) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment used in the determination or a statement that such explanation will be provided free of charge upon request. Generally, if notice of an adverse benefit determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period. However, if your claim is for group health benefits and the third-party plan administrator or Plan Administrator, as applicable, does not comply with the procedures set forth above, the Plan’s internal claims and appeal process will be deemed exhausted and you may initiate an external review of the claim (described below) or bring an action under Section 502(a) of ERISA with respect to the claim unless the violation is minor and does not cause (and is not likely to cause) prejudice or harm to you, occurs in the context of an ongoing, good faith exchange of information between the third-party plan administrator or Plan Administrator and you, is due to good cause or matters beyond the control of the third-party plan administrator or Plan Administrator, and is not reflective of a pattern or practice of non-compliance. You may make a written request to the third-party plan administrator or Plan Administrator for an explanation of the third-party plan administrator’s or Plan Administrator’s basis for asserting that it meets these requirements.

6.4 Appeals.

(a) Plan Appeals. If your claim is denied or deemed to be denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal in writing and request a review of your claim. Your appeal must be received by the Plan Administrator (or its delegate, if applicable) within the following time frames:

(i) Benefit claims: 180 days

(ii) All other claims: 60 days

You may submit written issues, comments, records, documents and other information related to your claim to the Plan Administrator (or its delegate, if applicable). You may also, upon request and at no charge, be provided reasonable access to and copies of all documents, records and other information relevant to your claim. In the case of benefit claim appeals, review on appeal will not take into consideration the initial claim determination and will be completed by a fiduciary of the Plan other than the individual that made the original claim determination or the subordinate of such individual.

(b) Appeal Notification. If your appeal is received by the appropriate deadline, the Plan Administrator (or its delegate, if applicable) will independently review your appeal and any additional information that you submit and notify you of its decision regarding your appeal within the following timeframes:

(i) Benefit claims - within a reasonable period, but no later than 60 days after receipt of your appeal.

(ii) All other claims – within a reasonable time, but no later than 60 days after receipt of your appeal. If special circumstances require, the time period may be extended for 60 days. The Plan Administrator (or its delegate, if
If your appeal is denied, the Plan Administrator (or its delegate, if applicable) will notify you of the necessary extension before the first 60-day period ends.

If your appeal is denied, the Plan Administrator (or its delegate, if applicable) will send you a notice with respect to the final internal adverse benefit determination that contains: (1) the specific reason(s) for the denial, (2) reference to the specific Plan provisions on which the adverse benefit determination is based, (3) a statement that you may receive, upon request and at no charge, reasonable access to and copies of all documents, records and information relevant to your claim, and (4) a statement describing any voluntary appeal procedures offered by the Plan and statement of your right to bring an action in federal court under Section 502(a) of ERISA. In addition to the information above, if your claim is a benefit claim, and it is denied on appeal, the denial notice will include: (5) if an internal rule, guideline, protocol or similar criterion was used in making the appeal decision, either the specific rule, guideline, protocol or other similar criterion or a statement indicating that a copy of such information will be provided free of charge to you upon request and (6) an explanation of the scientific or clinical judgment for the appeal denial, including applying the terms of the Plan to the request if the determination was based on medical necessity, experimental treatment or some other exclusion or limitation or a statement that a copy of this information will be provided upon written request at no charge.

In addition to the above, the Plan Administrator (or its delegate, if applicable) will provide a claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan Administrator (or its delegate, if applicable), or at the direction of the Plan Administrator (or its delegate, if applicable), in connection with the claim appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator’s (or its delegate’s, if applicable) notice of its decision on a claim appeal must be provided so that the claimant has a reasonable opportunity to respond prior to that date. In addition, if the Plan Administrator’s (or its delegate’s, if applicable) benefit claim appeal decision is based on a new or additional rationale from the initial claim decision, the claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the Plan Administrator’s (or its delegate’s, if applicable) notice of its decision on the benefit claim appeal must be provided so that the claimant has a reasonable opportunity to respond prior to that date.

Generally, if notice of an adverse benefit determination is not given to you within the applicable time period, your appeal will be considered denied as of the last day of the applicable review period. However, if your appeal is of a claim for benefits and the Plan Administrator (or its delegate, if applicable) does not comply with the procedures set forth above, the Plan’s internal appeal process will be deemed exhausted and you may initiate an external review of the claim (described below), if applicable, or bring an action under Section 502(a) of ERISA with respect to the claim unless the violation is minor and does not cause (and is not likely to cause) prejudice or harm to you, occurs in the context of an ongoing, good faith exchange of information between the Plan Administrator (or its delegate, if applicable) and you, is due to good cause or matters beyond the control of the Plan Administrator (or its delegate, if applicable), and is not reflective of a pattern or practice of non-compliance. You may make a written request to the Plan Administrator (or its
delegate, if applicable) for an explanation of the Plan Administrator’s (or its delegate’s, if applicable) basis for asserting that it meets these requirements.

6.5 External Review. There is an external review process for certain benefit claim reviews and appeal denials. An external review may be requested only for an adverse benefit determination with respect to a Claim Involving Medical Judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or a rescission of coverage (i.e., a cancellation or discontinuance of coverage that has a retroactive effect). A “Claim Involving Medical Judgment” is a claim for benefits involving, but not limited to, decisions based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational. Information regarding the external review process is available by contacting the Plan Administrator (or its delegate, if applicable).

6.6 Statute of Limitations. For purposes of filing any civil action against the Plan upon the exhaustion of all other available administrative remedies, a claimant may bring a legal action no later than one year from the date of completion of the Plan’s claims appeal process.

6.7 Misrepresentation and Fraud. If, for the purpose of obtaining or continuing to obtain benefits under the Plan, an eligible employee, Participant, Dependent or anyone acting on behalf of such person makes, or causes to be made, a false statement or misrepresentation, conceals or withholds information, commits fraud against the Plan or otherwise misleads the Plan or Plan Administrator (or its delegate, if applicable), the Plan shall be entitled to recover its damages, including benefits paid and legal fees, from the employee, Participant, Dependent or from any other person responsible for misleading or committing fraud against the Plan, and from the person for whom the benefits were provided.
ARTICLE VII

ADMINISTRATION

7.1 Plan Administrator. Responsibility for the administration of the Plan belongs to the Employer who is the Plan Administrator and a named fiduciary for purposes of ERISA. The “Administrator” of the Plan is the person, persons or entity appointed by the Plan sponsor or the Plan Administrator, in accordance with its delegated authority, from time to time to assist in the day-to-day administration of the Plan. If no Administrator has been appointed, the Administrator is the Plan Administrator. The Plan Administrator is responsible for maintaining all individual and Plan records, filing Plan tax returns and reports, authorizing payments, and resolving questions of Plan interpretation. In addition, the Plan Administrator has the specific discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. If a benefit is paid in error, that error does not amend the Plan nor obligate the Plan to continue to pay the same benefit in the future. Certain responsibilities of the Plan Administrator with respect to the Plan have been delegated to the Administrator, the third-party plan administrator and the third-party COBRA administrator. You can contact the Plan Administrator at the telephone number listed in Article II of this Summary.

7.2 Third-Party Plan Administrator. The third-party plan administrator for Plan is set forth in Section 2.4 of this Summary and third-party COBRA administrator for the Plan is set forth in Section 2.5 of this Summary. You can contact the third-party plan administrator and third-party COBRA administrator at the telephone number or website set forth in Section 2.4 and Section 2.5 of this Summary, respectively.
ARTICLE VIII

FUNDING

8.1 General Assets. All reimbursements from HRAs under the Plan shall be from the Employer’s general assets. The Plan is unfunded and the Employer is not required to establish any special or separate fund or to make any other segregation of assets in order to assure the payment of any amounts under the Plan; provided, however, that in order to provide a source of payment for the obligations under the Plan, the Employer has established a “grantor” trust. Except as otherwise determined by the Plan Administrator in its sole discretion, the actual investment return, if any, on amounts held in this trust for a Plan Year will be used to increase or decrease each Participant’s HRA balance prorata based on the Participant’s HRA balance at the beginning of that Plan Year relative to the total HRA balances under the Plan at the beginning of that Plan Year. For example, the actual investment return on amounts held in the trust for the 2017 Plan Year was $111,118 so the investment earnings credited to each Participant’s HRA for the 2017 Plan Year were calculated as follows:

\[
\text{([Participant’s HRA balance as of 1/1/2017] / (Total HRA balances as of 1/1/2017))} \times 111,118
\]
ARTICLE IX

AMENDMENT AND TERMINATION

9.1 Amendment. The Employer has the right to amend the Plan, in whole or in part, at any time with an instrument in writing executed by an officer of the Employer. In addition, the Trinity Health Benefits Committee (“Benefits Committee”) is authorized to approve amendments to the Plan in accordance with the Table of Authority for Welfare Benefit Plans incorporated into the Benefit Committee’s Charter. Anyone claiming an interest under the Plan will be bound by any amendment to the Plan. An amendment may be retroactive or prospective in the sole discretion of the Employer or the Benefits Committee, as applicable, except where prohibited by ERISA or the Code, but cannot retroactively exclude an employee who previously became a vested Participant, reduce the amount credited to a Participant’s HRA, or deprive a Participant of a benefit for a claim incurred prior to the amendment, except as otherwise agreed by the Participant or his or her bargaining representative.

The Plan may only be amended by a document in writing. Thus, the Plan may not be modified or amended simply by representations, verbal or otherwise, that may be made to you concerning the Plan. Accordingly, you should not consider the Plan to have been amended based on assertions made by a supervisor or a human resources representative, for instance. If you believe that you have received information that is contrary to the terms of the Plan or this Summary, please contact the Plan Administrator for clarification or confirmation.

9.2 Termination. While the Employer expects the Plan to be continued, future conditions affecting the Employer cannot be anticipated. Therefore, the Employer has reserved the right to completely or partially terminate the Plan. The Plan automatically terminates if the Employer goes bankrupt, goes out of business, or is sold or merged and the successor does not adopt the Plan. If the Plan is terminated, any HRA balances may be transferred to another plan, be utilized to pay benefits, or be utilized to offset negative account balances or pay administrative expenses.

9.3 Merger. The Employer may merge or consolidate the Plan with another plan. However, the Plan cannot be merged or consolidated with another plan unless your benefit under that other plan will be equal to at least the amount to which you would be entitled if the Plan had been terminated just before the change.

9.4 No Benefit Insurance. Benefits under the Plan are not insured under any insurance policy or the insurance provisions of ERISA which establish the Pension Benefit Guaranty Corporation. This is because the insurance provisions of ERISA do not include health reimbursement account plans.
ARTICLE X

MISCELLANEOUS

10.1 Contributions; No Guarantee of Tax Consequences. Generally, the Employer’s contributions under the Plan are not included in your income for federal income tax purposes or for Social Security or unemployment tax purposes. However, they may be part of your income for state and/or local income tax purposes. COBRA Continuation Coverage charges are not pre-tax and are made from your after-tax income. The Employer and the Plan Administrator do not make any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes.

10.2 Earnings/Forfeitures. Earnings, losses and forfeitures attributable to HRAs (no matter what type of contribution) are not taxable to you unless they are distributed to you in cash. If the Plan Administrator cannot locate a person entitled to a benefit payment under the Plan, the amount shall be a forfeiture.

10.3 Benefits. If you are a Retiree Participant, benefits received under the Plan for your or your eligible Dependent’s Eligible Medical Expenses are generally excluded from your income subject to IRS limits.

10.4 HIPAA Privacy Compliance. The Plan may have access to certain health information about you and your Dependents. This information is necessary to administer claims and provide benefits under the Plan. The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures. If you have any questions about how the Plan protects your PHI, if you would like information about the Plan’s privacy practices or if you want to make a complaint about the Plan’s privacy activities, contact the Plan Administrator.

10.5 Recovery of Overpayment. Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these overpayments from any individual (including you, an insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefit claims until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, one of your Dependents or one of your authorized representatives, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

10.6 Non-assignment of Benefits. Plan Participants and their eligible Dependents cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a Retiree Participant’s child if required by a QMCSO. In addition, subject to the written direction of a Retiree Participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a Retiree Participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, Plan Administrator and Employer to the extent of such payment.
No assignment currently in effect or prospective, may be made for the payment of benefits to a provider, including physicians, hospitals or other providers of services covered by the Plan or any benefit under the Plan. Plan payments directly to a provider for covered expenses shall not be construed as a waiver of this anti-assignment requirement. Further, any assignment recognized or accepted by the Plan shall be limited to the right to receive payment or benefits for Eligible Medical Expenses and shall not include the right to pursue claims or litigation of any other nature against the Plan, including, but not limited to, fiduciary claims or acting on behalf of a claimant in pursuing benefit claims under the Plan, or confer to the provider any specific rights under the Plan or ERISA.

10.7 **Misstatement of Fact.** In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

10.8 **No Enlargement of Employment Rights.** Nothing contained in the Plan is to be construed as a contract of employment between the Employer and you. The Plan shall not be deemed to give you the right to be retained in the employ of the Employer, nor shall it limit the right of the Employer to employ or discharge you or to discipline you, for any reason or for no reason.

10.9 **Authority to Construe and Apply Plan Documents.** To the full extent permitted by law, the Employer, the Plan Administrator and their designees under the terms of the Plan (the “Decision-makers”) shall have the discretionary authority to:

(a) Construe any uncertain or disputed term or provision in the Plan and related documents, and this Summary (collectively, “Plan Documents”), and

(b) Decide all questions of law and fact concerning the Plan Documents and their application (including, but not limited to, determining questions concerning eligibility and benefits).

The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to you, your Dependents, your estate and your beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law.

10.10 **Incapacity.** If the Plan Administrator or third-party plan administrator deems any person entitled to receive any amount under the Plan to be incapable of receiving or acknowledging payment by reason of minority, illness or infirmity, mental incompetency, or incapacity of any kind, the Plan Administrator or third-party plan administrator may make the payment in any one or more of the following ways:

(a) Directly to the person;

(b) To the person’s legal representative for the person’s exclusive benefit; or

(c) To the spouse, child or relative by blood or marriage of the person for the person’s exclusive benefit.
10.11 **Standard of Judicial Review.** Any review of an exercise of the discretionary authority described in Section 10.9 shall be based only on such evidence presented to or considered by the Decision-maker at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Decision-maker makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described in this Section and in the Plan.
ARTICLE XI

STATEMENT OF ERISA RIGHTS

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 shall be entitled to:

(a) Receive Information About Your Plan and Benefits.

(1) 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 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.

(2) 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 Plan Administrator may make a reasonable charge for the copies.

(3) 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.

(b) Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(c) 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 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 the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(d) Enforce Your Rights. If your claim for an ERISA welfare benefit 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.

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 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 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.

(e) 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.