Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) Summary Plan Description

Effective January 1, 2020

Overview

Trinity Health Corporation (Trinity Health) has established the Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) (Plan) in order to provide health and welfare benefits for eligible retirees of Trinity Health and its affiliates that are participating employers in the Plan and their dependents and other beneficiaries. Trinity Health and its affiliates that are participating employers in the Plan are individually and collectively referred to in this summary plan description as the "Employer."

This booklet is a summary plan description (Summary or SPD) prepared in compliance with the Employee Retirement Income Security Act of 1974, as amended (ERISA). This Summary, including the Supplements and incorporated documents that constitute part of this Summary, provides a general explanation of the Plan. The incorporated documents include the booklets and certificate and evidence of coverage documents for the Benefit Programs. The Plan, together with each Benefit Program, 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 SPD and the complexity of the Plan document, some details may not have been described or have been described only briefly.

The information contained in this SPD is accurate as of January 1, 2020. The provisions of the Plan described in this SPD may be changed from time to time. In addition, Trinity Health reserves the right to modify, suspend or terminate any of the benefits referenced in this SPD at any time.

If there is a conflict or discrepancy between any of the information in this SPD and the terms of the applicable Plan documents, the Plan documents will govern. The formal Plan documents are the only sources upon which you may properly rely to determine your benefits and rights under the Plan. The Plan has changed several times over the years and may be amended again in the future. Your rights are generally determined by the terms of the Plan in effect at the time you terminate employment.

At any time, you may review or obtain a copy of the current Plan documents, or a previous Plan document if relevant to you. To do so, contact the Trinity Health HR Service Center. Although an HR Service Center representative will help you obtain information about the Plan, an HR Service Center representative cannot make a binding determination as to your rights or benefits under the Plan. Only the Plan Administrator, Administrator and their delegated representatives indicated in the Plan documents and this SPD, if any, have that right. For this reason, Trinity Health cannot be bound by statements made by unauthorized personnel regarding the Plan and your rights and benefits under the Plan.

Except where the context clearly indicates otherwise, references to "you" and "your" in this summary plan description are intended to be references to the Eligible Retiree or Participant.

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.

THIS SUMMARY DESCRIBES THE PLAN. IT DOES NOT TAKE THE PLACE OF THE ACTUAL PLAN DOCUMENT OR EXTEND OR CHANGE THE PLAN IN ANY WAY. THE PLAN DOCUMENT GOVERNS THE OPERATION AND CONSTRUCTION OF THE PLAN. WHILE EVERY EFFORT HAS BEEN MADE TO HAVE THIS SUMMARY BE AS COMPLETE AND ACCURATE AS POSSIBLE. THIS SUMMARY CANNOT BE A FULL RESTATEMENT OF THE PLAN. THE FULL PROVISIONS OF THE PLAN CAN ONLY BE DETERMINED PRECISELY BY CONSULTING THE APPLICABLE PLAN DOCUMENTS. IF ANY CONFLICT OR DISCREPANCY SHOULD ARISE BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN OR IF ANY PART IS NOT COVERED OR IS ONLY PARTIALLY COVERED. THE TERMS OF THE ACTUAL PLAN WILL GOVERN.

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Definitions

The following provides you with definitions of many of the benefit terms used throughout this SPD. These words, when capitalized, have the meaning set forth below.

Administrator — means the person, persons or entity appointed by the Plan Administrator from time to time to assist in the day-to-day administration of the Plan.

Affiliated Employer — means a group of corporations, trades or businesses (whether or not incorporated) that are under common control, or an "affiliated service group." For this purpose, there are rules under the Code for determining whether there is common control or whether two or more entities are an affiliated service group.

Benefits Committee — means the Trinity Health Benefits Committee. The principal purpose and function of the Benefits Committee, which shares common religious bonds and convictions with the Catholic Church, is to oversee the administration of employee benefit plans and programs adopted by Trinity Health Corporation and its subsidiaries that provide benefits to colleagues throughout the health system and which are exempt from ERISA as "church plans." The Benefits Committee assists the Plan Sponsor in the administration of the Plan. Accordingly, all references in the SPD to the "Plan Administrator," are references to the Plan Sponsor, as assisted in discharging its duties by the Benefits Committee, in accordance with the Benefits Committee's Charter and By-Laws and its delegated authority, and only to the extent it does not detract from the Benefits Committee's principal purpose of administration of the church plans, or the Administrator, in accordance with its delegated authority in the Trinity Health Corporation Table of Authority for Welfare Benefit Plans.

Beneficiary — means an Eligible Dependent who is enrolled in one or more Benefit Programs under the Plan.

Benefit Service — means benefit service as determined under the Retirement Plan.

Child — means, except as otherwise provided in an Incorporated Document, an Eligible Retiree's or Participant's unmarried natural child, stepchild, foster child, or legally adopted child (if under the age of 18 at the time of placement).

Claimant — means a Participant or Beneficiary or his or her heir, legatee, administrator, executor, personal representative, beneficiary, or assign, who may make a claim for eligibility to participate in or a benefit under the Plan or a Benefit Program.

Claims Administrator — means the person(s) responsible for processing claims under the Plan or a Benefit Program under the Plan. The Claims Administrator has final discretionary authority to construe the terms of the Plan for purposes of final claims determinations with respect to those claims for which it is designated as the Claims Administrator.

Code — means the Internal Revenue Code of 1986, as amended from time to time.

Contributions — means the amount, if any, that a Participant or Beneficiary must pay for the benefits under a Benefit Program.

Eligible Dependent — means an Eligible Retiree's Spouse or Child who is eligible for coverage under a Benefit Program as specified the Plan or an Incorporated Document. To be an Eligible Dependent with respect to the Medical Benefit Program (Including Prescription Drug Program), an Eligible Retiree's Spouse or Child must have participated in a medical/prescription drug plan of the Employer or Plan Sponsor, or in their own employer's medical/prescription drug plan, for at least five (5) continuous years immediately before the Eligible Retiree retires (i.e., terminates from employment with the Employer and, if applicable, Plan Sponsor).

Except as otherwise provided in an Incorporated Document, an Eligible Retiree's or Participant's Child is an Eligible Dependent only if the Child is unmarried and considered a "dependent" of the Eligible Retiree or Participant under Section 152 of the Code (without regard to subsections (b)(1) and (d)(1)(B) for purposes of benefits under Code Sections 105 and/or 106). However, any Child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc. where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) is treated as a dependent of both parents. In addition, eligibility for coverage of a legally adopted Child pursuant to an interlocutory order of adoption begins at the time of placement in the Eligible Retiree's or Participant's home whether or not the adoption proceedings have been completed.

Notwithstanding the above, a Child who is a full-time student and Eligible Dependent covered under the Medical Benefit Program (Including Prescription Drug Program) or HRA Program will not cease to be an Eligible Dependent with respect to the Benefit Program solely due to the fact that the Child takes a medically necessary leave of absence (or reduces his or her hours to part-time status for a medically necessary reason) from an accredited college or university. The medically necessary leave of absence (or reduction of hours) must be verified by written certification from the Child's treating physician. The Child must be enrolled in the Benefit Program as an Eligible Dependent immediately prior to the medically necessary leave of absence (or reduction of hours) and the absence must otherwise cause the Child to lose coverage under the Benefit Program. The Child will continue to be an Eligible Dependent for up to one year after the first day of any verified medically necessary leave of absence or, if earlier, the date coverage would otherwise terminate under the Benefit Program.

If a husband and wife are both Eligible Retirees: (i) neither husband nor wife may be covered under the Plan or any Benefit Program under the Plan as both an Eligible Dependent and a Participant, and (ii) coverage shall not be duplicated for an Eligible Dependent of both the husband and wife.

Eligible Retiree — means a Retiree who is eligible to participate in the Plan in accordance with the eligibility requirements of a Benefit Program as specified by the applicable Employer or the applicable Incorporated

Document(s). However, an ***"HRA Eligible Retiree"*** is a Retiree who satisfies the requirements to be an HRA Eligible Retiree set forth in applicable SPD Supplement.

Employee — means an employee of an Employer (as determined by the Employer) who is not:

- A leased employee;
- Classified by the Employer as an independent contractor;
- A nonresident alien with no U.S. source income;
- A "self-employed individual" under Code Section 401(c); or
- Covered by a collective bargaining agreement, unless and to the extent participation in the Plan is expressly provided for under the bargaining agreement.

ERISA — means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Employer — means the participating employers in the Plan. The participating employers are the Holy Cross entities listed in the Holy Cross Supplement to the SPD and the Saint Joseph Mercy Health System entities listed in a Saint Joseph Mercy Health System Supplement to the SPD.

HIPAA — means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA — means health reimbursement account.

Incorporated Documents — means each contract, agreement, policy, arrangement for services or otherwise, and each SPD, other summary or similar document that relates to any Benefit Program under the Plan.

Medicare Eligible — means an individual is eligible for coverage under Medicare Part A for any reason. For purpose of the Plan an individual is Medicare Eligible on the day he or she becomes eligible for coverage under Medicare Part A for any reason and regardless of whether the individual actually enrolls in Medicare (Part A, B or D).

Participant — means an Eligible Retiree who has satisfied the applicable eligibility conditions and has elected to participate in one or more of the Benefit Programs under the Plan.

Period of Coverage — The Plan Year except: (a) for Eligible Retirees who first become Participants and Eligible Dependents who first become Beneficiaries during a Plan Year, the portion of the Plan Year following the date participation commences; and (b) for Participants and Beneficiaries who terminate participation during a Plan Year, the portion of the Plan Year prior to the date participation terminates.

Plan — means the Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) as described herein, and as amended from time to time.

Plan Administrator — means the Plan Sponsor. However, the Benefits Committee assists the Plan Sponsor in the administration of the Plan, in accordance with its Charter and By-Laws, to the extent it does not detract from the Benefits Committee's principal purpose of the administration and oversight of the employee benefit plans of the Plan Sponsor and its related and affiliated entities that are not employee benefit plans intended to qualify as "church plans" exempt from the requirements of ERISA, including the Plan. Accordingly, references in the Plan and this SPD to the "Plan Administrator," are references to the Benefits Committee, in accordance with its Charter and By-Laws, but only to the extent it does not detract from the Benefits Committee's principal purpose of the administration and oversight of the employee benefit plans of the Plan Sponsor and its related and affiliated entities that are employee benefit plans intended to qualify as church plans.

Plan Sponsor — means Trinity Health Corporation.

Plan Year — means the twelve (12) month period beginning on July 1 and end on the following June 30.

Retiree — means:

- If you are a former Employee of an Employer that is a Holy Cross entity listed in the Holy Cross Supplement to this SPD, you satisfy the requirements to be "Retiree" in the Holy Cross Supplement; and
- If you are a former Employee an Employer that is a Saint Joseph Health System entity listed in a Saint Joseph Health System Supplement to this SPD, you satisfy the requirements to be a "Retiree" in the applicable Saint Joseph Health System Supplement.

Retirement Plan — means the Trinity Health Pension Plan and any plan that has merged with and into the Trinity Health Pension Plan or, if an Employer is not a participating employer in the Trinity Health Pension Plan, the retirement plan specified by the Employer.

Spouse — means, except as otherwise provided in an Incorporated Document, the legally married husband or wife of an Eligible Retiree under applicable law; for this purpose, applicable law is the law of the State or foreign jurisdiction where the Eligible Retiree and Spouse were married. A spouse by common law marriage is not a Spouse for Plan purposes.

Treasury Regulations — means the Treasury Regulations promulgated under the Code by the Secretary of the Treasury, as amended from time to time.

Trinity Health — means, for purposes of this SPD, Trinity Health Corporation and all entities which are Affiliated Employers of Trinity Health Corporation, whether or not they are participating Employers, and all entities that are participating Employers in the Plan, and their Affiliated Employers, whether or not they are participating Employers.

Available Benefit Programs

The following ***"Benefit Programs"*** are available under the Plan.

1. Medical Benefit Program (including Prescription Drug Program) -- covers a variety of health-related services and supplies and prescription drugs and medications for Participants and Beneficiaries.

2. Trinity Health Retiree Health Reimbursement Arrangement (referred to as the "**HRA Program"**) -- a medical reimbursement plan under which certain eligible medical expenses incurred by Participants and Beneficiaries are reimbursed.

3. Life Insurance Program - provides life insurance coverage for Participants.

Each Benefit Program is further described in this Summary and the Incorporated Documents. This Summary incorporates by reference the Incorporated Documents applicable to the Benefit Programs listed above. Copies of the Incorporated Documents for a Benefit Program are generally provided to you once you are eligible to participate in the Benefit Program. If you do not have the Incorporated Documents, you may request them from the Administrator. See the ***"Important Plan Information"*** Section of the Summary for the Administrator's contact information.

Please refer to the Incorporated Documents applicable to a Benefit Programs for specific information concerning the Benefit Program, your eligibility for such Benefit Program, the specific benefits offered, and the circumstances which may result in your disqualification or ineligibility or in the denial, loss, forfeiture or suspension of your benefits.

Note: COBRA coverage and retiree health plans are not considered coverage based on current employment and therefore do not qualify for or toll/extend the Medicare Special Enrollment Period.

Eligibility and Participation

WHO IS ELIGIBLE?

You are eligible to participate in the Plan if you are an Eligible Retiree. If you are eligible for medical benefits as an active employee of Trinity Health or any Employer, you are not eligible to participate in the Plan or any Benefit Program under the Plan. In addition, except as otherwise provided in an Incorporated Document or this SPD, if you are eligible for Medicare Part B or become eligible for Medicare Part B, you must enroll in and pay for Medicare Part B in order to be eligible to participate, or to continue to participate, in the Plan and each Benefit Program hereunder.

If you are an Eligible Retiree, you may enroll your Eligible Dependent(s), if any, in a Benefit Program in which you enroll yourself and for which they satisfy the applicable eligibility requirements. However, if your Eligible Dependent is eligible for medical benefits as an active employee of Trinity Health or any Employer, the Eligible Dependent is not eligible for coverage under any Benefit Program under the Plan. In addition, except as otherwise provided in an Incorporated Document, if your Eligible Dependent is eligible for Medicare Part B or becomes eligible for Medicare Part B, the Eligible Dependent must enroll in and pay for Medicare Part B in order to be eligible for coverage under, or to continue to be eligible for coverage under, any Benefit Program.

HOW DO I BECOME A PARTICIPANT OR BENEFICIARY?

If you are an Eligible Retiree, in order to become a Participant in any Benefit Program in which you are eligible to participate that requires enrollment, you must enroll in the Benefit Program at the time and in accordance with the procedures established by the Administrator or applicable third-party administrator from time to time and after satisfaction of any waiting periods or other eligibility requirements, if any, specified in the applicable Incorporated Documents. In general, you will need to complete various enrollment documents (or enroll online, if directed by the Administrator or applicable third-party administrator) in order to participate in the Plan and the Benefit Programs and to enroll your Eligible Dependents. The Administrator or applicable third-party administrator will provide you with all the information you need to properly enroll in each Benefit Program available to you.

If you timely enroll yourself in a Benefit Program in accordance with the procedures established by the Administrator or applicable third-party administrator, unless otherwise provided in an Incorporated Document applicable to the Benefit Program or as provided below for the HRA Program, you become a Participant in that Benefit Program effective as of the later of the date you become an Eligible Retiree with respect to the Benefit Program or the first day of the month after you timely return the completed enrollment forms (or enroll online, if directed by the Administrator or applicable third-party administrator).

If you do not return any required enrollment form for a Benefit Program to the Administrator or applicable third-party administrator (or enroll online, if directed by the Administrator or applicable third-party administrator) until after the established enrollment deadline, you will be deemed to have elected not to participate in that Benefit Program.

If you are an Eligible Retiree, in order for your Eligible Dependent to become a Beneficiary (i.e., covered) under one or more Benefit Programs in which the Eligible Dependent is eligible to participate except the HRA Program, you must enroll your Eligible Dependent in the Plan and each applicable Benefit Program in accordance with the procedures established by the Administrator or applicable third-party administrator from time to time. Except as otherwise provided in an Incorporated Document or as described below for the HRA Program, you must enroll yourself in a Benefit Program in order to enroll your Eligible Dependent in the Benefit Program.

If you are an Eligible Retiree and you timely enroll yourself and your Eligible Dependent in the Plan and each applicable Benefit Program, except as otherwise provided in an Incorporated Document or below for the HRA Program, your Eligible Dependent will become a Beneficiary when you become a Participant (i.e., when your coverage becomes effective) or, if later, the first day of the month following the later of the date the individual becomes your Eligible Dependent or the date you enroll the individual. However, except as provided below with respect to the HRA Program or in an Incorporated Document, if you do not enroll your Eligible Dependent in a Benefit Program at the time you initially enroll yourself in the Benefit Program, you cannot enroll the Eligible Dependent in the Benefit Program at a later date.

In general, if you are an Eligible Retiree but you do not timely enroll yourself and your Eligible Dependent(s), if any, in a Benefit Program when you are initially eligible to participate in the Benefit Program, you cannot enroll yourself or your Eligible Dependent(s) in the Benefit Program at a later date. However, except as provided in an Incorporated Document:

- If you are an Eligible Retiree and, at the time you are initially eligible to participate in a health Benefit Program (such as the Medical Benefit Program (Including Prescription Drug Program)), you have the same type of health coverage from another group or individual plan or policy other than Medicare, including a group health plan of the Plan Sponsor, a participating Employer or one of their Affiliated Employers, you may postpone your and your Eligible Dependent's, if any, enrollment in the applicable health Benefit Program under the Plan until such other coverage terminates. In order to enroll yourself and your Eligible Dependent(s), if any, in the health Benefit Program after you are initially eligible to participate, you must provide proof of continued health coverage from another group or individual plan or policy other than Medicare to the Administrator in accordance with procedures established by the Administrator.
- If you are an Eligible Retiree and, at the time you initially enroll yourself in a health Benefit Program, your Eligible Dependent has the same type of health coverage from another group or individual

plan or policy other than Medicare, including a group health plan of the Plan Sponsor, a participating Employer or one of their Affiliated Employers, you may postpone enrolling your Eligible Dependent in the health Benefit Program until such other coverage terminates. However, in order to enroll your Eligible Dependent in the health Benefit Program after you initially enroll, you must provide proof of your Eligible Dependent's continued health coverage from another group or individual plan or policy other than Medicare to the Administrator in accordance with procedures established by the Administrator.

TERMINATION OF PARTICIPATION

Except as specifically provided in any Benefit Program, you will cease to be a Participant in a Benefit Program under the Plan as of the earliest of:

- The date specified in the applicable Incorporated Documents;
- The date the Plan terminates;
- The date the Benefit Program terminates;
- The date you stop making any required contributions, including any required contributions for Medicare Part B if you are eligible for Medicare Part B;
- Except as otherwise provided in an Incorporated Document, the date you become eligible for Medicare Part B if you do not enroll in and pay for Medicare Part B;
- The date you return to work as a part-time or full-time employee of an Employer or Trinity Health and are eligible for the Employer's or Trinity Health's group health benefits as an active employee;
- The date you begin active service in the armed forces of any country (unless coverage is continued as provided under USERRA);
- The date you elect to terminate participation;
- The date of your death;
- The date the Plan is amended so that you are no longer eligible to participate; and
- The date as of which you have received all of the benefits to which you are entitled under the Benefit Program (e.g., the date on which you have exhausted your HRA, if any).

A Beneficiary shall cease to be a covered under a Benefit Program under the Plan as of the earliest of:

- Except as otherwise provided in an Incorporated Document or with respect to the HRA Program, the date the Participant ceases to be a Participant;
- The date the Beneficiary ceases to be an Eligible Dependent;
- The date the Plan is amended so that the Eligible Dependent is no longer eligible for coverage;
- The date the Participant or Beneficiary stops making any required contributions, including any required contributions for Medicare Part B if the Beneficiary is eligible for Medicare Part B;

- Except as otherwise provided in the applicable Incorporated Document, the date the Beneficiary becomes eligible for Medicare Part B if he or she does not enroll in and pay for Medicare Part B;
- The date the Beneficiary becomes an employee of an Employer; or
- The date the Beneficiary begins active service in the armed forces of any country (unless coverage is continued as provided under USERRA).

If you are an HRA Eligible Retiree, in addition to the above:

- Your coverage under the Medical Benefit Program (including Prescription Drug Program) terminates on the date you become Medicare Eligible.
- If you timely enroll in the HRA Program, the Medical Benefit Program (including Prescription Drug Program) coverage of each of your Beneficiaries (i.e., each of your covered Eligible Dependents) will terminate on the earlier of the date set forth above or the date the Beneficiary becomes Medicare Eligible.
    - If you do not timely enroll in the HRA Program, the Medical Benefit Program (including Prescription Drug Program) coverage of each of your Beneficiaries (i.e., each of your covered Eligible Dependents) will terminate on the date you become Medicare Eligible.
    - In all cases, the Medical Benefit Program (including Prescription Drug Program) coverage of each Beneficiary, terminates no later than the date the Beneficiary becomes Medicare Eligible.

If a Participant dies, the Participant's Beneficiaries will continue to be covered under the Plan and the Benefit Programs under the Plan so long as they continue to satisfy the eligibility requirements and make any required contributions.

In addition to the above, other circumstances that can result in the termination, reduction, loss or denial of benefits under a Benefit Program (e.g., exclusions for certain medical procedures) are described in the Incorporated Documents.

Under certain circumstances, even though your participation in (or your Eligible Dependent's coverage under) a Benefit Program has terminated, the provisions of the specific Benefit Program may permit you (and/or your Eligible Dependent, if applicable) to continue to be covered under the Benefit Program at your own cost (called ***"COBRA Continuation Coverage"***). See the ***"COBRA Continuation Coverage"*** Section of this Summary below for more details.

REENROLLMENT

Except as otherwise provided in an Incorporated Document, if you are a Participant you may elect to discontinue your coverage under a Benefit Program other than the HRA Program at any time. However, except as otherwise provided in an Incorporated Document, if you are a former Participant, in order to reenroll in a Benefit Program other than the HRA Program, you must be an Eligible Retiree and must provide

proof of continued health or life insurance coverage, as applicable, from another group or individual plan or policy other than Medicare during the entire period you are not enrolled in the Benefit Program to the Administrator in accordance with procedures established by the Administrator. If you are a Participant and you elect to discontinue your coverage under a Benefit Program other than the HRA Program, coverage for your Beneficiaries will also be discontinued. Except as otherwise provided in an Incorporated Document, if you later elect to reenroll yourself in a Benefit Program other than the HRA Program you may reenroll your Eligible Dependents; provided, however, that to reenroll an Eligible Dependents, you must provide proof to the Administrator of the Eligible Dependent's continued health or life insurance coverage from another group or individual plan or policy other than Medicare during the entire period that the Eligible Dependent is not enrolled in the Benefit Program in accordance with procedures established by the Administrator.

Paying for your Benefits

A Participant or Beneficiary must pay a contribution or premium to participate in the Medical Benefit Program (Including Prescription Drug Program) and for any premiums and other costs for Medicare, an individual Medicare supplemental health care policy, a Medicare Advantage plan, Medicare prescription drug coverage, TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration. The Employer pays for coverage under Life Insurance Benefit Program and makes contributions to Health Reimbursement Accounts under the HRA Program.

If you are eligible to participate in the Medical Benefit Program (Including Prescription Drug Program), before the beginning of each Plan Year (or during your initial enrollment period if you are a new Eligible Retiree), the Administrator or its delegate will inform you of the amount of the required contributions for the Medical Benefit Program (Including Prescription Drug Program).

HRA Program

The HRA Program offers HRA Eligible Retirees and their Eligible Dependents a way to be reimbursed for certain Eligible Medical Expenses (defined below) that they pay out of pocket, such as premiums for coverage if they purchase a Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator.

WHAT IS A HEALTH REIMBURSEMENT ACCOUNT (HRA)?

If you are a Participant or Beneficiary in the HRA Program, an HRA will be established for you (although only one HRA will be established for all of an HRA Eligible Retiree's Beneficiaries). An HRA is a bookkeeping account established and maintained by the Plan Administrator or its delegate for each

Participant and Beneficiary in the HRA Program that reflects the amount of Employer contributions credited to the account reduced by the amount of Eligible Medical Expenses reimbursed from the account.

ELIGIBILITY

If you are an HRA Eligible Retiree, you become eligible to participate in the HRA Program effective as of the later of:

- The first day of the month following the date you become a Retiree;
- The first day of the month before the month in which you become Medicare Eligible due to age; or[1]
- The first day of the month following the later of the month in which you become Medicare Eligible due to disability or the date on which you provide the Administrator a copy of the letter from Social Security indicating that you have become Medicare Eligible due to disability.

If you are the Eligible Dependent of an HRA Eligible Retiree, you become eligible to participate in the HRA Program effective as of the later of:

- The first day of the month before the month in which you become Medicare Eligible due to age; or[2]
- The first day of the month following the later of the month in which you become Medicare Eligible due to disability or the date on which you provide the Administrator a copy of the letter from Social Security indicating that you have become Medicare Eligible due to disability.

PARTICIPATION

To participate in the HRA Program an HRA Eligible Retiree or Eligible Dependent of an HRA Eligible Retiree must be (and remain at all times during participation in the HRA Program):

- Enrolled in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator; or
- Enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration.

HRA Eligible Retirees

In general, if you are an HRA Eligible Retiree, you must enroll in the HRA Program within 45 days of the date you become eligible to participate in the HRA Program. This 45-day period is your ***"Initial HRA***

[1] Different rules may apply if you were Medicare Eligible as of December 31, 2010 or you became Medicare Eligible during January 2011. Please contact the Administrator for additional information.
[2] Different rules may apply if you were Medicare Eligible as of December 31, 2010 or you became Medicare Eligible during January 2011. Please contact the Administrator for additional information.

Enrollment Period." For example, if you are an HRA Eligible Retiree and you become Medicare Eligible on July 1, 2020, your Initial HRA Enrollment Period is June 1, 2020 through July 15, 2020.

- If you are HRA Eligible Retiree and you are not enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration, you enroll in the HRA Program by enrolling in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator in accordance with the procedures established by the Administrator and HRA Medicare Coordinator. When you timely enroll in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator, you become a Participant in the HRA Program and an HRA will automatically be established for you.
- If you are HRA Eligible Retiree and you are enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration, you enroll in the HRA Program in accordance with the procedures established by the Administrator and HRA Program Claims Administrator from time to time. In general, you will need to complete various enrollment documents (or enroll online, if directed by the Administrator or HRA Program Claims Administrator) in order to participate in the HRA Program. The Administrator or HRA Program Claims Administrator will provide you with all the information you need to enroll in the HRA Program. When you timely enroll in the HRA Program in accordance with the procedures established by the Administrator and HRA Program Claims Administrator, you become a Participant in the HRA Program and an HRA will be established for you.

Contact information for the HRA Medicare Coordinator and HRA Program Claims Administrator is set forth in the ***"Important Plan Information"*** Section of this Summary.

Subject to limited exceptions under procedures established by the Administrator in its sole and absolute discretion, if you do not enroll in the HRA Program by the end of your Initial HRA Enrollment Period, you will cease to be eligible to participate in the Plan, including the HRA Program, and, except as otherwise provided in an Incorporated Document, all coverage for you and your Eligible Dependents under the Plan and each Benefit Program will permanently terminate on the date you become Medicare Eligible. Except as provided in the "***Late Enrollment in the HRA Program***" Section of the Summary below, you will not be permitted to elect to participate in the Plan, including the HRA Program, at a later date. If you enroll in the HRA Program by the end of your Initial HRA Enrollment Period, you will become a Participant in the HRA Program and an HRA will be established for you effective as of the date you become eligible to participate in the HRA Program.

Eligible Dependents

If you are an HRA Eligible Retiree, your Eligible Dependent becomes eligible to participate in the HRA Program effective as of the later of:

- The first day of the month before the month in which you become Medicare Eligible due to age; or[3]
- The first day of the month following the later of the month in which you become Medicare Eligible due to disability or the date on which you provide the Administrator a copy of the letter from Social Security indicating that you have become Medicare Eligible due to disability.

In general, an Eligible Dependent must enroll (or be enrolled by the HRA Eligible Retiree) in the HRA Program during the Initial HRA Enrollment Period (i.e., within 45 days of the date he or she becomes eligible to participate in the HRA Program).

- If you are an Eligible Dependent of an HRA Eligible Retiree and you are not enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration, you enroll in the HRA Program by enrolling in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator in accordance with the procedures established by the Administrator and HRA Medicare Coordinator. When you timely enroll in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator, you become a Beneficiary in the HRA Program and an HRA will automatically be established for you (unless an HRA has already been established for another Eligible Dependent of your HRA Eligible Retiree because only one HRA will be established for all of an HRA Eligible Retiree's Eligible Dependents).
- If you are an Eligible Dependent of an HRA Eligible Retiree and you are enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration, you enroll in the HRA Program in accordance with the procedures established by the Administrator and HRA Program Claims Administrator from time to time. In general, you will need to complete various enrollment documents (or enroll online, if directed by the Administrator or HRA Program Claims Administrator) in order to participate in the HRA Program. The Administrator or HRA Program Claims Administrator will provide you and/or the HRA Eligible Retiree with all the information you need to enroll in the HRA Program. When you timely enroll in the HRA Program in accordance with the procedures established by the Administrator and HRA Program Claims Administrator, you become a Beneficiary in the HRA Program and an HRA will automatically be established for you (unless an HRA has already been established for another

[3] Different rules may apply if you were Medicare Eligible as of December 31, 2010 or you became Medicare Eligible during January 2011. Please contact the Administrator for additional information.

Eligible Dependent of the HRA Eligible Retiree because only one HRA will be established for all of an HRA Eligible Retiree's Eligible Dependents).

Contact information for the HRA Medicare Coordinator and HRA Program Claims Administrator is set forth in the ***"Important Plan Information"*** Section of this Summary.

Subject to limited exceptions under procedures established by the Administrator in its sole and absolute discretion, if an Eligible Dependent of an HRA Eligible Retiree does not enroll (and is not enrolled by the HRA Eligible Retiree) in the HRA Program by the end of his or her Initial HRA Enrollment Period, except as otherwise provided in an Incorporated Document, all coverage for the Eligible Dependent under the Plan and each Benefit Program will permanently terminate on the date the Eligible Dependent becomes Medicare Eligible. Except as provided in the "***Late Enrollment in the HRA Program***" Section of the Summary below, the Eligible Dependent cannot enroll (or be enrolled by the HRA Eligible Retiree) in the HRA Program at a later date. If an Eligible Dependent enrolls in the HRA Program by the end of his or her Initial HRA Enrollment Period, the Eligible Dependent will become a Beneficiary with respect to the HRA Program and, if an HRA has not already been established for the HRA Eligible Retiree's Eligible Dependents, an HRA will be established for the Beneficiary effective as of the date the Eligible Dependent becomes eligible to enroll in the HRA Program (i.e., as of the first day of the month before the month in which you become Medicare Eligible). ***Only one HRA will be established for all of an HRA Eligible Retiree's Eligible Dependents and Beneficiaries.***

Late Enrollment in the HRA Program

If, on the date you become eligible to participate in the HRA Program, you are:

(i) covered under a group health plan sponsored by an entity other than the Employer, Trinity Health or one of their Affiliated Employers;

(ii) covered under a group health plan sponsored by the Employer, Trinity Health or one of their Affiliated Employers; or

(iii) covered under any other group or individual health benefit plan or policy other than Medicare, TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration,

you may elect to enroll in the HRA Program at any time beginning on the date you are first eligible to enroll in the HRA Program and ending 45 days following the last to terminate of the coverage described in (i), (ii), or (iii), above (the ***"Late HRA Enrollment Period"***). However, in order to enroll after you first become eligible to participate in the HRA Program, you must provide proof of the continued health coverage described in (i), (ii), or (iii), as applicable, to the Administrator in accordance with procedures established by the Administrator. Subject to limited exceptions under procedures established by the Administrator:

- if an HRA Eligible Retiree does not enroll in the HRA Program by the end of the Late HRA Enrollment Period, the HRA Eligible Retiree cannot enroll in the HRA Program, and, except as otherwise provided in an Incorporated Document, all coverage for the HRA Eligible Retiree and his or her Eligible Dependents under the Plan and each Benefit Program will permanently terminate on the date the last day of the Late HRA Enrollment Period.
- if an Eligible Dependent does not enroll (and is not enrolled by the HRA Eligible Retiree) in the HRA Program by the end of the Late HRA Enrollment Period, the Eligible Dependent will not be permitted to enroll (or be enrolled) in the HRA Program, and, except as otherwise provided in an Incorporated Document, all coverage for the Eligible Dependent under the Plan and each Benefit Program will permanently terminate on the date the last day of the Late HRA Enrollment Period..

If you are an HRA Eligible Retiree and you enroll in the HRA Program during the Late HRA Enrollment Period, you will become a Participant in the HRA Program and an HRA will be established for you effective as of the first day of month following the date you enroll in the HRA Program.

If you are an HRA Eligible Retiree's Eligible Dependent and you enroll in the HRA Program by the end of the Late HRA Enrollment Period, you will become a Beneficiary with respect to the HRA Program and, if an HRA has not already been established for the Eligible Retiree's Eligible Dependents, an HRA will be established for you effective as of the first day of month following the date you enroll in the HRA Program.

Continuation of Coverage Under Other Benefit Programs

If you are an HRA Eligible Retiree, you become Medicare Eligible and you timely enroll in the HRA Program, your Eligible Dependents who are not Medicare Eligible may continue to be covered under one or more of the other Benefit Programs, subject to the terms of the applicable Incorporated Document(s) for that Benefit Program(s). For example, if you and your Eligible Dependent are enrolled in the Medical Benefit Program (Including Prescription Drug Program) under the Plan and you become Medicare Eligible but your Eligible Dependent is not Medicare Eligible, and you enroll in the HRA Program, except as otherwise provided in the Incorporated Document(s) for the Medical Benefit Program (Including Prescription Drug Program), your Eligible Dependent may continue to be enrolled in the Medical Benefit Program (Including Prescription Drug Program) until he or she becomes Medicare Eligible. Similarly, if you are an HRA Eligible Retiree and your Eligible Dependent becomes Medicare Eligible but you are not yet Medicare Eligible, your Eligible Dependent may enroll (or you may enroll your Eligible Dependent) in the HRA Program and you may continue to be enrolled in the other Benefits Program(s) under the Plan for which you are eligible (such as the Medical Benefit Program (Including Prescription Drug Program)), until you become Medicare Eligible.

Changing Medicare Plans

A Participant or Beneficiary who enrolls in the HRA Program by enrolling in an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator may change his/her Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator during the applicable Medicare open enrollment period (generally October 15 – December 7) and at such other times permitted by Medicare including during a Medicare special enrollment period) in accordance with the procedures established by the HRA Medicare Coordinator. A complete list of the Medicare special enrollment periods is located on Medicare's website (www.medicare.gov). In addition, each year Participants and/or Beneficiaries enrolled in a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator should receive a communication from the HRA Medicare Coordinator to notify them of any action (if applicable) they must take during Medicare's annual open enrollment period. Individuals are encouraged to talk to their Benefits Advisor at the HRA Medicare Coordinator who will review their situation and assist them appropriately.

BENEFITS

If you are a Participant in the HRA Program, you may receive reimbursement from your HRA for Eligible Medical Expenses incurred by you or your Eligible Dependents on or after the effective date of your enrollment in the HRA Program, up to the balance in your HRA (properly reduced as of any particular time for prior reimbursements from the HRA).

If you are a Beneficiary, you may receive reimbursement from your HRA for all Eligible Medical Expenses incurred by you or the Eligible Retiree on or after the effective date of your enrollment in the HRA Program, up to the balance in your HRA (properly reduced as of any particular time for prior reimbursements from the HRA).

ELIGIBLE MEDICAL EXPENSES

"Eligible Medical Expenses" are expenses for "medical care", as defined under Code Section 213(d), incurred by a Participant or Beneficiary during a Period of Coverage and after the effective date that an HRA has been established for the Participant or Beneficiary. Eligible Medical Expenses include premiums for an individual Medicare supplemental health care policy a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator and Medicare Part B premiums if you are enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration. Certain over-the-counter drugs and medicines (e.g., nonprescription drugs, such as antacids, allergy medicines, pain relievers, and cold medicines but not including toiletries, cosmetics, or vitamins) and over-the-counter medical supplies are Eligible Medical Expenses to the extent such supplies are for medical care (within the meaning Code Section 213(d)).

Eligible Medical Expenses do not include:

- Any expenses which are reimbursable under any other health insurance plan or program, whether or not sponsored by the Employer and whether insured, through a health maintenance organization, preferred provider organization or otherwise; and
- Medications/drugs prohibited from interstate shipment (which includes importation) to the United States because they have not been approved by the United States Federal Food, Drug and Cosmetic Act.

For purposes of the HRA Program, an expense is incurred when the Participant or Beneficiary is furnished the medical care or services giving rise to the claimed expense. In all cases, a Participant or Beneficiary, as applicable, must submit evidence that the Eligible Medical Expenses were paid in order to receive reimbursement from their HRAs.

CLAIMS

How to Get Reimbursed

Claims for reimbursement of Eligible Medical Expenses from an HRA must be filed with the HRA Program Claims Administrator. Contact information for the HRA Program Claims Administrator is set forth in the ***"Important Plan Information"*** Section of this SPD.

You have six months to file requests for reimbursement after you are no longer eligible for the HRA Program. The six-month deadline does not apply to you, as long you remain eligible to receive Contributions to your HRA.

Auto-Reimbursement

In most cases, you are automatically enrolled in "auto-reimbursement" when you initially purchase an individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator unless the health care provider for that Medicare supplemental health care policy, Medicare Advantage plan or Medicare prescription drug coverage does not offer this option. If you are enrolled in auto-reimbursement, once you have paid your premium, your premium will automatically be reimbursed to you from your HRA — up to the current balance. If you enroll with a health care provider that does not offer the auto-reimbursement option, you will be responsible for submitting claims for reimbursement of your premiums. In addition, if you do not want the auto-reimbursement feature when you enroll in a Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the Medicare Coordinator for the first time, contact the Medicare Coordinator when you enroll. If you want to decline the auto-reimbursement after you first enroll, please contact the HRA Program Claims Administrator.

Filing a Form for Reimbursement

When you (or your Eligible Dependent if you are the Participant) incur Eligible Medical Expenses after you are enrolled in the HRA Program that are not reimbursed through auto-reimbursement, go online to https://retiree.aon.com/TrinityHealth and print and complete the Your Spending Account Claim form. For purposes of the HRA Program, an expense is incurred when the Participant or Beneficiary is furnished the medical care or services giving rise to the claimed expense.

If you do not have online access, contact the HRA Program Claims Administrator to obtain the Your Spending Account Claim form ("Claim Form"). You can receive your reimbursement the fastest by faxing your completed Claim Form and copies of receipts to the HRA Program Claims Administrator's facsimile number listed in the ***"Important Information"*** Section of this SPD. You also have the option of mailing the completed Claim Form and copies of receipts to the HRA Program Claims Administrator's address listed in the ***"Important Information"*** Section of this SPD or uploading your claims on the HRA Program Claims Administrator's website. You will be reimbursed for Eligible Medical Expenses by check. However, for faster reimbursement, you may sign up to have reimbursements electronically deposited to your bank account. With electronic reimbursement, these funds are immediately available to you; you do not need to wait for a check to clear. *Note: Banking laws do not permit electronic deposit (direct deposit) to international bank accounts. (This does not apply to U.S. territories such as Puerto Rico.)*

Information Required for Reimbursement

To make a claim for reimbursement of an Eligible Medical Expense, complete, sign and date the Claim Form verifying the Eligible Medical Expense has not been reimbursed by another policy or plan and submit the Claim Form to the Claim Form to the HRA Program Claims Administrator in accordance with the above. You need to include supporting documentation and other information regarding your claim with your Claim Form so that the HRA Program Claims Administrator is able to confirm that the expenses claimed are Eligible Medical Expenses, including written evidence from an independent third party showing the nature and amount of the expense and certification by the Participant or Beneficiary that the expense qualifies for payment or reimbursement.

For premiums, the supporting documentation must show the following:

Premium amount(s) paid; and

Proof of payment (e.g., copies of bank statements, mailed checks or statements provided by your insurance carrier).

When submitting a claim for reimbursement of your out of pocket Eligible Medical Expenses other than premiums, your supporting documentation must include the following:

Type of service;

Date of service;

Service provider;

Who service is for; and

Requested reimbursement amount.

Note: Verbal or handwritten information for general merchandise, illegible receipts, credit card receipts, and statements with a forwarding balance will not be accepted.

Upon receipt of a properly documented claim for reimbursement of an Eligible Medical Expense, the HRA Program Claims Administrator will approve the claim and the Plan Administrator or its delegate will pay the claim amount to the Participant or Beneficiary, as applicable, up to the balance in the Participant's and Beneficiary's HRAs (properly reduced as of any particular time for prior reimbursements to the Participant and/or Beneficiary from the HRA(s)) as soon as administratively practicable.

If any balance remains in an HRA at the end of a Period of Coverage after all payments and reimbursements have been made for the Period of Coverage, the balance is carried over to pay or reimburse Eligible Medical Expenses incurred in a subsequent Period of Coverage.

If your claim for reimbursement from an HRA is denied in whole or in part, the HRA Program Claims Administrator will send you a written notice of its decision that includes: (a) the specific reason(s) for the claim's denial; (b) specific reference to pertinent HRA Program 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; (d) a description of the 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 appeal procedures have been exhausted); (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.

APPEALS OF CLAIM DENIALS

If your claim for reimbursement from an HRA is denied in whole or in part, you or a person you have designated as your authorized representative may file a Level I Appeal using the following procedures. In this SPD, a claim for reimbursement from your HRA for Eligible Medical Expenses received by either you (the Participant or Beneficiary), the Participant's Spouse, or one of the Participant's Eligible Dependents is

referred to as “your claim.” An appeal is a written request for benefits. Your written Level I Appeal must be filed within 180 days following the receipt of the claim denial notice.

A casual inquiry (even if it is in writing) regarding HRA eligibility requirements or a casual inquiry about benefits is not treated as an appeal and is not subject to these appeals procedures. You must send your claims to the HRA Program Claims Administrator and appeals to the appropriate Appeals Reviewer. If you file an appeal, you must do so in writing by U.S. mail or fax. The “Level I” Appeals Reviewer is the HRA Program Claims Administrator. The “Level II” Appeals Reviewer is the Plan Administrator or its delegate.

Level I Appeal

If you or your authorized representative timely file a written Level I Appeal with the Appeals Reviewer, the Appeals Reviewer will make a decision on the Level I Appeal and notify you of its decision as soon as practical, but no later than 30 days after its receipt of your Level I Appeal except as provided below. If you do not follow the required procedures for filing an appeal, the Appeals Reviewer will notify you and explain the proper procedures to follow in filing your appeal.

The 30-day review period may be extended for up to 15 days due to matters beyond the Appeals Reviewer’s control if, within 30 days after its initial receipt of your Level I Appeal, the Appeals Reviewer notifies you of the extension, the circumstances requiring the extension and the date by which the Appeals Reviewer expects to make a decision. The new due date for the Level I decision will not be later than 45 days after the date the Appeals Reviewer received your Level I Appeal. However, 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 (i) the day you respond to the notice, or (ii) at least 45 days from your receipt of the notice requesting additional information.

If you do not to provide the requested information within the specified timeframe, the Appeals Reviewer will decide your Level I Appeal without the requested information.

If your Level I Appeal is denied, in whole or in part, the Appeals Reviewer will send you a written notice of its decision that includes: (a) the specific reason(s) for the appeal’s denial; (b) specific reference to pertinent HRA Program provisions on which the decision is based; (c) a description of any additional material or information necessary for you to perfect your appeal and an explanation of why such material or information is necessary; (d) a description of the HRA Program’s Level II 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 the Level II Appeal (i.e., after the appeal procedures have been exhausted); (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.

Level II Appeal

If your Level I Appeal is denied, you will have 180 days following the receipt of the denial notice to file a written Level II Appeal with the Plan Administrator (i.e., the Level II Appeals Reviewer). The following procedures will apply in considering your Level II Appeal.

You or your authorized representative may submit your Level II Appeal in writing to the Appeals Reviewer who will make a decision on the Level II Appeal and notify you of its decision as soon as practical, but no later than 30 days after receipt of your Level II Appeal except as provided below. If you do not follow the required procedures for filing an appeal, the Appeals Reviewer will notify you and explain the proper procedures to follow in filing your appeal. You may submit written comments, documents, records, and other information relevant to your Level II Appeal. Upon request, you will be provided (free of charge) copies of all Appeals Reviewer's documents, records, and other information relevant to your Level II Appeal. The review of your Level II Appeal will consider all comments, documents, records, and other information you submit on your Level II Appeal and will not afford deference to the initial denial of your Level I Appeal.

The 30-day review period may be extended for up to 15 days due to matters beyond the Appeals Reviewer's control if, within 30 days after its initial receipt of your Level II Appeal, the Appeals Reviewer notifies you of the extension, the circumstances requiring the extension and the date by which the Appeals Reviewer expects to make a decision. The new due date for the Level II decision will not be later than 45 days after the date the Appeals Reviewer received your Level II Appeal. However, 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 (i) the day you respond to the notice, or (ii) at least 45 days from your receipt of the notice requesting additional information.

If your Level II Appeal is denied, in whole or in part, the Appeals Reviewer will send you a written notice of its decision including: (a) the specific reason(s) for the appeal's denial; (b) specific reference to pertinent HRA Program provisions on which the decision is based; (c) 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, (d) a statement describing any voluntary appeal procedures offered by the HRA Program, a statement of your right to bring an action in federal court under Section 502(a) of ERISA, and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; (e) 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; (f) an explanation of the scientific or clinical judgment for the appeal denial, including applying the terms of the HRA Program 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; and (g) the following statement: "You and the HRA Program may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Please note that you must exhaust your appeals under the HRA Program before you may bring a civil action under ERISA Section 502(a).

CONTRIBUTIONS

Participants and Beneficiaries may not make contributions to an HRA under the HRA Program. The applicable Employer will contribute to a Participant's or Beneficiary's HRA on an annual basis. The Employer contribution that will be made to a Participant's or Beneficiary's HRA, if any, for a Period of Coverage is set forth in the applicable SPD Supplement, as amended from time to time. Participants and Beneficiaries will have access to the full amount their HRAs on the first day of their coverage under the HRA Program.

COORDINATION OF BENEFITS

Benefits under the HRA Program are intended to pay or reimburse Eligible Medical Expenses not previously reimbursed or reimbursable by another health plan or program. To the extent that an otherwise Eligible Medical Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement under the HRA Program. If a Participant's or Beneficiary's Eligible Medical Expenses are reimbursable from the Participant's and/or Beneficiary's HRA(s), the Eligible Retiree's Code Section 104(h) Retiree Health Care Account under the Retirement Plan ("Retiree Health Care Account"), if any, and/or the Trinity Health Welfare Benefit Trust, if applicable, the Eligible Medical Expenses are reimbursable from the foregoing sources in the following order: (a) first from the Participant's and/or Beneficiary's HRA(s), (b) second from the Eligible Retiree's contributions to the Retiree Health Care Account, if any, (c) third from employer contributions to the Eligible Retiree's Retiree Health Care Account, if any, and (d) last from the Trinity Health Welfare Benefit Trust, if applicable.

TERMINATION OF PARTICIPATION

In addition to the general participation termination provisions set forth above in this Summary, a Participant will cease to be a Participant in the HRA Program upon the earliest of:

- termination of the HRA Program;
- the date on which the Participant ceases to be an HRA Eligible Retiree (e.g.,, the date the Participant ceased to be enrolled in individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare

Coordinator selected by the Plan Administrator or, if applicable, ceases to be enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration); or

- the date of the Participant's death.

In addition to the general participation termination provisions set forth above in this Summary, a Beneficiary will cease to be a Beneficiary in the HRA Program upon the earliest of:

- termination of the HRA Program;
- the date on which the individual ceases to be an Eligible Dependent;
- the date the individual ceases to be enrolled in individual Medicare supplemental health care policy, a Medicare Advantage plan and/or Medicare prescription drug coverage through the HRA Medicare Coordinator selected by the Plan Administrator or, if applicable, ceases to be enrolled in TRICARE For Life or other prescription drug/health benefits through the United States Veterans Health Administration); or
- the date of the Eligible Dependent's death.

Any balance in the HRAs of a Participant and his or her Beneficiaries after the later of the date the Participant and all of his or her Beneficiaries cease to be enrolled in the HRA Program shall be forfeited.

DISCRIMINATION PROHIBITED

The HRA Program is required to meet certain nondiscrimination provisions as outlined by the Code. The Employer reserves the right to limit reimbursements under the HRA Program and/or treat reimbursements under the HRA Program as taxable income if necessary to allow the HRA Program to satisfy these nondiscrimination requirements.

RECOVERY OF EXCESS REIMBURSEMENTS

An Employer (or the Plan Sponsor or Administrator acting on the Employer's behalf), may pursue such remedies as are available under applicable state and federal law to recover any amounts paid to or on behalf of a Participant or Beneficiary under the HRA Program which exceed the total amount credited, or that should be credited under the terms of the HRA Program, to the Participant's and/or Beneficiary's HRA, as applicable.

If you have any questions about the HRA Program and how it works after reading this SPD, contact the HRA Program Claims Administrator. You can also obtain information directly on the HRA Program Claims Administrator's Web site. The Web site address, as well as the phone number for the HRA Program Claims Administrator are listed in the ***"Important Plan Information"*** Section of this Summary.

Continuation of Coverage

COBRA CONTINUATION 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 is a temporary extension of health coverage, available to you and to other members of your family who are covered under the Plan, at group rates, 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 health care 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. For more information about your COBRA rights and obligations under the Plan and under federal law, please see the additional Incorporated Documents prepared for each Benefit Program to which COBRA applies.

The Plan Administrator, as listed at the end of this Summary, is responsible for administering COBRA Continuation Coverage. The Plan Administrator has contracted with the COBRA Administrator listed in the ***"Important Plan Information"*** Section 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 group health 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. A "qualified beneficiary" is someone who will lose group health coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Eligible Retirees and Spouses and Eligible Dependent Children of Eligible Retirees may be qualified beneficiaries.

If you are an Eligible Retiree covered by the Plan (i.e., the ***"Participant"***), you will become a qualified beneficiary if you lose your group health coverage under the Plan because your Employer or the Plan Sponsor files a proceeding in bankruptcy under Title 11 of the United States Code and that bankruptcy results in you losing group health coverage under the Plan.

If you are the Spouse or Eligible Dependent Child of a Participant, you will become a qualified beneficiary if you lose group health coverage under the Plan for any of the following reasons:

A. The death of the Participant;

B. Divorce or legal separation of the Participant and Spouse;

C. The Participant enrolling in Medicare (Part A, Part B or both);

D. For a Dependent Eligible Child only, ceasing to be an Eligible Dependent under the Plan; or

E. The Employer or the Plan Sponsor filing a proceeding in bankruptcy under Title 11 of the United States Code if the bankruptcy results in you losing group health coverage under the Plan.

If there is a choice among types of coverage under the Plan, each person eligible for COBRA Continuation Coverage is entitled to make a separate election among the types of 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 Eligible Retiree, commencement of a proceeding in bankruptcy with respect to the Employer or Plan Sponsor or enrollment of the Eligible Retiree in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the Participant and Spouse or an Eligible Dependent Child's loss of eligibility for coverage as an Eligible Dependent Child), you must notify the COBRA Administrator or Plan Administrator. The Plan requires you to notify the COBRA Administrator or Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the COBRA Administrator or Plan Administrator at the address listed in the *"Important Plan Information"* Section of this Summary. Your notice must be in writing and must include: (1) the Plan name, (2) the name of the 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 COBRA Administrator or Plan Administrator can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.

Once the COBRA 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 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 for up to 36 months. The cost of COBRA Continuation Coverage must be paid entirely by the qualified beneficiary. The premium cost for COBRA Continuation Coverage shall equal the full cost to the Plan for such period of coverage for similarly situated Covered Retirees, Spouses or other Eligible Dependents, for whom a qualifying event has not occurred. A qualified beneficiary must generally also pay an administration fee equal to two percent (2%) of the premium cost of COBRA Continuation Coverage for expenses incurred in administering COBRA Continuation Coverage.

If you have questions about your COBRA Continuation Coverage, you should contact the Plan Administrator, COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (***"EBSA"***). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. **In order to protect your family's rights, you should keep the Plan Administrator and COBRA Administrator informed of any change in the address of the Participant, Spouse or Eligible Dependent Child.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

USERRA CONTINUATION COVERAGE

If you perform service in the uniformed services you may elect continuation of coverage for any Benefit Program under the Plan that is considered to be a "health plan" (as defined in 38 USCS Section 4303(7)), as required by the USERRA. Please contact the Plan Administrator for additional information.

Additional Plan Features

MATERNITY HOSPITAL STAYS

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, in the event of a cesarean birth).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you are a Participant or Eligible Dependent receiving benefits under the Medical Benefit Program (Including Prescription Drug Program) in connection with a mastectomy and you elect breast reconstruction, the Medical Benefit Program (Including Prescription Drug Program) will cover benefits consistent with the Women's Health and Cancer Rights Act. These benefits are coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of the mastectomy, including lymphedemas.

These benefits are subject to the deductibles and coinsurance limitations, if any, applicable to the medical coverage available under the Medical Benefit Program (Including Prescription Drug Program) option that you choose under the Plan.

HIPAA PRIVACY COMPLIANCE

The Medical Benefit Program (Including Prescription Drug Program), Dental Benefit Program, Vision Benefit Program, and HRA Program under the Plan (the identified ***"health care components"***) may have access to certain health information about you, the Participant, and your Beneficiaries, if any. This information is necessary to administer claims and provide benefits under the Benefit Programs and 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.

As required by HIPAA, the Plan has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information (***"PHI"***). You will receive a copy of the Plan's Notice of Privacy Practices (the ***"Notice"***) that outlines how and when the Plan can use or disclose your PHI as well as your rights and protections under the law. If there are material changes made to the Plan's practices

and procedures regarding the use and protection of your PHI, you will receive a revised Notice. In addition, you may receive a copy of the Notice at any time by contacting the Plan's Privacy Official listed in the Notice.

The Plan has appointed one or more individuals to oversee the Plan's compliance with the HIPAA privacy rules and to address complaints. If you have any questions about how the Plan protects your PHI and your question is not answered by reviewing the information in the Notice, if you would like more information about the Plan's privacy practices or if you want to make a complaint about the Plan's privacy activities, contact the individual(s) identified in the Notice.

Claims Procedures

You should follow the procedures under each Benefit Program to request benefits under such program. Complete and proper claims for benefits made by Participants and Beneficiaries will be promptly processed. In the event of a delay in processing, the Participant or Beneficiary shall have no greater right or interest or other remedy against the Plan, Plan Administrator or Claim Administrator, if applicable, than as otherwise afforded by law. If your request for benefits under a Benefit Program is denied, you may appeal your claim under the claims procedures provided under the specific Benefit Program.

If the Benefit Program does not have a claims procedure and you believe you are being denied any rights or benefits under the Plan and you wish to seek those benefits or you have a claim regarding eligibility to participate in the Plan or a Benefit Program, you, or your authorized representative on your behalf, must file a written claim with the Administrator at the address listed in the back of this Summary. The Administrator will review your claim and notify you of its determination under the procedures set forth below. The procedures set forth below also apply to claims regarding eligibility to participate in the Plan.

CLAIMS NOTIFICATION

If your claim is wholly or partially denied, the Administrator 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 medical 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; (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; and (g) if your claim is not with respect to HIPAA "excepted benefits" (e.g., dental and vision benefits): (I) information sufficient to identify the claim involved, including the date(s) of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and the corresponding meaning of these codes, (II) the denial code, if any, and its corresponding meaning and a description of the standard, if any, that was used in

denying the claim, (III) a description of the available internal appeal and external review processes, including instructions on how to initiate an appeal; and (IV) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes. Notice of a denial of an urgent care claim will also contain a description of the expedited review process; this notice can be provided orally within the timeframe for the expedited review process if a written notice is provided no later than three days after the oral notice.

In addition to the information in (a) through (d) above, if your claim is a disability claim, the notice will also contain: (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination regarding you made by the Social Security Administration presented by you to the Administrator; (2) a copy of any internal rule, guideline, protocol or other similar criterion was relied on in making the adverse benefit determination, or a statement that such rules, guidelines, protocols or other criterion do not exist; (3) 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; and (4)) 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 your claim. A document, record or other item is deemed to be "relevant" if: (i) such item was used in making the claim determination or was submitted in the course of the claim even if the item was not relied upon in making the determination; (ii) such item demonstrates compliance with the administrative processes and safeguards that confirm that benefit conclusions are made consistently and in accordance with Plan documents and procedures; or (iii) provides any information regarding a policy or guidance regarding the claim denial, regardless as to whether such policy or guidance was used in the claim determination.

This notification will be given within the following timeframes, depending on the type of claim:

Urgent Care Claims – within 72 hours after receipt of your claim, unless you do not provide enough information for the Administrator to determine what benefits are payable under the Plan. If this occurs, the Administrator will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Administrator will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An ***"urgent care claim"*** is a claim for medical care or treatment where a delay in making a determination could jeopardize the life or health of you or your dependent or the ability of you or your dependent to regain maximum function, or, in the opinion of your or your dependent's physician, would subject you or your dependent to severe pain that cannot be adequately managed without the requested treatment.

Pre-Service Claims – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Administrator, but only if the Administrator notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the 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 (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A ***"pre-service claim"*** is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include pre-authorization for hospital stays, second surgical opinions, etc.

Post-Service claims – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Administrator's control if the 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 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 (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A ***"post-service claim"*** is any claim for medical benefits that is not a pre-service claim.

Ongoing treatment – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an adverse benefit determination. The Administrator must notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care treatment beyond the approved period of time or number of treatments, the Administrator will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

Disability claims – within a reasonable time, but no later than 45 days after receipt of your claim. The review period may be extended for an additional 30 days due to matters beyond the Administrator's control if the Administrator notifies you of the extension before the end of the 45-day period, the circumstances requiring the extension and the date by which the Administrator expects to make a decision. If, prior to the end of the first 30-day extension, the Administrator determines that a decision cannot be made within the 30-day extension, the period for making a decision may be extended another 30 days, as long as the Administrator notifies you of the reasons requiring the extension and the date by which the Administrator expects to make a decision.

Other claims – the Administrator will notify you within 90 days. An extension of an additional 90 days is available if written notice is given to you before the initial 90-day period ends.

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 and you may request an appeal of the deemed denial. However, if your claim is for group health benefits and the Administrator 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 Administrator and you, is due to good cause or matters beyond the control of the Administrator, and is not reflective of a pattern or practice of non-compliance. You may make a written request to the Administrator for an explanation of the Administrator's basis for asserting that it meets these requirements. In addition, if your claim is for disability benefits and the Administrator does not comply with the procedures set forth above, you are deemed to have exhausted the administrative remedies available under the Plan with respect to your disability claim and, except as provided in Department of Labor Regulations Section 2560.503-1(l)(2)(ii), you are entitled to pursue any available remedies under ERISA Section 502(a).

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 (except in the case of an urgent care claim appeal) and request a review of your claim. Your appeal must be received by the Plan Administrator within the following time frames:

- Medical benefit claims (including urgent care, pre-service, post-service and ongoing treatments) = 180 days
- Disability claims = 180 days
- All other claims = 60 days

You may submit written issues, comments, records, documents and other information related to your claim to the Plan Administrator. 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 medical care and disability 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.

Appeal Notification

If your appeal is received by the appropriate deadline, the Plan Administrator will independently review your appeal and any additional information that you submit. The Plan Administrator will notify you of its decision regarding your appeal within the following timeframes:

Urgent-care claims – as soon as possible, but no later than 72 hours after receipt of your appeal.

Pre-Service claims – within a reasonable period, but no later than 30 days after receipt of your appeal.

Post-Service claims – within a reasonable period, but no later than 60 days after receipt of your appeal.

Disability claims – within a reasonable time, but no later than 45 days after receipt of your appeal. If the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the appeal, the time period may be extended for 45 days. The Plan Administrator will notify you of the necessary extension before the initial 45-day period ends.

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 will notify you of the necessary extension before the first 60-day period ends.

If your appeal is denied, the Plan Administrator will send you a notice with respect to the final internal adverse benefit determination that contains: (a) the specific reason(s) for the denial, (b) reference to the specific Plan provisions on which the adverse benefit determination is based, (c) 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 (d) a statement describing any voluntary appeal procedures offered by the Plan or specific Benefit Program, a statement of your right to bring an action in federal court under Section 502(a) of ERISA, and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

In addition to the information above, if your claim is a medical benefit claim, and it is denied on appeal, the denial notice will include: (e) 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; (f) an

explanation of the scientific or clinical judgment for the appeal denial, including applying the terms of the Plan or Benefit Program 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; and (g) if your claim is not with respect to HIPAA "excepted benefits" (e.g., dental and vision benefits): (I) information sufficient to identify the claim involved, including the date(s) of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and the corresponding meaning of these codes; (II) the denial code, if any, and its corresponding meaning and a description of the standard, if any, that was used in denying the claim and a discussion of the decision; (III) a description of the available external review processes, including instructions on how to initiate an external review; and (IV) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

In addition to the information in (a) through (d) above, if your claim is a disability claim, the notice will also contain: (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and Ci) a disability determination regarding you by the Social Security Administration presented to the Plan Administrator; (2) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist; and (3) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, the notice shall include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided free of charge upon request. In addition to the above, the Plan Administrator will provide you, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan Administrator (or at the direction of the Plan Administrator) 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 notice of its decision on your claim appeal must be provided so that you have a reasonable opportunity to respond prior to that date.

In addition to the above, the Plan Administrator must provide you, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan Administrator (or at the direction of the Plan Administrator) 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 notice of its decision on a claim appeal must be provided so that you have a reasonable opportunity to respond prior to that date. In addition, if the Plan Administrator's claim appeal decision is based on a new or additional rationale from the

initial claim decision, you 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 notice of its decision on the claim appeal must be provided so that you have 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 group health benefits and the Plan Administrator 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) 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 and you, is due to good cause or matters beyond the control of the Plan Administrator, and is not reflective of a pattern or practice of non-compliance. You may make a written request to the Plan Administrator for an explanation of the Plan Administrator's basis for asserting that it meets these requirements. In addition, if your claim is for disability benefits and the Administrator does not comply with the procedures set forth above, you are deemed to have exhausted the administrative remedies available under the Plan with respect to your disability claim and, except as provided in Department of Labor Regulations Section 2560.503-1(l)(2)(ii), you are entitled to pursue any available remedies under ERISA Section 502(a).

The Plan Administrator may permit additional voluntary levels of appeal

External Review

There is an external review process for certain group health 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 under group health plan that has a retroactive effect). A ***"Claim Involving Medical Judgment"*** is a claim for group health benefits involving, but not limited to, decisions based on the group health 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 Administrator.

STATUTE OF LIMITATIONS

For purposes of filing any civil action against the Plan or a Benefit Program upon the exhaustion of all other available administrative remedies, you may bring a legal action no later than one year from the date of completion of the Plan's or Benefit Program's claims appeal process, or if earlier, three years from the time

"proof of loss" for the applicable benefit is required under the applicable Benefit Program. If a "proof of loss" timeframe does not otherwise exist under the applicable Benefit Program(s), the proof of loss timeframe will be deemed to be a submission within 90 days following the date you experience an event entitling you to the applicable benefit under the Plan.

MISREPRESENTATION AND FRAUD

If, for the purpose of obtaining or continuing to obtain benefits under the Plan and/or a Benefit Program, an Eligible Retiree, Eligible 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 and/or a Benefit Program, or otherwise misleads the Plan, Benefit Program, Employer, Administrator or Plan Administrator, the Plan and/or Benefit Program shall be entitled to recover its damages, including benefits paid and legal fees, from the Eligible Retiree, Eligible Dependent or from any other person responsible for misleading or committing fraud against the Plan and/or Benefit Program, and from the person for whom the benefits were provided.

Coordination of Benefits

Certain types of plans coordinate the payment of benefits. Except as otherwise provided in an Incorporated Document, benefits for medical and healthcare related expenses paid by a Benefit Program under this Plan will be coordinated with benefits payable under other plans, including:

- Plans provided by an employer, union, trust or similar plan;
- Other group health plans that cover you or your dependents; and
- Governmental programs or coverage required by law (*i.e.*, Medicare and no-fault automobile insurance).

The Plan does not coordinate benefits with individual, privately-paid coverage except no-fault automobile insurance.

If you are covered by more than one group plan, one plan is primary. Except as otherwise provided in an Incorporated Document, the primary plan pays benefits first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a benefit (if any). When benefits are coordinated, the plans decide which plan pays first (*i.e.*, primary), which pays second (*i.e.*, secondary), etc. Except as otherwise provided in an Incorporated Document, below are the guidelines the Plan uses to determine which plan is primary.

A. A plan is considered primary if the plan: (1) has no coordination of benefits provision; (2) coordinates benefits according to different rules; (3) is a plan required by law (*i.e.*, Workers' Compensation); or (4) constitutes a no-fault motor vehicle insurance or third party liability policy.

B. The plan covering the person as an employee, rather than as a dependent, is primary and pays benefits first. The plan covering an active employee pays first before the plan covering a laid-off or retired employee.

C. If both parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the birthday rule, then the rules of that plan determine the order of benefits. If the other plan uses the gender rule, the father's plan is primary.

D. In the case of a divorce or separation, the plan of the parent (who hasn't remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan is always primary.

E. If the parent with custody remarries, his or her plan pays benefits first, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan is always primary.

If a determination can't be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

Subrogation and Reimbursement

The Plan, including the Benefit Programs under the Plan, do not cover expenses for which another party may be responsible as a result of having caused or contributed to an injury, sickness or other loss. Notwithstanding any other subrogation or right of reimbursement provisions contained in any Benefit Program or applicable Incorporated Document, if you or your dependent or your or your dependent's heir, legatee, administrator, executor, personal representative, beneficiary, or assignee (collectively, the ***"Claimant"***), has any claim, right, or cause of action against any other person for payment of expenses covered under this Plan other than:

A. Another benefit plan, as described in the ***"Coordination of Benefits"*** Section of this Summary; or

B. In the case of a Retiree, one or more of his or her dependents; or

C. In the case of a dependent, the Retiree upon which he or she is dependent and any other dependents of such Retiree;

benefits may be withheld under the Plan (including any Benefit Program under the Plan) when a party other than the Participant or Beneficiary may be liable for such expenses until such liability is legally determined.

In certain circumstances, you, your dependent, or another Claimant may have an obligation to reimburse the Plan for payments made to or on behalf of you or your dependent. In particular, if you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant (such as under a policy of insurance), then payments made by the Plan (including any Benefit Program under the Plan) are only made on the condition that the Plan will be reimbursed by you, your dependent, and/or other Claimant to the extent of any amounts received from the third party. It does not matter whether the amounts received from the third party are as a result of a judgment rendered in a lawsuit, as a settlement of a claim, or otherwise.

If you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant, the Plan shall, to the extent of its payment of benefits, be subrogated to all of your, your dependent's, and any other Claimant's rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. As a result, if a Claimant does not pursue recovery from a liable third party, the Plan may pursue the claim on the Claimant's behalf. In addition, a Claimant agrees to reimburse the Plan for any benefits paid under the Plan, and any out-of-pocket expenses incurred by the Plan, Plan Administrator, Administrator, Claim Administrator, Plan Sponsor, or any Employer in pursuing such recovery, out of any monies recovered from a third party as the result of judgment, settlement or otherwise.

The subrogation and reimbursement obligation applies to any full or partial recovery from a third party, even if the Claimant has not been "made whole" for the loss accruing because of the alleged negligent, willful or other conduct of the third party. Further, the Plan's right of reimbursement applies on a first-dollar basis. In other words, the reimbursement right shall be in first priority over you, your dependent, and any other Claimant to the extent of any benefits paid hereunder. The reimbursement obligation applies to any amounts paid by a third party, is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement or judgment, and is not subject to offset or reduction by reason of any legal fees or other expenses incurred by the Claimant in securing such recovery.

By filing a claim for and accepting benefits under this Plan, any Claimant shall be deemed to have consented to the Plan's rights of subrogation and reimbursement and to have agreed to cooperate with the Plan Sponsor, Employer, Administrator, Claim Administrator and/or Plan Administrator in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, regardless of whether the Claimant chooses to pursue such claim, right or cause of action. A Claimant may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your dependents may be delayed, withheld, or denied unless the Claimant cooperates fully and, upon the request of the Plan Sponsor, Employer, Administrator, Claim Administrator or Plan Administrator, enters into a subrogation and reimbursement agreement with the Plan. The Plan's right to subrogation and reimbursement do not apply, however, to a recovery obtained by you or your dependent from an insurance company on a policy under which you or your dependent is entitled to indemnity as a named insured person.

The Plan shall have an equitable lien against any right the Claimant may have to recover any payments made by the Plan from any other party. Recovery shall be limited to the amount of payments made from this Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment, settlement or otherwise, where the Plan has paid expenses otherwise eligible as covered expenses under the Plan prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or programs or the Employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future benefit payments otherwise available to the Claimant under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien. The Plan's provisions regarding subrogation, reimbursement, equitable liens or other equitable remedies are intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

Administrative and Legal Information

PLAN ADMINISTRATOR

The Plan Administrator is responsible for maintaining all individual and Plan records, filing Plan tax returns and reports, and resolving questions of Plan interpretation. Certain responsibilities of the Plan Administrator with respect to the Plan have been delegated to the Administrator. In addition, the Plan Administrator may utilize the services of insurance companies and/or professional third-party administrators to assist with administration of the Plan including certain Claims Administrators. Contact information for the Plan Administrator, Administrator and certain Claims Administrators is listed in the ***"Important Plan Information"*** Section of this Summary.

REQUIRED PARTICIPANT INFORMATION

You must provide the Plan Administrator, Administrator and Claim Administrator with the information that is requested of you from time to time for the purpose of the Plan's administration. The Plan Administrator, Administrator and Claim Administrator will rely on the information you provide.

SOURCE OF FINANCING

In general, the benefits provided under this Plan will be paid from the general assets of the Employer and by any insurance policies purchased by the Employer. Participants and Beneficiaries may be required to make contributions to the Plan based on the Benefit Programs elected. To the extent permitted by applicable law, the Employer is not obligated to establish a separate trust or fund under the Plan; however, the Employer has elected to fund certain benefits under the Plan through a voluntary employees' beneficiary association (***"VEBA"***).

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 expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

NON-ASSIGNMENT OF BENEFITS

Retirees, Eligible Retirees, Participants and Beneficiaries 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 Participant's child if required by a qualified medical child support order ("QMCSO"). In addition, subject to the written direction of a Participant or Beneficiary, all or a portion of benefits provided

by the Plan may, at the option of the Plan, and unless a Participant or Beneficiary 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 or a Benefit Program shall be limited to the right to receive payment or benefits for covered expenses and shall not include the right to pursue claims or litigation of any other nature against the Plan or a Benefit Program, including, but not limited to, fiduciary claims or acting on behalf of a Claimant in pursuing benefit claims under the Plan or a Benefit Program, or confer to the provider any specific rights under the Plan, a Benefit Program, or ERISA.

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.

ELECTRONIC DELIVERY

This SPD and other important Plan information may be delivered to you through electronic means. This SPD contains important information concerning the rights and benefits of your Plan. If you receive this SPD (or any other Plan information) through electronic means you are entitled to request a paper copy, free of charge, from the Plan Administrator. The electronic version of this document contains substantially the same style, format and content as the paper version.

NO ENLARGEMENT OF EMPLOYMENT RIGHTS

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

NO GUARANTEE OF TAX CONSEQUENCES

The Plan Sponsor, Employer, Plan Administrator and Administrator do not make any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from a Participant's or Beneficiary's gross income for federal or state income tax purposes. It is the Participant's or Beneficiary's obligation to determine whether each payment under the Plan is excludable from his or her gross income for federal and state income tax purposes.

AUTHORITY TO CONSTRUE AND APPLY PLAN DOCUMENTS

To the full extent permitted by law, the Plan Sponsor, the Administrator, the Plan Administrator and their designees under the terms of the Plan (the ***"Decision-makers"***) shall have the discretionary authority to:

A. Construe and interpret any uncertain or disputed term or provision in the Plan, Benefit Programs (except policies underlying any fully insured Benefit Programs) 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 Retirees, Eligible Dependents, Participants, Beneficiaries, their estates and their beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law.

STANDARD OF JUDICIAL REVIEW

Any review of an exercise of this discretionary authority 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.

Amendment and Termination

The Plan Sponsor has the right to amend the Plan or any Benefit Program in the Plan, in whole or in part, at any time with an instrument in writing executed by an officer of the Plan Sponsor. In addition, the Administrator and the Plan Administrator are authorized to approve amendments to the Plan in accordance with the Plan and Trinity Health Corporation Table of Authority for Welfare Benefit Plans. Anyone claiming an interest under the Plan will be bound by any such amendment. While the Plan Sponsor expects the Plan to be continued, future conditions affecting the Plan Sponsor and Employer cannot be anticipated. Therefore, the Plan Sponsor has reserved the right to terminate the Plan or to discontinue permanently paying benefits under the Plan, a Benefit Program, or any portion thereof. Moreover, 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.

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.

Your Rights Under ERISA

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:

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 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 Plan 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

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 beneficiaries 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.

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 Plan Sponsor or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for 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 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 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.

Important Plan Information

Plan Name	Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered)
Plan Number	506
Employer Identification Number	35-1443425
Plan Year	July 1 – June 30
Plan Administrator	Trinity Health Corporation 20555 Victor Parkway Livonia, Michigan 48152 734-343-1000 (phone)
Administrator	Trinity Health Corporation Attn: Senior Vice President, Total Rewards 20555 Victor Parkway Livonia, Michigan 48152 734-343-1000 (phone)
HRA Program Claims Administrator	Alight Solutions - Your Spending Account™ (YSA) P.O. Box 64030 The Woodlands, TX 77387-4030 877-458-9656 (facsimile) https://retiree.aon.com/TrinityHealth Contact information for HRA Program appeals: Claims and Appeals Management (CAM) P.O. Box 1407 Lincolnshire, IL 60069-1407
HRA Medicare Coordinator	Aon Retiree Health Exchange™ ("Retiree Exchange") – an independent medical plan exchange that contracts with medical carriers to offer Medicare Eligible individuals a variety of individual Medicare supplemental health care policies and offers assistance in helping an individual choose the one that best meets his/her health care coverage needs. ▪ The Retiree Exchange is a "voluntary" benefit, not subject to ERISA. The individual insurance products are not subject to ERISA because the Employer and Plan Sponsor have not t established or maintained the individual insurance products. ▪ Medicare Eligible Retirees and Eligible Dependents who enrolled in a plan through the Mercer's Medicare Exchange prior to January 1, 2020 have a choice of changing their coverage by enrolling in an individual insurance plan via the Retiree Exchange or remaining enrolled in an individual insurance plan via Mercer's Medicare Exchange. ▪ Once a Medicare Eligible Retiree or Eligible Dependent enrolled in a plan through the Mercer's Medicare Exchange prior to January 1, 2020 enrolls in medical and/or prescription drug coverage through Retiree Exchange, he/she is not allowed to go back into

	medical and/or prescription drug coverage through Mercer's Medicare Exchange. ▪ If a Participant or Beneficiary enrolls through the Retiree Exchange, they will be billed directly by the carrier for the coverage they elect. ▪ Individuals on severance will not transition to the Retiree Exchange until the severance period ends • Individuals on severance who are pre-65 and Medicare Eligible will transition to the Retiree Exchange once their severance period ends and their employment status is updated to retire. • Individuals on severance who are age 65 and older will transition to the Retiree Exchange once their severance period ends and their employment status is updated to retire. • Individuals on severance who turn age 65 will transition to the Retiree Exchange once their severance period ends and their employment status is updated to retire.
COBRA Administrator	WageWorks, Inc. 877-502-6272 https://www.wageworks.com
HR Service Center	Trinity Health Corporation HR Service Center East Building, 4th Floor - Room E4310 20555 Victor Parkway Livonia, Michigan 48152 877-750-HR4U(4748) (phone) 312-957-2567 (facsimile) HR4U@trinity-health.org
Type of Plan	Welfare Benefit
Agent for Service of Process	Legal process may be served on CT Corp. at: 30600 Telegraph Road Bingham Farms, Michigan 48025. Legal process also may be served upon the Plan Administrator at the address shown above.

Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) Summary Plan Description

Holy Cross Supplement

1. You may be eligible to participate in one or more Benefit Programs under the Plan as described in this Supplement if you are a former Employee (or Eligible Dependent of a former Employee) of one of the following Holy Cross entities (each a ***"Holy Cross Participating Employer"***):

Trinity Continuing Care Services – Indiana, Inc.
Holy Cross CareNet, Inc.
Mount Carmel Health System – Retirees who are Medicare Eligible and living within the MediGold HMO service area are eligible for the MediGold HMO product and are not eligible for a self-funded medical plan or the HRA Program
Mount Carmel Medical Center – Retirees who are Medicare Eligible and living within the MediGold HMO service area are eligible for the MediGold HMO product and are not eligible for a self-funded medical plan or the HRA Program
Mount Carmel East Hospital – Retirees who are Medicare Eligible and living within the MediGold HMO service area are eligible for the MediGold HMO product and are not eligible for a self-funded medical plan or the HRA Program
Holy Cross Hospital of Silver Spring, Incorporated
Saint Alphonsus Regional Medical Center, Inc.
Saint Agnes Medical Center
Saint Joseph Regional Medical Center, Inc.
Saint Joseph Regional Medical Center - South Bend Campus Inc.
Saint Joseph Regional Medical Center - Plymouth Campus, Inc.
Saint Joseph's Visiting Nurse Association, Inc. (final return filed 6/30/05)
Our Lady of Peace Hospital, Inc.
Holy Cross Medical Center

Saint John's Health System
St. Ann's Hospital
The Academy of the Holy Cross, Inc.
Holy Cross Services Corporation
Holy Cross Ministries of Utah
Holy Cross Ministries Net-Work, Inc. (merged into Sisters of the Holy Cross, Inc. effective 8/31/05)

2. Retiree. You are a ***"Retiree"*** for purposes of this Supplement if you are a former Employee of a Holy Cross Participating Employer and you:

   a. Were hired by a Holy Cross Participating Employer prior to December 31, 2001;

   b. Retired as an Employee of a Holy Cross Participating Employer or the Plan Sponsor;

   c. Were in continuous employment with a Holy Cross Participating Employer and/or the Plan Sponsor between your most recent date of hire by the Holy Cross Participating Employer prior to December 31, 2001 and your date of retirement from employment with the Holy Cross Participating Employer or Plan Sponsor; and

   d. Satisfy the following applicable requirement:

      i. If you retired from employment with a Holy Cross Participating Employer prior to December 31, 2001, you satisfied the eligibility requirements to participate in the Plan which were in effect at the time of your termination from employment;

      ii. If you retired from employment with the Holy Cross Participating Employer or the Plan Sponsor on or after January 1, 2002 through December 31, 2004 (December 31, 2005 for Employees of Holy Cross Hospital, Silver Spring, MD), you retained eligibility to participate in the Plan based on a one-time election made on or before December 31, 2001; or

      iii.. If you retire from employment with a Holy Cross Participating Employer or the Plan Sponsor on or after January 1, 2005, your combination of age and years of benefit service under the Retirement Plan was at least 65 on or before December 31, 2004 (on or before December 31, 2005 for retirees of Holy Cross Hospital, Silver Spring, MD), and you elected to retain eligibility for benefits under the Plan during the 2004 re-election period.

3. HRA Eligible Retiree. You are an ***"HRA Eligible Retiree"*** if you are a Retiree from a Holy Cross Participating Employer and you[4]:

   a. Are at least age 58 on the date your employment with your Holy Cross Participating Employer terminates;

   b. Earned (accrued) at least 10 years of benefit service under the Retirement Plan after age 45 or, if you are a Retiree from Trinity Continuing Care Services you earned (accrued) at least 10 years of benefit service under the Retirement Plan as of August 1, 2004;

   c. Live in the United States (not required if you are receiving benefits from the Trinity Health Long-Term Disability Plan);

   d. Have been participating in a health plan for at least five (5) continuous years immediately before your employment with your Holy Cross Participating Employer and/or the Plan Sponsor terminates; and

   e. Do not reside in the MediGold service area.

4. HRA Contributions. As of the first business day of the calendar year or, if the HRA Eligible Retiree enrolls in the HRA Program or the Eligible Dependent enrolls or is enrolled in the HRA Program during a calendar, the effective date of his/her enrollment in the HRA Program, the applicable Holy Cross Participating Employer shall credit an amount to each Participant's and Beneficiary's HRA determined under this Section

   a. Employer Contributions to Participant's HRA. On an annual basis, each Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Participants' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Employer, a Holy Cross Participating Employer shall credit an Employer contribution of $2,412.17 to the HRA of a Participant who is an HRA Eligible Retiree of a Holy Cross Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

   b. Employer Contributions to Beneficiary's HRA. On an annual basis, each Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Beneficiaries' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Employer, a Holy Cross Participating Employer shall credit an Employer contribution of $1,474.11 to the HRA of the Beneficiary who is the Beneficiary of an HRA Eligible Retiree of a Holy Cross Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by

[4] Different requirements applied prior to January 1, 2015.

the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

Regardless of the number of an Eligible Retiree's Beneficiaries, only one contribution will be made to the Beneficiaries' HRA for all of the Eligible Retiree's Beneficiaries (instead of for each of the Eligible Retiree's Beneficiaries). For example, if an Eligible Retiree of a Holy Cross Participating Employer has two (2) Beneficiaries on January 1, 2020, the Employer will contribute $1,474.11 to the Beneficiaries' HRA for the 2020 calendar year.

c. Prorated HRA Contribution for Mid-Year Enrollment. If a Participant or Beneficiary is first enrolled in the HRA Program during a calendar year, the amount that will be credited to the Participant's or Beneficiary's HRA will be prorated as follows:

$$\frac{\text{Amount that would be credited to the HRA for the entire calendar year}}{12} \times \text{Number of whole months during the calendar year that the Participant or Beneficiary is enrolled in the HRA Program}$$

For example, if an HRA Eligible Retiree becomes a Participant on July 1, 2020 the amount that will be credited to the Participant's HRA for the January 1, 2020 through December 31, 2020 calendar year is $1,206.09 computed as follows:

($2,412.17/12) x 6 = $1,206.09

Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) Summary Plan Description
Saint Joseph Mercy Health System Supplement – Livingston

1. You may be eligible to participate in one or more Benefit Programs under the Plan as described in this Supplement if you are a former Employee (or Eligible Dependent of a former Employee) of the Saint Joseph Mercy Livingston Hospital (formerly McPherson Hospital) location (***"Saint Joseph Participating Employer"***).

2. Retiree. You are a ***"Retiree"*** for purposes of this Supplement if you are a former Employee of the Saint Joseph Participating Employer and you:

    a. Retired from employment with the Saint Joseph Participating Employer prior to January 1, 1993, and are eligible for coverage under the Plan in accordance with the terms of the applicable Incorporated Documents; or

    b. Retire from employment with the Saint Joseph Participating Employer on or after January 1, 1993 and, as of January 1, 1993:

        i. Had five (5) or more years of vesting service under the Retirement Plan; and

        ii. Your age plus years of vesting service under the Retirement Plan equaled 65 or more.

3. HRA Eligible Retiree. You are an ***"HRA Eligible Retiree"*** if you are a Retiree from a Saint Joseph Participating Employer, are Medicare Eligible, and you[5]:

    a. Are at least age 55 on the date your employment with your Saint Joseph Participating Employer terminates;

    b. Live in the United States; and

    c. Either:

        i. Are at least age 62 and have at least 10 years of vesting service under the Retirement Plan; or

        ii. Are at least age 65 and have at least 5 years of vesting service under the Retirement Plan.

4. HRA Contributions. As of the first business day of the calendar year or, if the HRA Eligible Retiree enrolls in the HRA Program or the Eligible Dependent enrolls or is enrolled in the HRA Program during a calendar year, the first business day of the calendar month before the month in which his/her enrollment is effective, the applicable Saint Joseph Participating Employer shall credit an amount to each Participant's and Beneficiary's HRA determined under this Section.

    a. Employer Contributions to Participant's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited

[5] Different requirements applied prior to January 1, 2015.

to Participants' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $3,216.23 to the HRA of a Participant who is an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

b. Employer Contributions to Beneficiary's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Beneficiaries' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $1,340.10 to the HRA of the Beneficiary who is the Beneficiary of an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

Regardless of the number of an Eligible Retiree's Beneficiaries, only one contribution will be made to the Beneficiaries' HRA for all of the Eligible Retiree's Beneficiaries (instead of for each of the Eligible Retiree's Beneficiaries). For example, if an Eligible Retiree of the Saint Joseph Participating Employer has two (2) Beneficiaries on January 1, 2020, the Employer will contribute $1,340.10 to the Beneficiaries' HRA for the 2020 calendar year.

c. Prorated HRA Contribution for Mid-Year Enrollment. If a Participant or Beneficiary is first enrolled in the HRA Program during a calendar year, the amount that will be credited to the Participant's or Beneficiary's HRA will be prorated as follows:

$$\frac{\text{Amount that would be credited to the HRA for the entire calendar year}}{12} \times \text{Number of whole months during the calendar year that the Participant or Beneficiary is enrolled in the HRA Program}$$

For example, if an HRA Eligible Retiree becomes a Participant on July 1, 2020 the amount that will be credited to the Participant's HRA for the January 1, 2020 through December 31, 2020 calendar year is $1,608.12 computed as follows:

($3,216.23/12) x 6 = $1,608.12

Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) Summary Plan Description
Saint Joseph Mercy Health System Supplement – Ann Arbor

1. You may be eligible to participate in one or more Benefit Programs under the Plan if you are a former Employee (or Eligible Dependent of a former Employee) of the Saint Joseph Mercy Hospital Ann Arbor location (***"Saint Joseph Participating Employer"***).

2. Retiree. You are a ***"Retiree"*** for purposes of this Supplement if you are a former Employee of the Saint Joseph Participating Employer and you:

    a. Retired from employment with the Saint Joseph Participating Employer prior to January 1, 1993, and are eligible for coverage under the Plan in accordance with the terms of the applicable Incorporated Documents; or

    b. Retire from with employment with the Saint Joseph Participating Employer on or after January 1, 1993 and, as of January 1, 1993:

        i. Had five (5) or more years of vesting service under the Retirement Plan; and

        ii. Your age plus years of vesting service under the Retirement Plan equaled 65 or more.

3. HRA Eligible Retiree. You are an ***"HRA Eligible Retiree"*** if you are a Retiree from the Saint Joseph Participating Employer, are Medicare Eligible, and you[6]:

    a. Are at least age 55 on the date your employment with your Saint Joseph Participating Employer terminates (or terminated);

    b. Live in the United States; and

    c. Either:

        i. Are at least age 62 and have at least 20 years of vesting service under the Retirement Plan; or

        ii. Are at least age 65 and have at least 5 years of vesting service under the Retirement Plan.

4. HRA Contributions. As of the first business day of the calendar year or, if the HRA Eligible Retiree enrolls in the HRA Program or the Eligible Dependent enrolls or is enrolled in the HRA Program during a calendar year, the first business day of the calendar month before the month in which his/her enrollment is effective, the applicable Saint Joseph Participating Employer shall credit an amount to each Participant's and Beneficiary's HRA determined under this Section.

    a. Employer Contributions to Participant's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Participants' HRAs for an entire 12-month period. For the calendar year beginning on January

[6] Different requirements applied prior to January 1, 2015.

1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $3,216.23 plus an additional $36.60 per month for Medicare Part B reimbursement, if applicable, to the HRA of a Participant who is an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

b. Employer Contributions to Beneficiary's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Beneficiaries' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $2,948.21 to the HRA of the Beneficiary who is the Beneficiary of an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

Regardless of the number of an Eligible Retiree's Beneficiaries, only one contribution will be made to the Beneficiaries' HRA for all of the Eligible Retiree's Beneficiaries (instead of for each of the Eligible Retiree's Beneficiaries). For example, if an Eligible Retiree of the Saint Joseph Participating Employer has two (2) Beneficiaries on January 1, 2020, the Employer will contribute $2,948.21 to the Beneficiaries' HRA for the 2020 calendar year.

c. Prorated HRA Contribution for Mid-Year Enrollment. If a Participant or Beneficiary is first enrolled in the HRA Program during a calendar year, the amount that will be credited to the Participant's or Beneficiary's HRA will be prorated as follows:

$$\frac{\text{Amount that would be credited to the HRA for the entire calendar year}}{12} \times \text{Number of whole months during the calendar year that the Participant or Beneficiary is enrolled in the HRA Program}$$

For example, if an HRA Eligible Retiree becomes a Participant on July 1, 2020 the amount that will be credited to the Participant's HRA for the January 1, 2020 through December 31, 2020 calendar year is $1,827.72 computed as follows:

($3,655.43 (assuming $36.60 for 12 months)/12) x 6 = $1,827.72

Trinity Health Corporation Retiree Benefit Plan 506 (Grandfathered) Summary Plan Description
Saint Joseph Mercy Health System Supplement – Mercywood

1. You may be eligible to participate in one or more Benefit Programs under the Plan if you are a former Employee (or Eligible Dependent of a former Employee) of the Saint Joseph Mercy Hospital Mercywood location (***"Saint Joseph Participating Employer"***).

2. Retiree. You are a ***"Retiree"*** for purposes of this Supplement if you are a former Employee of the Saint Joseph Participating Employer and you:

   a. Retired from employment with the Saint Joseph Participating Employer prior to January 1, 1993, and are eligible for coverage under the Plan in accordance with the terms of the applicable Incorporated Documents; or

   b. Retire from employment with the Saint Joseph Participating Employer on or after January 1, 1993 and, as of January 1, 1993:

      i. Had five (5) or more years of vesting service under the Retirement Plan; and

      ii. Your age plus years of vesting service under the Retirement Plan equaled 65 or more.

3. HRA Eligible Retiree. You are an ***"HRA Eligible Retiree"*** if you are a Retiree from the Saint Joseph Participating Employer, are Medicare Eligible, and you[7]:

   a. Are at least age 55 on the date your employment with your Saint Joseph Participating Employer terminates (or terminated);

   b. Live in the United States; and

   c. Either:

      i. Are at least age 62 and have at least 20 years of vesting service under the Retirement Plan; or

      ii. Are at least age 65 and have at least 5 years of vesting service under the Retirement Plan.

4. HRA Contributions. As of the first business day of the calendar year or, if the HRA Eligible Retiree enrolls in the HRA Program or the Eligible Dependent enrolls or is enrolled in the HRA Program during a calendar year, the first business day of the calendar month before the month in which his/her enrollment is effective, the applicable Saint Joseph Participating Employer shall credit an amount to each Participant's and Beneficiary's HRA determined under this Section.

   a. Employer Contributions to Participant's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Participants' HRAs for an entire 12-month period. For the calendar year beginning on January

[7] Different requirements applied prior to January 1, 2015.

1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $3,216.23, if applicable, to the HRA of a Participant who is an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

b. Employer Contributions to Beneficiary's HRA. On an annual basis, the Saint Joseph Participating Employer shall determine, in its sole discretion, the maximum dollar amount that may be credited to Beneficiaries' HRAs for an entire 12-month period. For the calendar year beginning on January 1, 2020, and subsequent calendar years unless and until changed by the Saint Joseph Participating Employer, the Saint Joseph Participating Employer shall credit an Employer contribution of $2,948.21 to the HRA of the Beneficiary who is the Beneficiary of an HRA Eligible Retiree of the Saint Joseph Participating Employer on the first day of the calendar year. For subsequent calendar years, the Employer contribution may be changed by the Employer in its sole discretion. Further, the amount of Employer contributions may be modified at any time and from time to time in the sole discretion of the Employer.

Regardless of the number of an Eligible Retiree's Beneficiaries, only one contribution will be made to the Beneficiaries' HRA for all of the Eligible Retiree's Beneficiaries (instead of for each of the Eligible Retiree's Beneficiaries). For example, if an Eligible Retiree of the Saint Joseph Participating Employer has two (2) Beneficiaries on January 1, 2020, the Employer will contribute $2,948.21 to the Beneficiaries' HRA for the 2020 calendar year.

c. Prorated HRA Contribution for Mid-Year Enrollment. If a Participant or Beneficiary is first enrolled in the HRA Program during a calendar year, the amount that will be credited to the Participant's or Beneficiary's HRA will be prorated as follows:

$$\frac{\text{Amount that would be credited to the HRA for the entire calendar year}}{12} \times \text{Number of whole months during the calendar year that the Participant or Beneficiary is enrolled in the HRA Program}$$

For example, if an HRA Eligible Retiree becomes a Participant on July 1, 2020 the amount that will be credited to the Participant's HRA for the January 1, 2020 through December 31, 2020 calendar year is $1,608.12 computed as follows:

($3,216.23/12) x 6 = $1,608.12