AETNA PREFERRED PROVIDER PLAN

MEDICAL AND PRESCRIPTION DRUG SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2024

CONTENTS

PURPOSE

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 for the health care coverage under the Medical Benefit Program (including the Prescription Drug Program) component of Plan 504 of the Trinity Health Corporation Welfare Benefit Plan ("THWBP" or "Welfare Plan") that is provided through the Aetna Life Insurance Company ("Aetna") Preferred Provider Organization ("PPO") health plan options ("Plan"). This Summary Plan Description ("SPD") is intended to provide you with an overview of important information (including the prescription drug benefits administered by OptumRx) available when you are covered under the Plan. Coverage through the Plan is offered to benefits-eligible Colleagues of Trinity Health Corporation ("Trinity Health") and the Trinity Health Ministries and Trinity Health affiliates that have adopted the Plan and their eligible Dependents.

This SPD may be an electronic version of the SPD on file with Trinity Health and Aetna. In case of any discrepancy between an electronic version of this SPD and the printed version on file with Trinity Health, the terms set forth in the printed version on file with Trinity Health will prevail. In addition, in case of any discrepancy between the SPD (electronic or printed) and the actual Plan document, the Plan document will prevail. To obtain a printed copy of this SPD and/or the Plan document, please contact the Plan Administrator.

HIGHLIGHTS

This SPD features:

- Terms you should know
- Eligibility and participation rules
- An explanation of how your medical benefits may coordinate with other medical coverage
- Details about continuing group health coverage
- An understanding of the administration of the Plan
- An overview of your rights required by federal law
- Contact information
- Highlights of your medical and Prescription Drug coverage

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 document 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 who 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 the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, 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 Claims 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 Individual pays a percentage of his or her Covered Expenses for a Covered Service after his or her 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

This is 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 a R.N. or a L.P.N. directed by a 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 Substance Use Disorder therapy 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 includes meeting at least twice a month with an organization devoted to the treatment of alcoholism or drug use. Detoxification, which means mainly treating the aftereffects of a specific episode of substance use, and Maintenance care, which means providing an environment free of Substance Use Fisorders, are not the Effective Treatment of Subsutance Use Disorders.

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 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 his or her 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 he or she 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 which makes policy; this group must have at least one Physician and one R.N. It has full-time supervision by a Physician or a R.N. and full-time administrator. This agency keeps complete medical records on each person and meets 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 which has Hospice Care available 24 hours a day and meets any licensing or certification standards set forth by the jurisdiction where it provides skilled nursing and medical social services and psychological and dietary counseling. A Hospice Care Agency also provides or arranges for other services which will include: services of a Physician, 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 SubstanceUse 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.

MEDICALLY NECESSARY
All Covered Services under the Plan are subject to the requirement of being Medically Necessary and subject to uniform standards of medical practice. 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 length of care, the treatment or medical supply, 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 condition, disease, Injury or Illness; and
- The care does not meet covered Experimental or Investigative criteria 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, a psychologist or a psychiatric social worker. For the purpose of benefits under this Plan, a Mental Disorder includes, but is not limited to: 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 Substance Use Disorder only if any separate benefit for a particular type of treatment does not apply to 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 of the co-morbid conditions that demonstrates 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 or 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. All Aetna health plan options that are included in the Plan are not 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 the HR Service Center, by going online at https://hr4u.trinity-health.org; 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, the Plan also includes the Prescription Drug 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 OptumRx.

PLAN ADMINISTRATOR
Trinity Health Corporation.

PLAN YEAR
The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31. 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 helps you and your Physician or other Provider determine whether the services being recommended are Covered Services under the Plan.

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 assistants 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** — Trinity Health Corporation's and its Ministries' Hospitals, facilities and satellite locations and those practitioners listed in the Provider Directory as Tier 1 Network Providers.
- **Tier 2 Network Providers** (also referred to as "In-Network Providers" and "Preferred Care Providers") — Hospitals, Physicians and other licensed facilities or Health Care Professionals who have contracted with Trinity Health or its Ministries proprietary networks or Aetna to accept Aetna's Negotiated Charge as payment in full for Covered Services.
- **Tier 3 Out-of-Network Providers** (also referred to as "Non-Network Providers" and "Nonparticipating 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.

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:

- On-site licensed Behavioral Health Provider, medical or Substance Use Disorder professionals 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 a "surgery" under the Current Procedural Terminology ("CPT") code.

URGENT CARE PROVIDER

This is a freestanding medical facility which 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 law or regulation. 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 a sudden Illness, Injury, or condition that does not require the level of care provided in an emergency room but is severe enough to require prompt medical attention to avoid serious deterioration of the Covered Individual's health, an extended Illness or prolonged impairment, or require more hazardous treatment and includes a condition which would subject the Covered Individual to 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 Office definition of Employment Classifications Policy if your Employer does not have an employment classification policy or procedure), or 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 and whose participation in the Plan is not provided for in the collective bargaining agreement. A copy of your Employer's employment classification policy or procedure or the ACA Employee Eligibility Procedure can be obtained from the Plan Administrator or:

- If your Employer is supported by the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, 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 ADULT

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 Post-Tax Eligible Adult set forth below.

CRITERIA FOR 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 satisfies the Internal Revenue Service's definition of a spouse with respect to the Colleague;
- The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities; and
- The person is not legally married to someone other than the Colleague.

In addition to the above, a person who satisfies the requirements set forth below to be a Post-Tax Eligible Adult will be treated as a Pre-Tax Eligible Adult (a "Non-Spouse Pre-Tax Eligible Adult") if the person is the Eligible Colleague's dependent for federal income tax purposes. In order for a person who is not the Eligible Colleague's spouse to be treated as a Non-Spouse Pre-Tax Eligible Adult, the Eligible Colleague will need to complete the Trinity Health Corporation Welfare Benefit Plan Certification Regarding Tax Dependent Status of a Non-Spouse Eligible Adult within 30 days of enrolling the person in the Plan. The Trinity Health Corporation Welfare Benefit Plan Certification Regarding Tax Dependent Status of a Non-Spouse Eligible Adult can be obtained:

- If your Employer is supported by the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, from your Employer's local HR/benefits representative.

An Eligible Colleague's contributions for 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.

CRITERIA FOR POST-TAX ELIGIBLE ADULTS

A person is an Eligible Colleague's Post-Tax Eligible Adult if he or she has a current, valid domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry OR he or she satisfies all of the following:

- The person does not satisfy the Internal Revenue Service's definition of a spouse with respect to the Colleague;
- The person shares the Colleague's permanent residence;
- The person is financially interdependent with the Colleague;
- The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities;
- The person is not legally married to someone other than the Colleague;
- The person is not the Colleague's:
  - Parent/Step-parent;
  - Parent's/Stepparent's other descendant (i.e., the Colleague's sibling, niece, nephew);
  - Grandparent/Step-Grandparent or one of their descendants (e.g., the Colleague's aunt, uncle, cousin, etc.);
  - In-law;
  - Renter, boarder, tenant, or employee; or
  - Child* or grandchild.

*Dependent Children are separately eligible for coverage up to age 26, as described below.

An Eligible Colleague's contributions for the cost of a Post-Tax Eligible Adult's coverage under the Plan will be withheld from the Colleague's compensation on a post-tax basis and the Employer's portion of the cost of such coverage will be taxable income to the Colleague.

DEPENDENT CHILDREN

An Eligible Colleague's Dependent Children are eligible for coverage under the Plan through the end of the Plan Year 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 Eligible Colleague's Eligible Adult*;

- The legally adopted children of or children placed for adoption with the Eligible Colleague or, Eligible Colleague's Eligible Adult*; or
- Children for whom the Eligible Colleague or Eligible Colleague's Eligible Adult are the court-appointed legal guardian; and

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

*Children of a non-spouse Eligible Adult may be covered under the Plan only if their Eligible Adult is covered under the Plan.

In addition, the children who satisfy both of the criteria set forth above are Dependent Children eligible for coverage under the Plan after they turn age 26 if they meet all of the following criteria:

- They are totally and permanently Disabled and became Disabled prior to their 26th birthday;
- They are unmarried;
- They are continuously enrolled in a group health plan prior to their 26th birthday; and
- They either:
  - Live 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
  - Are not anyone's "qualifying children" for the year (as defined in Internal Revenue Code Section 152(c)) and the Eligible Colleague, Eligible Colleague's Pre-Tax Eligible Adult who is not a Non-Spouse Pre-Tax Eligible Adult, or 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. In order 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 the complete eligibility rules and documentation requirements for you and your Eligible Dependents, visit:

- https://hr4u.trinity-health.org if your Employer is supported by the HR Service Center; or
- https://mybenefits.trinity-health.org if your Employer is not supported by the HR Service Center.

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 affected child (and, if you are not already enrolled in the Plan, you must also enroll). Additionally, the Employer may withhold from your paycheck any contributions required for such coverage.

A QMCSO is a court order or court-approved settlement agreement that provides for health benefits for a child of a group health plan participant or enforces one of the mandatory provisions of state law regarding the provision of health insurance to minors in such cases. A QMCSO gives the child the same rights as a Colleague to receive benefits under a group health plan.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the Employer to cover a child under the Plan. Federal law provides that 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

- Your Dependent if already covered under the Plan or other group health plan offered by your Employer or one of its related or affiliated entities as a Colleague or Dependent;
- Any individual who does not meet the definition of an Eligible Colleague or an Eligible Dependent as described in this Eligibility section of this SPD.

If you are not eligible for coverage under the Plan, your Dependents also are not eligible for coverage.

PARTICIPATION

WHEN PARTICIPATION BEGINS

You may elect coverage under the Plan within 30 days of the date you are first eligible for coverage (your "Initial Enrollment Period") or during the Annual Open Enrollment. If you are a newly hired Eligible Colleague and you elect coverage for yourself during your Initial Enrollment Period (i.e., within 30 days of your date of hire), your coverage will begin (i.e., you become a participant) date of hire. If you are a newly hired Eligible Colleague and you elect coverage for your Eligible Dependents during your Initial Enrollment Period, your Eligible Dependents' coverage will begin on the same day your coverage begins if you provide timely Dependent verification.

If you become an Eligible Colleague after your initial date of hire by your Employer, your coverage will begin (i.e., you become a participant) the date you become eligible for benefits (there is no waiting period). Your Eligible Dependents' coverage will begin on the same day your coverage begins if you provide timely Dependent verification.

You must enroll yourself in the Plan in order to enroll your Dependents in the Plan.

The following table shows when coverage begins for you and your Eligible Dependent(s) if you enroll yourself and your Eligible Dependent(s) during your Initial Enrollment Period:

Covered Individual:	**Effective Date of coverage:**
Newly Hired Eligible Colleague and his or her Eligible Dependent(s)	First day of the Eligible Colleague's active employment with the employer if the Eligible Colleague enrolls within 30 days of the 1st day of active employment with the employer,
Colleague who is not benefits-eligible becomes an Eligible Colleague and his or her Eligible Dependent(s)	• The date the colleague becomes an Eligible Colleague of the employer if the Eligible Colleague enrolls within 30 days of the date the ccolleague becomes an Elgibile Colleague of the employer.

Upon electing coverage under the Plan for your Eligible Dependents, you will have 30 days to provide documentation to verify the eligibility of each of your Dependents that you enrolled in the Plan and, if you have enrolled a Non-Spouse Pre-Tax Eligible Adult, the Trinity Health Corporation Welfare Benefit Plan Certification Regarding Tax Dependent Status of a Non-Spouse Eligible Adult.

The required documentation is set forth in the Trinity Health Dependent Verification Documentation Requirements, a copy of which can be obtained from the Plan Administrator or on:

- https://hr4u.trinity-health.org if your Employer is supported by the HR Service Center; or
- https://mybenefits.trinity-health.org if your Employer is not supported by the HR Service Center.

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 Trinity Health Corporation Welfare Benefit Plan Certification Regarding Tax Dependent Status of a Non-Spouse Eligible Adult 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 any Employer in a benefits-eligible position, you may either both elect individual coverage or one of you may cover the other as a Dependent. 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 one 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. Each year, the benefit plans and the contributions for coverage are reviewed by Trinity Health and may be revised. 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 :

- The HR Service Center if your Employer is supported by the HR Service Center; or
- Your Employer's local HR/benefits representative if your Employer is not supported by the HR Service Center.

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) except under the circumstances described in the Special

Enrollment Periods section below or if you and/or your Dependents experience a change in status event described in the Change in Status section below. The Annual Open Enrollment period is held during the fall of each year.

SPECIAL ENROLLMENT PERIODS

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 insurance coverage, you may enroll yourself and/or your 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 for the other coverage

"Loss of eligibility" includes loss of coverage due to legal separation, death, divorce, 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, termination of a benefit package option, if the coverage is provided through an HMO, you no longer 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, 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 you and/or your Eligible Dependents may enroll 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 is terminated. 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 at the beginning of the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your Eligible Dependent(s) prior to such time).

If you acquire a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you will be entitled to special enrollment 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. You may not enroll your legal spouse due to your acquisition of a child through birth, adoption, or placement for adoption.
- ***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.
- ***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, as applicable, who becomes your Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption. However, you (the non-enrolled Colleague) must also be eligible to enroll in the Plan, 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 after the date of the event that entitles you and/or your Eligible Dependent(s) to the special enrollment period[1]. If you timely enroll yourself and/or your new Eligible Dependent, coverage will become 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 at the beginning of 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).

In addition to the above, you may enroll yourself and/or your Eligible Dependent(s) in the Plan if (1) 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 (2) 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 due to one of these reasons no later than 60 days after the date of the event that entitles you and/or your Eligible Dependent(s) to the special enrollment period. If you enroll yourself and/or your Eligible Dependent(s) in the Plan within 60 days after the date of the event[2], coverage will become 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 at the beginning of 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).

Please note, the HIPAA special enrollment provisions set forth above do not apply to a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult and his/her children who are not also the Eligible Colleague's children except a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom the Eligible Colleague has a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government registry and his or her children.

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 or domestic partnership status, civil union status, or status under a similar arrangement that is currently recognized and registered with a state or local government registry, meaning your:
  - Marriage;
  - Divorce;
  - Legal separation;
  - Annulment;
  - The death of your spouse or other Eligible Adult; or
  - The commencement or termination of a relationship with a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry.

- Change in number of Dependents, including birth, death, adoption, and placement for adoption. This event does not apply to children of a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult who are not also your children, except that the event does apply to the children of a Non-Spouse Pre- Tax Eligible Adult or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with the state or local government registry.
- Change in employment status of the Colleague, spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom the Colleague has a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government agency or Dependent Child that causes you, your spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government registry or Dependent Child 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 the Colleague, spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom the colleague has a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government or 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.
- Cost or Coverage — A significant change in the cost or coverage of a benefit plan offered to you, your spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government, or 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 the employer of your spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government, or Dependent Child, 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 <u>not</u> allow you to revoke coverage entirely, unless no other similar coverage is available).
- You, your spouse Pre-Tax Eligible Adult, Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom the Colleague has a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government, or Dependent Child become covered or lose benefit coverage under Medicare or Medicaid, 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 the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”).

You commence or return from an unpaid leave of absence as permitted and regulated by the Family 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 your Dependent or former Dependent (other than a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult and his or her children who are not also your children, except a Non-Spouse Pre-Tax Eligible Adult or Post-Tax Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government registry and his or her children) during an open enrollment period under another employer’s group health plan that differs in time from the Annual Open Enrollment period.

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

In addition to the above:

- If your employment status changes but the employment status change does not cause you to lose eligibility for coverage under the Plan, you may revoke or change your (and your Eligible Dependents', if any) coverage under the Plan within 30 days of the date of your 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 or your Eligible Adult's employer's group health plan or a lower cost group health plan option under this Plan) with the new coverage 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 complete enrollment documents (or the online enrollment process, if directed by your Employer) to revoke or change your (and your Eligible Dependents', if any) Plan coverage and corresponding contribution election within 30 days of the date of your employment status change, you must wait until the next Annual Open Enrollment period to revoke or change the Plan coverage, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to revoke or change your coverage prior to such time).
- You must cancel your (and your Eligible Dependents' if any) Plan coverage in order to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period. In order to cancel Plan coverage, the Health Insurance Marketplace coverage must be effective immediately after the day the Plan coverage is cancelled. You must complete enrollment documents (or the online, enrollment process, if directed by your Employer) to revoke your (and your Eligible Dependents', if any) Plan coverage to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period.

The following table shows when coverage begins for your new Dependent if you timely elect coverage for the Dependent:

Eligible Dependent	Effective Date of Coverage:
New Dependent Eligible Adult: Spouse or Eligible Adult with whom you have a valid domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry	Date Dependent becomes Colleague's Eligible Adult (e.g., date of marriage)
New Dependent Eligible Adult: Non-spouse Eligible Adult with whom you have a valid domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry	May not be enrolled during the Plan Year; may be enrolled during the next Annual Open Enrollment period with coverage effective as of the following January 1
New Dependent Children: Newborn	Date of birth
New Dependent Children: Stepchildren	Date of marriage
New Dependent Children: Adopted, placed for adoption and/or legal guardianship	Date of adoption, placement for adoption, and/or legal guardianship
New Dependent: Non-Spouse Eligible Adult's Children (not including a Non-Spouse Eligible Adult with whom you have a valid domestic partnership, civil union, or similar arrangement that is currently recognized and registered with a state or local government registry)	May not be enrolled during the Plan Year; may be enrolled during the next Annual Open Enrollment period with coverage effective as of the following January 1

In addition to the above, in order for your Dependent Child to remain covered under the Plan after he or she reaches age 26, the child must be Disabled before reaching age 26 and you must notify the Plan Administrator or HR Service Center (if your Employer is supported by the HR Service Center) or your Employer's local HR/benefits representative (if your Employer is not supported by the HR Service Center) by the end of the calendar year in which the Dependent reaches age 26.

ENROLLING AFTER YOU WAIVE PARTICIPATION

If you choose not to participate in the Plan, your next opportunity to enroll will be during the next Annual Open Enrollment unless you have a qualified change in status event or there is a special enrollment right.

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 that creates a legal obligation for the Employer to extend coverage under the Plan, while you are not being paid by the Employer, you may, at your option, continue coverage during the period of absence 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 paychecks during the absence.

REHIRED COLLEAGUES

If you terminate employment with all of the Employers before becoming a participant and you are later re-employed by any Employer as a benefits-eligible Colleague, you must satisfy the eligibility requirements in order to participate in the Plan without regard to any prior period of employment with an Employer.

If you terminate employment with all of the Employers after becoming a participant and you are rehired into a benefits-eligible position within 30 days from your last day worked for any Employer, you will be automatically re-enrolled in the Plan as of your rehire date in the same benefit health plan option and coverage level as in effect before the termination of your employment unless an election change is permitted due to a special enrollment event or change in status event.

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

If you terminate employment with all of the Employers and you are subsequently rehired by an Employer, you will not be treated as a new Eligible Colleague and, therefore, will not be required to again meet the eligibility and participation requirements to the extent required by the rehire rules set forth in the employer shared responsibility provisions of the ACA and the guidance issued thereunder and ACA Employee Eligibility Procedure. Your coverage will be effective as of your rehire date if you enroll in the Plan within 30 days of that date in accordance with the procedures established by the Plan Administrator. Please see the ACA Employee Eligibility Procedure for additional information. You can obtain a copy of the ACA Employee Eligibility Procedure from the Plan Administrator or:

- If your Employer is supported by the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, from your Employer's local HR/benefits representative.

WHEN COVERAGE ENDS

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

- The last day of the month in which your employment with your Employer ceases (except as otherwise provided under the Trinity Health Corporation Severance Pay Plan, the Trinity Health Corporation Severance Pay Policy or another severance policy or separation, employment, severance or similar agreement);
- The date of your death;
- The date you cease to be an Eligible Colleague (e.g., the date of a reduction in hours that causes you to be ineligible to participate in the Plan);
- The date on which you fail to make a required contribution toward the cost of coverage under the Plan;
- The day you elect to terminate your participation (whether pursuant to your Annual Open Enrollment election or pursuant to a qualified change in status); or

- The date the Plan is terminated.

If you are an ACA full-time Eligible Colleague of an Employer for a Plan Year (i.e., you averaged at least 30 hours of service per week for the Employer during the applicable measurement period for that Plan Year or you are hired by the Employer during the Plan Year and you are expected to work an average of at least 30 hours per week when you are hired), as determined under the Plan Administrator's policies and procedures to implement the employer mandate provisions of the ACA and guidance issued thereunder, you will not cease to be eligible for coverage under the Plan until the later of the earliest date set forth above or the last day of the applicable stability period. Please see the ACA Employee Eligibility Procedure for additional information. You can obtain a copy of the ACA Employee Eligibility Procedure from the Plan Administrator or:

- If your Employer is supported by the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, from your Employer's local HR/benefits representative.

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

- The date the individual ceases to satisfy the requirements set forth in the Eligibility section of the SPD to be an Eligible Adult (e.g., your divorce or legal separation from the individual, if applicable);
- The date your coverage terminates, except that, in the event of your death, in which case your coverage ends 60 days from the date of your death;
- The last day of the pay period in which a change in employment status occurs that affects your eligibility to participate in the Plan (i.e., reduction in hours that causes you to be ineligible to participate);
- The date on which a required contribution for the eligible Adult's coverage under the Plan is not made in a timely manner; or
- The date the Plan is terminated.

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

- The last day of the Plan Year in which the child turns age 26 (or ceases to satisfy the requirements set forth in the Eligibility section of the SPD for Disabled children to be eligible for coverage after they reach age 26);
- If the individual is the child of your Eligible Adult Dependent and is not also your natural child, adopted child, child who has been placed with you for adoption or child for whom you are the court-appointed legal guardian, the date the Eligible Adult ceases to satisfy the requirements set forth in the Eligibility section of the SPD to be an Eligible Adult;
- The date your coverage terminates except that, in the event of your death, 60 days from the date of your death;
- The date on which a required contribution for the child's coverage under the Plan is not made in a timely manner;
- The date the Plan is terminated;
- For a child covered pursuant to a QMCSO, the date the child is no longer covered under a QMCSO; or
- The date you elect to terminate the Eligible Dependent's coverage (whether pursuant to you 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 Plan's coordination of benefits ("COB") procedures will apply 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.

COORDINATING WITH ANOTHER EMPLOYER'S PLAN

COB is how plans coordinate benefits when you are covered by more than one health care or motor vehicle insurance plan or policy. The Plan, which is administered by the Plan Administrator and the Claims Administrator, requires that your benefit payments be coordinated with benefit payments from another health care or motor vehicle insurance plan or policy for services and/or supplies that may be payable under either plan, so that payment responsibilities will be fair. If you are covered by more than one health care or motor vehicle insurance plan or policy, COB guidelines (explained below) determine which plan pays for Covered Services first. 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.

The plan that pays first is your primary plan. This primary plan must provide you with the maximum benefits available to you under that plan. The plan that pays second is your secondary plan. This 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 the level of payment, when added to the benefits payable under another plan, will cover up to the total of the eligible expenses. COB also makes sure that the combined payments of all coverage will not exceed the actual cost approved for your care.

GUIDELINE TO DETERMINE WHICH PLAN IS PRIMARY AND 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 information regarding coordination with Medicare, please refer to the section of this SPD titled "Coordination With Medicare."

If the claimant is an active Colleague this Plan will be primary to:

- A plan covering the claimant as a dependent;
- A plan covering the claimant as a COBRA participant;
- A plan covering the claimant as a retiree in another group health plan; or
- A plan covering the claimant as a dependent of a retiree in another group plan.

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 a retiree; or
- A plan covering the Eligible Adult as an active Colleague.

If the claimant is the child of an active Colleague this Plan will be primary to a plan covering the child as a:

- Dependent of the Colleague's Eligible Adult, provided the Eligible Adult is also an active colleague, if the Colleague's birthday (day and month) is earlier in the year than the Colleague's Eligible Adult's birthday;
- COBRA participant or a dependent of a COBRA participant;
- CHIP participant; or

- Dependent of a retiree.

If both parents have the same birth date, the coverage that has been in effect the longest will be primary for the Dependent Child.

This Plan will be secondary to a plan covering the child as a dependent of the Colleague's Eligible Adult provided the Eligible Adult is also an active colleague, if the Colleague's birthday (day and month) is later in the year than the Colleague's Eligible Adult.

If the claimant is a child of an active Colleague and a court decree designates financial responsibility or establishes which parent must provide primary coverage and/or the order of payment, this Plan will follow the court decree.

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 which covers the parent who does not have custody of the child.
- The plan that covers the step parent who does not have custody of the child.

If there is a court decree that orders joint custody and does not determine primary status for benefit coverage, the Plan's regular provisions establishing the primary status for children of active Colleagues will apply.

If the claimant is a COBRA participant in this Plan, this Plan will be secondary to a plan covering the claimant as:

- An active colleague;
- A dependent of an active Colleague;
- 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 a plan has no COB provision, it will always be primary.

COORDINATION WITH MEDICARE

ACTIVE COLLEAGUES OR DEPENDENTS 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 Employer, and are also eligible for Medicare due to age, you may:

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

Drop your coverage under this Plan and enroll in Medicare, in which case Medicare would be your primary medical coverage

COVERED INDIVIDUALS ELIGIBLE FOR MEDICARE DUE TO DISABILITY

This Plan is primary and Medicare is secondary if you are eligible for Medicare by reason of disability (but not age), and your coverage under this Plan is on account of your (or someone else's) current employment with the Employer. If coverage under this Plan is not on account of current employment status with the Employer, and you are eligible for Medicare solely by reason of disability, Medicare is primary and this Plan is secondary. Note that in this latter case — where this Plan is secondary — this Plan will deem you or your Dependent, to be enrolled in Medicare Parts A, B and D even if you or your Dependent have not so enrolled.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

This Plan is *primary* and Medicare is secondary if you are eligible for Medicare solely on the basis of End Stage Renal Disease ("ESRD"), are not eligible for Medicare by reason of age or disability, and your coverage under this Plan is on account of your (or someone else's) current employment with the Employer. However, this Plan is primary only during the first 30 months of such eligibility for Medicare benefits. 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.
- Once this Plan becomes secondary after the 30-month period ends, ESRD medical related claims may be rejected if proof of Medicare review/payment is not provided.

If you are eligible for Medicare solely on the basis of ESRD, you must be covered by Parts A and B to get the full benefits available under Medicare to cover 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 Medicare Part A and defer enrolling in Part B during the 30-month coordination period, you will be charged a premium penalty by Medicare when you enroll in Part B if you delay enrolling by 12 or more months. In addition, this provision does not apply if at the start of your eligibility for this Plan you were already eligible for Medicare benefits and this Plan's benefits were payable on a secondary basis.

In order to assist your Employer and the Claims Administrator in complying with Medicare Secondary Payer ("MSP") laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator and/or your Employer regarding the Medicare eligibility of you and your spouse and covered Dependent(s). In addition, if you or your spouse or covered Dependent becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact the Claims Administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

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 the HR Service Center (if your Employer is supported by the HR Service Center) or your Employer's local HR representative (if your Employer is not supported by the HR Service Center) 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 inappropriately, 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 is the secondary (or tertiary) payer, you remain responsible for all primary patient liability resulting from primary insurance sanctions, penalties or Network restrictions, unless your primary insurer is an HMO.
- As secondary (or tertiary) payer, the Plan will not apply contract Network restrictions unless the primary insurer denied benefits for the service.
- As secondary (or tertiary) payer, 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.

FILING COB CLAIMS TO YOUR SECONDARY CARRIER

You must always (or must always have your health care Provider) submit claims to your primary carrier first. Then you or your Provider should submit a claim for the secondary balance to the Claims Administrator. If 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 Medical 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).

SUBMITTING COORDINATED 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 ("EOB") form, a claim should be submitted to the plan that pays second for processing of any unpaid expenses.

If you send the claim to the secondary plan before receiving an EOB from the primary plan, there will be a delay in processing the payment and may result in a rejection of the claim.

TRAVEL OUTSIDE OF THE UNITED STATES

When traveling outside of the United States, you have access to emergency and accidental injury benefits as long as 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 if the charges are in U.S or foreign currency. Be sure to also indicate 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.

The COBRA continuation coverage described in this section of the SPD does not apply to non-spouse Eligible Adult Dependents and their covered Dependent Children who are not also the Colleague's children. However, pursuant to a voluntary Employer program, an individual covered under the Plan who is an Eligible Colleague's non-spouse Eligible Adult Dependent or non-spouse Eligible Adult Dependent's child who is not also the Colleague's child may be eligible to continue coverage under the Plan when he or she would otherwise lose coverage. The terms of such continuation coverage are generally the same as the COBRA continuation coverage described in this section. Please contact the HR Service Center (if your Employer is supported by the HR Service Center) or your Employer's local HR/benefits representative (if your Employer is not supported by the HR Service Center) or the Plan Administrator for information regarding continuation coverage for non-spouse Eligible Adult Dependent and their children.

If your (or your Dependent's) coverage under the Plan would otherwise end because of any qualifying event (see below), then you (or your Dependent) have the right to continue group health coverage under the Plan if you (or your Dependent) were covered under the Plan on the day immediately preceding the qualifying event. An individual who would lose coverage under the Plan because of a qualifying event is 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.

An individual who elects to continue coverage will be required to pay the full cost of the coverage plus an applicable administration fee. The time period for which the continuation is available is set forth below in conjunction with the corresponding qualifying event. If continuation of coverage is elected, coverage will continue as though termination of employment or loss of eligible status had not occurred. If any changes are made to the coverage for Colleagues in active service, the coverage provided to individuals under this continuation provision will be changed similarly.

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.

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 Adult Dependents and their covered Dependent 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 are 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:

- **Disability Extension of 18-Month Period of Continuation Coverage**

  If you or anyone in your family covered under the Plan 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 an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time 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 make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the later of: (i) the date of the qualifying event (the Colleague's termination of employment or reduction in hours); (ii) the date of the Social Security Administration determination; or (iii) the date on the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In addition, you must notify the Plan Administrator of the Social Security Administration’s determination before the end of the 18-month period of COBRA continuation coverage.** This notice should be sent to the Plan Administrator at the address listed for the Plan Administrator in this SPD. 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.

  The Colleague, the qualified beneficiary or any representative on behalf of the Colleague or the qualified beneficiary can provide the notice.

- **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

  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 to the qualified beneficiaries receiving continuation coverage if the Colleague or former Colleague dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Dependent to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.**

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. When the qualifying event is the end of employment or reduction of hours of employment, death of the Colleague, commencement of a proceeding in bankruptcy with respect to the Employer or enrollment of the Colleague in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. For 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.**

Once the Plan Administrator receives notice that a qualifying event has occurred, a COBRA election notice will be provided to each of the qualified beneficiaries (within 14 days after receiving notice of the qualifying event). Each qualified beneficiary will 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 ALL NOTICES

The qualifying event notice and second qualifying event notice must be sent within the applicable time(s) set forth above to the Plan Administrator at the address listed for the Plan Administrator in this SPD. 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.

The Colleague, the qualified beneficiary or any representative on behalf of the Colleague or the qualified beneficiary can provide the notice.

COST OF CONTINUATION OF COVERAGE[3]

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 OF 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 (under 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.

If you were terminated or experienced a reduction of hours that qualifies for a trade readjustment allowance or alternative trade adjustment assistance, 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 reductions (amounts that lower your out-of-pocket costs for deductibles, co-insurance, and co-payments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP).

Coverage through the Federal 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 through the Federal 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 medical 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 THWBP and 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 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;
  - 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 shall 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 final medical claim determinations. Aetna shall not be 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 final Prescription Drug claim determinations.

Each fiduciary under this Plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall 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 shall 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 shall 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 protected health information, including certain rights to see and copy the information, to receive an accounting of certain disclosures of the information and, under certain circumstances, to amend the information. 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 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 he/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 shall 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 BENEFITS

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 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 in order 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 ("EOBS") 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 15 calendar 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 a 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 a 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.

STATUTE OF LIMITATIONS FOR CIVIL ACTIONS No court action concerning a claim for benefits under the Plan 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 the 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 as a result of having caused or contributed to an Injury, Illness or other loss. This means that, 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, entity, organization or insurer, including, but not limited to, your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay for those benefits or expenses. This process is referred to as subrogation. The amount of the Plan's subrogation rights shall equal the full amount you are entitled to receive up to the total amount paid by the Plan for the benefits or expenses for Covered Services.

The Plan's right of subrogation applies on a first-dollar basis and shall have priority over your or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services 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. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

The Plan's right of subrogation allows 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 that claim. You must cooperate with the Plan Administrator and Employer in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter 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.

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 recovered by suit, claim, settlement or otherwise, from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured motorist coverage, for those benefits or expenses (even if the amounts recovered are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the full amount you receive up to the total amount paid by the Plan for the benefits or expenses for Covered Services.

The Plan's right of reimbursement applies on a first-dollar basis and shall have priority over your or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services 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. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole' before the Plan may be entitled to assert its right of reimbursement.

By filing a claim for and/or accepting benefits (whether the payment of such benefits is made to you or made on behalf of you to any Provider) under this Plan, 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 respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, and shall enter into a reimbursement agreement with the Plan upon the request of the Plan Administrator or Employer.

EQUITABLE LIEN AND OTHER EQUITABLE REMEDIES

The Plan shall have 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 party, including an insurer or another group health program, but limited to the total amount paid by the Plan for the benefits or expenses for Covered Services. 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 shall also attach to any money or property that is 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 of recovery for benefits or expenses for Covered Services paid by the Plan, up to the total amount paid by the Plan for the benefits or expenses for Covered Services (sometimes referred to as "proceeds"). The lien may be enforced against any party who possesses proceeds representing an amount paid by the Plan for the benefits or expenses for Covered Services including, but not limited to, you, your representative or agent; third party; third party's insurer, representative, or agent; and/or any other source possessing funds representing an amount paid by the Plan for the benefits or expenses for Covered Services. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future Covered Expenses otherwise available to you under the Plan by an amount up to the total amount paid by the Plan for the benefits or expenses for Covered Services that is subject to the equitable lien.

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 enunciated 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 provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrine commonly referred to as the "common fund" rule.

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 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 PLAN'S REIMBURSEMENT ACTIVITIES

You have an obligation to assist the Plan in obtaining reimbursement of the total amount paid on your behalf for the benefits or expenses for Covered Services, and to provide the Plan with any information concerning your other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including your insurer(s)) that may be obligated to provide payments or benefits to you or for your benefit. You are required to (a) 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, (b) cooperate fully in the Plan's exercise of its rights to subrogation and reimbursement, (c) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the total amount paid on your behalf for the benefits or expenses for Covered Services and notifying the Plan) or to prejudice the Plan's ability to enforce the terms of this provision, (d) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (e) 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 Plan's 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.

RECOVERY OF 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;
- 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
- To reduce future payments to the Provider who received the overpayment by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Medical Claims Administrator, Aetna. Under this process, Aetna reduces future payments to a Provider by the amount of the overpayments the Provider received, and then credits the recovered amount to the plan that overpaid the Provider. Payments to Providers under this Plan are subject to the same process when Aetna recovers overpayment for other plans administered by Aetna.

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

Your failure to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to you under the Plan of an amount up to the aggregate amount paid on your behalf for the benefits or expenses for Covered Services that has not been reimbursed to the Plan.

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 shall have 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, modify, or terminate this Plan at any time in its sole discretion by action of a duly authorized representative. 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.

In the event that any such action results in the termination of coverage, benefits will only be paid for claims incurred prior to the date of termination of coverage.

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

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 that any medical expenses of individuals covered by this Plan will be paid.

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 Employer Identification Number: 35-1443425 734-343-1000 (phone)
Name of Plan and Type of Plan	The Medical Benefit Program (including the Prescription Drug Program) under component Plan 504 of the Trinity Health Corporation Welfare Benefit Plan. This Plan is a welfare benefits plan providing medical and prescription drug benefits.
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	Benefits under the Plan are self-insured. The Plan is funded through the general assets of the Employer. In the event of Plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Plan should be terminated, only claims incurred prior to the date of such termination would be paid by the Plan.
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 Service Center (if your Employer is supported by the HR Service Center) or your Employer's local HR representative (if your Employer is not supported by the HR Service Center).
COBRA Administrator	Health Equity 877-502-6272 (phone) https://www.healthequity.com
HR Service Center	Trinity Health Corporation HR Service Center 20555 Victor Parkway Livonia, Michigan 48152 877-750-HR4U(4748) (phone) 312-957-2567 (facsimile) HR4U@trinity-health.org
Type of Plan	Welfare Benefit
Agent for Service of Process	Legal process may be served on CT Corp. at: 30600 Telegraph Road Bingham Farms, Michigan 48025. .

HOW SERVICES ARE PAID THROUGH THE PLAN

Both you and the Employer pay a portion of the total cost for your health care coverage. This is called "cost sharing." The total cost of your health care coverage includes payroll contributions, Copayments, Coinsurance amounts, Deductibles, claim costs, and administrative fees. Here is an explanation of how your health care coverage is paid.

PAYING FOR COVERAGE

When you elect coverage under the Plan, you agree to pay for your coverage through payroll contributions. The amount of your contributions is based on the Aetna health plan option and level of coverage you choose.

WHAT IS THE PLAN DEDUCTIBLE?

In general, you must first meet the annual Deductible before the Plan starts to pay its portion of the Covered Expenses for Covered Services. The amount of the Deductible is based on your coverage level (e.g., individual, two person or family coverage) and the Aetna health plan option in which you are enrolled (e.g., Traditional, Health Savings, or Essential Plan). However, the annual Deductible does not apply to certain services including, preventive services, prenatal and postnatal care, and hospice care. The Plan pays 100 percent of the Covered Expenses for these preventive services before you have met the annual Deductible. Also, for certain Covered Services (e.g., Physician office visits) you may only be required to pay a Copayment even if you have not yet met the annual Deductible. (This is not applicable, for example, under the Health Savings health plan option.)

Each Plan Year, a Covered Individual (also referred to as a "member") must satisfy the "per member" or individual Deductible(s) specified in the Benefits Summary applicable to the Aetna health plan option in which he or she is enrolled before the Plan will pay any benefits (except with respect to certain Covered Services as explained above). Depending on the Aetna health plan option in which the Covered Individual is enrolled, there may be a separate individual Deductible amount for Covered Services rendered by Tier 1 Network Provider and Tier 2 Network Provider (also referred to as an "In- Network Provider" and "Preferred Care Provider"). However, amounts applied toward the Tier 1 Deductible will be applied to the Tier 2 and amounts applied toward the Tier 2 Deductible will be applied to the Tier 1 Except under the Health Savings health plan option when there is two person or family coverage, after a Covered Individual has received Covered Services for more than the individual Deductible in a Plan Year, the Covered Individual's Plan benefits will begin. Under the Health Savings health plan option when there is two person or family coverage, after one or more Covered Individuals have received Covered Services for more than the two person or family Deductible in a Plan Year, each Covered Individual's Plan benefits will begin Please see the Benefits Summary applicable to the Aetna health plan option in which you are enrolled for detailed information regarding the Deductible amount(s) and the Covered Services for which the Plan pays benefits before you satisfy the annual Deductible.

If you have two person or family coverage and you and the other Covered Individual(s) have reached the two person or family Deductible(s) specified in the Benefits Summary applicable to the Aetna health plan option in which you are enrolled for the Plan Year, it will not be necessary for anyone else in your family to meet the two person or family Deductible amount(s) in that Plan Year. That is, for the remainder of that Plan Year only, no other family member is required to meet the two person or family Deductible) before receiving benefits. However, except under the Health Savings health plan option, no Covered Individual may apply more than the individual Deductible(s) toward the two person or family Deductible amount(s). Under the Health Savings health plan option, one Covered Individual may satisfy the entire two person or family coverage Deductible amount(s). Except under the Health Savings health plan option when there is two person or family coverage, once a Covered Individual meets the individual Deductible, Plan benefits for that Covered Individual begin even if the two person or family Deductible has not yet been reached.

Example: If you have family coverage, you have four Dependents, the individual Deductible is $1,500 and the family Deductible is $3,000 for the Plan Year, if you and one of your Dependents each pay $1,500 toward the Deductible for Covered Services, the $3,000 family Deductible has been met and you and all of your Dependents (including the Dependents which have not yet incurred any Covered Expenses) may receive Covered Services without being required to pay any additional Deductible for the Plan Year. However, in this example, no single family member may contribute more than $1,500 toward the family

Deductible (unless they are enrolled in the Health Savings health plan option).

The Deductible is satisfied on a calendar year basis with expenses from January through December.

When an individual's coverage becomes effective during a calendar year, the Deductible will apply only to expenses that are incurred after the coverage effective date. Prescription Drug Deductibles, Copayments and Coinsurance cannot be used to satisfy the Plan's calendar year Deductible.

COINSURANCE AND COPAYMENTS

Once you (and your covered Dependents, if applicable) have met the annual Deductible, you will pay a Copayment and/or Coinsurance amount for the Covered Services you (and your covered Dependents, if applicable) receive. A Copayment is a fixed flat-dollar amount you pay. The Plan pays the remaining amount. When you pay Coinsurance, you pay a percentage of the Covered Expense and the Plan pays the remaining percentage. However, Covered Expenses for Covered Services received from Out-of-Network Providers are not covered and you will be responsible for the full cost of services.

WHAT IS YOUR OUT-OF-POCKET MAXIMUM EXPENSE?

You will continue to pay Copayment or Coinsurance amounts for Covered Services until you meet the Out-of-Pocket Maximum. The Out-of-Pocket Maximum is the most you will pay for Covered Expenses during a Plan Year. Once you meet the Out-of-Pocket Maximum (based on your Aetna health plan option and coverage level) the Plan will pay the remaining Covered Expenses for that Plan Year. You should note, certain expenses do not count toward the Out-of-Pocket Maximum and are listed below.

The following amounts are not counted toward the Out-of-Pocket Maximum expense limit and, therefore, not eligible for 100 percent payment even if the Out-of-Pocket Maximum expense limit is met:

- Amounts over the Reasonable Charges
- Non-covered expenses
- Applicable penalties

Expenses applied toward the Tier 1 Out-of-Pocket Maximum will be applied to the Tier 2 Out-of-Pocket Maximum and expenses applied toward the Tier 2 Out-of-Pocket Maximum will be applied to the Tier 1 Out-of-Pocket Maximum..

The Plan is designed to provide levels of benefits based on the choices you make. By choosing the services of a Trinity Health Facility or a Network Provider, you will receive a higher level of payment. Detailed information about how benefits will be paid can be found in the Benefits Summary.

TRANSFERRING DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Should you transfer to a Ministry who uses a different third-party administrator (TPA), that year's deductible and out-of-pocket maximums will transfer to the new TPA provided both plans are self-insured.

In addition, if you cover one or more dependents and die during the year, the family deductible and out-of-pocket maximum will follow your surviving dependents under any COBRA plan they elect.

HOW WILL YOU BENEFIT FROM CHOOSING A NETWORK PROVIDER?

In addition to the Tier 1 Network Providers Aetna has contracted with certain Physician and Hospital Providers to be the Plan's Tier 2 Network Providers. The Tier 1 and Tier 2 Network Providers are collectively referred to as the "Network Providers". The Plan, Aetna, the Employer, and the Plan Administrator do not provide any guarantee concerning the care provided by Network Providers. You, together with your Physician, are ultimately responsible for determining the appropriate treatment regardless of coverage by this Plan.

WHAT HAPPENS IF YOU ARE NOT ABLE TO USE A NETWORK PROVIDER?

When you or your covered Dependents choose to receive Covered Services or supplies from a Trinity Health facility or other Network Provider, the Plan will pay as described in the Benefits Summary.

NOTE: For some Ministries, if a Network Provider cannot perform a course of treatment or procedure, you must obtain an approved referral prior to receiving services by an Out-of-Network Provider. In order to complete this process, you must contact Aetna at 1-800-544-5108. Whenever possible, a referral to a Trinity Health Physician, Trinity Health Facility or an aligned Provider will be provided. When that is not possible, your doctor may provide a referral to an Out-of-Network Provider. Please remember that the referral must be obtained prior to receiving the services from an Out-of-Network Provider. Failure to obtain an approved referral prior to receiving services will result in benefits not being covered. . Please refer to the Benefits Summary for further information.

If you or your covered Dependents reside in an area where Network Providers are not available, the Plan will pay benefits at the Network level when Covered Services have been referred in accordance with the above.

If you or your covered Dependents need Emergency treatment for an accidental bodily Injury or a life-threatening medical Emergency and seek treatment (via car or ambulance) at the nearest facility that is not a Network Provider, the Plan will pay benefits at the Network level.

If a Covered Service cannot be performed by a Network Provider, the Plan will pay benefits at the Network level (with approved referral). Any related laboratory tests, X-rays or follow-up visits by the same Non-Network Provider will be paid at the Network level. It is your responsibility to investigate the availability of a needed Provider.

If you seek or are referred for Covered Services from an Out-of-Network Provider and such Covered Services can be performed by a Network Provider, the Plan will not pay the benefits performed Out-of-Network. Any related laboratory tests, X-rays or follow-up visits by the same Non-Network Provider will not be paid by the Plan. It is your responsibility to investigate the availability of a needed Provider.

If you or your covered Dependents use a Trinity Health or a Tier 2 Network facility for Inpatient or Outpatient Covered Services, but the Trinity Health or Tier 2 Network facility uses an Out-of-Network Provider for anesthesia, the interpretation of laboratory tests and X-rays and other Medically Necessary Covered Services, the Plan will pay benefits at the Network level.

If you or your covered Dependents are admitted to an Out-of-Network Hospital through the Emergency room, the Plan will pay benefits for that confinement at the Network level until you are stable. At that point, the Plan may no longer pay benefits for for the Out-of-Network care, unless you are transferred to a Trinity Health or Tier 2 Network facility.

COVERED MEDICAL EXPENSES

The Plan provides benefits for Covered Services that are Medically Necessary or are specified preventive services, subject to the reimbursement limitations of the Reasonable Charge and any Deductibles, Copayments, Coinsurances or benefit maximums detailed in the Benefits Summary applicable the Aetna health plan option in which you are enrolled.

This section of the SPD explains the benefits covered by the Plan. In addition, most specific services, procedures and supplies that are not covered are listed in this SPD. Please refer to the applicable Benefits Summary for additional information regarding the Covered Services under the Plan.

HEALTH MANAGEMENT SERVICES

The services outlined in this section of the SPD are part of Aetna Health Management Services. Together, they ensure that you receive high quality, cost-effective care.

It is important to remember that this Plan covers only those procedures, services, and supplies that are Medically Necessary unless otherwise specified. For a service to be covered it must be considered necessary for the diagnosis or treatment of an Illness or Injury and the care must be given at the appropriate level. In determining questions of reasonableness and necessity, consideration is given to the customary practices of Physicians in the community where the service is provided.

Services, which are NOT considered to be Medically Necessary, include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures which could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures which are unlikely to provide a Physician with additional information when used repeatedly.
- Procedures which are not ordered by a Physician or which are not documented in a timely fashion in the patient's medical record, or which can be performed with equal effectiveness at a lower level of care facility (e.g., on an Outpatient basis).

For example, a medically unnecessary Hospital admission would be one, which does not require acute Hospital bed patient care and could have been provided in a Physician's office, Hospital Outpatient department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a Hospital admission primarily for observation, evaluation, or diagnostic study, which could be provided adequately and safely on an Outpatient basis is considered to be medically unnecessary.

DISEASE MANAGEMENT PROGRAM

You and your covered Dependents, can get support managing a medical condition with a disease management program. A "disease management program" is a wellness program designed to help you control a medical condition that you have in ways that work for you. You can:

- Work with a nurse when it fits your schedule;
- Take online disease management classes to boost your nurse coaching sessions;
- Interact with the program online and/or via email in addition to the nurse calls; and
- Call the dedicated disease management line toll free 24/7.

You can keep track of important health information including conditions, medications (and drug interactions) and appointments. The result is an interactive, customized approach to wellness, empowering you to better manage your health.

Trinity Health, your employer and the Plan are committed to helping you achieve your best health. Rewards for participating in a wellness program are available to Colleagues enrolled in the Plan (or another Trinity Health group health plan). If you feel you are unable to meet the standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Contact Aetna at the customer service number on your insurance card and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

BEGINNING RIGHT MATERNITY PROGRAM

A healthy baby begins with a healthy pregnancy. That's why Aetna offers Beginning Right Maternity Program — a free prenatal program that offers personalized education and valuable support for you and your baby's health. The maternity program connects you with an Aetna registered nurse who provides information to support the health of your baby and to address your questions or concerns. The nurse can help by:

- Conducting a confidential health assessment questionnaire
- Offering suggestions on how to reduce risks during pregnancy
- Addressing any questions or concerns following the birth of your child
- Helping you get access to free online materials and self-help books

It's easy to sign up for the program:

- Call toll free at 1-800-CRADLE-1 (1-800-272-3531), weekdays from 8 a.m. to 7 p.m. E.T.; or
- Log in to Aetna Navigator at www.aetna.com and look under Health Programs.

MENTAL DISORDERS AND/OR SUBSTANCE USE DISORDER

All Inpatient services (including partial hospitalization), intensive Outpatient services, and Outpatient psychiatric testing for Mental Disorders and/or Substance Use Disorders require pre-certification through Aetna Behavioral Health. Please note that if pre-certification is not received for these services, benefits will not be payable. For pre-certification coordination contact:

Aetna, Inc.

P.O. Box 981107

El Paso, TX 79998-1107

1-800-632-3862

Benefits available under this Plan for the treatment of Mental Disorders and/or Substance Use Disordersare payable as described in Benefits Summary.

INPATIENT FACILITY COPAYMENT

For certain Aetna health plan options covered under the Plan, there is an Inpatient Admissions Copayment for each Hospital, Convalescent Facility, and treatment facility confinement of a Covered Individual. The Inpatient Hospital Admissions Copayment will only be applied once to all Hospital confinements, regardless of cause, which are separated by 10 days or less. Please refer to Plan Benefit Summary applicable to the Aetna health plan option in which you are enrolled for additional details.

GENETIC TESTING/SCREENING AND COUNSELING

Genetic testing/screening is done to look for Genetic Disorders, abnormalities in a person's genes, or the presence/absence of key proteins whose production is directed by specific genes.

Please refer to the Benefits Summary applicable for the Aetna health plan option in which you are enrolled for additional information.

Covered Individuals must be referred by a Physician to a Genetic Counselor before testing can occur. You will be asked to sign a consent form before the test is performed. Only one evaluation visit can initially be approved.

Genetic counseling, testing and/or screening is covered when all of the following conditions are met:

- A Covered Individual is referred by a Physician to a Genetic Counselor before the testing or screening.
- Informed written consent is obtained before and after testing or screening.
- The testing or screening has been proven valid (regulatory agency approval).
- Factors exist to justify that a Covered Individual is at increased risk for a genetic disorder.
- Knowledge of presence or absence of condition would directly affect medical care, where:
    - The disease is treatable or preventable; or
    - The test or screening results will lead to a marked change in the intensity of surveillance/treatment of that disease.

NOTE: Tests commonly performed on amniotic fluid by a Physician do not require genetic counseling.

Genetic testing or screening is performed:

- To determine whether a person has a Genetic Disorder;
- To determine whether a person is a carrier of a Genetic Disorder;
- To determine a person's risk of developing a disease;
- To predict response to therapy;
- If there is a history of spontaneous abortions;
- If a Covered Individual gave birth to a child with a Genetic Disorder or chromosomal abnormality;
- If there is a family history of certain inherited Genetic Disorders, or the Covered Individual has symptoms of certain inherited Genetic Disorders and requires a diagnosis;
- For a Dependent Child if there is an increased risk of developing a childhood malignancy; and
- For an adopted child, where the family history is unavailable or unknown, for conditions that manifest themselves during childhood and for which preventive measures or therapy may be undertaken during childhood.

Genetic counseling, testing and/or screening may be covered for non-Covered Individuals when breast cancer susceptibility gene ("BRCA") testing is required to assess the need for Prophylactic Mastectomies or Oophorectomies for a Covered Individual. In order for genetic counseling, testing and/or screening to be covered under the Plan for a non-Covered Individual, all of the following criteria must be met:

- The information is needed to adequately assess risk in the Covered Individual;
- The information will be used in the immediate care of the Covered Individual; and
- The non-Covered Individual's plan (if any) will not cover the test (proof required).

The following are NOT COVERED under the Plan:

- Routine, ongoing, or long-term genetic counseling
- Genetic testing to determine the paternity of a child
- Genetic testing to determine the sex of a child

- Genetic testing to determine one's own genetic predisposition
- General population screening for Genetic Disorders (example: cystic fibrosis)
- Prenatal genetic screening undertaken with the intention of aborting the child
- Genetic testing or screening in children or adolescents, except as provided in this SPD
- Genetic testing/screening for any individual who is not an Eligible Colleague or Dependent as defined in the section titled "Eligibility" of this SPD
- Genetic testing for:
    - Huntington's Chorea Disease;
    - Li-Fraumeni syndrome;
    - Melanoma and melanoma-associated syndromes;
    - Ataxia Telanglextasaia-associated susceptibilities; and
- Surgical procedure and related expenses that are performed as a precautionary measure when there is no presence of cancer or other disease (e.g., preventative mastectomy).

Please note that regardless of any genetic testing that is performed on behalf of a Covered Individual and covered under the Plan, the Plan will not discriminate in its health coverage on the basis of genetic information pursuant to the Genetic Information Nondiscrimination Act of 2008 ("GINA"). The Plan will comply with the requirements of GINA to the extent applicable.

INPATIENT HOSPITAL EXPENSES

For an approved Hospital admission, the Plan will cover the following charges made by a Hospital for giving room and board and other Hospital services and supplies to a Covered Individual who is confined as a full-time Inpatient. All benefits are subject to any Deductibles, Copayments (including the Inpatient Admissions Copayment), Coinsurances or benefit maximums detailed in the Benefits Summary applicable to the Aetna health plan option in which you are enrolled.

In some cases, you are required to pay for services even when they are Medically Necessary. These limited situations are:

- When you do not inform the Hospital that you are an Aetna member either at the time of admission or within 30 days after you are discharged; and
- When you fail to provide the Hospital with information that identifies your coverage.

PRE-CERTIFICATION OF HOSPITAL AND OTHER INPATIENT ADMISSIONS

A Hospital stay can be a serious and expensive part of your course of treatment. This Plan has a special program, Pre-Certification of Services, to make sure that you are not hospitalized unnecessarily. If you are admitted to (or registered as a patient at) a Hospital or a rehabilitation facility, whether for Emergency treatment, elective non-Emergency treatment, or maternity care in excess of 48 hours for normal deliveries or 96 hours for cesarean delivery, you or a member of your family should call Aetna at the number listed on your ID card. The call should be made prior to the elective Hospital admission. It is your responsibility in conjunction with your Physician's office to obtain Pre-Certification of Services. If Pre-Certification of Services isn't obtained when required, service may not be covered by the Plan.

An Aetna nurse and your admitting Hospital review your Inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The Aetna nurse:

- Checks the Medical Necessity of the Hospital admission and length of stay against generally accepted medical standards;

- Suggests alternative treatment settings, if appropriate; and
- Assists with discharge planning.

You will be notified by mail of the approved length of stay. Additional days may be assigned if determined by the Claims Administrator to be Medically Necessary.

The final decision regarding treatment and hospitalization is yours. Maximum allowable Plan benefits are paid as long as these steps are followed prior to any Inpatient hospitalization.

If you or a covered Dependent are admitted to a Hospital for any reason without prior approval, contact Aetna by telephone within two business days of the admission. The contact may be made by you, a family member, or your Physician. If contact has not been made in two business days of the admission, services may not be covered by the Plan.

ROOM AND BOARD

Plan benefits include the cost of a semi-private room, the use of special units such as intensive, burn, or cardiac care, meals and special diets, and general nursing care. However, the cost of a private room is generally not covered. If you request a private room, the Plan will pay the cost of a semi-private room, and you must pay the difference. However, if a private room is used, the daily room and board charge will be covered if the Covered Individual's Preferred Care Provider requests the private room and the request is pre-approved by Aetna.

HOSPITAL SERVICES AND SUPPLIES

The following services and supplies are covered when they are needed during a Hospital admission:

- **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a Hospital anesthesiologist when billed as a Hospital service.
- **Blood services** — Includes blood derivatives, whole blood, blood plasma and supplies used for administering the services beginning with the first pint of blood.
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or Injury when billed as a Hospital service.
- **Drugs** — Includes medicines prescribed and given during a Hospital admission.
- **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other Hospital equipment used during the Hospital stay.
- **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the Hospital admission.
- **Prosthetic and orthotic appliances** — Includes items that are surgically implanted in the body, such as heart valves.
- **Special care units** — Includes operating, delivery and recovery rooms.
- **CAT, MRA, PET and MRI scans** — Covers scans of the head and body when required for eligible diagnoses.
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an Illness or Injury.
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an Illness or Injury.

FACILITY OUTPATIENT DIAGNOSTIC SERVICES

Covered Expenses include the following diagnostic and radiology services provided by a facility:

- **Complex Imaging Services (CAT, MRA, PET and MRI scans and Nuclear Medicine)** received by a Covered Individual on an Outpatient basis when performed in one of the following facilities approved by Aetna:
  - A Physician's office;
  - A Hospital Outpatient department or Emergency room; or
  - A licensed radiological facility.
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an Illness or Injury.
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an Illness or Injury.
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or Injury when not billed as a Hospital service.

PROFESSIONAL DIAGNOSTIC SERVICES

Covered Expenses include the following diagnostic and radiology services provided by a Health Care Professional:

- **Complex Imaging Services (CAT, MRA, PET and MRI scans and Nuclear Medicine)** received by a Covered Individual on an Outpatient basis when performed in one of the following facilities approved by Aetna:
  - A Physician's office;
  - A Hospital Outpatient department or Emergency room; or
  - A licensed radiological facility.
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an Illness or Injury.
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
- **Diagnostic radiology** — Includes ultrasound and X-rays required for the diagnosis of an Illness or Injury.
- **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or Injury when not billed as a Hospital service.

OUTPATIENT HOSPITAL EXPENSES

Charges made by a Hospital for Hospital services and supplies (listed above), which are given to a person who is not confined as a full-time Inpatient.

OUTPATIENT SURGICAL SERVICES

Covered Expenses include charges for Outpatient Surgery and related surgical services to the extent shown below.

Covered Expenses include charges made for Surgery performed in:

- A Surgery center;
- The Outpatient department of a Hospital; or
- An office based surgical facility of a Physician or a Dentist.

For the Surgery charges and related surgical services to be covered, the Surgery must satisfy all of the following requirements:

- It is not expected to:
  - Result in extensive blood loss;
  - Require major or prolonged invasion of a body cavity; or
  - Involve any major blood vessels.
- It can safely and adequately be performed only in a Surgery center, a Hospital or an office based surgical facility of a Physician or a Dentist.
- It is not normally performed in the office of a Physician or a Dentist.

The Covered Expenses include charges:

- On behalf of a salaried staff Physician by the Outpatient department of a Hospital; and
- Services and supplies furnished in connection with the Surgery by the Surgery center, Hospital or office based surgical facility of a Physician or Dentist on the day of the procedure.

No benefits are paid for charges incurred for Outpatient Surgery and related surgical services while the Covered Individual is confined as a full-time Inpatient in a Hospital.

CONVALESCENT & SKILLED NURSING FACILITY EXPENSES

Charges made by a Convalescent Facility for the following services and supplies are Covered Services if they are furnished to a Covered Individual while confined to the Convalescent Facility to heal from an Illness or Injury:

- Board and room (this includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily room and board in a private room over the semi-private room rate.)
- Use of special treatment rooms
- X-ray and lab work
- Physical, occupational or speech therapy
- Oxygen and other gas therapy
- Other medical services usually given by a Convalescent Facility (this does not include private or special nursing or Physician's services)
- Medical supplies

Benefits will be paid for no longer than the Convalescent Days Maximum during any one calendar year. Also, the Inpatient Admissions Copayment applies.

LIMITATIONS TO CONVALESCENT FACILITY & SKILLED NURSING EXPENSES

This section does not cover charges made for treatment of:

- Substance Use Disordr;
- Brain Disorders;
- Intellectual disavility; or
- Any other Mental Disorder.

HOME HEALTH CARE EXPENSES

Home Health Care expenses are covered if:

- The charges are made by a R.N. or L.P.N. or a nursing agency for “skilled nursing services;” or
- The charge is made by a Home Health Care Agency under a Home Health Care plan for care given to a Covered Individual in his or her home.

The following services are covered as “skilled nursing services:”

- Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than four hours for the purpose of performing specific skilled nursing tasks; and
- Private duty nursing by a R.N. or L.P.N. if the Covered Individual’s condition requires skilled nursing care and visiting nursing care is not adequate.

Home Health Care expenses are charges for:

- Part-time or intermittent care by a R.N. (or L.P.N. if an R.N. is not available);
- Physical, occupational, and speech therapy;
- Part-time or intermittent home health aide services for patient care;

The following to the extent they would have been covered under this Plan if the Covered Individual had been confined in a Hospital or Convalescent Facility:

  - Medical supplies;
  - Drugs and medicines prescribed by a Physician; and
  - Lab services provided by or for a Home Health Care Agency.

There is a maximum to the number of visits covered in a calendar year for each Covered Individual for Home Health Care Expenses.

As to skilled nursing care:

- Each visiting nurse shift or private duty nursing shift of four hours or less counts as one visit; and
- Each such shift of over four hours but less than eight hours counts as two visits.

As to Home Health Care:

- Each visit by a nurse or therapist is one visit; and
- Each visit of up to four hours by a home health aide is one visit.

LIMITATIONS TO HOME CARE EXPENSES

Covered Expenses for skilled nursing care do not include charges for:

- That part or all of any nursing care that does not require the education, training, and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs and companionship activities;
- Any private duty nursing care, given while the Covered Individual is an Inpatient in a Hospital or other health care facility;
- Care provided to help a Covered Individual in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting;
- Care provided solely for skilled observation except as follows:
  - For no more than one, four-hour period per day for a period of no more than 10 consecutive days following the occurrence of:
    - Change in patient medication;
    - Need for treatment of an Emergency condition by a Physician, or the onset of symptoms indicating the likely need for such services;
    - Surgery; or
    - Release from Inpatient confinement; or
  - Any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

Covered Expenses for Home Health Care do not include charges for:

- Services or supplies that are not a part of the Home Health Care plan;
- Services of a social worker; and
- That part or all of any nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs, and companionship activities.

HOSPICE CARE EXPENSES

A Hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. A patient is considered terminally ill when his or her attending Physician has certified in writing that the patient's life expectancy is six months or less.

Hospice Care benefits replace the benefits normally available under the Plan with benefits that are specific to the patient's needs. These may include alternative services to provide more appropriate care for the patient. However, services for medical conditions unrelated to the terminal Illness are subject to the Plan's medical coverage guidelines.

COVERED EXPENSES

The Covered Expenses under the Hospice Care program are charges made by a Hospice, Hospital or Convalescent Facility for the following:

- Inpatient Care — Room and board and other services and supplies furnished to a Covered Individual while a full-time Inpatient for pain control and other acute and chronic symptom management.

  Not included is any charge for daily room and board in a private room over the semi-private room rate.

- Outpatient Care — Services and supplies furnished to a Covered Individual while not confined as a full-time Inpatient. The Covered Expenses for Outpatient care under the Hospice Care program include:
  - Charges made by a Hospice Care Agency for:
    - Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours in any one day;
    - Medical social services under the direction of a Physician. These include:
      - Assessment of the Covered Individual's:
        - Social, emotional, and medical needs; and
        - Home and family situation;
    - Identification of the community resources which are available to the Covered Individual; and
    - Assisting the Covered Individual to obtain those resources needed to meet his or her assessed needs.
  - Psychological and dietary counseling.
  - Consultation or case management services by a Physician.
  - Physical and occupational therapy.
  - Part-time or intermittent home health aide services for up to eight hours in any one day (these consist mainly of caring for the Covered Individual).
  - Medical supplies.
  - Drugs and medicines prescribed by a Physician.
  - Charges made by the Providers listed below for Outpatient Care, but only if the Provider is not an associate of a Hospice Care Agency; and the Hospice Care Agency retains responsibility for the care of the Covered Individual.
    - A Physician for consulting or case management services.
    - A physical or occupational therapist.
  - A Home Health Care Agency for:
    - Physical and occupational therapy;
    - Part-time or intermittent home health aide services for up to eight hours in any one day (these consist mainly of caring for the Covered Individual);
    - Medical supplies;
    - Drugs and medicines prescribed by a Physician; and
    - Psychological and dietary counseling.

EXCLUSIONS AND LIMITATIONS

Charges for the following are not Covered Expenses under the Hospice Care program:

- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling (this includes estate planning and the drafting of a will).

- Homemaker or caretaker services. These are services which are not solely related to care of the Covered Individual and include sitter or companion services for either the Covered Individual who is ill or other members of his or her family, transportation, housecleaning and maintenance of the house.
- Respite care in excess of 60 days per calendar year (this is care furnished during a period of time when the Covered Individual's family or usual caretaker cannot, or will not, attend to his or her needs).

PREVENTIVE SERVICES

It is the intent of the Plan to be in compliance with the requirements of the Patient Protection and Affordable Care Act ("ACA") and provide coverage without Copayment for the preventive services recommended by the U.S. Preventive Services Task Force Recommendations Grade A & B. The Plan covers preventive services received at Trinity Health Tier 1 and other Network Providers at 100 percent (and therefore does not require you to share in the costs associated with such services received in-Network). The Plan covers preventive services received at Out-of-Network Providers subject to the standard member cost-sharing as outlined in the Benefits Summary applicable to the Aetna health plan option in which you are enrolled. Preventive services include but are not limited to the following:

- **Preventive physical exam (also referred to as "Health Maintenance Exam")** — A Covered Individual has coverage for one preventive physical per benefit period, beginning at the age of 18. A preventive physical exam is a medical exam given by a Physician for a reason other than to diagnose or to treat a suspected or identified Injury or Illness.
- **Laboratory and screening services** — A Covered Individual has coverage for preventive laboratory, diagnostic tests and X-rays related to a Health Maintenance Exam which include but are not limited to:
  - Chemical profile;
  - Complete blood count (CBC);
  - Fecal occult blood screening;
  - Urinalysis;
  - Chest X-ray;
  - EKG;
  - Sickle cell test;
  - TB test;
  - PPD (purified protein derivative) test;
  - Fasting glucose test;
  - CRP (C-reactive protein) test;
  - Digital rectal exam;
  - TSH (thyroid stimulating hormone);
  - PFT (pulmonary function test); and
  - Bone density scan.
- **Annual gynecological exam** — A Covered Individual who is a female has coverage for one preventative gynecological exam per benefit period, beginning at age 18.

- **Preventive mammograms** — A Covered Individual who is a female has coverage for preventive/baseline mammogram (breast X-ray) or screening digital breast tomosynthesis (3D mammography).
- **Pap smear** — A Covered Individual who is a female has coverage for one annual routine gynecological exam including laboratory services for one preventive pap smear per benefit period, beginning at age 18. More frequent pap smears are covered as diagnostic services for the following conditions:
  - Previous Surgery for vaginal, cervical or uterine malignancy;
  - Presence of a suspected lesion in the vaginal, cervical or uterine areas; and
  - Post-Surgery.
- **Prostate specific antigen ("PSA") screening** — A Covered Individual who is a male has coverage for PSA screening laboratory test..
- **Depression screening** — A Covered Individual has coverage for one depression screening per benefit period, beginning at age 40.
- **Endoscopic procedures (proctosigmoidoscopy, sigmoidoscopy, colonoscopy, etc.)** — The first endoscopic procedure, in-Network, per calendar year is covered at 100 percent. The service is covered at 100 percent for preventive only, outside of preventative, the benefit is paid as outlined in the Benefit Summary applicable to the Aetna health plan option in which you are enrolled. One colorectal cancer screening every 10 years is covered for Covered Individuals age 45 or over for the routine screening for cancer. The Plan also covers one sigmoidoscopy every 5 years for a Covered Individual age 45 or over.

- **Immunizations** — Coverage under the Plan also includes the following:
  - Pediatric immunizations that have in effect a recommendation from the United States Center for Disease Control and Prevention ("CDC"), Advisory Committee on Immunizations Practices ("ACIP"), American Academy of Pediatrics, and the American Academy of Family Physicians.
  - Adult immunizations, including all of the recommended childhood immunizations and all adult immunizations that have in effect a recommendation from the CDC and the ACIP.
  - Immunizations and vaccines required while traveling out of the country.
- **Well-baby and child care exam** — Benefits include visits to a Physician to monitor the development of a child up to and including the age of 17. Benefits are subject to the following frequency limitations:
  - Seven exams from birth through the first 12 months of life;
  - Three exams in the 13th through 24th months of life;
  - Three exams in the 25th through 36th months of life; and
  - An annual physical examination thereafter through age 17.

To qualify as a covered exam, the Physician's exam must include at least:

- A review and written record of the Dependent Child's complete medical history;
- A check of all body systems; and
- A review and discussion of the exam results with the Dependent Child or with the parent or guardian.

NOTE: An Office Visit charged in conjunction with an immunization will not count towards the annual preventive physical examination.

LIMITATIONS TO PREVENTIVE PHYSICAL EXAM EXPENSES

This section does not cover charges for:

- Services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- Services which are for diagnosis or treatment of a suspected or identified Injury or Illness;
- Exams given while the Covered Individual is confined in a Hospital or other place for medical care;
- Services not given by a Physician or under his or her direction;
- Medicines, drugs, appliances, equipment or supplies;
- Psychiatric, psychological, personality or emotional testing or exams;
- Exams in any way related to employment;
- Premarital exams;
- Vision, hearing or dental exams;
- A Physician's office visit in connection with immunization or testing for tuberculosis; or
- Services and supplies furnished by an Out-of-Network Provider.

PREVENTIVE HEARING EXAM EXPENSES

Covered Expenses include charges for one preventive hearing exam per Plan Year. The exam must be performed by:

- A Physician certified as an otolaryngologist or otologist; or
- An audiologist who either:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and
  - Who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Cochlear implant replacement is covered if the following requirements are met:

- The device is beyond the manufacturer's warranty; and
- The manufacturer is no longer servicing the device.

Not included are charges for:

- Any ear or hearing exam to diagnose or treat an Illness or Injury;
- Drugs or medicines;
- Any hearing care service or supply which is a Covered Expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- Any hearing care service or supply for which a benefit is provided under any Workers' Compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any service or supply received while the person is not a Covered Individual;
- Any exams given while the Covered Individual is confined in a Hospital or other facility for medical care;

- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government, or
- Any service or supply furnished by an Out-of-Network Provider.

OUTPATIENT THERAPY

OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY

Covered Expenses include charges by a Physician or a licensed or certified physical, occupational or speech therapist for short term rehabilitation services which are expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- An Injury;
- An Illness;
- Congenital defects; or
- Autism Spectrum Disorder (ASD) diagnosis.

Short-term rehabilitation services consist of the following furnished to a Covered Individual who is not confined as an Inpatient in a Hospital or other facility for medical care:

- Physical therapy;
- Occupational therapy; or
- Speech therapy.

In order to be covered under the Plan, the physical, occupational or speech therapy must be expected to result in significant improvement of the Covered Individual's condition within 60 days from the date the therapy begins.

- Physical, occupational and/or speech therapy where Mental Health/Substance Use Disorder is a diagnosis, do not have a visit limit.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Any services which are Covered Expenses in whole or in part under any other group plan sponsored by an Employer;
- Services received while the Covered Individual is confined in a Hospital or other facility for medical care;
- Services not performed by a Physician or under his or her direct supervision;
- Services rendered by a physical, occupational, or speech therapist who resides in the Covered Individual's home or who is a part of the family of either the Covered Individual or the Covered Individual's spouse (or other person who would qualify as the Covered Individual's Eligible Adult if the Covered Individual was an Eligible Colleague);
- Services rendered for the treatment of delays in speech development, unless resulting from:
  - Illness;
  - Injury;
  - For congenital defects; or
  - A diagnosis of Autism Spectrum Disorder (ASD).
- Special education, including lessons in sign language, to instruct a Covered Individual whose ability to speak has been lost or impaired to function without that ability;

- Treatment for which a benefit is or would be provided under the Chiropractic Care section, whether or not benefits for the maximum number of visits under that section have been paid;
- Speech therapy for learning disabilities other than Autism Spectrum Disorder (ASD).

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- Details the treatment to be rendered and the frequency and duration of the treatment; and
- Provides for ongoing reviews and is renewed only if therapy is still necessary.

CARDIAC REHABILITATION

The Plan provides coverage for cardiac rehabilitation services. This benefit is payable if it is provided:

- In a Hospital-based or freestanding (not owned or operated by a Hospital) cardiac rehabilitation center;
- By a licensed Physician or Health Care Professionals working under the direct supervision of a licensed Physician;
- Within six months of a diagnosis of acute myocardial infarction, angina pectoris or a prior related professional cardiac service, including coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation or heart valve surgery;
- For Physician prescribed exercises to cardiac patients during phases II and III of their cardiac rehabilitation treatments; and
- Within the 12-week total time allowed for cardiac rehabilitation.

Phase II services include:

- Six-week program that follows Inpatient admission or Outpatient services for a heart condition;
- Complete medical history;
- Stress test with electrocardiogram monitoring;
- Lipid profile;
- ECG;
- Three exercise sessions per week; and
- Nutrition and risk factor recognition classes.

NOTE: Patient education services and ECG testing are not covered as a separately identifiable service when reported as part of cardiac rehabilitation.

CHEMOTHERAPY

A Covered Individual may receive chemotherapy treatment in a Hospital, in the Outpatient department of a Hospital or in a Physician's office. Benefits include the administration and cost of drugs when ordered by a Physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy and provided as part of a chemotherapy program. if the treatment is considered Experimental or Investigative the treatment must meet specific criteria outlined in exclusions in order to be covered. Coverage includes three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

NON-SURGICAL WEIGHT MANAGEMENT PROGRAM

The Plan will cover nutritional and/or behavioral based counseling services for the purpose of non-surgical weight loss. These benefits are not subject to Deductible and Out-of-Pocket Maximums. Upon successful completion of the non-surgical weight loss program, benefits are payable at 100% up to a $500 annual maximum, to include:

- Outpatient counseling or therapy;
- Office visits rendered by a licensed Physician;
- Lab services performed during a course of treatment;
- Behavioral and/or nutritional counseling services for weight loss rendered by a Trinity Health Ministry; and
- Nationally recognized programs that include behavioral modification and/or nutrition counseling as part of their programs (such as the behavioral health and/or nutritional counseling program offered by Jenny Craig, Weight Watchers and LA Weight Loss), for the purpose of non-surgical weight loss.

Not covered are:

- Charges for food and/or nutritional supplements
- Health clubs, gyms, personal trainers, exercise classes or exercise equipment
- Services administered exclusively in a Web-based forum
- Pharmacotherapy and/or injection expenses associated with weight loss
- Charges for over-the-counter diet aids
- Charges in connection with hypnotism, and/or biofeedback training
- Services and/or programs not approved and/or provided in the United States

HUMAN ORGAN TRANSPLANTS

Human organ transplants are covered under the Plan when received at:

- A participating Hospital (including a Trinity Health Hospital);
- An aligned facility accredited to perform solid organ transplants; or
- A respective third-party administrator's quality designated facilities.

NATIONAL MEDICAL EXCELLENCE (NME) PROGRAM®

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within an NME patient's local geographic al area. When care is directed to a facility ("Medical Facility") more than 100 miles from the patient's home, the Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described in the Benefits Summary applicable to the Aetna health plan option in which the patient is enrolled and this SPD.

BENEFIT PERIOD

The "Benefit Period" is the period of time that begins five days before and ends one year after the organ transplant. All specified human organ transplant payable services, except anti-rejection drugs, must be provided during this period of time.

INPATIENT PAYABLE HOSPITAL SERVICES

When performed in a designated facility, transplantation of the following organs is covered:

- Heart
- Heart-lung(s)
- Liver
- Lung(s)
- Pancreas
- Partial liver
- Kidney-liver
- Lobar lung
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Combined small intestine-liver
- Multivisceral transplants (as determined by Aetna)

When directly related to the transplant, payment is made

for:

- Facility and professional services.
- Anti-rejection drugs and other transplant related Prescription Drugs, as needed.
- Medically Necessary services needed to treat a condition arising out of the organ transplant surgery if the condition:
- Occurs during the Benefit Period; and
- Is a direct result of the organ transplant surgery.
- Up to $10,000 travel and lodging (lodging refers to hotel or motel) during the initial transplant surgery. This includes:
- Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor).

Note: In certain cases, the Claims Administrator may consider a return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the Benefit Period. The cost of the travel must still fall under the $10,000 travel and lodging maximum.

- Cost of acquiring the organ (the organ recipient must be a Covered Individual). This includes, but is not limited to:
  - Surgery to obtain the organ
  - Storage and transportation of the organ
  - Living donor transplants such as partial liver, lobar lung, small bowel and kidney transplants that are part of a simultaneous kidney transplant
  - Payment for covered services for a donor if the donor does not have transplant coverage under any other health care plan
- Immunizations for certain common infectious diseases during the first 24 months post-transplant are covered. The Plan pays for immunizations as recommended by the Advisory Committee on Immunization (ACIP).

PRECERTIFICATION FOR SPECIFIED HUMAN ORGAN TRANSPLANT SERVICES

If precertification is not obtained before receiving the human organ transplant services described, the services will not be covered.

LIMITATIONS ON TRAVEL AND LODGING EXPENSES

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Expenses under any other part of the Plan.

Travel Expenses do not include expenses incurred by more than one Companion who is traveling with the NME patient.

Lodging Expenses do not include expenses incurred by more than one Companion per night.

LIMITATIONS AND EXCLUSIONS

During the benefit period, the deductible and coinsurance may apply to the specified human organ transplants and related procedures.

No payment will be made for:

- Meals while traveling during the initial transplant surgery
- Services that are not Aetna benefits
- Services rendered to a recipient who is not an Aetna participant
- Living donor transplants not listed in this benefit
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval
- Transplant procedures and related services that are not precertified
- Transplant surgery that is not performed in a designated facility, unless medically necessary and approved by the Aetna medical director
- Transportation and lodging costs under circumstances other than those related to the initial pre certified transplant surgery and hospitalization
- Items that are not considered directly related to the travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, Internet service, and entertainment; such as cable television, books, magazines and movie rentals)
- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to the organ transplant surgery, such as expenses for evaluation and testing, however these expenses may be covered under your hospital, medical, surgical benefits program
- Experimental transplant procedures (unless the procedure satisfies specific coverage criteria relating to experimental and investigative services.

CHIROPRACTIC CARE

Covered Expenses include charges incurred for:

- Manipulative (adjustive) treatment; or
- Other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine up to 20 visits per calendar year.

The Chiropractic Care maximum does not apply to expenses incurred:

- While the Covered Individual is a full-time Inpatient in a Hospital;
- For treatment of scoliosis;
- For fracture care; or
- For Surgery (including pre- and post-surgical care given or ordered by the operating Physician).

WEIGHT MANAGEMENT

The Plan covers the services as described below.

All expenses related to the treatment of Morbid Obesity that are otherwise payable under the Plan will be considered allowable expenses (e.g. Surgery, hospitalization, anesthesia, office visits for a Physician, lab testing, psychotherapy, etc.; services will be payable as described in each respective section of this SPD) as long as expenses are incurred at an Institutes of Quality (IOQ) or a Tier 1 facility. For purposes of determining these benefits, the Plan will base the determination of Morbid Obesity on the Covered Individual's Body Mass Index (BMI) or overweight status. A BMI greater than 40, or more than pounds overweight for a female or more than 100 pounds overweight for a male will be considered indicative of Morbid Obesity. A BMI greater than 35 but less than 40 will also be considered indicative of Morbid Obesity where the patient is experiencing obesity related health conditions such as high blood pressure or diabetes. Documentation of the medical treatment of the co-morbid conditions that demonstrates the Covered Individual meets these criteria must be provided.

Additionally, the Plan will review a Covered Individual's patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. For example, this review will consider whether the Covered Individual has been unable to lose weight through non-surgical, conventional measures and whether the Covered Individual's ability to manage the surgical intervention and required post-operative care has been assessed through a psychological evaluation.

The Plan will review if the Covered Individual has undergone a Physician supervised nutrition, exercise and weight loss program for a minimum of six months, within the 12 months immediately preceding the proposed Surgery, during which the Covered Individual was found unable to meet the Physician's weight loss goals. Unsuccessful weight loss attempts and lifestyle changes will require documentation by medical office progress notes and a letter from the attending Physician as to why non-invasive weight loss attempts are no longer a standard of care for the Covered Individual.

If confirmation is obtained from the attending surgeon that the program the Covered Individual will be under includes a complete support team with required follow ups, etc. a psychological evaluation is not required.

Other limitations include:

- Appendectomies and cholecystectomies in conjunction with surgical treatment of Morbid Obesity will be considered incidental and not covered unless the Covered Individual has an existing condition that requires the additional surgical treatment.
- Subsequent panniculectomy (Surgery to remove loose skin) resulting from weight loss will be covered only if it is Medically Necessary as a result a documented history of treatment by a Physician for related Illnesses for a minimum of six months where the treated condition is no longer controlled through any other means.
- Bariatric Surgical intervention beyond one course of treatment per lifetime.

Prescription Drugs associated with weight loss are covered under the Prescription Drug program under the Plan.

EMERGENCY MEDICAL CARE

EMERGENCY CARE

If treatment:

- Is received in the Emergency room of a Hospital or a free-standing emergency center while a Covered Individual is not a full-time Inpatient; and
- The treatment is Emergency Care;

Covered Expenses for charges made by the Hospital or a free-standing emergency center for such treatment will not require pre-certification and any Copayment amount or Coinsurance percentage will be the same regardless of whether the Emergency Care services are received in-Network or Out-of-Network. In addition, unless applicable State law prohibits balance billing (i.e., prohibits an Out-of-Network Provider to bill a Covered Individual for the difference between the Provider's charges and the total amount collected by the Provider, including payments from the Plan and Copayments and Coinsurance from the Covered Individual), the benefits provided for eligible Emergency Care received Out-of-Network will be equal to the greatest of: (i) the median of the amount negotiated with in-Network Providers for the Emergency Care provided, excluding any Copayments and Coinsurance (this amount is disregarded if no per-service amount is negotiated); (ii) the amount the Plan generally pays for Out-of-Network services without reduction for Out-of-Network
cost-sharing generally applicable to Out-of-Network services but excluding the Copayment or Coinsurance that would apply if the services were received in-Network; and (iii) the amount that would be paid under Medicare Parts A and B, excluding any in-Network Copayment and Coinsurance. However, if Emergency Care is received Out-of-Network, any Out-of-Network Deductible, Out-of-Pocket Maximum and other Out-of-Network cost-sharing requirements (other than the normal Out-of-Network Copayment amount and Coinsurance percentage) apply.

For certain Aetna health plan options covered under the Plan, a separate Emergency room visit Copayment applies to each visit by a Covered Individual to a Hospital's Emergency room or free-standing emergency center, unless the Covered Individual is admitted to the Hospital as an Inpatient immediately following a visit to a Hospital Emergency room or free-standing emergency center. Please refer to Benefits Summary applicable to the Aetna health plan option in which you are enrolled for additional details regarding any applicable Hospital Emergency room or a free-standing emergency center visit Copayment.

NON-EMERGENCY CARE

Benefits for treatment that is not Emergency Care but is received in the Emergency room of a Hospital or free-standing emergency center will be paid in accordance with the Benefit Summary applicable to the Aetna health plan option in which you are enrolled.

For certain Aetna health plan options covered under the Plan, a separate Emergency room visit Copayment applies to each visit by a Covered Individual to a Hospital's Emergency room or free-standing emergency center, unless the Covered Individual is admitted to the Hospital as an Inpatient immediately following a visit to a Hospital Emergency room or free-standing emergency center. Please refer to Benefits Summary applicable to the Aetna health plan option in which you are enrolled for additional details regarding any applicable Emergency room visit Copayment.

TREATMENT BY AN URGENT CARE PROVIDER

You should not seek medical care or treatment from an Urgent Care Provider if your Illness, Injury, or condition is an Emergency condition. Please go directly to the Emergency room of a Hospital, free-standing emergency center,or call 911 (or the local equivalent) for ambulance and medical assistance.

This Plan pays for the charges made by an Urgent Care Provider to evaluate and treat an Urgent Condition.

When travel to a Network Urgent Care Provider for treatment of an Urgent Condition is not feasible, such treatment by an Out-of-Network Urgent Care Provider may be paid at the Network level of benefits. If a claim for treatment of an Urgent Condition is paid at the Out-of-Network level and you believe that it should have been paid at the Network level, please contact customer service at the toll-free number on your I.D. card.

For certain Aetna health plan options under the Plan, a separate Urgent Care Provider visit Copayment applies to each visit to an Urgent Care Provider. Please refer to the Benefits Summary applicable to the Aetna health plan option in which you are enrolled for additional details.

Refer to the Benefits Summary applicable to the health plan option in which you are enrolled for Covered Expenses for charges made by an Urgent Care Provider to treat a non-Urgent Condition. A non-urgent condition includes, but is not limited to, the following:

- Routine or preventive care (this includes immunizations);
- Follow-up care;
- Physical therapy;
- Elective surgical procedures; and
- Any lab and radiologic exams which are not related to the treatment of the Urgent Condition.

AMBULANCE SERVICES

Ground and air professional ambulance services required because of an Injury or Hospital admission are covered. Services must be Medically Necessary and prescribed by the attending Physician. The patient may be transported to and from the Hospital, between Hospitals, and between Hospitals and approved medical facilities. A licensed ambulance company must provide services. This benefit includes the equipment used, mileage and waiting time. Services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation are not covered.

Refer to the Benefits Summary applicable to the health plan option in which you are enrolled for additional details regarding any applicable Copayment

MENTAL WELL- BEING RESOURCES POWERED BY SPRING HEALTH

By caring for ourselves physically, mentally, emotionally and spiritually, we can be at our best. Available resources powered by Spring Health include:

- Six free therapy and six coaching sessions per year. Beginning the 7th therapy visit Spring Health will submit claims to BCBSM which will begin being paid at the Tier 1 network level.
- Diverse providers – Find the therapist that's right for you across specialty, gender, race, language and other filters.
- Dedicated support – A Care Navigator can provide guidance, help find the right therapist, and schedule appointments.
- Wellness exercises – Access to self-guided exercises to help you improve your mental well-being and build health habits.
- Personalized care – A short online mental well-being assessment and care plan designed for you is available.
- Work-life Services – Support and resources are available for legal and financial services, child or elder care, travel, and more.

Contact Spring Health by calling 1-855-629-0554 or online at trinityhealth.springhealth.com. Use the work-life code: trinity health.

MENTAL HEALTH CARE AND SUBSTANCE USE DISORDER TREATMENT

Certain expenses for the treatment shown below are Covered Expenses.

INPATIENT TREATMENT

The following coverage applies if a Covered Individual is a full-time Inpatient in either a Hospital or a Residential Treatment Facility:

- Hospital — Covered Expenses include:
  - Treatment of the medical complications of Substance Use Disorders (this means such as cirrhosis of the liver, delirium tremens, or hepatitis);
  - Effective Treatment of Alcoholism or Drug Use; or
  - Effective Treatment of a Mental Disorder.
- Residential Treatment Facility — Covered Expenses for the Effective Treatment of Alcoholism or Drug Use or the Treatment of a Mental Disorder include:
  - Room and Board (any charge for daily room and board in a private room over the semi-private room rate is not covered unless the Covered Individual's Network Provider requests the private room and the request is pre-approved by Aetna); and
  - Other necessary services and supplies.

OUTPATIENT TREATMENT

Expenses for the Effective Treatment of Substance Use Disorder or the Treatment of Mental Disorders are covered if a Covered Individual is not a full-time Inpatient at either a Hospital or a Residential Treatment Facility.

OTHER COVERED SERVICES

Charges made by a Physician including:

- Office visits and virtual visits/telehealth visits (including primary care and specialty Physicians, presurgical consultations and the initial visit to determine pregnancy).
- Inpatient medical care (Physician visits). Charges by hospitalists, anesthesiologists, interventists, radiologists, pathologists, emergency department physicians and neonatologists are payable at the same tier as the facility where the services occurred.
- Charges for anesthetics and oxygen.
- Rental of durable medical and surgical equipment. In lieu of rental, the following may be covered:
    - The initial purchase of such equipment if evidence is provided to the Claims Administrator that long-term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.
    - Repair of purchased equipment.
    - Replacement of purchased equipment if evidence is provided to the Claims Administrator that it is needed due to a change in the Covered Individual's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.
- Prosthetic and Orthotic appliances.
- Artificial limbs and eyes.
- Private duty nursing.
- Maternity Services, including:
    - Pre-Natal and Post-Natal Care.
    - Delivery and Nursery Care.
- Allergy testing and therapy.
- Injections.
- The following needed for the treatment of or related to conditions of the teeth, mouth, jaws, or jaw joints or supporting tissues (this includes bones, muscles, and nerves).
    - Surgery needed to:
        - Treat a fracture, dislocation, or wound.
        - Cut out:
            - Teeth partly or completely impacted in the bone of the jaw;
            - Teeth that will not erupt through the gum;
            - Other teeth that cannot be removed without cutting into bone;
            - The roots of a tooth without removing the entire tooth; or
            - Cysts, tumors, or other diseased tissues.

- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.
- Dental work, Surgery and Orthodontic Treatment needed to remove, repair, replace, restore or reposition of the following due to injury:
  - Natural teeth damaged, lost, or removed; or
  - Other body tissues of the mouth fractured or cut.
  - Any such teeth must have been:
    - Free from decay; or
    - In good repair; and
    - Firmly attached to the jawbone at the time of the Injury.

  The treatment must be done in the calendar year of the accident or the next one. If crowns (caps), dentures (false teeth), bridgework or in-mouth appliances are installed due to such Injury, Covered Expenses include only charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of Orthodontic Treatment after the Injury.
- Oral Surgeries covered are Gingivectomies, Alveoectomies, Alveoloplasty, Vestibuloplasty and the removal of impacted teeth when performed in an outpatient basis including office.
- Surgical treatment of Temporomandibular Joint Syndrome (TMJ), including related X-rays.

  For the Covered Expenses listed above, a "Physician" includes a Dentist.

Except as provided for Injury, Covered Expenses do not include charges:

- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- For root canal therapy; or
- For routine tooth removal (not needing cutting of bone).

  In addition, Covered Expenses do not include

  charges:
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace, or restore filling, crowns, dentures or bridgework;
- For non-surgical periodontal treatment;
- For dental cleaning, in-mouth scaling, planning or scraping;
- Manipulations, appliances and other therapies for the treatment of Temporomandibular Joint Syndrome (TMJ);
- For myofunctional therapy; this is:

- Muscle training therapy; or
- Training to correct or control harmful habits.

PRESCRIPTION DRUGS

Prescription Drugs that are necessary for the treatment of an Illness or Injury of a Covered Individual when prescribed by a Physician are covered as described below. Prescription Drugs furnished during a Hospital confinement will be payable as described in the section of this SPD titled "Inpatient Hospital Expenses."

Prescription Drugs purchased in a participating pharmacy are covered by the Prescription Drug benefit administered by OptumRx. Participating pharmacies can be found by creating an account and logging in on www.optumrx.com. The participating pharmacy will fill the prescription with a generic equivalent unless a generic substitute is not available. For each new or refilled prescription, you simply pay the Copayment or Coinsurance shown in the Benefits Summary applicable to the Aetna health plan option in which you are enrolled. When Prescription Drugs are purchased at a pharmacy, the Prescription Drug program will allow up to a 34-day supply. If you need a brand name drug and a generic equivalent drug is available you will be charged the difference in ingredient cost between the brand and generic drug, in addition to the brand Copayment.

Maintenance Drugs — Prescription Drugs that are taken on an ongoing basis to treat routine ailments, disorders, and long-term or chronic medical conditions are considered to be a maintenance drug. After three 30-day fills, the member will be required to fill the drug as a 90-day supply through OptumRx Mail Service Pharmacy, CVS retail pharmacy (for certain Ministries) or an Onsite pharmacy at a Trinity Health facility/Trinity Health Pharmacy Services (THPS) mail order. Otherwise the drug will no longer be covered under this Plan and the member will be responsible for the full cost of the drug. Members should contact the HR Service Center or their Benefit Representative to confirm whether their location offers maintenance drug coverage at OptumRx retail pharmacies.

- If your Employer is supported by the HR Service Center, by going online at https://hr4u.trinity-health.org; or
- If your Employer is not supported by the HR Service Center, from your Employer's local HR/benefits representative

Generic Step Therapy — Generic step therapy may apply to certain brand drugs that have multiple generic options. If generic step therapy applies to a brand drug, a member will be required to try one or more generic alternatives before the brand is covered under the Plan.

Specialty Pharmacy — Specialty Pharmacy encourages utilization of clinically appropriate and lowest net-cost specialty medication within select therapeutic categories.

COVERED DRUGS

The following are covered drugs and supplies unless listed as an exclusion below:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug
- Insulin
- Needles, syringes and pumps
- Over The Counter (OTC) Diabetic Test Strips and Lancets
- Retin-A through age 25
- Tazorac cream through age 25
- Zostavax

- Pediatric Fluoride Vitamins
- Legend Pediatric Fluoride Vitamin Drops up to a 50-day supply
- Inhalers, Assisted Devices

PRIOR AUTHORIZATION REQUIRED

Prior Authorization is a drug class management technique that requires select prescriptions to meet defined criteria before they are covered by the Plan. Prior Authorization requires prescribers to confirm Medical Necessity and allows member to appeal if Plan coverage for the drug is denied. The drugs requiring drug class management such as Prior Authorization, Step Therapy and Dispensing Limits are updated periodically and are subject to change. The following drugs are covered only after OptumRx receives and approves prior authorization from your Physician:

- Retin-A/Avita/Altinac (cream only) age 26 and older
- Tazorac cream age 26 and over
- Growth hormones/Growth Hormone Releasing Hormones
- Oral Contraceptives (including pre-packaged Oral Contraceptives up to a 91-day supply, but not including Emergency Contraceptives) for females only (medical diagnosis only)
- PDST (Preferred Drug Step Therapy) — For a list of drugs that require PDST, contact OptumRx Customer Service
- Transdermal and Intravaginal Contraceptives for females only (medical diagnosis only)
- Anti-Obesity/Weight Loss Drugs (Legend Anti-Obesity Preparations)
- Erythroid Stimulants
- Myeloid Stimulants
- Platelet Proliferation Stimulants
- Multiple Sclerosis Agents
- Tysabri
- Interferons
- Xolair
- Provigil
- Specialty Drugs — For a drug list, contact OptumRx Customer Service

NOTE: Drugs for cancer therapy and the reasonable cost of administering them are usually covered. The Prescription Drug program may implement prior authorization rules to determine if the cancer therapy is eligible for coverage under the Plan based on the Plan rules. Certain off-label uses of cancer drugs may not be eligible for coverage under the Plan if there is insufficient published evidence to determine the toxicity, safety and/or efficacy of the cancer therapy for the specific cancer it is prescribed to treat.

EXCLUSIONS

The following are excluded from coverage unless specifically listed as a benefit under “Covered Drugs”:

- Non-Federal Legend Drugs
- Contraceptive medications, jellies, creams, foams, devices, implants or injections, whether or not dispensed by prescription, which are purchased or prescribed for the sole purpose of preventing conception, including diaphragms

- Emergency contraceptives
- Renova
- Yohimbine
- Non-sedating antihistamines/non-sedating antihistamine combo products (SPECs: Z2O, Z2Q)
- Zostavax through age 59
- Drugs to treat impotency/male sexual dysfunction, erectile dysfunction (ED) drugs
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth, to remove hair, or for cosmetic purposes only (e.g., Rogaine)
- Depigmenting agents and cosmetic Botox
- Allergy Sera
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Diagnostic agents
- Elastic bandages and supports
- Ostomy products
- Continuous glucose monitors
- Alcohol wipes
- Intravenous drugs
- Drugs labeled "Caution-limited by Federal law to investigational use", or Experimental drugs, even though a charge is made to the Covered Individual
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other drug or medical service for which no charge is made to the Covered Individual
- Medication which is to be taken by or administered to a Covered Individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, Convalescent Facility, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order
- Charges for the administration or injection of any drug
- Over-the-counter (OTC) drugs
- Non-prescription smoking cessation procedures and smoking deterrents

DISPENSING LIMITS

- The amount of drug which is to be dispensed per prescription or refill (regardless of dosage form) will be in quantities prescribed up to a 34-day supply.
- Thalomid limited to a 28-day supply.

FILING CLAIMS

In certain situations, you or your Dependent will have to file your own claims in order to obtain benefits for Prescription Drugs. This is primarily true when you or your Dependent did not receive an ID card, the pharmacy was unable to transmit a claim or you or your Dependent purchases a drug at a pharmacy that does not participate in the OptumRx program. To do so, follow these instructions:

- Complete a Prescription Drug claim form. These forms are available from your Employer or the Prescription Drug Claims Administrator's office.
- Attach copies of all pharmacy receipts to be considered for benefits. These receipts must be itemized.
- Mail the completed claim form with attachments to the Prescription Drug Claims Administrator at:

OptumRx

P.O. Box 650334 Dallas,

TX 75265-0334

In any case, claims must be filed no later than one year after the date a service or supply is received. Claims not filed within one year from the date a service or supply is received will not be eligible for payment under the Plan.

If you or your Dependent purchases a drug at a pharmacy that does not participate in the OptumRx program, and your claim is approved, you will be reimbursed the amount that would have been paid to the pharmacy minus the cash Copayment you would have paid at a participating pharmacy.

If your claim is wholly or partially denied, within 30 days after its receipt of your claim, the Prescription Drug Claims Administrator will notify you of its decision in a written or electronic communication pursuant to Department of Labor Regulations Sections 2520.104b-1(c)(1), (iii) and (iv), which will contain:

- 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 and 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 internal 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 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.

- 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.

A 15-day extension of the time period for deciding claims may be allowed, provided that the Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator must notify you before the end of the 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim. If you do not provide the required information within the 45-day period, your claim will be decided based on the information that has been provided to the Claims Administrator and may be denied. If an extension is necessary due to your failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Claims Administrator sends you an extension notification until the date you respond to the request for additional information, or the expiration of the 45-day period within which you were to provide the additional information, if earlier. The Claims Administrator will notify you of its determination with respect to your claim within 15 days after the earlier of these dates.

CLAIMS APPEAL PROCEDURES

If your claim has been denied in whole or in part, you may appeal the decision. Your written request for review or reconsideration must be made in writing to the address indicated in the claim denial letter within 180 days after you receive notice of a claim denial. While the Claims Administrator will honor telephone requests for information, such inquiries will not constitute a request for appeal. You may designate an Authorized Representative to act for you in the appeal procedure. Your designation of an Authorized Representative must be in writing as it is necessary to protect against disclosure of information about you except to your Authorized Representative.

As part of your appeal, you or your Authorized Representative have the right to:

- Submit written comments, documents, records and other information relating to your claim for benefits that you wish to have considered;
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;
- A review that does not defer to the initial claim determination and that is conducted by someone other than the individual who made the adverse determination, and who is not such person's subordinate; and
- In cases where the claim denial was based in whole or in part on medical judgment, require the individual reviewing the appeal to consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted in connection with the initial claim determination, and who is not such person's subordinate.

Ordinarily, a decision on an appeal will be reached within 30 days after receipt of your appeal.

The Claims Administrator will notify you if your appeal is denied. Such notification will include:

- 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 or 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;
- 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 by the Claims Administrator, the Claims Administrator must provide you, free of charge, any new or additional evidence considered, relied upon, or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with the claim appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Claims Administrator's notice of its decision on your claim appeal must be provided so that you have a reasonable opportunity to respond prior to that date. In addition, if the Claims Administrator'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 the Claims Administrator's notice of its decision on your claim appeal must be provided so that you have a reasonable opportunity to respond prior to that date.

EXTERNAL REVIEW

There will be an external review process for claim review denials that 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. Information regarding the external review process is available by contacting OptumRx Customer Service at 800-875-0867.

NOTE: This Plan does not coordinate benefits on Prescription Drug charges that are provided through Pharmacy Benefit Managers.

For questions related to your Prescription Drug program, contact OptumRx at 1-855-540-5950.

COVID-19 EXPENSES

Testing, treatment and vaccination for COVID-19 is subject to the normal Plan provisions except as follows:

- COVID-19 diagnostic testing and related services covered at 100%.through end of the public health emergency declared by the Secretary of Health and Human Services related to COVID-19.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Essential Assist Plan (with HRA) option requires a Covered Individual to meet a Deductible and then pays Covered Expenses at the percentages outlined in the Benefit Summary with the Covered Individual paying the additional amount due (e.g., Coinsurance) until the annual Out-of-Pocket Maximum is met. If your Employer offers the Essential AssistPlan (with Low Income HRA)option and you enroll in this health plan option, in order to help you pay qualified medical espenses and meet your Deductible and Out-of-Pocket Maximum, a Health Reimbursement Account will be established for you. A Health

Reimbursement Account ("HRA") is an account established and maintained by the Plan Administrator or its designee that reflects the amount of Employer contributions credited to the account less the amount of Eligible Medical Expenses reimbursed from the account for Covered Services incurred by you or one of your Dependents who is a Covered Individual.

If you enroll in the Essential Plan (with Low Income HRA) effective as of the first day of a Plan Year, the amount credited to your HRA for the Plan Year is as follows:

- Individual coverage: $1,000
- Family coverage: $2,000

The amount credited to your HRA for a Plan Year is pro-rated if you enroll in the Essential AssistPlan (with HRA) during the Plan Year. For example, if you enroll in the Essential AssistPlan (with HRA) as of July 1 and elect family coverage, $1,000 will be credited to your HRA for the Plan Year ($2,000 x (6 months/12 months)). If you experience a special enrollment right or qualified change in status event and, as a result, you elect to cover a Dependent or cover additional Dependents, (for example, you change from the Individual coverage level to the Family coverage level as a result of the birth of a baby or marriage), an additional pro-rated amount will be credited to your HRA. However, your HRA balance will not be reduced if, as a result of a qualified change in status event, a Dependent is removed from your Plan coverage.

Colleagues have the choice when to utilize their HRA funds. Medical claims will not automatically be paid with HRA funds as claims are processed. Colleagues will be able to use HRA funds for both qualified medical and prescription expenses, including over-the-counter prescription products You have several options for accessing your HRA funds including:

- Swiping your Health Equity debit card at time of service/purchase. Save your receipts as you may be asked to upload them to the website or mobile app to substantiate your claim
- Pay providers directly online
- File a claim online to request reimbursement for paid eligible out-of-pocket expensesthrough the HealthEquity website at www.healthequity.com/wageworks or through the Health Equity mobile app EZ Receipts (Download at http://www.healthequity.com/wageworks/employees/go-mobile
- In addition, you can contact the customer service at the telephone number on the back of your debit card.

If a Colleague transfers out of the Essential Assist Plan (with HRA) into another health plan option under the Plan (e.g., the Traditional or Health Savings Plan), the Colleague's HRA cannot be used to pay for expenses incurred while the Colleague is covered under the non-Essential Assist Plan (with HRA). For example, if a Colleague is enrolled in the Essential Assist Plan (with HRA) for the 2023 Plan Year and elects coverage under the Traditional Plan for the 2024 Plan Year, even if the Colleague has a balance in his or her HRA on December 31, 2023, the Colleague's HRA will not be able to be used to pay for any medical expenses incurred by the Colleague or his or her Dependents during the 2024 Plan Year. Similarly, if a Colleague is enrolled in the Essential Assist Plan (with HRA) for the 2024 Plan Year, experiences a special enrollment event and, as a result, elects to change his or coverage option to the Traditional Plan for the rest of the 2024 Plan Year, even if the Colleague has a balance in his or her HRA, the Colleague's HRA will not be able to be used to pay for any medical expenses incurred by the Colleague or his or her Dependents on or after the effective date of their enrollment in the Traditional Plan.

Similar to the above, if a Colleague transfers into the Essential Assist Plan (with HRA) from another health plan option under the Plan (e.g., the Traditional or Health Savings Plan), the Colleague's HRA cannot be used to pay for expenses incurred while the Colleague is covered under the non- Essential Assist Plan (with HRA). For example, if a Colleague is enrolled in the Traditional Plan for the 2023 Plan Year and elects coverage under the Essential Assist Plan (with HRA) for the 2024 Plan Year, the Colleague's HRA will not be able to be used to pay for any medical expenses incurred by the Colleague or his or her Dependents during the 2024 Plan Year. Also, if a Colleague is enrolled in the Traditional Plan for the 2023 Plan Year, experiences a special enrollment event and, as a result, and elects to change his or coverage option to the Essential Assist Plan (with HRA) for the rest of the 2023 Plan Year,

the Colleague's HRA will not be able to be used to pay for any medical expenses incurred by the Colleague or his or her Dependents before the effect date of their enrollment in the Essential Assist Plan (with HRA).

The only exception to the above is if a Colleague is enrolled in the Essential Assist Plan (with HRA) for one Plan Year, has a balance in his or her HRA at the end of the claim run-out period for that Plan Year and his or her Employer does not offer the Essential Assist Plan (with HRA) in the next Plan Year. In this case, the balance in the Colleague's HRA will be rolled into a limited-purpose health reimbursement account ("LPHRA"). The Colleague will be able to receive reimbursement from his or her LPHRA for dental and vision expenses incurred by the Colleague or his or her tax dependents that are "medical care" (as defined by Internal Revenue Code Section 213(d)) and that are not reimbursed by any other source (and for which the Colleague will not seek reimbursement from any other source). The expenses must be incurred between the first day of the Plan Year in which the Colleague is no longer enrolled in the Essential Assist Plan (with HRA) and the last day of the following Plan Year. In other words, the Colleague has 24 months to use the amount credited to his or her LPHRA. For example, if a Colleague was enrolled in the Essential Assist Plan (with HRA) for the 2023 Plan Year, her Employer does not offer the Essential Assist Plan (with HRA) for the 2024 Plan Year, and she has a balance of $400 in her HRA as of April 1, 2024, a LPHRA will be established for the Colleague. (Expenses incurred by the Colleague or her Dependents after December 31, 2023 are not eligible for reimbursement from her HRA). The Colleague will be able to receive reimbursement from her LPHRA for the eligible dental and vision expenses incurred by the Colleague or her tax dependents between January 1, 2024 and December 31, 2025. If there is a balance in the Colleague's LPHRA on December 31, 2025 that cannot be used to pay eligible dental and vision expenses incurred by the Colleague or her tax dependents between January 1, 2024 and December 31, 2025, it will be forfeited.

If an amount is rolled from your HRA into a LPHRA, you will receive additional information from the Plan Administrator regarding your LPHRA and how to receive reimbursement for eligible expenses from your LPHRA.

SPECIAL RULES

The following special rules apply to the HRA if your coverage under the Essential AssistPlan (with HRA) health plan option terminates.

- If you have a COBRA qualifying event and elect COBRA coverage, the premiums for the COBRA coverage are not payable from your HRA.
- If you have a COBRA qualifying event, you must elect COBRA coverage under the Essential Plan (with Low Income HRA) in order to receive reimbursement from your HRA for any Eligible Medical Expenses incurred after your coverage under the Plan would otherwise end due to the qualifying event.
- If you terminate employment with all of the employers and you are not eligible for COBRA coverage or do not elect COBRA coverage under the Essential AssistPlan (with HRA), claims payment under the HRA will cease at the end of the month following your last day of employment. Any claims incurred on or before your last day of coverage will be reimbursable by the HRA, provided they are filed no later than 9 days from your termination date. Any balance remaining in your HRA is forfeited.

If, at Annual Open Enrollment or due to a special enrollment right or qualified change in status event, you elect to move from the Essential Assist Plan (with HRA) to another health plan option offered by your Employer, claims payment under the HRA will continue for Eligible Medical Expenses incurred which you were covered under the Essential AssistPlan (with HRA) if they are submitted for payment within90 days of termination of coverage in the Essential Assist Plan (with HRA)..

To make the best use of your HRA funds, you will want to become involved in the cost of the care you receive. You should become a savvy health care consumer so your funds will last as long as possible. The Health Equity website at www.healthequity.coms includes information on your HRA, and other information designed to help you make wise decisions regarding your health care

Trinity Health may amend or terminate the Essential Assist Plan (with HRA) option under the Plan and the HRA program, in whole or in part, at any time. This includes the amount that will be credited to a

Colleague's HRA as set forth above. Consent of any Covered Individual or any other person is not required to amend or terminate the Essential Assist Plan (with HRA) or the HRA program, except to the extent the right to terminate is limited by a collective bargaining agreement, if any.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account ("HSA") is an individual trust or custodial account arrangement that is established and maintained by a Colleague with a qualified trustee or custodian, respectively, outside of the Plan, and that satisfies the requirements of Section 223 of the Internal Revenue Code. It is a tax-advantaged account that the Colleague can use to save and pay for qualified healthcare expenses, now or in the future.

ELIGIBILITY

In order to make contributions to an HSA (or for someone else to make contributions to your HSA) you must satisfy the following requirements:

- You must be covered under an HSA-qualified high deductible health plan ("HDHP"). The Health Savings Plan (with HSA) health plan option under the Plan is an HSA-qualified HDHP.
- You cannot be enrolled in Medicare, Medicaid or Tricare (military healthcare).
- You cannot have received any Veterans Administration health benefits in the last three months.
- You cannot be claimed as a tax-dependent by another taxpayer.
- You cannot be covered under any impermissible non-HDHP health coverage. In general, this means that you cannot be covered by any other health insurance that reimburses you for health expenses you incur, unless it is another HSA-qualified HDHP. For example, health flexible spending accounts ("FSAs") and health reimbursement arrangements ("HRAs") may make you ineligible for an HSA unless they are: (1) "limited purpose" (limited to dental, vision or preventive care) or (2) "post deductible" (pay for medical expenses after the plan deductible is met). HRAs that set aside money only for retiree health expenses are also acceptable. Accordingly, if you have a health FSA under the Trinity Health Corporation Welfare Benefit Plan for all or part of a Plan Year, you are not eligible to contribute to an HSA for that Plan Year, even if you are enrolled in the Health Savings Plan (with HSA). In addition, if you have a health FSA under the Trinity Health Corporation Welfare Benefit Plan, and you enroll in the Health Savings Plan (with HSA) for the next Plan Year, in order for any contributions to be made to your HSA for that next Plan year, your health FSA balance must be exhausted by the end of the prior Plan Year or it will be forfeited. For example, if you have a health FSA for the 2023 Plan Year and you enroll in the Health Savings Plan (with HSA) for the 2024 Plan Year, your health FSA balance must be exhausted by December 31, 2023 in order for any contributions to be made to your HSA during the 2024 Plan Year. If it is not exhausted by December 31, 2023, it will be forfeited.

If you cease to satisfy all of the requirements set forth above, contributions can no longer be made to your HSA but you can maintain your HSA and spend the amounts contributed while you were eligible to contribute. Also, the money in your HSA is entirely your own and your HSA is portable, which means that you keep your HSA even if you cease to be covered under the Health Savings Plan (with HSA) or your employment with your Employer terminates. Also, since the HSA is owned by you, there is no "use- it-or-lose-it" provision, like with a health FSAs. Instead, your unused contributions to your HSA roll over each year, with interest and/or investment earnings compounding on a tax-free basis, like an IRA or 403(b) or 401(k) plan.

CONTRIBUTIONS

The IRS sets a limit on the amount that may be contributed to your HSA for any calendar year.

Colleagues 55 and over can make an additional "catch-up" contribution. These limits include both Colleague and Employer contributions to an HSA. Also, in the year you enroll in Medicare, you must prorate your "catch-up" contribution for the number of months you had HSA-qualified HDHP coverage, prior to the month your Medicare enrollment is effective.

If amounts have been contributed to your HSA which exceed your maximum allowable contribution, you may withdraw the excess amount and any earnings on the excess amount prior to April 15th of the following year without paying a tax penalty. However, you must pay income tax on your excess contributions and income tax on any earnings of the excess contribution. If you do not withdraw the excess contribution to your HSA prior to April 15th of the following year, you must pay a 6 percent excise tax on the excess contribution, and on any earnings of the excess contribution. If in the next year you decreased your maximum contribution by the amount of your excess contribution made the year before, you do not have to pay the 6 percent excise tax again. If, however, you leave the excess contribution in, and do not decrease your maximum contribution by the amount of your excess contribution made the year before, you will have to pay the 6 percent excise tax each year the excess contributions and earnings are in your HSA.

If your Employer offers the Health Savings Plan (with HSA) health plan option, you enroll in this health plan option, and you satisfy the eligibility requirements set forth above, you and your Employer may make contribution to your HSA. You will be able to make pre-tax payroll deduction contributions to your HSA if you have established an HSA with HealthEquity for each month that you are enrolled in the Health Savings Plan (with HSA) and satisfy the eligibility requirements set forth above. **You may establish an HSA with a trustee or custodian other than HealthEquity. However, in order to make pre-tax contributions to your HSA and receive any Employer contributions to your HSA, you must establish an HSA with HealthEquity.**

WITHDRAWALS

Tax-free withdrawals can be made from your HSA to pay for qualified medical expenses incurred by you and your spouse and tax-dependents after the HSA is established so long as the expenses are not reimbursed by insurance or any other source. There is a wide range of allowable tax-free HSA expenditures, including vision and dental expenses, and, for example, braces for your children. A description of eligible HSA expenditures can be found in IRS Publication 502 and is located at the web at: www.irs.gov/pub/irs-pdf/p502.pdf. Publication 502 has great examples, but it is not the definitive list (please see Table A for a partial list of allowable tax-free expenses and Table B for non-allowable expenses). In general, health insurance premiums and contributions for self-funded health coverage (e.g., coverage under the Plan) are not qualified medical expenses. However, the following are HSA-qualified medical expenses:

- COBRA continuation coverage premiums for the HSA holder and his or her spouse and tax-dependents;
- Premiums for a qualified long-term care insurance contract (subject to certain age limits in the Internal Revenue Code);
- Premiums for a health plan maintained while the HSA holder or his or her spouse or tax-dependent is receiving unemployment compensation under federal or state law; and
- For HSA holders who are age 65 or older, any deductible health insurance other than a Medicare supplemental policy.

If a distribution from your HSA is used for purposes other than a qualified medical expense, then the amount withdrawn is subject to both income tax and a 20 percent penalty, unless you are over the age of 65. If you are age 65 or older, the amount withdrawn from your HSA for non-medical purposes is treated as retirement income, and is subject to normal income tax, but is not subject to the 20 percent penalty.

If you make a withdrawal from your HSA for an expense that you thought was a qualified medical expense but turned out not to be a qualified medical expense, the amount withdrawn can be returned to your HSA if there is clear and convincing evidence that the expenditure was a mistake of fact. Such repayment to your HSA must be made on or before April 15th of the year following when you knew, or should have known, the expenditure was a mistake.

If you enroll in the Health Savings Plan (with HSA), you will receive additional information from the Plan Administrator regarding HSAs.

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

Allowable Expenditures from Your HSA	
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.
- 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).

1/1/2021

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.