Trinity Health

AETNA PLAN
MEDICAL AND PRESCRIPTION DRUG SUMMARY PLAN DESCRIPTION

JANUARY 1, 2026

CONTENTS

PURPOSE

Trinity Health Corporation ("Trinity Health") provides health coverage for benefits-eligible colleagues and their dependents through a Medical Benefit Program (including the Prescription Drug Program), which is part of the Trinity Health Corporation Welfare Benefit Plan. This document, along with other referenced documents (e.g., Benefits Summary, Summary Plan Description for the Trinity Health Corporation Welfare Benefit Plan, etc.), constitutes the Summary Plan Description ("SPD") for health coverage options provided through Aetna Life Insurance Company. Those coverage options are referred to in this SPD as the "Plan."

This SPD serves as both an official Plan document and the SPD. To obtain a printed copy of this SPD and/or other Plan documents, please contact the Plan Administrator.

HIGHLIGHTS

This SPD describes:

- Terms you should know;
- Eligibility and participation rules;
- Highlights of your medical and prescription drug coverage;
- How your medical benefits coordinate with other medical coverage;
- Details about continuing group health coverage;
- How the plan is administered;
- Your rights under certain federal laws; and
- Important contact information.

TERMS YOU SHOULD KNOW

It is important that you understand how the Plan works and your rights as a Covered Individual. Important terms are defined below. These defined terms will be capitalized throughout the SPD for your convenience. Any references to "you" or "your" in this SPD are references to the Eligible Colleague unless the context clearly indicates otherwise.

ALLOWED AMOUNT

The maximum amount Aetna will pay a contracted provider for a given health care service.

ANNUAL OPEN ENROLLMENT

Annual Open Enrollment is the period of time each year when you may enroll yourself and your eligible Dependents for coverage under the Plan, make applicable changes to your existing coverage under the Plan, and terminate coverage under the Plan, effective as of the first day of the next Plan Year.

AUTHORIZED REPRESENTATIVE

A Physician rendering the service for which a bill is submitted,(but not a designee of the Physician) or a person whom a Covered Individual has authorized in writing to act on his or her behalf. If a claim is an urgent care pre-service claim, the Plan will consider a Health Care Professional with knowledge of a claimant's medical condition as an Authorized Representative.

If a Covered Individual wishes to authorize another person (e.g., family member) to act on his or her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he or she must first notify the Plan Administrator of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from the Plan Administrator or:

- If your Employer is supported by HR Shared Services, by going online at https://www.myworkday.com/trinityhealth/login.htmld, , searching under HIPAA Privacy Compliance and clicking on the attachment named "Authorization For Use & Disclosure of Protected Health Information" or

- If your Employer is not supported by HR Shared Services, from your Employer's local human resources ("HR") benefits representative.

The Plan Administrator or its delegate will also recognize a court order giving a person authority to act on a Covered Individual's behalf.

BEHAVIORAL HEALTH PROVIDER

A licensed organization or Health Care Professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

CLAIMS ADMINISTRATOR

An entity that reviews and determines whether to pay claims under the Plan. The Plan has different C l a i m s Administrators based on the type of claim. The Claims Administrator for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an adverse benefit determination. Each is independently responsible for notifying you of the adverse benefit determination, based on the type of claim, as well as reviewing any appeal you may make.

COBRA

Those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which regulate the conditions and manner under which an Employer must offer continuation of group health coverage to qualified beneficiaries (i.e., covered Colleagues and their covered spouses and Dependent Children) whose coverage would otherwise terminate under the terms of the Plan.

COINSURANCE

A Covered Individuals pays a percentage of their Covered Expenses for a Covered Service their Deductible is met. The portion that a Covered Individual pays is called Coinsurance. The Plan pays the remaining percentage of the Covered Expenses for the Covered Service.

COLLEAGUE

A person who is employed by an Employer as a common law employee.

CONVALESCENT FACILITY

An institution that is licensed to provide, and does provide, the following on an Inpatient basis for persons healing from an Illness or Injury: professional nursing care by an R.N. or an L.P.N. directed by an R.N. and physical restoration services to help patients to meet a goal of self-care in daily living activities. It provides 24-hour-a-day nursing care by licensed nurses and is supervised full-time by a Physician or R.N. A

Convalescent Facility is not mainly a place for rest, for the aged, for custodial or educational care, or for care of Substance Use Disorder or Mental Disorders.

COPAYMENT

A Copayment is a cost-sharing arrangement in which a Covered Individual pays a fixed amount towards the cost of a specific Covered Service. An example of a Copayment is a flat dollar fee for a Physician's office visit.

COVERED EXPENSE

A Covered Expense is the Negotiated Charge or Reasonable Charge, as applicable, for a Covered Service upon which the Plan will base its payment. Some Covered Expenses are subject to certain limitations.

COVERED INDIVIDUAL

An Eligible Colleague or Eligible Dependent who is enrolled in the Plan.

COVERED SERVICES

Services, treatments or supplies identified as payable under the Plan. Covered Services must be Medically Necessary to be payable, unless otherwise specified.

CUSTODIAL CARE

Services and supplies furnished to a person primarily for personal comfort or convenience that provide general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the person's condition. Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non- professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by the person receiving the care.

DEDUCTIBLE

A Deductible is the amount a Covered Individual pays each Plan Year before the Plan starts to pay its portion of the Covered Individual's Covered Expenses.

The Deductible is satisfied on a calendar year basis with Covered Expenses incurred from January through December. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the service or treatment. Some Covered Expenses are paid before the deductible is met (e.g., health maintenance exam).

DENTIST

This means a person legally qualified to treat the diseases and conditions that affect the teeth and gums, especially the repair and extraction of teeth and the insertion of artificial ones or a Physician who is licensed to do the dental work performed.

DEPENDENT

A Dependent is an Eligible Colleague's Eligible Dependent as set forth in the Eligibility section of this SPD.

DISABLED

Disabled means incapable of self-sustaining employment because of mental or physical incapacitation.

EFFECTIVE TREATMENT OF SUBSTANCE USE DISORDER

This means a program of therapy for Substance Use Disorders that is prescribed and supervised by a Physician and either has a follow-up therapy program directed by a Physician on at least a monthly basis, or which includes meeting at least twice a month with an organization devoted to the treatment of Sustance Use

Disorders.. The Effective Treatment of Substance Use Disorders does not include detoxification, which means mainly treating the aftereffects of a specific episode of a Substance Use Disorder, or maintenance care, which means providing an environment free of alcohol or drugs.

EFFECTIVE TREATMENT OF A MENTAL DISORDER

This is a program that is prescribed and supervised by a Physician and is for a Mental Disorder that can be favorably changed.

EMERGENCY

An Emergency is a sudden, serious, and unexpected onset of a medical condition, having symptoms so acute and of such severity as to require immediate medical attention to prevent permanent danger to one's health or other serious medical results, impairment to bodily function or permanent lack of function of bodily organs or appendages. An Emergency may or may not require Hospital admission, and treatment must be approved by a Physician or surgeon.

EMERGENCY CARE

This means the treatment given in an emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to get immediate medical care could result in placing the person's health in serious jeopardy, could result in serious impairment to the person's bodily function, could result in serious dysfunction to the person's bodily part or organ, or, in the case of a pregnant woman, could result in serious jeopardy to the health of the fetus.

EMPLOYER

The Employer is Trinity Health Corporation and, where applicable and appropriate, the Trinity Health Ministries and other Trinity Health related and affiliated entities that have adopted the Plan.

EXPERIMENTAL OR INVESTIGATIVE

A service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Aetna makes this determination based on a review of established criteria:

- Opinions of Aetna and local and national medical societies, organizations, committees, or governmental bodies
- Accepted national standards of practice in the medical profession; and
- Scientific data such as controlled studies in peer review journals or literature.

GENETIC COUNSELOR

A Health Care Professional with a specialized graduate degree(s) and experience in medical genetics and counseling.

GENETIC DISORDER

A disease caused in whole or in part by a variation or mutation of a gene. Genetic Disorders can be passed on to family members who inherit the genetic abnormality.

HEALTH CARE PROFESSIONAL

A Physician or other person licensed, accredited, or certified to perform specific health services consistent with state law.

HOME HEALTH CARE

An organized skilled patient care plan for the care and treatment of a Covered Individual in their home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the Covered Individual would require confinement in a Hospital or skilled nursing facility if the patient did not have the care or treatment stated in the plan.

HOME HEALTH CARE AGENCY

An agency that mainly provides nursing and other therapeutic services and is associated with a professional group. The professional group must make policy, must have at least one Physician and one R.N., must have full-time supervision by a Physician or an R.N., and must have a full-time administrator. The agency must keep complete medical records on each person and meet licensing standards..

HOSPICE CARE

Hospice Care is a plan, in writing, by the attending Physician for home or Inpatient care that treats the special needs of a terminally ill person and his or her family.

HOSPICE CARE AGENCY

An agency or organization that has Hospice Care available 24 hours a day and meets any applicable licensing or certification standards in the jurisdiction where it provides skilled nursing services, medical social services, psychological counseling, and dietary counseling. A Hospice Care Agency also provides or arranges for other services which include: Physician services, physical and occupational therapy, part-time home health aide services which mainly consist of caring for terminally ill persons, and Inpatient care in a facility when needed for pain control and acute and chronic symptom management. A Hospice Care Agency employs personnel which include at least one Physician, one R.N. and one licensed or certified social worker. It establishes policies governing the provision of Hospice Care and assesses the patient's medical and social needs. The Hospice Care Agency develops a Hospice Care program to meet those needs and provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Hospice Care Agency. A Hospice Care Agency permits all area medical personnel to utilize its services for their patients and keeps a medical record on each patient. It utilizes volunteers that are trained in providing services for non-medical needs and has a full-time administrator.

HOSPITAL

A Hospital is a public or private facility that is licensed to operate according to specific legal requirements. It must provide care and treatment by Physicians and nurses for an Illness or Injury using medical, surgical and diagnostic facilities on its premises. A Hospital can also include tuberculosis facilities, psychiatric facilities and Substance Use Disorder treatment facilities that are licensed to operate according to specific legal requirements.

ILLNESS

Illness is a sickness or disease that requires treatment by a Physician. For purposes of this SPD, "Illness" includes mental illness and pregnancy.

INJURY

A sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact. (Strains and spasms are considered an Illness rather than an Injury.)

INPATIENT

Services are considered Inpatient if they are provided while a Covered Individual receives treatment in a Hospital or other health care facility and incurs room and board charges.

L.P.N.

This means a licensed practical nurse legally qualified and licensed to provide practical nursing services at the time and place a service is rendered or performed

MEDICALLY NECESSARY

This means:

- The service is for the treatment or diagnosis of symptoms of an Injury, Illness, condition or disease;
- The service is consistent with the diagnosis and is appropriate for the symptoms;
- The type, level, and duration of the service, and the setting are needed to provide safe and adequate care;
- The service is commonly and usually noted throughout the medical field as proper to treat or diagnose the Injury, Illness, condition, or disease; and
- The care is not Experimental or Investigative as determined by the Plan's Claims Administrator.

A service or supply is not Medically Necessary if made, prescribed, or delivered mainly for the convenience of the patient or Provider. The fact that a Physician has prescribed a procedure or treatment does not mean that it is Medically Necessary.

MENTAL DISORDER

This is a disease commonly understood to be a Mental Disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, psychologist' or psychiatric social worker. For the purpose of benefits under this Plan, a Mental Disorder includes, but is not limited to: a Substance Use Disorder, schizophrenia, bipolar disorder, Pervasive Mental Development Disorder (Autism), panic disorder, major depressive disorder, psychotic depression, and obsessive-compulsive disorder. However, for the purpose of benefits under this Plan, a Mental Disorder will include a Substance Use Disorder only if any separate benefit for a particular type of treatment does not apply to the Substance Use Disorder.

MORBID OBESITY

A Body Mass Index ("BMI") that is greater than 40 kilograms per meter squared. A BMI greater than 35 but less than 40 kilograms per meter squared will also be considered Morbid Obesity where the patient is experiencing obesity related health conditions such as but not limited to high blood pressure or diabetes.. Documentation of the medical treatment demonstrating the patient meets these criteria must be provided.

NEGOTIATED CHARGE

This is the maximum charge a Preferred Care Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

NETWORK

A Network is a group of Physicians, Hospitals, pharmacies, and other health care Providers that have agreed to provide health care services subject to negotiated fee arrangements.

ORTHODONTIC TREATMENT

This is any medical service, dental service, or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw joint relationship, whether or not for the purpose of relieving pain. It does not include the installation of a space maintainer or a surgical procedure to correct malocclusion.

OUT-OF-NETWORK

Out-of-Network refers to care or services from a Physician, Hospital, or other health care Provider that is not a member of the Plan's Network and is not subject to a negotiated fee arrangement.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the most a Covered Individual will pay for Covered Expenses during a Plan Year. Prescription Drug expenses apply to the Out-of-Pocket Maximum.

OUTPATIENT

Services are considered Outpatient if they are provided while a Covered Individual receives treatment either outside a Hospital or other health care Provider or in a Hospital or other health care Provider, but the Covered Individual does not incur room and board charges.

PHYSICIAN

A Physician is a doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform Surgery at the time and place a service is rendered or performed. The term Physician may also include categories of limited practice professionals who are legally qualified and licensed as specified elsewhere in this document.

PLAN

The Plan is the health care coverage under the Medical Benefit Program (including Prescription Drug Program) component of Plan 504 of the Trinity Health Corporation Welfare Benefit Plan that is provided through the Aetna health plan options. Not all Aetna health plan options are offered by each Employer. To determine which of the Aetna health plan options are offered by your Employer please contact the Plan Administrator or:

- If your Employer is supported by HR Shared Services, by going online at https://www.myworkday.com/trinityhealth/login.htmld; or
- If your Employer is not supported by the HR Service Center, please contact your Employer's local HR/benefits representative.

Also, please refer to the applicable Benefits Summary for additional details regarding the Aetna health plan options that are offered by your Employer. Except where context indicates otherwise, references to the Plan also include the Prescription Drug Program provided through OptumRx.

PLAN ADMINISTRATOR

Trinity Health Corporation.

PLAN YEAR

The Plan Year is the calendar year. You have the opportunity to change your medical coverage during the Annual Open Enrollment period before the new Plan Year begins.

PRECERTIFICATION

A process that allows Physicians and other professional providers to determine if Aetna will cover the cost of the proposed service before it is provided. For example, Aetna may require precertification for services that may not always be Medically Necessary, or with respect to over utilized Providers clinical documentation must be submitted in writing explaining wy the proposed procedure is Medically Necessary.

PREFERRED CARE PROVIDER

This is a health care Provider that has contracted to furnish services or supplies for a Negotiated Charge, but only if the Provider is, with Aetna's consent, included in the Provider Directory as a Preferred Care Provider for the service or supply involved. The Provider Directory may be obtained by searching at www.aetna.com.

PRESCRIPTION DRUG

Those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a Physician, Dentist, advanced practice registered nurses, physician assistant, or pharmacist and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

PROVIDER

A person (such as a Physician) or a facility (such as a Hospital) that provides services or supplies related to medical care (not including Prescription Drugs).

- **Tier 1 Network Providers** — the Trinity Health network providers, are facilities or physicians aligned with Trinity Health that provide the lowest deductibles, coinsurance and copays. The Clinically Integrated Network includes these Tier 1 physicians who work to improve the health of our colleagues and the communities in which they live and work. For services unavailable through Trinity Health network providers, select Aetna providers will be available at the Tier 2 benefit level
- **Tier 2 Network Providers** – Includes select Aetna providers (facilities and physicians) not listed under Tier 1. Tier 2 providers can save you money, but not as much as using the Tier 1 Network.
- **Tier 3 Out-of-Network Providers** — Hospitals, Physicians and other licensed facilities or Health Care Professionals who have not contracted with Trinity Health, a Trinity Health Ministry proprietary network or Aetna to accept a Negotiated Charge as payment in full for Covered Services. Because these Nonparticipating Providers are not a part of the Tier 1 or Tier 2 Networks, a Covered Individual will be responsible for full cost of services in most cases.

R.N.

This means a registered nurse legally qualified and licensed to provide nursing services at the time and place a service is rendered or performed.

REASONABLE CHARGE

The Reasonable Charge for a service or supply is the lowest of: (i) the Provider's usual charge for furnishing it; (ii) the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and (iii) the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished. In determining the Reasonable Charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of Providers in the area.

Aetna may consider factors, such as the complexity, degree of skill needed, type of specialty of the Provider, range of services or supplies provided by a facility, and prevailing charge in other areas. In some circumstances, Aetna may have an agreement with a Provider (either directly, or indirectly through a third party), which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.

RESIDENTIAL TREATMENT FACILITY — SUBSTANCE USE DISORDER

This is an institution that meets all the following requirements:

- Licensed Behavioral Health Provider or, medical or Substance Use Disorder professionals available on-site 24 hours per day/seven days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Only treats patients who are admitted by a Physician;
- Has access to necessary medical services 24 hours per day/seven days a week;
- If the Covered Individual requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/seven days a week, which must be actively supervised by an attending Physician;

- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy sessions with at least an R.N. or Masters-Level Health Care Professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has an individualized active treatment plan for each patient directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service;
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally; and
- 24-hours per day/seven days a week supervision by a Physician with evidence of close and frequent observation.

RESIDENTIAL TREATMENT FACILITY — MENTAL DISORDERS

This is an institution that meets all the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/seven days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Only treats patients who are admitted by a Physician;
- Has access to necessary medical services 24 hours per day/seven days a week;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs;
- Offers group therapy session with at least an R.N. or Masters-Level Health Care Professional;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);

- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;
- Has peer-oriented activities;
- Services are managed by a licensed Behavior Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director);
- Has an individualized active treatment plan for each patient directed toward the alleviation of the impairment that caused the admission;
- Provides a level of skilled intervention consistent with patient risk;
- Meets all applicable licensing standards established by the jurisdiction in which it is located; and
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

SUBSTANCE USE DISORDER

Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being;
- Cause the person to lose self-control; and/or;
- Endanger the safety or welfare of others because of the substance's habitual influence on the person.

SURGERY

A cutting operation, suturing of a wound, treatment of a fracture, relocation of dislocation, radiotherapy (if used in lieu of a cutting operation) diagnostic and therapeutic endoscopic procedures, laser surgery, and injections classified as "surgery" under the Current Procedural Terminology ("CPT") code.

URGENT CARE PROVIDER

This is a freestanding medical facility that provides scheduled and unscheduled medical services to treat an Urgent Condition, that routinely provides ongoing scheduled and unscheduled medical services for more than eight consecutive hours and that makes charges. An Urgent Care Provider is licensed and certified as required by any state or federal. In addition, an Urgent Care Provider keeps a medical record on each patient, provides an ongoing quality assurance program which includes reviews by Physicians other than those who own or direct the facility, is run by a staff of Physicians, has at least one Physician on call at all times, and has a full-time administrator who is a licensed Physician. A "Preferred Urgent Care Provider" is an Urgent Care Provider that is also a Tier 1 or Tier 2 Network Provider. A Hospital emergency room and the Outpatient department of a Hospital are not Urgent Care Providers.

URGENT CONDITION

This means, with respect to a Covered Individual, a sudden Illness, Injury, or condition that does not require the level of care provided in an emergency room but which is severe enough to require prompt medical attention to avoid serious deterioration of the health, an extended Illness or prolonged impairment, more hazardous treatment or severe pain that could not be adequately managed without prompt care or treatment.

ELIGIBILITY

ELIGIBLE COLLEAGUES

You are eligible to participate in the Plan (an "Eligible Colleague") if you are a benefits-eligible colleague, as defined in your Employer's employment classification policy or procedure (or the System Services Employment Classifications Policy, if applicable), in accordance with the ACA Employee Eligibility Procedure. Certain individuals are not eligible to participate in the Plan including leased employees, individuals classified as independent contractors by an Employer, and union employees who are members of a collective bargaining agreement that does not provide for participation in the Plan . A copy of your Employer's employment classification policy or procedure or the ACA Employee Eligibility Procedure may be obtained from the Plan Administrator or:

- If your Employer is supported by the HR Shared Services , by going online at https://www.myworkday.com/trinityhealth/login.htmld: or

- If your Employer is not supported by the HR Shared Services, from your Employer's local HR/benefits representative.

ELIGIBLE DEPENDENTS

An Eligible Colleague's "Eligible Dependents" include one Eligible Adult and each of the Eligible Colleague's and/or Eligible Adult's Dependent Children.

ELIGIBLE ADULTS

An Eligible Colleague may elect coverage for one Eligible Adult under the Plan. An "Eligible Adult" is a person who satisfies the criteria to be a Pre-Tax Eligible Adult or a Post-Tax Eligible Adult, as set forth below. The cost of a Pre-Tax Eligible Adult's coverage under the Plan will be withheld from Colleague's compensation on a pre-tax basis. The cost of a Post-Tax Eligible Adult's coverage will be withheld from the Colleague's compensation on a post-tax basis, meaning it is still taxable income to the Colleague.

PRE-TAX ELIGIBLE ADULTS

A person is an Eligible Colleague's Pre-Tax Eligible Adult if he or she satisfies all the following:

- The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or any related affiliates;

- The person is not legally married to someone other than the Colleague; and

To be the Eligible Colleague's tax dependent under federal law, a Non-Spouse Eligible Adult must:

- Be a member of the same household in the year being enrolled;

- Receives over one-half of support from the Colleague in the year enrolled;

- Be a U.S. citizen, a U.S. national, or a resident of the U.S, Canada, or Mexico in the year being enrolled; and

- Not eligible to be claimed by someone else as a "qualifying child as defined in Internal Revenue Code Section 152(c).

The Eligible Colleague must also complete the Certification Tax Dependent Status Non-Spouse Eligible Adult within 30 days of enrolling the person in the Plan. This can be obtained:

- If your Employer is supported by HR Shared Services, by going online at https://www.myworkday.com/trinityhealth/login.htmld; or

- If your Employer is not supported by HR Shared Services, from your Employer's local HR/benefits representative.

POST-TAX ELIGIBLE ADULTS

A Post-Tax Eligible Adult means a Non-Spouse Eligible Adult that is **Not** the Eligible Colleague's tax dependent under federal law. A Non-Spouse Eligible Adult means a person who;

Is not otherwise covered under the Plan or any other group health plan offered by the Employer or any related entities;

- Is not legally married to someone including the colleague;
- Is not the Colleague's:
    - Parent or step-parent;
    - Parent's or stepparent's other descendant (i.e., the Colleague's sibling, niece, nephew);
    - Grandparent's or step-Grandparent's other descendant (e.g., the Colleague's aunt, uncle, cousin, etc.);
    - In-law;
    - Renter, boarder, tenant, or employee;
    - Child* or grandchild; or
    - Legal spouse; and
- Either;
    - Has a current valid domestic partnership, civil union, or other similar arrangement with the Eligible Colleague that is currently recognized and registered with a state or local government registry; or:
    - Shares the Eligible Colleague's permanent residence and is financially interdependent with the Eligible Colleague.

DEPENDENT CHILDREN

An Eligible Colleague's Dependent Children are eligible for coverage under the Plan through the end of the month in which they turn age 26, regardless of marital status, student status, residency, financial dependency or other requirements. "Dependent Children" are individuals who meet both of the following criteria:

- They are:
    - The natural children of the Eligible Colleague or the Eligible Colleague's Eligible Adult*;
    - The legally adopted children of or children placed for adoption with the Eligible Colleague or the Eligible Colleague's Eligible Adult*; or
    - Children for whom the Eligible Colleague or Eligible Colleague's Eligible Adult are the court-appointed legal guardian only through the end of the month in which the guardianship ends child turns (e.g., when the child turns 18 unless otherwise validly extended in accordance with applicable law); and

- They are not otherwise covered under the Plan or any other group health plan offered by the Employer or any related entities.

****Children of a Non-Spouse Eligible Adult may be covered under the Plan only if the Eligible Adult is covered****.

In addition, Dependent Children are eligible for coverage after they turn age 26 only if they are:

- Totally and permanently Disabled and became Disabled prior to their 26th birthday;
- Unmarried;
- Continuously enrolled in a group health plan prior to their 26th birthday; and
- Either:
    - Living in the same house as the Colleague for more than half of the year and do not provide more than half of their own support for the year; or
    - Not anyone's "qualifying child" for the year (as defined in Internal Revenue Code Section 152(c)), and the Eligible Colleague, the Eligible Colleague's spouse who is a Pre-Tax Eligible Adult, or a Covered Eligible Adult provides over half of their support for the year.

If you wish to continue coverage for a Disabled child, you must notify the Plan Administrator within 30 days of the date the child reaches age 26. For the child to continue to be an Eligible Dependent, you may be required to show the child's continued dependency and Disability on an annual basis.

To view eligibility rules and documentation requirements for you and your Eligible Dependents, visit:

- https://www.myworkday.com/trinityhealth/login.htmld if your Employer is supported by HR Shared Services; or
- https://www.myworkday.com/trinityhealth/login.htmld if your Employer is not supported by HR Shared Services.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will also provide coverage as required by the terms of a Qualified Medical Child Support Order ("QMCSO"). This coverage applies even if you do not have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that may otherwise exist for Dependent child coverage. If the Plan Administrator receives a valid QMCSO and you do not enroll the Dependent Child, the custodial parent or state agency may enroll the child (and, if you are not already enrolled in the Plan, you must also enroll). The Employer may withhold from your paycheck any contributions required for such coverage.

A QMCSO is generally a court order, a court-approved settlement agreement, or a National Medical Child Support Notice issued by a state child support agency that requires health coverage for a child. A QMCSO gives the child the same rights as a Colleague to receive benefits under a group health plan.

A QMCSO must meet certain form and content requirements to be valid. The Plan Administrator follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions or would like a copy of the child support order qualification procedures, please contact the Plan Administrator.

WHO'S NOT ELIGIBLE

Any person who does not meet the definition of a Dependent is not eligible for coverage under the Plan. If you are not eligible for coverage under the Plan, your Dependents also are not eligible for coverage.

PARTICIPATION

WHEN PARTICIPATION BEGINS

The following table shows when coverage begins for you and your Eligible Dependent(s) if you enroll yourself and your Eligible Dependent(s) due to any event listed in the 1st column of the table

Eligible Employee's Event	Effective Date
New Hires	1st day of active employment with Employer, *if the Eligible Employee enrolls within 30 days of such date*
Rehires	1st day of active employment with Employer after rehire, *if the Eligible Employee enrolls within 30 days of such date*
Employment Status Change (Employee becomes an Eligible Employee)	The date the employee becomes an Eligible Employee (e.g., move from contingent to full-time), *if the Eligible Employee enrolls within 30 days of such date*
Transfers between participating Employers	The transfer date, *if the Eligible Employee makes permissible changes within 30 days of such date*

Upon electing coverage for your Eligible Dependents, you will have 30 days to provide documentation to verify the eligibility of each Dependent and, if you have enrolled a Non-Spouse Pre-Tax Eligible Adult, the Non Spouse Adult Eligibility and Tax Status Certification form.

The required documentation is set forth in the Trinity Health Dependent Verification Documentation Requirements, a copy of which can be obtained;

- https://www.myworkday.com/trinityhealth/login.htmld if your Employer is supported by HR Shared Services; or
- https://www.trinity-health.org/my-benefits/health-welfare your Employer is not supported by the HR Shared Services.

Coverage for your Dependents will remain in an "ineligible" status until appropriate documentation is provided. Failure to provide appropriate documentation within 30 days will result in the termination of your election for coverage for your Dependents. However, if you have enrolled a Non-Spouse Pre-Tax Eligible Adult and you provide the appropriate verification documentation within 30 days of your election but you do not provide the completed Non Spouse Adult Eligibility and Tax Status Certification form. within 30 days of your election, the Eligible Adult will be treated as a Post-Tax Eligible Adult.

NOTE: Certification of eligibility may be required periodically for your covered Dependents.

During Annual Open Enrollment, you will make elections under the Plan for the following Plan Year. Benefits coverage begins on January 1 of the new Plan Year and remains in effect for the entire Plan Year (unless you change your coverage due to a special enrollment or change in status event described below).

NOTE: If you and your Eligible Adult are employed by an Employer in a benefits eligible position you may either both elect individual coverage or one of you may cover the other as a Dependendt. You and your Eligible Adult are not eligible to be covered as both a Colleague and a Dependent under the Plan. In addition, if both you and your Eligible Adult are covered as Colleagues under the Plan, only on of you may elect coverage for your Dependent Children.

MAKING BENEFIT ELECTIONS

When you are eligible to participate in the Plan, you may enroll yourself and your Eligible Dependent(s) by following your Employer's benefit enrollment process. When you first become eligible to enroll in the Plan and during each Annual Open Enrollment period, you will be provided more detailed information about the benefit plan choices, along with instructions about how to enroll and the enrollment deadline.

When you enroll, you will choose your benefit coverage level from the following:

- Individual
- Colleague and Child/children
- Colleague Plus One Eligible Adult
- Family coverage

You and your Employer share the cost of the coverage you elect under the Plan. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The benefit plans and contributions for coverage are reviewed by Trinity Health and may be revised each year.

Information about Colleague contributions is provided during your Initial Enrollment Period and during Annual Open Enrollment. In addition, current contribution amounts are available by contacting :

- https://www.myworkday.com/trinityhealth/login.htmld if your Employer is supported by HR Shared Services ; or
- https://www.trinity-health.org/my-benefits/health-welfare if your Employer is not supported by HR Shared Services.

If you do not enroll in the Plan during your Initial Enrollment Period, you and your Eligible Dependents will not be eligible to enroll for coverage under the Plan until the next Annual Open Enrollment period (to be effective on the first day of the next Plan Year) unless you are eligible to make a mid-year election change as described in the "Special Enrollment Periods" and "Changes in Status" Sections below .The Annual Open Enrollment period is held during the fall of each year.

SPECIAL ENROLLMENT PERIODS

You may be entitled to a special enrollment period under provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), as described below.

LOSS of ELIGIBILITY

If you do not elect coverage under the Plan for yourself and/or your Eligible Dependents when you are first eligible to do so because of other health coverage, you may enroll yourself and Eligible Dependents in this Plan if the other coverage is terminated as a result of loss of eligibility. You must enroll within 30 days after your loss of eligibility from the other coverage. For example If you lose eligibility for other coverage as of May 1st due to a divorce, you would have to enroll in the Plan no later than May 31st.

"Loss of eligibility" includes loss of coverage due to:

- legal separation, death, divorce, an individual ceasing to be a dependent under the coverage, termination of employment in a class eligible for coverage, reduction in hours of employment, the

exhaustion of applicable lifetime benefits under the coverage, an individual ceasing to be a dependent under the coverage, or termination of a benefit package option:

- If the coverage is provided through an HMO, you no longer reside, live or work in the HMO's service area (and there is no other coverage available under the plan);
- The exhaustion of COBRA continuation coverage; or
- The employer that maintains the group health plan no longer contributing toward the cost of such coverage or the plan no longer offering coverage to a class of similarly situated individuals that includes you and/or your Eligible Dependent (e.g., the plan terminates coverage for all part-time colleagues but continues coverage for full-time colleagues, and you are a part- time colleague).

"Loss of eligibility" does not include a loss of coverage due to failure to pay premiums or termination for cause, such as making a fraudulent claim. If you do not elect coverage for yourself and/or your Eligible Dependents when you are first eligible to do so because you and/or your Eligible Dependents have COBRA continuation coverage under another plan, you and/or your Eligible Dependents must exhaust the COBRA coverage before enrolling in this Plan under a special enrollment period.

If you timely enroll yourself and/or your Eligible Dependent(s) in the Plan, coverage will be effective on the date the other coverage terminated. If you do not timely enroll, you must wait until the next Annual Open Enrollment period to enroll, with coverage to be effective in the next Plan Year (unless another event occurs that would allow you to enroll yourself and/or your Eligible Dependent(s) prior to such time).

NEW ELIGIBLE DEPENDENT

If you acquire a new Eligible Dependent (other than a Non-Spouse Eligible Adult or a child thereof who is not also the Eligible Colleague's child) as a result of marriage, birth, adoption, or placement for adoption, you will be entitled to special enrollment period in the Plan if you meet one of the following conditions:

- ***Non-Enrolled Colleague:*** If you are an Eligible Colleague but have not enrolled in the Plan, you may enroll upon your marriage, or upon the birth, adoption, or placement for adoption of your Eligible Dependent Child.
- ***Non-Enrolled Spouse:*** If you are an Eligible Colleague who is already enrolled in the Plan, you may enroll your spouse at the time of his or her marriage to you or upon the birth, adoption, or placement for adoption of an eligible Dependent Child. You may not enroll your legal spouse due to your acquisition of a child through birth, adoption, or placement for adoption if the child causing the event is not added..
- ***New Dependents of an Enrolled Colleague:*** If you are an Eligible Colleague who is already enrolled in the Plan, you may enroll a child who becomes your Eligible Dependent Child as a result of marriage, birth, adoption, or placement for adoption and any other eligible child who is not already enrolled.
- ***New Dependents/Spouse of a Non-Enrolled Colleague:*** If you are an Eligible Colleague but you are not enrolled in the Plan, you may enroll a spouse or child who becomes your Eligible Dependent as a

result of marriage, birth, adoption, or placement for adoption. However, you (the non-enrolled Eligble Colleague) must also and enroll in the Plan at the same time.

You must enroll yourself and/or your new Eligible Dependent(s) no later than 30 days (60 days in the case of birth or adoption) after the date of the event that entitles you and/or your Eligible Dependent(s) to the special enrollment period[1]. For example, a colleague is married on May 1st. 30 days begins the day after the event and would end on May 31st.

If you timely enroll yourself and/or your new Eligible Dependent(s), coverage will be effective as of the date of the event. If you do not timely enroll yourself and/or your new Eligible Dependent(s), you must wait until the next Annual Open Enrollment period to enroll, with coverage to be effective in the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your new Eligible Dependent(s) prior to such time.

Status Changes for Post-Tax Dependents

If your Post-Tax Eligible Adult or their child (who is not also your child) experiences a qualified change in status, you may change elections **only** for such post-tax Dependents. To make election changes for any pre-tax Dependents, such as your Pre-Tax Eligible Adult or your child, you or your pre-tax Dependent must experience a qualified change in status.

MEDICAID and CHIP COVERAGE

You will also be entitled to a special enrollment period in the Plan for yourself and/or your Eligible Dependent(s) if either:

- You and/or your Eligible Dependent(s) lose Medicaid or Children's Health Insurance Program ("CHIP") coverage due to no longer being eligible for those benefits, or
- You and/or your Eligible Dependent(s) become eligible for premium assistance in the Plan under a Medicaid program or CHIP.

You must enroll in the Plan no later than 60 days after the date of the event. If you timely enroll, coverage will be effective as of the date of the event. If you do not timely enroll yourself and/or your Eligible Dependent(s), you must wait until the next Annual Open Enrollment period to enroll, with coverage to be effective in the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your new Eligible Dependent(s) prior to such time).

CHANGES IN STATUS

The benefit choices you make for a Plan Year are in effect for one entire Plan Year and generally may be changed only during the Annual Open Enrollment period. Elections you make during Annual Open Enrollment are effective beginning January 1 of the following Plan Year. The exception to this rule prohibiting election changes during a Plan Year is the occurrence of a special enrollment event described above or a qualified change in status event described in this section. Qualified change in status events include the following:

- Change in legal marital status, meaning your marriage, divorce, separation, annulment, or the death of your spouse.
- Change in the number of Dependents, including the birth, death, adoption, or placement for adoption of an Eligible Dependent Child, or a person becoming or ceasing to be a Non-Spouse Eligible Adult
- Change in employment status of you, your spouse, your Non-Spouse Eligible Adult, or your Dependent Child, which causes the affected individual to either gain or lose eligibility for an employer's benefit program, including:
    - Commencement or termination of employment;
    - Change in worksite that removes the affected individual from a benefit plan's service provider area;

- Commencement or termination of an unpaid leave of absence; or

- Any employment status change that affects the eligibility of the individual to participate in a benefit program or plan of an employer, including a change from part-time to full-time employment or vice-versa, a change from being paid on a salaried basis to being paid on an hourly basis, or a strike or lockout.

- Change in residence of you, your spouse, your Non-Spouse Eligible Adult, or your Dependent Child that removes the affected individual from the Plan's service provider area (such a change entitles you to make a new Plan election selecting another medical plan coverage option, but generally does not permit you to opt out of medical plan coverage entirely unless no other relevant coverage is available).

- Dependent meeting or ceasing to meet the Plan's definition of Dependent, such as attainment of a specified age or a change in the Plan's eligibility requirements.

- A significant change in the cost or coverage of a benefit plan offered to you, your spouse, your Non-Spouse Eligible Adult, or your Dependent Child, including a new benefit option being added, a benefit option being eliminated or significantly curtailed, a coverage change made under a plan offered by the Employer or other employer of an affected individual, or a significant increase in the cost of a benefit (such qualified change in status permits you to make a new medical plan benefit selection, but does not allow you to revoke coverage entirely, unless no other similar coverage is available).

- Gaining or losing coverage under Medicare or Medicaid by you, your spouse, your Non-Spouse Eligible Adult, or your Dependent Child, other than for pediatric vaccines.

- A judgment, decree, or order requiring coverage for an Eligible Dependent Child (e.g., QMCSO).

- A special enrollment right you may be entitled to under HIPAA, as described in the previous section.

- You begin or end an unpaid leave of absence under the Family and Medical Leave Act ("FMLA").

- A change in coverage under another employer's group health plan if the other group health plan permits participants to make an election change under the circumstances listed above, or an election of coverage by you, your spouse, your Non-Spouse Eligible Adult, or your Dependent Child during an open enrollment period under another employer's group health plan that differs in time from the Plan's Annual Open Enrollment period.

- If you want to make an election change due to the occurrence of a qualified change in status event, you must make the election change within 30 days (60 days in the case of a birth or adoption) after the date the event occurs. Appropriate documentation is required. You may only make coverage changes under the Plan that are consistent with the qualified change in status event. If you timely make an election change due to change in status event and provide required documentation, the change will be effective as of the date of the event.

In addition to the above:

- If your employment status changes but you do not lose eligibility for Plan coverage, you may revoke or change Plan coverage for you and your Eligible Dependents, if any, within 30 days of the employment status change, if you intend to enroll in other health coverage that is "minimum essential coverage," as defined in the ACA (e.g., Health Insurance Marketplace coverage, your Eligible Adult's employer's group health plan, or a lower cost option under this Plan). The new coverage must be effective no later than the first day of the second month following the month that includes the date the Plan coverage is revoked or changed. If you do not timely complete the enrollment process, you must wait until the next Annual Open

Enrollment period (unless another event occurs which would allow you to revoke or change your coverage prior to such time).

- You may cancel Plan coverage for you and your Eligible Dependents, if any, to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period. To cancel Plan coverage, the Health Insurance Marketplace coverage must be effective immediately after the day the Plan coverage is cancelled. You must complete the enrollment process to revoke coverage.

LEAVES OF ABSENCE

If you are not at work with the Employer due to an unpaid FMLA, leave of absence, an unpaid period of military service lasting more than 30 days, an unpaid leave of absence pursuant to the Employer's policies or any other reason for which your Employer must extend coverage under the Plan while you are not being paid , you may, at your option, continue coverage during the leave in accordance with your Employer's leave of absence policy.

If you are absent from work for any paid leave of absence, you must continue the coverage you elected under the Plan and your contributions for the coverage will continue to be deducted from your paycheck during the absence.

REHIRED COLLEAGUES

If you terminate employment becoming a participant and are later rehired by an Employer as a benefits-eligible Colleague, you must satisfy the Plan eligibility requirements at the time to participate.

If you terminate employment after becoming a participant and are later rehired by an Employer as a benefits-eligible Colleague within 30 days after your last day worked, you will automatically be reenrolled in the Plan with same coverage. Your coverage will be effective as of the first day of active employment on or after the rehire date. You will be able to change your coverage if you experience a special enrollment event or change of status event, or otherwise during the next Annual Open Enrollment.

If you terminate employment after becoming a participant and are rehired into a benefits-eligible position more than 30 days after your last day worked, you may enroll yourself (and your Dependents, if applicable) in the Plan, effective as of your reemployment date. You must enroll within 30 days of your rehire date. If you do not enroll within 30 days, you will not be able to enroll until the next Annual Open Enrollment period unless you experience a special enrollment event or change of status event.

If you terminate employment and are later rehired by an Employer, you may still be eligible for coverage under the Plan, even if you are in a non-benefits eligible position, in accordance with the ACA Employee Eligibility Procedure. You may obtain a copy of the ACA Employee Eligibility Procedure from the Plan Administrator.

WHEN COVERAGE ENDS

Your participation in this Plan will end on the earliest of the following dates:

Event	When Plan Coverage Ends
Termination of Employment	The last day of the month in which employment terminates, except as provided under the Trinity Health Corporation Severance Plan or similar arrangement. Payroll deductions for coverage stop the day after employment ends or, if not possible, after the payroll period ends. Continuation of coverage will be offered in accordance with COBRA.
Death of Eligible Employee	Coverage for the Eligible Employee's enrolled Eligible Dependents ends 60 days after the Eligible Employee's death**,** except as provided under the Trinity Health Corporation Severance Plan or similar arrangement. Payroll deductions for coverage stop the day after employment ends or, if not possible, after the payroll period ends. Continuation of coverage will be offered in accordance with COBRA.
Employee Ceases to Be an Eligible Employee	Date the employee ceases to be an Eligible Employee, except an ACA Eligible Employee (averaged 30 hours of service per week for the Employer during a measurement period or expected to work at least 30 hours/wk when hired is eligible for medical coverage (and an HRA, if applicable) through the end of the Initial or Standard Stability Period (as defined in the ACA Policy). Payroll deductions for coverage stop in the payroll period in which the change is entered into the system.
Mid-Year Election Change Event	If an election is timely made (within 30 or 60 days, as applicable) of the event, coverage ends retroactive to the date of the event. Any election change must be consistent with the event. Payroll deductions for coverage stop in the payroll period in which the change is entered into the system.

Your Eligible Adult Dependent's coverage under the Plan will end on the earliest of:

- The date the individual ceases to be an Eligible Adult (e.g., your divorce);
- The date your coverage ends, except, in the event of your death, in which case your Eligible Adult's coverage ends 60 days after your death;
- The last day of the pay period in which a change in employment status affects your eligibility (e.g. reduction in hours);
- The date on which a required contribution for the Eligible Adult's coverage is not timely paid; or
- The date the Plan is terminated.
- Your Dependent Child's coverage under the Plan will end on the earliest of:
- The end of the month in which the child turns age 26 or ceases to satisfy the eligibility requirements for Disabled children after they reach age 26;
- If the individual is the child of your Eligible Adult Dependent and is not also your Dependent Child, the date the Eligible Adult loses coverage;
- The date your coverage ends, except, in the event of your death, in which case your Dependent Child's coverage ends 60 days after your death;
- The date on which a required contribution for the child's coverage is not timely paid;

- The date the Plan is terminated;
- The date the child is no longer covered under a QMCSO, if applicable: or
- The date you elect to terminate the Eligible Dependent's coverage (whether pursuant to your Annual Open Enrollment election or pursuant to an election following a Qualified Change in Status event).

Your coverage and your Dependent's coverage under the Plan will cease at the times described above unless COBRA continuation coverage is elected as described in the Continuation of Group Health Coverage section of this SPD.

The Plan may not rescind an individual's coverage unless such individual fails to pay the required premiums or contributions toward the cost of coverage under the Plan, or such individual commits fraud with respect to the Plan or makes an intentional misrepresentation of a material fact.

COORDINATION OF BENEFITS

The coordination of benefits ("COB") procedures describe how the Plan coordinates benefits when you or your covered Dependents are covered under both the Plan and another health care plan, such as one provided by your Dependent's employer, Medicare or a no-fault insurance policy. The plan that pays first is the "primary" plan. The primary plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is the "secondary" plan. The secondary plan provides payments toward the balance of the cost of covered services up to the total allowed amount under that plan.

COB makes sure that Plan's payment, when added to the benefits payable under another plan, will provide coverage up to the total of the eligible expenses. The combined payments of all coverage will not exceed the actual cost approved for your care. COB letters of inquiry, which request information about other plans, may be sent on an annual or more frequent basis in order to keep the Plan's records up to date.

DETERMINING WHICH PLAN IS PRIMARY AND WHICH IS SECONDARY

When both this Plan, paying as secondary, and the primary plan have a preferred Provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

NOTE: For coordination with Medicare, please see the section titled "Coordination With Medicare." For coordination with no-fault auto coverage, please see the section titled "No-Fault Auto Coverage."

If the claimant is an active Colleague this Plan will be primary to a plan covering the claimant as a dependent, a COBRA participant, a retiree, or a dependent of a retiree.

If the claimant is the Eligible Adult of an active Colleague this Plan will be primary to a plan covering the Eligible Adult as a COBRA participant.

This Plan will be secondary to a plan covering the Eligible Adult as an active colleague or a retiree.

If the claimant is an active Colleague's child, this Plan will be primary to a plan covering the child as a COBRA participant, dependent of a COBRA participant, CHIP participant, or dependent of a retiree. If the other plan covers the child as a dependent of the Colleague's Eligible Adult, and if the Eligible Adult is an active employee, then:

- This Plan is primary if the Colleague's birthday is earlier in the year than the Eligible Adult's birthday;
- This Plan is secondary, if the Colleague's birthday is later in the year than the Eligible Adult's; and
- If both the Colleague and the Eligible Adult have the same birthday, the coverage that has been in
- If the claimant is an active Colleagues child and a court order designates financial responsibility, establishes which parent must provide primary coverage, and/or sets the order of payment, this Plan will follow the court order. If there is a court order for joint custody that does not determine primary status for benefit coverage, then the Plan's regular COB rules apply.

If rules are not established, this Plan will pay in the following order:

- The plan that covers the parent who has custody of the child.
- The plan that covers the stepparent who has custody of the child.
- The plan that covers the parent who does not have custody of the child.
- The plan that covers the stepparent who does not have custody of the child.
- If the claimant is a COBRA participant in this Plan, this Plan will be secondary to a plan covering the claimant as an active employee, a dependent of an active employee, a retiree, or a dependent of a retiree.~~;~~

If a claimant is covered by another plan as a COBRA participant, then the primary plan will be the plan in effect the longest.

Notwithstanding the above, if another plan has no COB provision, it will always be primary.

COORDINATION WITH MEDICARE

The Plan complies with Medicare's coordination of benefit requirements. The following is a brief overview of those rules.

ACTIVE COLLEAGUES & DEPEENDENTS OF ACTIVE COLLEAGUES ELIGIBLE FOR MEDICARE DUE TO AGE

If you are covered under this Plan due to your (or someone else's) current employment with the an Employer, and you are also eligible for Medicare due to age, you may:

- Continue your coverage under this Plan (to the extent eligible) and defer enrollment in Medicare; or
- Drop your coverage under this Plan and enroll in Medicare; or
- Continue your coverage under this Plan and enroll in Medicare in which case this Plan would be primary and Medicare secondary as long as your coverage under this Plan is attributable to current employment with an Employer.

COVERED INDIVIDUALS ELIGIBLE FOR MEDICARE DUE TO DISABILITY

If you are eligible for Medicare by reason of disability (but not age), then;

- This Plan is primary and Medicare is secondary, if your Plan coverage is on account of your (or someone else's) current employment with an Employer; and
- Medicare is primary and this Plan is secondary, if your Plan coverage is t on account of current employment with an Employer. The Plan will deem you or your Dependent to be enrolled in Medicare Parts A, B, and D, even if you or your Dependent has not so enrolled.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

If you are eligible for Medicare solely on the basis of End Stage Renal Disease ("ESRD"), and if your coverage under this Plan is on account of your (or someone else's) current employment with an Employer, then this Plan is primary, but only during the first 30 months after you become eligible for Medicare.. This 30-month period generally begins on the earlier of:

- The first day of the fourth month during which a regular course of renal dialysis starts; or
- If you receive a kidney transplant, the first day of the month during which you become eligible for Medicare.
- After the 30-month period ends, Medicare becomes primary and this Plan secondary. At that time, ESRD medical related claims may be rejected if proof of Medicare payment is not provided.

If you are eligible for Medicare solely based on ESRD, you should be covered by Parts A and B to maximize coverage of ESRD treatment. You may also enroll in Part D if you need coverage for certain prescribed drugs that may not be covered under Part B. If you enroll in Part A and defer enrolling in Part B by 12 or more months during the 30-month coordination period, you may be charged a premium penalty by Medicare when you enroll in Part B.

To comply with Medicare Secondary Payer ("MSP") laws, you must promptly provide any information from the Claims Administrator and/or your Employer regarding the Medicare eligibility of you and your dependents. Please contact Aetna at the customer service number on the back of you insurance card whenever the Medicare status of you or any Dependent changes. If you or a covered dependent has ESRD, your ESRD Care Coordinator through your provider can assist with reaching out to Medicare.

UPDATING COB INFORMATION — YOUR RESPONSIBILITY

It is important to keep your COB records updated. If there are any changes in coverage information for you or your Dependent(s), notify HR Shared Services or your Employer's local HR representative (if your Employer is not supported by HR Shared Services) and the Claims Administrator immediately. Please help the Plan Administrator and Claims Administrator serve you better by responding to requests for COB information quickly. The Plan will request updated COB information at least yearly. If COB information such as cancellation of other coverage, switching other coverage carriers, or changes in custody or court ordered coverage for Dependent Children is not updated, claims could be rejected or incorrect information may be sent to your health care Providers. If the information you provided on your latest COB letter of inquiry is more than one year old and a claim is submitted under the Plan for you or your Dependent, the claim will be temporarily held. The Claims Administrator will send you a new letter of inquiry requesting information about other carriers. When you respond, the Claims Administrator will update your record. The claim will then be processed according to the appropriate COB rules. However, if you do not respond to the Claims Administrator's letter of inquiry within 45 days of its receipt, the claim will be denied due to lack of current COB information. In addition, all other claims for you and your Dependents will be denied until the COB letter of inquiry is returned.

SPECIFIC INFORMATION ABOUT YOUR COB

The Plan includes non-duplicative payment COB. This means when the Plan pays secondary:

- You remain responsible for all primary patient liability resulting from primary coverage.

- The Plan will not apply contract Network restrictions unless the primary insurer denied benefits for the service.

- The Plan will cover the remaining non-sanctioned patient liability up to the amount the Plan would have paid had the Plan been primary for Covered Services only.

SUBMITTING COB CLAIMS

Claims for benefits should first be sent to the claims administrator of the plan that pays first. Then, after receiving an Explanation of Benefits, a claim should be submitted to the plan that pays secondary for processing of any unpaid expenses.

If the Plan is secondary, and your Provider will not submit a secondary claim to the Claims Administrator, then you can submit the claims as follows:

- Obtain an explanation of benefits from the primary carrier.

- Ask your Provider for an itemized receipt or detailed description of the services, including charges for each service.

- If you made any payments for the service, provide a copy of the receipts you received from the Provider.

- Make sure the Provider's name and complete address is on your receipts. Also include the Provider's tax ID number.

- Send these items to the appropriate address as indicated on the claim.

Please make copies of all forms and receipts for your own files because the Claims Administrator cannot return the originals to you.

NO-FAULT AUTO COVERAGE

If you are involved in a motor vehicle accident, payment for medical services will be coordinated between the Plan and your auto insurance carrier as follows:

- Whether your auto coverage is coordinated or uncoordinated, your auto insurance carrier is primary.

- The Plan will be secondary to your no-fault auto insurance, if any. The Claims Administrator will reject auto accident-related claims received without proof of primary payment by the auto insurer.

It is important that you discuss this with your auto insurance company. Note that coverage under the Plan is "qualified health coverage" for purposes of Michigan no-fault insurance under MCL 500.3107d(7)(b)(i).

COVERAGE WHEN YOU TRAVEL

Travel Within the United States

Aetna's extensive Provider network makes it easy to find participating doctors and Hospitals when you travel away from home. Here's how it works:

- **Participating Providers** — Present your Aetna ID card to out-of-state Participating Providers. They will bill your plan for payment. Your Provider will accept the approved amount or Negotiated Charge as payment in full. You are responsible for any out-of-pocket costs (Deductibles, Copayments, and

Coinsurances) as identified in this SPD. Your out-of-pocket costs are usually calculated on the lower of the Provider's actual charge or the Negotiated Charge.

NOTE: If a Participating Provider bills you for charges other than what is required by your Plan, remind the Provider that they should accept the Aetna payment as payment in full.

- **Non-Participating Provider** — If your out-of-state Provider does not participate with the local Aetna, ask if the Provider can send the bill directly to Aetna. If not, you will need to get an itemized receipt and send it to Aetna for reimbursement. See the "Filing a Claim for Benefits and Review Procedures" section of this SPD for instructions on how to submit a claim.

Travel Outside of The United States

When traveling outside of the United States, you have access to emergency and accidental injury benefits when services are provided by a licensed Physician or an accredited Hospital

Most Hospitals and doctors in foreign countries will ask you to pay the bill upfront. Try to get itemized receipts, preferably written in English.

When you submit your claim, please indicate whether the charges are in U.S or foreign currency, and whether payments should go to you or to the Provider. The Plan will pay the amount approved by the Claims Administrator for Covered Services at the rate of exchange in effect on the date you received your services, less any Deductibles, Copayments and Coinsurances that may apply.

CONTINUATION OF GROUP HEALTH COVERAGE

Continued coverage under the Plan is available as required by COBRA.

While COBRA continuation coverage does not apply to non-spouse Eligible Adults and their children (who are not also the Colleague's children), those Dependents may continue coverage through a voluntary Employer program, the terms of which are generally the same as COBRA. Please contact HR Shared Services (or your Employer's local HR/benefits representative, if applicable) or the Plan Administrator for more information.

If a Covered Individual's Plan coverage would otherwise end because of a qualifying event (see below) then such Covered Individual may continue coverage that was in effect on the day before the qualifying event. A Covered Individual who would lose coverage under the Plan because of a qualifying event is called a: qualified beneficiary." Your child who is born or placed for adoption with you during a COBRA continuation coverage period is also a qualified beneficiary.

You may have other options available to you when you lose coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of- pocket costs. For more information about the Marketplace options available, visit www.healthcare.gov or call 1-800-318-2596.

Investigate your eligibility for Medicare (www.medicare.gov) and Social Security benefits (www.ssa.gov) and apply if you determine you should.

QUALIFYING EVENTS

Continuation coverage is available for up to eighteen (18) months to qualified beneficiaries who would lose coverage under the Plan due to either of the following qualifying events:

- The Colleague's termination of employment with his or her Employer for any reason except gross misconduct; or

- Reduced work hours of the active Colleague. The reduction in the Colleague's work hours is not a qualifying event for non-spouse Eligible Adults and their Children (who are not also the Colleague's children).

Continuation coverage is available for up to thirty-six (36) months to a covered Dependent who would lose coverage under the Plan due to any one of the following qualifying events:

- The Colleague's death;
- The Colleague and his or her spouse become divorced or legally separated;
- Loss of eligibility of Dependent Child status under the Plan; or
- Loss of eligibility due to the Colleague becoming covered by Medicare (under Part A, Part B, or both).

When the qualifying event is the termination of the Colleague's employment or reduction of the Colleague's hours of employment, and the Colleague became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Colleague lasts until 36 months after the date of Medicare entitlement. For example, if a covered Colleague becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for his or her Dependents can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the termination of a Colleague's employment or reduction of the Colleague's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

DISIBILITY EXTENSION

If you or any Dependent is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to 11 additional months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have began before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. **You must notify the Plan Administrator of the Social Security Administration's determination within 60 days of the later of:**

- **The date of the qualifying event (the Colleague's termination of employment or reduction in hours);**
- **The date of the Social Security Administration determination; or**
- **The date on the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.**

In addition, you, the qualified beneficiary, or a representative of either must notify the Plan Administrator of the Social Security Administration's determination before the end of the 18-month period of COBRA continuation coverage. The notice must be in writing and must include:

- The Plan name;
- The name of the Colleague and the disabled qualified beneficiary, if different;
- The date of the Social Security Administration's determination of disability; and

- A copy of the Social Security Administration's determination of disability

SECOND QUALIFYING EVENT EXTENSION

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, they can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available if the Colleague or former Colleague dies, becomes entitled to Medicare (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan. In all cases, the second event must have been capable of causing you or your Dependents to lose coverage under the Plan had the first qualifying event not occurred. **You must notify the Plan Administrator of the second qualifying event within 60 days thereof.**

ELECTION 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. If the qualifying event is the colleague's termination of employment, reduction of hours, death, entitlement to Medicare (Part A, Part B, or both), or commencement of a proceeding in bankruptcy with respect to the Employer, the Employer must notify the Plan Administrator of the qualifying event within 30 days thereof. For other qualifying events (divorce or legal separation, or because a child is no longer eligible to be a Dependent), the Colleague or covered Dependent (or any representative) must notify the Plan Administrator **within 60 days after the qualifying event occurs or COBRA continuation coverage will not be offered.**

Within 14 days after the Plan Administrator receives notice that a qualifying event has occurred, a COBRA election notice will be provided to each qualified beneficiary. Each qualified beneficiary will then have 60 days to elect COBRA coverage from the later of the date the election notice is sent or the date on which coverage under the Plan would be lost due to the qualifying event. 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. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Colleagues may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

REQUIREMENTS FOR QUALIFYING EVENT NOTICES

Notice of a qualifying event or second qualifying event must be sent within the applicable time(s) set forth above to the Plan Administrator . The notice must be in writing and must include:

- The Plan name;
- The name of the Colleague and each qualified beneficiary impacted by the qualifying event or second qualifying event;
- The type of qualifying event or second qualifying event; and
- The date of the qualifying event or second qualifying event.

You, the qualified beneficiary or a representative of either may send the notice.

COST IF CONTINUATION COVERAGE

The cost of continuation of coverage for each individual generally is an amount equal to 102 percent of the total cost to the Plan for the period of coverage for similarly situated covered Colleagues or Dependents for whom a qualifying event has not occurred (including the portion of such cost paid by both the Employer and Colleague for active Colleagues and their Dependents). However, if a qualified beneficiary has elected to extend his or her COBRA continuation coverage as a result of Disability, the cost of continuation coverage shall be 150 percent of the cost to the Plan during the 11-month extension that occurs after the original 18-month continuation coverage period, or such longer period as may be available due to the occurrence of another qualifying event during the disability extension period.

Payment of the initial premium is considered timely if it is received within 45 days after a timely COBRA continuation coverage election. All subsequent payments for COBRA continuation coverage are due and payable on the first day of each calendar month for which COBRA continuation coverage is desired. However, premium payments will be considered timely if they are made within 30 days of the premium payment due date.

TERMINATION OF CONTINUATION COVERAGE

A qualified beneficiary's continuation coverage will terminate prior to time periods set forth above in the following situations:

- The Employer ceases to provide any group health plan for Colleagues.
- Any required premium is not paid in full on time.
- The qualified beneficiary becomes covered, after electing COBRA continuation coverage, under any other group health plan.
- The qualified beneficiary becomes covered by Medicare (Part A, Part B, or both) after electing COBRA continuation coverage.
- The qualified beneficiary engages in conduct that would justify the Plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).
- With respect to coverage in excess of 18 months by reason of disability, the end of the first month that begins after a final determination under the Social Security Act that the disabled individual is no longer disabled.

TRADE ACT OF 1974

Special COBRA rights may apply to you if you have been terminated or experienced a reduction of hours and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a Federal law called the Trade Act of 1974 (as reauthorized by the Trade Adjustment Assistance Reform Act of 2002). If you qualify for these special rights, you may be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if COBRA coverage has not already been elected), but only within a limited period of 60 days (or less) and only during the six months immediately after your group health plan coverage ended. In addition, a special tax credit may be available to you if you are an eligible individual.

Please contact the Plan Administrator regarding additional rights that may be applicable to you. If you have questions about the tax credit provisions in the Act, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.http://doleta.gov/tradeact.

USERRA CONTINUATION COVERAGE

If you perform service in the uniformed services you may elect up to 24 months of continuation coverage under the Plan, as required by the Uniformed Service Employment and Reemployment Rights Act ("USERRA"). The procedures set forth for electing COBRA continuation coverage apply to this election for continuation coverage. Contact the Plan Administrator for additional information about USERRA continuation coverage.

THE HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You may also learn whether you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Coverage through the Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit in the Marketplace.

Certain states have their own marketplaces, while other states use the federal Marketplace. You can access the Marketplace for your state through the federal Marketplace web site, www.HealthCare.gov.

You always have 60 days from the time you lose your Plan coverage to enroll in Marketplace coverage. That is because losing your job-based Plan medical coverage is a Marketplace "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should act right away.** In addition, during what is called an annual "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov**.**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful — if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances after your 60-day COBRA election period expires.

IF YOU HAVE QUESTIONS

If you have questions concerning the Plan or COBRA continuation coverage, please feel free to contact the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.http://dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.HealthCare.gov.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

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

PLAN ADMINISTRATION

SECTION 1557 NONDISCRIMINATION AND ACCESSIBILITY LAW

The Trinity Health Corporation Welfare Benefit Plam and the Plan comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan, through Trinity Health and the other participating employers in the Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters; as
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters; and
    - Information written in other languages.

If you need these services, contact the Plan Administrator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jodi Weiner, Trinity Health Corporation Vice President, Benefits & Well-Being, 20555 Victor Parkway, Livonia, MI 48152, (855) 812-1297 (telephone), (248) 347- 5437 (fax), ACAsection1557@trinity-health.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jodi Weiner is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

See the notice at the end of this SPD for additional details.

EMPLOYMENT RIGHTS

Nothing in the Plan or this SPD in any way creates an expressed or implied contract of employment or constitutes or provides a promise or guarantee of employment or continued employment. Nor do these documents change any such employment relationship to be other than employment "at will." Your employment may be suspended, changed, or otherwise terminated by either you or your Employer at any time.

NO WARRANTY OF HEALTH CARE PROVIDERS

The Plan provides payment for Covered Expenses. The Plan, Trinity Health and the other participating Employers make no warranties or representations regarding the delivery or quality of care.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Trinity Health is the named fiduciary with respect to this Plan, within the meaning of Section 402(a)(1) of ERISA. Trinity Health shall exercise all discretionary authority and control with respect to management of this Plan, which is not specifically granted to another fiduciary.

Trinity Health may delegate certain of its fiduciary responsibilities under this Plan to persons who are not named fiduciaries of the Plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility will be made by written instrument executed by Trinity Health a copy of which will be kept with the records of this Plan.

Aetna has, by written instrument, been designated as the fiduciary for medical claims and appeals of adverse benefit determinations for medical claims submitted to the Plan. By making this designation, it is Trinity Health's intention that Aetna make final claim determinations and have final discretion in construing the terms

of the Plan with respect to medical claim determinations. Aetna is not responsible for any fiduciary responsibilities other than those outlined in this paragraph.

OptumRx has, by written instrument, been designated as the fiduciary for Prescription Drug claims and appeals of adverse benefit determinations for Prescription Drug claims submitted to the Plan. By making this designation, it is Trinity Health's intention that OptumRx make final claim determinations and have final discretion in construing the terms of the Plan with respect to Prescription Drug claim determinations.

Each fiduciary under this Plan is solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary has a duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary will have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary will be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this Plan will be deemed to relieve any person from liability for his or her own misconduct or fraud.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

HIPAA was enacted, among other things, to improve the portability and continuity of health care coverage. In addition, HIPAA contains provisions designed to protect the security and privacy of health care information. The following are summaries of HIPAA's primary impact on the Plan.

PRIVACY OF HEALTH INFORMATION

HIPAA requires that health plans protect the confidentiality of private health information. The Plan may have access to certain private health information about you and your covered Dependents. This information is necessary to administer claims and provide benefits under the Plan. The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures.

The Plan and its business associates (which are generally people or entities that perform certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, the Plan) may use and disclose information about you that is protected by HIPAA (referred to as "protected health information" or "PHI") without your consent, written authorization or opportunity to agree or object for treatment, payment, and health plan operations. The Plan and its business associates may also use or disclose your PHI without your consent as required by law. The Plan and its business associates will disclose your PHI to your personal representative when the personal representative has been properly designated through appropriate written documentation. In addition, you may authorize the use or disclosure of your PHI to another person and for the purpose you designate. If you grant an authorization, you may withdraw it, in writing, at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. The Plan, its business associates and Trinity Health will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Trinity Health.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the PHI, to receive an accounting of certain disclosures of the PHI and, under certain circumstances, to amend the PHI. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under the HIPAA privacy rules have been violated.

As required by HIPAA, the Trinity Health Corporation Welfare Plan has adopted certain privacy policies and procedures related to the use and disclosure of PHI by its component plans that are health plans, including the Plan. You will receive a copy of the Welfare 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 Welfare 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 Welfare Plan's Privacy Officer at:

Trinity Health
20555 Victor Parkway
Livonia, MI 48152

The Welfare Plan has appointed its Privacy Officer to oversee the Welfare 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 Welfare Plan's privacy practices or if you want to make a complaint about the Welfare Plan's privacy activities, contact the individual(s) identified in the Notice.

NON-DISCRIMINATION DUE TO HEALTH STATUS

Any rule for eligibility that discriminates based on a "health factor" of a Colleague or a Dependent of that Colleague is prohibited. For instance, the Plan is prohibited from containing an actively-at-work requirement that is based on a health factor of a Colleague. An exception is made with regard to a Colleague's first day of work (e.g., if an individual does not report to work on his/her first scheduled work day, then he or she need not be covered and any waiting period for coverage need not begin). Similarly, a Dependent cannot be refused enrollment or coverage based on a "health factor" such as confinement in a health care facility.

A "health factor" means any of the following:

- Health status;
- A medical condition (whether physical or mental condition);
- Claims experience;
- Receipt of health care;
- Medical history;
- Evidence of insurability (including conditions arising out of acts of domestic violence and participation in certain recreational activities, including high-risk activities);
- Disability; and
- Genetic information.

"Rules for eligibility" include, but are not limited to, rules relating to:

- Enrollment;
- The effective date of coverage;
- Waiting (or affiliation) periods;
- Special enrollment;

- Eligibility for benefit options/packages (including rules for individuals to change their selection among benefit options/packages);

- Benefits (including rules related to covered benefits, benefit restrictions, and cost-sharing mechanisms such as Coinsurance, Copayments and Deductibles);

- Continued eligibility; and

- Terminating coverage of any individual under a Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Plan 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).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998 (the "WHCRA"), since the Plan provides medical and surgical benefits for mastectomies, the Plan also provides coverage for reconstructive Surgery and related services related that may follow mastectomies. In compliance with the WHCRA, the Plan covers:

- Reconstruction of the breast on which the mastectomy was performed;

- Reconstruction and Surgery of the other breast to achieve symmetry between the breasts; and

- Prostheses and treatment of physical complications of all stages of the mastectomy (including lymphedema).

Coverage will be provided in a manner determined in consultation with the attending Physician and the patient. The Plan's Deductibles, Coinsurance, and Copayments that are in effect at the time service is provided will apply to the coverage described above.

PLAN ADMINISTRATOR POWERS

The Plan Administrator is empowered and authorized to make rules and regulations and establish procedures with respect to the Plan and to determine or resolve all questions that may arise as to the eligibility, benefits, status and right of any person claiming benefits under the Plan. The Plan Administrator has the power and discretionary authority to construe and interpret the Plan and to correct any defect, supply any omissions, or reconcile any inconsistencies in the Plan, and generally do all other things which need to be handled in administering this Plan.

The exercise of the Plan Administrator's authority shall be binding upon all interested parties, including, but not limited to Covered Individuals, their estates and their beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law.

The Plan Administrator will determine eligibility for benefits under the Plan. The Plan Administrator has delegated fiduciary responsibility for medical claims to Aetna and has delegated fiduciary responsibility for Prescription Drug claims to OptumRx. The Plan will be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not pre-empted by federal law, the laws of the state of Michigan.

FILING A CLAIM FOR HEALTH BENEFITS AND REVIEW PROCEDURES

You may file claims for benefits, and appeal adverse claim decisions, either yourself or through an Authorized Representative.

HOW TO SUBMIT A CLAIM FOR HEALTH BENFITS

A claim must be filed before a benefit payment can be made. There are three (3) types of claims:

- A “pre-service claim” means a claim for a benefit where your plan conditions receipt of the benefit, in whole or in part, on obtaining approval in advance of receiving medical care.

- An “urgent care claim” means a pre-service claim for medical care or treatment where the time periods for non-urgent predeterminations could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a Physician who knows your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking.

- If a Physician with knowledge of your medical condition determines that the claim is one involving urgent care, the Plan Administrator or its delegate will treat it as such. Absent a determination by your Physician, the Plan Administrator or its delegate will determine whether a claim is one involving urgent care by using the judgment of a prudent layperson with average knowledge of health and medicine.

- A “post-service claim” means all other claims that are not “pre-service claims” or “urgent care claims”.

The Plan Administrator has delegated its authority to make claim determinations, other than claim determinations with respect to Prescription Drug claims, to Aetna the Medical Claims Administrator. You or your Authorized Representative generally must file claims in writing with your Aetna customer service office at:

Aetna Life Insurance Company
151 Farmington Avenue
Harford, CT 06156

You or your Authorized Representative may, however, file urgent care claims by telephone at the number listed on the back of your identification card from the Plan ("ID card"). If you go to Network Providers, you will generally not have to file claims because claims are submitted directly to Aetna for you. However, if you receive medical services or supplies from Out-of-Network Providers, or you receive care out of the country, you may be required to file your own claims. Please check with your Provider to find out if the Provider is going to submit a claim on your behalf.

If you need a claim form, contact an Aetna customer service representative at the number on the back of your card. To file a claim in writing, follow these steps:

- Obtain an itemized statement from the Provider that includes the following information:
    - Name of the patient and the Colleague;
    - Contract number (from your ID card);
    - Provider’s name and address;
    - Provider’s federal tax ID number;
    - Description of services or supplies;
    - Diagnosis (nature of Illness or Injury);

- Date of each service or date each supply is received; and
- Dates of admission and discharge (if admitted to a Hospital).

You may include cash register receipts, canceled checks or money order stubs with your itemized receipt, but they may not substitute for an itemized receipt.

NOTE: If you receive medical services out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and U.S. currency amounts.

- Complete a separate claim for each family member. Multiple services or supplies for the same patient may be attached to one claim.
- Attach all itemized receipts and statements to the claim form. Make sure the Colleague's name and contract number from the Aetna ID card are on all receipts and attachments.
- Review all claims to be sure they are accurate and complete. Incomplete forms will cause your payment to be delayed. Be sure to sign and date each claim. Always keep a copy of your claims and receipts because Aetna cannot return them to you.
- Mail all claims to the address shown on the form. If you do not have a claim form, send the itemized receipt to your Aetna customer service office at the address listed above.

You or your Authorized Representative must submit pre-service claims (including urgent care claims) before you receive Covered Services. Post-service claims must be submitted as soon as possible after you receive Covered Services or supplies and must be submitted by the filing deadline. The filing deadline for Aetna post-service claims is 12 months after the date of service.

Claims not filed within the required time period will not be eligible for payment.
You must follow this claims procedure to obtain your right to review. If you do not follow this process, you could lose your right to review and, in an extreme case, even your right to file a lawsuit.

EXPLANATION OF BENEFITS AND NOTIFICATION LETTERS

Aetna will send you a letter to notify you of its decision regarding pre-service claims (including urgent care claims). However, if the claim is an urgent care claim, Aetna may provide you its decision orally and then provide you a letter notifying you of its decision within three (3) days of their decision. With respect to

post-service claims, Aetna will send you an explanation of benefits ("EOB") statement after Aetna has processed your claim, including a claim submitted directly to Aetna for you by a Provider. The EOB shows you what services have been paid by the Plan and what, if anything, you owe. It is not a bill. Please check the EOB carefully to make sure that you received the services or supplies listed. It is very important that you notify Aetna if you did not receive the services or supplies or if there are any discrepancies.

If your claim is denied in whole or in part, your written notification letter or EOB from Aetna will include:

- The specific reason(s) for the denial;
- References to the pertinent Plan provisions on which the decision is based;
- A description of any additional material or information needed to perfect the claim, including an explanation of why such material or information is necessary;
- A description of the Plan's internal claim review/appeal procedure, the time limits applicable to such procedure, and a statement of your right to bring a civil action under Section 502(a) of ERISA after the Plan's claim review/appeal procedure has been exhausted;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the decision, either the specific rule, guideline, protocol or other similar criterion or a statement indicating that a rule, guideline, protocol or other similar criterion was relied upon in making the decision and a copy of the rule, guideline, protocol or other criterion will be provided free of charge upon request;
- If the claim denial is based on a Medical Necessity or not meeting the criteria for covered Experimental or Investigative treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- If the claim denial concerns an urgent care claim, a description of the expedited review process applicable to the claim;
- Information sufficient to identify the claim involved, including the date 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 (along with the corresponding meaning of these codes);
- The denial code, if any, and its corresponding meaning;
- A description of the standard, if any, that was used in denying the claim; and
- A description of available external review processes, including instructions on how to initiate an appeal.

The letter or EOB will be given within the following timeframes, depending on the type of claim:

- **Urgent Care Claims** — within 72 hours after Aetna's receipt of your claim, unless you do not provide enough information for Aetna to determine what benefits are payable under the Plan or if you fail to follow the Plan's procedures for filing claims. If this occurs, Aetna 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. Aetna will notify you of its determination as soon as possible, but no later than 48 hours after the earlier of (i) Aetna's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

- **Pre-Service Claims** — within a reasonable time, but no longer than 15 days after Aetna's receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond Aetna's control, but only if Aetna notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which Aetna 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.

- For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to Aetna, but which otherwise fail to follow the procedures for filing pre-service claims, you or your Authorized Representative will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

- **Post-Service Claims** — within a reasonable time, but no later than 30 days after Aetna's receipt of your claim. The review period may be extended for 15 days due to matters beyond Aetna's control if Aetna notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which Aetna 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.

- **Ongoing Course of Treatment** — if you are receiving an ongoing treatment (i.e., treatment over a period of time or a specified number of treatments) that has been previously approved by the Plan, any reduction or termination of the ongoing treatment is a claim denial. Aetna will notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care beyond the approved period of time or number of treatments, Aetna will notify you of its decision as soon as possible, but no later than 24 hours after Aetna receives your claim, provided that your request is 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.

Online EOB statements provide the same information as paper EOB statements but allow you to view statements quickly and easily 24 hours a day, seven days a week. Online EOB statements also allow you to view statements securely from any personal computer, search for statements by date or patient name, track benefit payments, and download or print statements. You can access your online EOB statements by visiting www.aetna.com.

NOTE: When you sign up to receive online EOB statements, you will no longer receive paper statements through the mail.

HEALTH CLAIMS: INTERNAL APPEALS

As an individual enrolled in the Plan, you have the right to file an appeal of an Adverse Benefit Determination relating to services or supplies you have received or could have received from your health care Provider.

An "Adverse Benefit Determination" is a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. An Adverse Benefit Determination may be based on:

Your eligibility for coverage, including a retroactive termination of coverage (whether or not there is an adverse effect on any particular benefit);

- Coverage determinations, including Plan limitations or exclusions;
- The results of any utilization review activities;
- A decision that the service or supply does not meet covered Experimental or Investigative criteria; or
- A decision that the service or supply is not Medically Necessary.
- A "Final Internal Adverse Benefit Determination" is an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

EXHAUSTION OF INTERNAL APPEALS PROCESS

Generally, you are required to complete all internal appeal processes of the Plan before being able to obtain External Review (described below) or bring an action in litigation. However, if Aetna or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under section 502(a) of ERISA or under state law, as applicable.

FULL AND FAIR REVIEW OF CLAIM DETERMINATIONS AND APPEALS

To appeal an Adverse Benefit Determination, you must follow the review procedures below. These procedures vary, depending on whether you are appealing a decision on a pre-service, post-service or urgent care claim.

All appeals of Adverse Benefit Determinations must be in writing, except appeals with respect to urgent care claims, which may be made orally.

INTERNAL APPEAL PROCEDURE

Internal Appeal Procedure — Post-Service Claims

Under the appeal procedure for post-service claims, you are entitled to a two-step appeal process. Aetna must provide you with a written determination within 30 calendar days of Aetna's receipt of your written appeal at each level.

The appeal procedure for post-service claims provides two levels of appeal:

- To initiate level 1 appeal, you or your Authorized Representative must send Aetna a written statement explaining why you disagree with Aetna's determination as set forth in the EOB statement or the letter Aetna sends notifying you that Aetna has not approved your post-service claim. Please include in your request: the group name (that is, Trinity Health), your name, member ID, or other identifying information shown on the front of the EOB or claim denial letter, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim. An Aetna representative may call you or your healthcare Provider to obtain medical records and/or other pertinent information in order to respond to your appeal. You or your Authorized Representative must file an appeal of the Adverse Benefit Determination in writing no later than 180 calendar days after you receive the EOB statement or the letter Aetna sends notifying you that it has not approved your post-service claim. Mail your written appeal to Aetna at the address provided in this SPD. Aetna will respond to your appeal in writing within 30 days of its receipt of your appeal. If your appeal is denied, Aetna will provide you a notification that includes:

- The specific reason(s) for the denial;

References to the pertinent Plan provisions on which the denial is based;

- If any internal rule, guideline or protocol or other similar criterion was relied upon in making the decision either the specific rule, guideline, protocol or other similar criterion or a statement indicating that a rule, guideline, protocol or other similar criterion was relied upon in making the decision and a copy of the rule, guideline, protocol or other criterion will be provided free of charge upon request;

- If the claim denial is based on a Medical Necessity, Experimental or Investigative treatment not meeting criteria for coverage or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- 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; and

- A statement describing any voluntary appeal procedures offered by the Plan and your right to bring a civil action for benefits under section 502(a) of ERISA.

If your claim appeal is going to be denied, Aetna must provide you, free of charge, any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna) 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 Aetna'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, if Aetna's decision on your claim appeal 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 Aetna'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.

If you agree with Aetna's response, it becomes the final determination, and the review ends.

- If you disagree with Aetna's response to your level 1 appeal, you may then proceed to level 2. You must request level 2 reviews in writing no later than 60 days after you receive Aetna's level 1 appeal determination. You have not exhausted the Plan's internal review procedure (and, therefore, cannot initiate a civil action under section 502(a) of ERISA to obtain benefits) unless and until you have requested a level 2 review.

  - Mail your request for a level 2 appeal review to the address specified in the letter Aetna sends notifying you that Aetna has not approved your level 1 appeal.

  - Again, please provide all documentation, records and comments that support your position. Aetna will provide you a written determination within 30 days of Aetna's receipt of your request for level 2 appeal. Aetna's written level 2 determination will be the final determination.

- If you do not agree with a Final Internal Adverse Benefit Determination by Aetna, or if Aetna fails to issue its determination at each appeal level within the 30-day time frame or otherwise fails to comply with the appeal procedures for level 1 or level 2, you have the right to bring a civil action under section 502(a) of ERISA to obtain your benefits. You also have the right to request an External Review if the claim and appeal denials involve 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.

Internal Appeal Procedure — Pre-Services Claims

The appeal procedure for pre-service claims is identical to the appeal procedure for post-service claims, except that Aetna must provide you with written determinations within shorter time frames. Appeals of pre-service claims also are handled in a two-step process. Aetna will issue its determination within 15calendar days of Aetna's receipt of your level 1 appeal and within 15 calendar days of your level 2 appeal. You still have 60 days after receipt of the level 1 appeal determination to file your level 2 appeal.

If you do not agree with a Final Internal Adverse Benefit Determination by Aetna, or if Aetna fails to issue its determination at each level within the 15-day time frame or otherwise fails to comply with the appeal procedures for level 1 or level 2, you have the right to request an External Review (if the claim and appeal denials involve 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) and/or bring a civil action under section 502(a) of ERISA to obtain your benefits.

Internal Appeal Procedure — Urgent Care Claims

The appeal procedure for urgent care claims is as follows:

- You or your Physician may submit your request for an internal appeal to Aetna orally by calling the telephone number included in the claim denial letter or Aetna Member Services Unit at the toll-free telephone number on your ID card or in writing at the address provided in this SPD.

- All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile or other similar method. You will be notified by Aetna of its decision as soon as possible, taking into account the medical exigencies, but no later than 36 hours after the appeal is received. If Aetna's decision is communicated orally, Aetna must provide you or your Authorized Representative with written confirmation of its decision within three days.

  If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received by Aetna. If Aetna's decision is communicated orally, Aetna must provide you or your Authorized Representative with written confirmation of its decision within three days.

- If you do not agree with a Final Internal Adverse Benefit Determination by Aetna, or if Aetna fails to issue their determinations within the time frames set forth above or otherwise fails to comply with the appeal procedures, you have the option to request an External Review (if the claim and appeal denials involve 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) and/or bring a civil action under section 502(a) of ERISA to obtain your benefits.

In addition to the information found above, the following requirements apply to the internal appeal of pre-service, post-service and urgent care claims:

- In writing, you may authorize another person, including but not limited to a Physician, to act on your behalf at any stage in the standard internal review procedure.

- The Plan and Aetna do not impose any review fees or costs.

- Although Aetna has set time frames within which to give you its final determination on all three types of claims, you have the right to allow Aetna additional time if you wish.

- Aetna will provide you, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

- You may submit written comments, documents, records and other information relating to your claim for benefits, and Aetna will consider this information even if it was not submitted or considered in the initial benefit determination.

- The person who reviews your Adverse Benefit Determination will be someone other than the person who issued that determination and who is not the subordinate of such person. The determination Aetna makes on appeal will be a new determination; the initial determination Aetna made on your claim will not be afforded deference in the appeal.

- If your appeal involves an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item does not meet coverage criteria as Experimental, Investigative or not Medically Necessary or appropriate, Aetna will consult with a Health Care Professional who has appropriate training and experience in the medical field or specialty involved.

- Upon request, Aetna will identify the medical experts whose advice was obtained in connection with the Adverse Benefit Determination, even if Aetna did not rely on that advice in making the determination.

- On appeal, Aetna will advise you of the specific reason for an Adverse Benefit Determination with reference to the specific Plan provisions on which the determination is based.

- If Aetna relies on an internal rule, guideline, protocol or other similar criterion in making the Adverse Benefit Determination, Aetna will advise you and provide a copy of the rule, guideline, protocol or other similar criterion free of charge upon request.

- If the Adverse Benefit Determination is due to lack of Medical Necessity or to not meeting coverage criteria as Experimental or Investigative treatment, or similar exclusion, Aetna will advise you and provide an explanation of the scientific or clinical judgment free of charge upon request.

- If the Plan provides for any voluntary appeal procedures beyond the level 2 review, Aetna will advise you of those procedures in its level 2 appeal response.

HEALTH CLAIMS: EXTERNAL REVIEW

External Review is a review of an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization ("ERO") or by the State Insurance Commissioner, if applicable.

A Final External Review Decision is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of the internal appeal procedure described above before you can request External Review, other than in the case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary External Review.

You may file a request for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day

that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a request for External Revenue, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a request for External Revenue will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file a request for External Review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice

CLAIMS: ELIGIBLE FOR EXTERNAL REVIEW

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your claim will be eligible for External Review if the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law or all of the levels of the Plan's internal appeal procedure have been exhausted; and

- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination involves medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or relates to a rescission of coverage, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination or Final Internal Adverse Benefit Determination based upon your eligibility to participate in the Plan is not eligible for External Review.

If upon the final internal level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within five business days following the date of receipt of the request for External Review, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the Plan's internal claims and appeal procedure (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll- free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of

receipt, additional information that the ERO must consider when conducting the External Review. Within one business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals procedure. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending Health Care Professional's recommendation;
- Reports from appropriate Health Care Professionals and other documents submitted by the Plan, you, or your treating Provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would

jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

LIMITATIONS FOR CIVIL ACTIONS

Any action or proceeding arising out of or related to the Plan (may only be brought in a federal or state court located in the State of Michigan. No such action or proceeding may be filed more than one year from the date you have exhausted (or deemed to have exhausted) the Plan's internal claims and appeals procedure and, if applicable, external review process, or if earlier, one year from the time "proof of loss" for any applicable benefit is required. If a "proof of loss" timeframe does not otherwise exist, the proof of loss timeframe will be deemed to be a submission within 90 days following the date of the service, supply or treatment upon which the claim for benefits is based.

NON-ASSIGNMENT OF BENEFITS

No assignment currently in effect or prospective, may be made for the payment of benefits to a Provider, including Physicians, Hospitals or other Providers of services covered by the Plan or any benefit under the Plan. Plan payments directly to a Provider for Covered Expenses shall not be construed as a waiver of this anti-assignment requirement. Further, any assignment recognized or accepted by the Plan shall be limited to the right to receive payment or benefits for Covered Expenses and shall not include the right to pursue claims or litigation of any other nature against the Plan, including, but not limited to, fiduciary claims or acting on behalf of a Covered Individual in pursuing benefit claims under the Plan, or confer to the provider any specific rights under the Plan or ERISA.

SUBROGATION AND RIGHT OF REIMBURSEMENT

SUBROGATION

The Plan does not cover expenses for which another party may be responsible. To the extent the Plan provides or pays benefits or expenses for Covered Services, you automatically assign to the Plan and the Plan assumes your (and your heirs', estate's or legal representative's) legal rights to recover the amount of those benefits or expenses from any person or, entity that may be legally obligated to pay for those benefits or expenses, including, but not limited to, your own insurer and any under insured or uninsured coverage. This process is referred to as subrogation. The amount of the Plan's subrogation rights shall equal the full amount you are entitled to recover, up to the total amount paid by the Plan for the benefits or expenses for Covered Services (the "Recoverable Amount").

The Plan's right of subrogation applies on a first-dollar basis and has priority over your or anyone else's rights until the Plan recovers the amount in full. The Plan's right of subrogation for the Recoverable Amount is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity, and applies to funds paid for any reason, including non-medical or dental charges, attorney fees, or other costs and expenses. The Plan expressly rejects and supersedes the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its subrogation rights.

The Plan's subrogation rights allow the Plan to pursue any claim, right or cause of action that you (and your heirs, estate or legal representatives) may have, whether or not you (or your heirs, estate or legal representatives) choose to pursue the claim. You must cooperate with the Plan Administrator and Employer in any way they may deem necessary or appropriate to make, perfect or prosecute your rights, including entering into a subrogation agreement with the Plan upon the request of the Plan Administrator or Employer. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable for your injuries.

REIMBURSEMENT

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, you must repay the Plan from, and the Plan has the right to reimbursement from, any amounts you recover from any person or entity, whether through a lawsuit, settlement, or otherwise, and regardless whether the amounts recovered are designated as payments of medical expenses. The amount of the Plan's reimbursement rights is equal to the Recoverable Amount.

The Plan's right of reimbursement applies on a first-dollar basis and has priority over your or anyone else's rights until the Plan recovers the Recoverable Amount.in full.. The Plan's right of reimbursement for Recoverable Amount is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity, and applies to funds paid for any reason, including non-medical or dental charges, attorney fees, or other costs and expenses. The Plan expressly rejects and supersedes the "make-whole" rule, which might otherwise require that you be "made whole" before the Plan may be entitled to assert it's right of reimbursement.

By filing a claim for and/or accepting Plan benefits (whether the payment of such benefits is made to you or made on behalf of you to any Provider), you are deemed to have consented to the Plan's right of reimbursement and to have agreed to cooperate with the Plan Administrator and Employer in any way they may deem necessary or appropriate to make, perfect or prosecute your rights, including entering into a reimbursement agreement with the Plan upon the request of the Plan Administrator or Employer.

EQUITABLE LIEN AND OTHER EQUITABLE REMEDIES AND OTHER EQUITABLE REMEDIES

The Plan has an equitable lien against any right you may have to recover all or part of the benefits or expenses for Covered Services paid by the Plan from any person or entity, including an insurer or another group health plan, but limited to the Subrogation Amount. The equitable lien also attaches to any right to payment from Workers' compensation, whether by judgment or settlement, where the Plan has paid Covered Expenses prior to a determination that the Covered Expenses arose out of and in the course of employment. Payment by Workers' compensation insurers or the Employer will be deemed to mean that such a determination has been made.

This equitable lien also attaches to any money or property obtained by anybody (including, but not limited to, you, your attorney, and/or a trust), whether by judgment, settlement or otherwise, as a result of an exercise of your rights, up to the Recoverable Amount. The lien may be enforced against any person or entity who possesses or controls such proceeds, including but not limited to, you, your representative, your agent, a third party, or an insurer. The Plan is also entitled to seek any other equitable remedy against any such person or entity. In the Plan Administrator's discretion of the Plan, the Plan may reduce any future Covered Expenses otherwise available to you under the Plan, up to the Recoverable Amount. This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were recognized in the United States Supreme Court's decisions entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 U.S., 204 (1/8/2002); and Sereboff v. Mid Atlantic Medical Services, Inc., 126 Sup. Ct. 1869 (2006). The Plan's terms regarding subrogation, equitable liens and other equitable remedies are intended to supersede the federal common law doctrine referred to as the "common fund" rule.

By accepting Plan benefits (whether the payment of such benefits is made to you or made on behalf of you to any Provider), you agree that if you receive any payment from any third party as a result of an Injury, Illness, or condition for which benefits are paid by the Plan, you will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.

ASSISTING IN THE PLAN'S REIMBURSEMENT ACTIVITIES

You have duty to assist the Plan when attempting to obtain reimbursement of the Recoverable Amount, and to provide the Plan with any information concerning your other insurance coverage (whether through automobile insurance, other group health plan, or otherwise) and any other person or entity (including any insurers) that may be obligated to provide payments or benefits to you or for your benefit. You must:

- Notify the Plan Administrator within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness, or a condition sustained by you;
- Cooperate fully in the Plan's exercise of its rights to subrogation and reimbursement;
- Not do anything to prejudice the Plan's rights (such as settling a claim against another party without including the Plan as a co-payee for the total Recoverable amount) or to prejudice the Plan's ability to enforce the terms of this provision;
- Sign any document the Plan Administrator deems relevant to protecting the Plan's subrogation, reimbursement or other rights, and
- Provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the Plans rights. Failure to provide requested information may result in the termination of your coverage under the plan or the institution of court proceeding against you.

OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or your Eligible Dependent(s) who are Covered Individuals; or

This provision and the rights above do not affect any other right of recovery the Plan may have with respect to overpayments.

In the event that any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator or its delegate has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits (whether the payment of such benefits is made to you or made on behalf of you to any Provider) from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond to you by reason of your present or future domicile.

AMENDMENT OR TERMINATION OF THE PLAN

Trinity Health intends to continue this Plan indefinitely. However, certain circumstances may require that this Plan be amended or terminated. Trinity Health expressly reserves the right to amend the, Plan at any time for any reason. In addition, the Administrator and the Benefits Committee are authorized to approve amendments to the Plan in accordance with the Trinity Health Corporation Table of Authority for Welfare Benefit Plans.

Anyone claiming an interest under the Plan will be bound by any such amendment.

If any amendment results in the termination of coverage, benefits will only be paid for claims incurred prior to the date coverage was terminated.

The Plan may only be amended by a document in writing. Thus, the Plan may never be amended by oral representations, verbal or otherwise, that may be made to you concerning the Plan. In the event of any inconsistency, the Plan's written terms will always control. If you believe you have received information that is contrary to the terms of the Plan, please contact the Plan Administrator for clarification.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

The Plan is a self-funded plan. Covered Individuals in this Plan are not insured. In the event this Plan does not ultimately pay expenses that are eligible for payment under this Plan for any reason, the individuals covered by this Plan may be liable for those expenses.

The Medical Claims Administrator, Aetna, merely processes claims and does not insure any medical expenses of individuals covered by this Plan.

Complete and proper claims for benefits made by Covered Individuals will be promptly processed. In the event of a delay in processing, the Covered Individual shall have no greater right or interest or other remedy against the Medical Claims Administrator than as otherwise afforded by law.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) STATEMENT OF PARTICIPANT RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("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 and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 collective bargaining agreements, 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 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 other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- You may be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

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

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain 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 domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, of 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 INFORMATION ABOUT THE PLAN

Plan Sponsor	Trinity Health Corporation 20555 Victor Parkway Livonia, MI 48152 EIN: 35-1443425 734-343-1000 (phone)
Name of Plan and Type of Plan	The Medical Benefit Program (including the Prescription Drug Program) is a component under Plan 504 of the Trinity Health Corporation Welfare Benefit Plan.
Plan Number	504
Plan Year	January 1 - December 31
Plan Administrator and Named Fiduciary	Trinity Health Corporation 20555 Victor Parkway Livonia, Michigan 48152 734-343-1000 (phone)
Type of Administration and Fund	The Plan is funded through the general assets of the Employer. There is no separate funding for the Plan. The Plan is administered by Trinity Health.
Medical Claims Administrator	The following entity is responsible for the day-to-day administration of the Plan (Aetna health plan options) described in this SPD, including claims processing: Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156
Prescription Drug Claims Administrator	The following entity is responsible for the day-to-day administration of the Prescription Drug benefits under the Plan described in this SPD, including claims processing: OptumRx P.O. Box 650334 Dallas, TX 75265-0334
Cost of the Plan	You and your Employer share the cost of providing Plan benefits for you and your Eligible Dependents.
Request for Plan Information	Requests to review Plan documents, requests for copies of Plan documents, and questions regarding Plan operations should be directed to Plan Administrator at the address and telephone number provided above or the HR Shared Services (if your Employer is supported by the HR Shared Services) or your Employer's local HR representative (if your Employer is not supported by the HR Shared Services).

COBRA Administrator	Health Equity 877-502-6272 (phone) https://www.healthequity.com
HR Shared Services	Trinity Health Corporation HR Shared Services 20555 Victor Parkway Livonia, Michigan 48152 877-750-4748 (phone) 312-957-2567 (facsimile) https://www.myworkday.com/trinityhealth/login.htmld
Agent for Service of Process	Legal process may be served. at: CT Corporation 30600 Telegraph Road Bingham Farms, Michigan 48025.

Table A: Allowable Expenditures from Your HSA

There have been thousands of cases involving the many nuances of what constitutes "medical care" for purposes of section 213(d) of the Internal Revenue Code. A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. The determination often hangs on the word "primarily". Below is a partial list of allowable tax-free expenditures from your HSA.

Allowable Expenditures from Your HSA	
Acupuncture	Substance Abuse Treatment
Ambulance	Artificial Limb
Artificial Teeth	Bandages
Birth Control Pills (by prescription)	Breast Reconstruction Surgery (mastectomy)
Car Special Hand Controls (for disability)	Certain Capital Expenses (for the disabled)
Chiropractors	Christian Science Practitioners
COBRA premiums	Contact Lenses
Cosmetic Surgery (if due to trauma or disease)	Crutches
Dental Treatment	Dermatologist
Diagnostic Devices	Disabled Dependent Care Expenses
Drug Addiction Treatment (inpatient)	Drugs (prescription)
Eyeglasses	Fertility Enhancement
Guide Dog	Gynecologist
Health Institute (if prescribed by physician)	H.M.O. (certain expenses)

Hearing Aids	Home Care
Hospital Services	Laboratory Fees
Lasik Surgery	Lead Based Paint Removal
Learning Disability Fees (prescription)	Legal Fees (if for mental illness)
Life Care Fees	Lodging (for outpatient treatment)
Long-Term Care (medical expenses)	Long-Term Care Insurance (up to allowable limits)
Meals (associated with receiving treatments)	Medical Conferences (for ill spouse/dependent)
Medicare Premiums	Medicare Deductibles
Nursing Care	Mentally Retarded (specialized homes)
Obstetrician	Nursing Homes
Operations — Surgical	Operating Room Costs
Optician	Ophthalmologist
Organ Transplant (including donor's expenses)	Optometrist
Orthopedic Shoes	Orthodontics
Osteopath	Orthopedist
Over-the-Counter Medicines (only with a prescription)	Out-of-pocket expenses while enrolled in Medicare
Pediatrician	Oxygen and Equipment
Podiatrist	Personal Care Services (for chronically ill)
Prenatal Care	Postnatal Treatments
Prosthesis	Prescription Medicines
Psychiatric Care	PSA Test
Psychoanalysis	Psychiatrist
Psychologist	Psychoanalyst
Radium Treatment	Registered Nurse
Special Education for Children (ill or disabled)	Qualified Long-Term Care Services
Spinal Tests	Smoking Cessation Programs
Sterilization	Specialists
Telephones and Television for the Hearing	Splints
Therapy	Surgeon
Treatment	Transportation Expenses for Health Care

Vitamins (if prescribed)	Vaccines
Wheelchair	Weight Loss Programs
X-rays	Wig (hair loss from disease)

Table B: Non-Allowable Expenditures from Your HSA
Below is a partial list of expenditures that are not allowable tax-free expenditures from your HSA.

Non-Allowable Expenditures from Your HSA	
Advance Payment for Future Medical Expenses	Athletic Club Membership
Automobile Insurance Premium	Babysitting (for healthy children)
Boarding School Fees	Bottled Water
Commuting Expenses for the Disabled	Controlled Substances
Cosmetics and Hygiene Products	Dancing Lessons
Diaper Service	Domestic Help
Electrolysis or Hair Removal	Funeral Expenses
Hair Transplant	Health Programs at Resorts, Health Clubs and Gyms

GENERAL EXCLUSIONS

In addition to the exclusions and limitations listed elsewhere in this SPD, unless otherwise stated, the Plan does not provide coverage for the following charges:

- Those for services and supplies that are not Medically Necessary, as determined by Aetna in accordance with the terms of the Plan, for the diagnosis, care, or treatment of the Illness or Injury involved. This applies even if they are prescribed, recommended, or approved by the Covered Individual's attending Physician.

- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the Covered Individual's attending Physician.

- Those for or in connection with services or supplies that are, as determined by Aetna, to be Experimental or Investigative. A drug, a device, a procedure, or treatment will be determined to be Experimental or Investigative if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved;

- If required by the FDA, approval has not been granted for marketing;

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental, Investigative, or for research purposes; or

- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental, Investigative, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with an Illness if Aetna determines that:

- The Illness can be expected to cause death within one year, in the absence of effective treatment; and

- The care or treatment is effective for that Illness or shows promise of being effective for that Illness as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the Illness.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.

- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the Covered Individual’s Illness or Injury.

- Those for or related to the following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training or carbon dioxide therapy.

- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.

- Those for wilderness therapy including health resorts, recreation programs, outdoor skills programs, relaxation of lifestyle programs and services provided in conjunction with any of these programs.

- Those for services of a resident Physician or intern rendered in that capacity.

- Those that are made only because there is health coverage.

- Those that a Covered Individual is not legally obliged to pay.

- Those, as determined by Aetna, to be for Custodial Care.

- Those for services and supplies:

- Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government; or

- Furnished, paid for, or for which benefits are provided or required under any law of a government; this exclusion will not apply to "no fault" auto insurance if it is required by law, is provided on other than a group basis, and is included as plan or policy with which benefit payments are coordinated as described in the “Coordinating With Another Employer’s Plan” section of this SPD; in addition, this exclusion will not apply to a plan established by government for its own associates or their dependents; or Medicaid.

- Those for or related to any eye Surgery mainly to correct refractive errors.

- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.

- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

    - Sildenafil citrate;

    - Phentolamine;

    - Apomorphine;

    - Alprostadil; or

    - Any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically indicated as covered in this SPD.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically indicated as covered in this SPD.

- Those for or related to artificial insemination, in-vitro fertilization, certain fertility drugs or embryo transfer procedures.

- Those for GIFT (Gamete Intrafallopian Transfer) and ZIFT procedures.

- Those for contraceptive pills, devices, implants and injections, unless Medically Necessary.

- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies are specifically indicated as covered in this SPD.

- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.

- Those for or in connection with speech therapy for a congenital defect (unless following surgery) or learning disabilities; this exclusion does not apply to charges for speech therapy that is expected to restore speech to a Covered Individual who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of an Illness or Injury.

- Those for services and supplies that, in the opinion of the Claims Administrator or its authorized representative, are associated with Injuries, Illness, or conditions suffered due to the acts or omissions of a third party.

- Those for claims filed later than one year from the date the charge was incurred.

- Those for incurred by a surrogate mother.

- Those for termination of pregnancy (abortion).

- Those incurred as a result of committing an assault, felony or any illegal or criminal activity.

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- Those for services rendered for treatment of any Injury or Illness for which benefits are available under Workers' Compensation or Employer Liability Law, whether or not such coverage is in force and whether or not such benefits are received by the Covered Individual. Occupational Illness or Injury includes those as a result of any work for wage or profit.

- Those for Custodial Care, rest therapy and care in nursing or rest home facilities.

- Those for plastic Surgery, reconstructive Surgery, cosmetic Surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to

    - :improve the function of a part of the body that;

    - Is not a tooth or structure that supports the teeth; and

- Is malformed:
- As a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or
- As a direct result of:
  - Illness; or
  - Surgery performed to treat an Illness or Injury.
- Repair an Injury. Surgery must be performed:
  - In the calendar year of the accident which causes the Injury; or
  - In the next calendar year.

- Those to the extent they are not Reasonable Charges, as determined by Aetna.
- Those for a voluntary sterilization procedure or reversal of a sterilization procedure.
- Those for services, care, treatment, and referrals rendered by the Covered Individual's family, including but not limited to spouse, mother, father, grandmother, grandfather, in-laws, son, daughter, step-children or any person who resides with the Covered Individual.
- Those for a service or supply furnished by a Network Provider in excess of such Provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the Plan are paid.
- Those for eyeglasses.
- Those for vision aids.
- Those for hearing aids.
- Those for communication aids.
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs, or supplies, even if otherwise covered under this document. This also includes prescription drugs supplied if:
  - Such prescription drugs or supplies are unavailable or illegal in the United States; or
  - The purchase of such prescription drugs or supplies outside of the United States is considered illegal.
- Cancer Treatment Centers of America (CTCA) — There is no Network or Out-Of-Network coverage for both health care services provided by the facility; and health care services provided by physicians and other health care professionals at the facility.
- Services performed at Mayo Clinic.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a Covered Individual lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

This is a summary of the most important provisions of the Plan. Details of the Plan provisions can be found in the official Plan document. The Plan document is always used in cases requiring a legal interpretation of the Plan. If there is any difference between a Plan document and this summary, your rights will be based on the provisions of the Plan document (and any legal rules that require changes not yet written in to the Plan document).

1/1/2026

Version: #1

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

The Trinity Health Corporation Welfare Benefit Plan ("Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan, through Trinity Health Corporation and the other participating employers in the Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters

If you need these services, contact Jodi Weiner. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Jodi Weiner, Trinity Health Corporation Vice President, Benefits & Well- Being, 20555 Victor Parkway, Livonia, MI 48152, (855) 812-1297 (telephone), (248) 347-5437 (fax), ACAsection1557@trinity-health.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jodi Weiner is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1- 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.