Form 5500

Annual Return/Report of Employee Benefit Plan
This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110
1210-0089

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information
For calendar plan year 2020 or fiscal plan year beginning 10/01/2020 and ending 09/30/2021

A This return/report is for:  □ a multiemployer plan  □ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)

□ a single-employer plan  □ a DFE (specify) __

B This return/report is:  □ the first return/report  □ the final return/report

□ an amended return/report  □ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. □

D Check box if filing under:  □ Form 5558  □ automatic extension

□ special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
TRINITY HEALTH ERISA PENSION PLAN

1b Three-digit plan number (PN) 021

1c Effective date of plan 10/01/1996

2a Plan sponsor’s name (employer, if for a single-employer plan)

Mailing address (include room, apt., suite no. and street, or P.O. Box)

City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

TRINITY HEALTH CORPORATION

20555 VICTOR PARKWAY
LIVONIA, MI 48152

2b Employer Identification Number (EIN) 35-1443425

2c Plan Sponsor’s telephone number 734-343-1043

2d Business code (see instructions) 622000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE
Filed with authorized/valid electronic signature. 07/01/2022 HEIDI KING

Signature of plan administrator Date Enter name of individual signing as plan administrator

SIGN HERE

Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan sponsor

SIGN HERE

Signature of DFE Date Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.
### Plan administrator’s name and address

**TRINITY HEALTH CORPORATION**  
**BENEFITS COMMITTEE**  
**20555 VICTOR PARKWAY**  
**LIVONIA, MI 48152**

#### Administrator’s EIN
- **3b** Administrator’s EIN  
  35-1443425

#### Administrator’s telephone number
- **3c** Administrator’s telephone number  
  734-343-1043

### If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan,
enter the plan sponsor’s name, EIN, the plan name and the plan number from the last return/report:

#### a Sponsor’s name
- **4a** Sponsor’s name

#### b Plan Name
- **4b** Plan Name

### Total number of participants at the beginning of the plan year
- **5** Total number of participants at the beginning of the plan year

### Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).

#### a(1) Total number of active participants at the beginning of the plan year
- **6a(1)** 3266

#### a(2) Total number of active participants at the end of the plan year
- **6a(2)** 2807

### b Retired or separated participants receiving benefits
- **6b** 2131

### c Other retired or separated participants entitled to future benefits
- **6c** 3712

### d Subtotal. Add lines 6a(2), 6b, and 6c.
- **6d** 8650

### e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.
- **6e** 160

### f Total. Add lines 6d and 6e.
- **6f** 8810

### g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)
- **6g**

### h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested
- **6h** 0

### 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)
- **7**

### If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
- **8a**
  - **1A**
  - **1C**
  - **1I**
  - **3H**

### b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

### Plan funding arrangement (check all that apply)
- **9a**
  - (1) Insurance
  - (2) Code section 412(e)(3) insurance contracts
  - (3) X Trust
  - (4) General assets of the sponsor

### Plan benefit arrangement (check all that apply)
- **9b**
  - (1) Insurance
  - (2) Code section 412(e)(3) insurance contracts
  - (3) X Trust
  - (4) General assets of the sponsor

### 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

#### a Pension Schedules
  - (1) X R (Retirement Plan Information)
  - (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
  - (3) X SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

#### b General Schedules
  - (1) X H (Financial Information)
  - (2) I (Financial Information – Small Plan)
  - (3) 0 A (Insurance Information)
  - (4) X C (Service Provider Information)
  - (5) X D (DFE/Participating Plan Information)
  - (6) G (Financial Transaction Schedules)
<table>
<thead>
<tr>
<th>Part III</th>
<th>Form M-1 Compliance Information (to be completed by welfare benefit plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11a</td>
<td>If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ........................................... □ Yes □ No</td>
</tr>
</tbody>
</table>

If "Yes" is checked, complete lines 11b and 11c.

| 11b      | Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ........... □ Yes □ No |

| 11c      | Enter the Receipt Confirmation Code for the 2020 Form M-1 annual report. If the plan was not required to file the 2020 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) |

  Receipt Confirmation Code______________________