

*Your
Group
Plan*

Trinity Health Corporation

PCA PPO SPD

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The Plan described in this Handbook is a benefit plan of the Trinity Health Corporation (“Trinity Health”). The Plan provides benefits to eligible associates of Trinity Health and the Trinity Health Ministry Organizations that have adopted the Plan (collectively referred to as the “Employer”) and their eligible dependents. The Plan benefits are not insured with Aetna Life Insurance Company (“Aetna”) but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna, the Trinity Health Corporation Welfare Benefit Plan (“Welfare Benefit Plan”) and Trinity Health, as the sponsor of the Welfare Benefit Plan.

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This Handbook provides a general explanation of the Plan. While we have tried to describe the Plan as completely and accurately as possible, due to the relatively brief nature of this Handbook and the complexity of the Plan document, some details may not have been described or have been described only briefly. **We strongly urge you to read this Handbook in its entirety.** If you have further questions, or if you would like to review the entire Plan document, copies are available from the Plan Administrator.

This Handbook may be an electronic version of the Handbook on file with Trinity Health and Aetna Life Insurance Company. In case of any discrepancy between an electronic version of this Handbook 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 Handbook (electronic or printed) and the actual Plan document, the Plan document will prevail. To obtain a printed copy of this Handbook and/or the Plan document, please contact the Plan Administrator listed at the end of this Handbook.

Trinity Health may modify, amend or terminate the Plan and this Handbook at any time at its discretion. Coverage under this Plan, or receipt of any benefit from the Plan, does not in any way affect your employment relationship with your Employer, or in any way limit your Employer's right to terminate your employment.

Information in this Handbook describes the benefits covered under the Plan. If you have any questions, please contact the Member Services Unit at the toll-free phone number listed on your Identification Card.

General Information About Your Coverage

WHO IS ELIGIBLE FOR BENEFITS?

You are eligible to participate in the Plan if you are a regularly scheduled benefit eligible full-time or part-time **associate**, as described in your Employer’s policy that defines associate classifications. Coverage will generally become effective after you satisfy the waiting period described in your Employer’s policy that defines associate benefit eligibility.

Shown below is a list of **dependents** that are eligible for coverage under the Plan. Upon election for coverage, you will have 31 days to provide documentation to verify the eligibility of each of your covered **dependents, including your spouse**. The required documentation is set forth in the Trinity Health Dependent Verification Documentation Requirements, a copy of which can be obtained at <http://mybenefits.trinity-health.org/auditdocrequirements.pdf>. Coverage for your **dependents** will remain in an “ineligible” status until appropriate documentation is provided. Failure to provide appropriate documentation within 31 days will result in the voluntary termination of your election.

NOTE: If you and your spouse 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 spouse. You and/or your spouse are not eligible to be covered as both an **associate** and a **dependent** under the Plan. In addition, if both you and your spouse are covered as **associates** under the Plan, only one of you may elect coverage for your dependent children.

Any references in this section of this handbook to “you” or “your” are references to the “eligible associate” unless the context clearly indicates otherwise.

SPOUSE

Your spouse is eligible for coverage under the Plan provided:

1. The person is legally married to you under applicable State and Federal law and the IRS recognizes the person as your spouse for income tax purposes. A person who is your spouse as a result of a common law marriage is not eligible for coverage under the Plan.
2. The person is not otherwise covered under the Plan or any other group health plan offered by the Employer.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn 19, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They either:
 - have the same principal place of abode as you for more than half of the taxable year, and they do not provide more than half of their own support for the taxable year (a “qualifying child”); or

- have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) (\$3,650 for 2009), you provide over half of their support, and they are not anyone else's qualifying child.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) (Continued)

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn age 24, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They are enrolled as full-time students for at least five months of the year..
5. They either:
 - have the same principal place of abode as you for more than half of the taxable year, and they do not provide more than half of their own support for the taxable year (also a "qualifying child"); or
 - have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) (\$3,650 for 2009), you provide over half of their support, and they are not anyone else's qualifying child.

DEPENDENT CHILDREN BY BIRTH, MARRIAGE, ADOPTION, LEGAL GUARDIANSHIP OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) (Continued)

Dependent children are eligible for coverage under the Plan through the end of the calendar year in which they turn age 26, provided they meet all of the following criteria:

1. They are unmarried.
2. They are the natural, legally adopted or court appointed children of either you and/or your legal spouse (a legal spouse is a person who is legally married to you under applicable State and Federal law and who the IRS recognizes as your spouse for income tax purpose; a spouse by common law marriage is not considered your legal spouse for Plan purposes).
3. They are not otherwise covered under the Plan or any other group health plan offered by the Employer.
4. They have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) (\$3,650 for 2009).
5. You provide over half of their support for the taxable year.
6. They are not anyone else's qualifying child.

Dependent children who are totally and permanently disabled are eligible for coverage beyond age 26, provided they also meet all of the following criteria:

- They are continuously enrolled in a creditable plan prior to their 19th or 26th birthday, and
- They are deemed legally disabled by mental or physical incapacity (i.e., unable to engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months) prior to their 19th or 26th birthday.

Continuation of Coverage for Dependent Students Taking a Leave of Absence from School due to Illness or Injury

Effective on and after January 1, 2010, an unmarried child who is a full-time student will not cease to be an eligible dependent child solely due to the fact that the child takes a medically necessary leave of absence from school (or reduces his or her school hours to part-time status for a medically necessary reason). The medically necessary leave of absence (or reduction of hours) must be verified by written certification from the child's treating physician. The child must be enrolled in the Plan as an eligible dependent immediately prior to the medically necessary leave of absence (or reduction of hours) and the absence must otherwise

cause the child to lose coverage under the Plan. The child will continue to be a dependent for one year after the first day of any verified medically necessary leave of absence or, if earlier, the date coverage would otherwise terminate under the Plan because the child does not satisfy the other eligibility requirements for dependent coverage (e.g., because the child attains age 26).

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 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. Additionally, the Employer may withhold from your paycheck any contributions required for such coverage.

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 Employer 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.

Unless the context clearly indicates otherwise, a reference in this Handbook to “dependents” includes both an associate’s spouse and dependent child(ren) who satisfy the requirements set forth above to be eligible for coverage under the Plan.

WHO IS NOT ELIGIBLE FOR BENEFITS?

1. Your common law spouse;
2. Your legal spouse and/or dependent child(ren) if covered under the Plan or other group health plan offered by the Employer as an **associate** or **dependent**;
3. Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); and
4. Any individual who does not meet the definition of an **associate** or **dependent** as described in the WHO IS ELIGIBLE FOR BENEFITS? Section of this handbook.

ENROLLMENT PROCEDURE

You may enroll for coverage through your Employer’s benefit enrollment process. For example, your Employer’s benefit enrollment process may require you to complete an enrollment form or enroll electronically. If you want to enroll yourself and/or your eligible **dependents** in the Plan, you must follow your Employer’s benefit enrollment process. Please review your Employer’s policy regarding benefit enrollment to find out your Employer’s benefit enrollment process.

Your “Initial Enrollment Period” is the 31-day period beginning on the date you are first eligible for coverage. If you complete your enrollment within the Initial Enrollment Period, you and your eligible **dependents** will be enrolled in this Plan as described under the section of this handbook titled WHEN WILL COVERAGE BEGIN? You must enroll yourself for coverage, in order for your **dependents** to be eligible for coverage under this Plan.

You and your Employer will 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. Your Employer will determine the rate of any required contributions in accordance with your Employer’s policy. Please see the Plan Provision Appendix.

If you do not enroll during the 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 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 below). The annual Open Enrollment Period is held during the fall of each year.

WHEN WILL COVERAGE BEGIN?

You must follow your specific Employer's benefit enrollment process within 31 days of your date of eligibility. Your coverage will begin in accordance with your Employers policy. Please see Plan Provision Appendix.

SPECIAL ENROLLMENT PERIODS

Special Enrollment for Coverage Under Medical Program

Under the Health Insurance Portability and Accountability Act ("HIPAA"), special enrollment rights are available to certain eligible associates who previously declined coverage under the Plan and wish to enroll themselves and/or one or more of their eligible dependents. If you are an associate who is eligible to participate in the Plan, you will have a special enrollment right regardless of when you would otherwise be eligible to enroll under the Plan. Therefore, these provisions supplement any other enrollment period otherwise available to you. You will be entitled to special enrollment, if all of the following conditions are met:

1. You did not elect coverage under the Plan for yourself and/or you eligible **dependent** when you were first eligible to do so, because:
 - you and/or your eligible dependent were covered under a group health plan or had health insurance at the time coverage was previously offered; and
 - you stated in writing at the time you declined coverage that the reason you were declining was because you had other similar coverage; and
 - you and/or your eligible dependent lose such coverage because of a loss of eligibility for that coverage due to:
 - termination of employment in a class eligible for such coverage;
 - reduction in hours of employment;
 - death;
 - divorce or legal separation;
 - the exhaustion of COBRA continuation coverage;
 - the other employer no longer contributing toward the cost of such coverage;
 - the exhaustion of applicable lifetime benefits under the coverage;
 - an individual ceases to be a dependent under the plan;
 - the plan terminates a benefit package option;
 - if your 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); or
 - the plan no longer offers 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 associates but continues coverage for full-time associates, and you are a part-time associate); and
2. You elect coverage not later than 31 days after the date of the loss of coverage for one of the reasons stated above.

Coverage under the Plan for a special enrollee will become effective on the date set forth in your Employer's policy, but no later than the first day of the first calendar month beginning after the date on which you timely enroll.

Special Enrollment for New Dependents

The HIPAA special enrollment provisions also apply if you acquire an eligible **dependent** through marriage, birth, adoption or placement for adoption. If you are an eligible **associate**, you will be entitled and provided that you elect coverage not later than 31 days after such event. You will be entitled to special enrollment, if you meet one of the following conditions:

- **Non-Enrolled Associate:** If you are an eligible **associate** but you have not enrolled in the Plan, you may enroll upon your marriage or upon the birth, adoption, or placement for adoption of your child.
- **Non-Enrolled Spouse:** If you are an eligible **associate** who is already enrolled in the Plan, you may enroll your spouse at the time of his or her marriage to you. You may also enroll your spouse if you acquire a child through birth, adoption, or placement for adoption.
- **New Dependents of an Enrolled Associate:** If you are an eligible **associate** who is already enrolled in the Plan, you may enroll a child who becomes your eligible **dependent** as a result of marriage, birth, adoption, or placement for adoption.
- **New Dependents/Spouse of a Non-Enrolled Associate:** If you are an eligible **associate** but you are not enrolled in the Plan, you may enroll a spouse, or **dependent** child, as applicable, who becomes your eligible **dependent** as a result of marriage, birth, adoption, or placement for adoption. However, you (the non-enrolled **associate**) must also be eligible to enroll in the Plan, and actually enroll in the Plan at the same time.

You must enroll yourself and/or your new eligible **dependent(s)** no later than 31 days after the date of the event that entitles you and/or your eligible **dependent(s)** to the special enrollment period. If you are entitled to special enrollment and enroll within 31 days of the date of the event, coverage will become effective on the date set forth in your Employer's policy; provided, however, that coverage will become effective on the date of the event for birth, adoption or placement for adoption if you timely enroll and, with respect to marriage, coverage will become effective no later than the first day of the first calendar month beginning after the date on which you timely enroll. If you do not timely enroll, enrollment for yourself and/or your new eligible **dependent(s)** must wait until the next Open Enrollment Period, 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).

Special Enrollment for Medicaid/Children's Health Insurance Program

Effective April 1, 2009, HIPAA special enrollment rights also apply if (1) you and/or your eligible **dependent** 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** become eligible for premium assistance in the Plan under a Medicaid program or CHIP. You must enroll 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** to the special enrollment period. If you are entitled to special enrollment and you enroll within 60 days after the date of the event, coverage will become effective as of the date set forth in your Employer's policy, but no later than the first day of the first calendar month beginning after the date on which you timely enroll. If you do not timely enroll, enrollment for you and/or your eligible **dependent** must wait until the next Open Enrollment Period, 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** prior to such time).

CHANGE IN STATUS

Once you make your coverage election for a **plan year** (January 1 through December 31) (or in your initial year of eligibility, for the remaining portion of the **plan year**), you generally cannot change or revoke your election until the beginning of the next plan year unless you have a qualified change in status (described below). This rule applies whether your election was to opt out of coverage, to begin participation, or to continue coverage by making no other affirmative election.

Qualified Change in Status

A **qualified change in status** includes the following events that may impact you or your dependent's eligibility for coverage under the Plan:

- Change in marital status, including marriage, divorce, legal separation, annulment or death of spouse.
- Change in number of **dependents**, including birth, death, adoption, and placement for adoption.

- Change in employment status of the **associate**, spouse or **dependent** that causes you, your spouse or dependent 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 return from 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, or a change from salaried to hourly pay, or, a strike or lockout.
- Change in residence of the **associate**, spouse or **dependent** that removes the affected individual from a benefit plan's service provider area (such a change entitles you to make a new plan election selecting another coverage option, but generally does not permit you to opt out of 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, ceasing to be a student, 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 or other dependent, 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, former spouse or dependent, or a significant increase in the cost of a benefit (such qualified change in status permits you to make a new benefit selection, but does not allow you to revoke coverage entirely, unless no other similar coverage is available).
- You, your spouse or other dependent become covered or lose benefit coverage under Medicare or Medicaid, other than for pediatric vaccines.
- A judgment, decree or order requiring **dependent** coverage (e.g., **QMCSO**).
- A special enrollment right you may be entitled to under the provisions of HIPAA.
- You commence or return from an unpaid leave of absence as permitted and regulated by the FMLA.
- An election of coverage by your spouse, former spouse or dependent during an open enrollment period that differs in time from the open enrollment period offered by the Employer

Any election change or revocation you make must be consistent with the qualified change in status. You must change or revoke your election within 31 days after the change in status event occurs. The change or revocation will be effective as soon as is administratively practicable after it is received by the Employer, but in no event earlier than the first pay period beginning after a new election is completed and returned to the Employer. Changes in elections due to a qualified change in status shall only be effective as to contributions and benefits under the Plan on and after the effective date of such change. However, election changes made due to a special enrollment right as provided by HIPAA may result in coverage being made available retroactively to the date of the qualified change in status.

LEAVE OF ABSENCE

If you are not at work due to an unpaid, Employer-approved leave of absence, period of military service lasting more than 31 days, or any other reason that creates a legal obligation for the Employer to extend coverage under the Plan, you may, at your option, continue coverage during the period of absence in accordance with your Employers 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 ASSOCIATES

If you terminate employment prior to becoming a participant and an Employer subsequently reemploys you, 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 after becoming a participant and an Employer subsequently reemploys in a position that entitles you to participate in the Plan, you shall have the opportunity to re-enroll in the Plan immediately upon reemployment. You must follow your Employer's benefit enrollment process within 31 days of your reemployment. Your coverage will begin in accordance with your Employers policy. Please see Plan Provision Appendix. If you do not enroll within 31 days of your reemployment, you will not be able to enroll yourself and/or your eligible **dependents** in the Plan until the next annual Open Enrollment Period except under the circumstances described in the "Special Enrollment Periods" section or if you and/or your **dependents** experience a "Change in Status" event.

WHEN WILL COVERAGE END?

Your and your **dependents'** coverage under the Plan will end when the Plan is terminated. In addition, you and your **dependents'** coverage under the Plan will end when you no longer meet the eligibility requirements of this Plan or you die. Your coverage and

that of your enrolled **dependent(s)** will end on the last day of the pay period during which you cease to be eligible to participate or die or the last day of the pay period in which you make a contribution toward the cost of coverage, if earlier.

In addition, the coverage of your **dependent(s)** will end when they no longer meet the eligibility requirements of this Plan as defined by your Employer policy.

NOTE: If your coverage terminates and/or if your **dependent(s)** cease to be covered for any of the above reasons, you and/or your **dependent(s)** may be eligible to continue coverage under the Plan. Please refer to the section titled CONTINUATION COVERAGE RIGHTS UNDER COBRA for further information.

When you and/or your dependent(s) lose coverage under the Plan, you and/or your dependant(s) (as applicable) will be provided with a Certificate of Creditable Coverage as required by HIPAA. The Certificate of Creditable Coverage will indicate the time period that you or your dependent(s) were covered by the Plan, subject to HIPAA's portability requirements. You and/or your dependent(s) may also request a Certificate of Creditable Coverage within 24 months of losing coverage under the Plan. If you and/or your dependent(s) need to request a Certificate of Creditable Coverage, you and/or your dependent(s) can do so by contacting the Plan Administrator. The request must be in writing and must include: (1) the name(s) of the individual(s), (2) the time period to be covered by the Certificate of Creditable Coverage, and (3) a mailing address where the Certificate of Creditable Coverage should be sent.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a temporary extension of coverage under the Plan that can become available to you when you would otherwise lose your coverage under the Plan. It can also become available to the members of your family who are covered under the Plan when they would otherwise lose their coverage. **The information in this Handbook is intended provide notice and explain, in a summary fashion, COBRA continuation coverage, when it may become available to you and your family, what you must do to continue your coverage under the Plan, including what to do to protect the right to receive it.** This information gives you only a summary of your COBRA continuation coverage rights. Both you and your spouse, if any, should take the time to read this information carefully. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, you, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an associate covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an associate, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-associate dies;

- The parent-associate's hours of employment are reduced;
- The parent-associate's employment ends for any reason other than his or her gross misconduct;
- The parent-associate becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If your employer offers retiree coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired associate covered under the Plan, the retired associate will become a qualified beneficiary with respect to the bankruptcy. The retired associate's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

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 associate, commencement of a proceeding in bankruptcy with respect to the Employer or enrollment of the associate 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 **associate** or covered **dependent (or any representative)** **MUST** notify the Plan Administrator. **The Plan requires the associate or covered dependent (or representative) to notify the Plan Administrator within 60 days after the qualifying event occurs. The notice must be sent to the Plan Administrator at the address listed at the end of this Handbook. The notice must be in writing and must include: (1) the Plan name, (2) the name of the covered associate and each qualified beneficiary impacted by the qualifying event, (3) the type of qualifying event and (4) the date of the qualifying event. If the Plan Administrator is not notified within 60 days after the date of the qualifying event COBRA continuation coverage will not be offered.**

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered associates may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the associate, the associate's enrollment in Medicare benefits (under Part A, Part B, or both), the associate's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, COBRA continuation coverage lasts for up to 18 months. However, if the qualifying event is the associate's termination of employment or reduction in hours of employment and the qualifying event occurs within the 18-month period after the associate becomes enrolled in Medicare, the associate's spouse and dependent children are entitled to COBRA continuation coverage for up to 36 months from the date the associate enrolled in Medicare. There are two additional 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 associate's termination of employment or reduction in hours); (ii) the date of the Social Security Administration determination; and (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 at the end of this Handbook. The notice must**

be in writing and must include: (1) the Plan name, (2) the name of the associate and the disabled qualified beneficiary, if different, (3) the date of the Social Security Administration's determination of disability and (4) a copy of the Social Security Administration's determination of disability. The associate, the qualified beneficiary or any representative on behalf of the associate 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, the spouse and dependent children in your family 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 spouse and any dependent children receiving continuation coverage if the associate or former associate dies, becomes enrolled in Medicare (under Part A, Part B, or both) (and the former associate's enrollment in Medicare Part A and/or Part B would have been a qualifying event if it occurred before the former associate's termination of employment or reduction in hours of employment), 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 spouse or dependent child 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. This notice must be sent to the Plan Administrator at the address listed for the Plan Administrator at the end of this Handbook. The notice must be in writing and must include: (1) the Plan's name, (2) the name of the associate and each qualified beneficiary impacted by the second qualifying event, (3) the nature of the second qualifying event and (4) the date of the second qualifying event. The associate, the qualified beneficiary or any representative on behalf of the associate or the qualified beneficiary can provide the notice.**

Keep Your 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 family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

USERRA CONTINUATION OF 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 above for electing COBRA continuation coverage apply to this election for continuation coverage. Contact the Plan Administrator for additional information about USERRA continuation coverage.

If You Have Questions

If you have questions concerning the Plan or COBRA continuation coverage, please feel free to contact the COBRA Administrator or the Plan Administrator. For more information about your rights under 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 Associate Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Health Expense Coverage

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

The Plan, Aetna, the Employer, and the Plan Administrator assume no responsibility for the outcome of any covered services or supplies. The Plan, Aetna, the Employer and the Plan Administrator make no express or implied warranties concerning the outcome of any covered services or supplies.

Special Comprehensive Medical Expense Coverage

Special Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Handbook.

The Plan Provisions Appendix outlines the payment percentages that apply to the Covered Medical Expenses described below.

HOW ARE MEDICAL BENEFITS PROVIDED?

The Plan provides coverage for most **medically necessary** services, procedures and supplies. Most specific services that are not covered are listed in this Handbook.

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 Plan Provisions Appendix.

HOW WILL YOU BENEFIT FROM CHOOSING A NETWORK PROVIDER?

The Plan has contracted with certain **physician** and **hospital** providers to be the Plan's **Network providers**. The Plan, Aetna, the Employer, and the Plan Administrator do not provide any guarantee concerning the care provided by **Network providers**. Copies of the provider directories can be obtained, at no charge, from the Human Resources / Organization and Talent Effectiveness <http://mybenefits.trinity-health.org>

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 **dependent(s)** choose to receive covered services or supplies from a **Network provider**, the Plan will pay as described in the Plan Provisions Appendix.

If you and your covered **dependents** reside in an area where **Network providers** are not available, the plan will pay benefits at the Non-Network level.

If you or your covered **dependents** need emergency treatment for an accidental bodily **injury** or a **life-threatening medical emergency** outside the Network area at a provider that is not a Trinity Health or **Network provider**, the plan will pay benefits at the Network level. Related ambulance expenses will be paid at the Network level.

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 Trinity Health **Network provider**, the plan will pay benefits at the Network level. Related ambulance expenses will be paid at the Network level.

If a **Network provider** refers you or your covered **dependent** to a **Non-Network provider** and such specialty provider and/or service is not available through a **Network provider**, the plan will pay benefits at the Network level. Any related laboratory tests, x-rays or follow-up visits by the same **Non-Network provider** will be paid at the Network level.

If a **Network provider** refers you or your covered **dependent** to a **Non-Network provider** and such specialty provider and/or service is available through a **Network provider**, the plan will pay benefits at the Non-Network level. Any related laboratory tests, x-rays or follow-up visits by the same **Non-Network provider** will be paid at the Non-Network level.

If you or your covered **dependents** use a Trinity Health or a Network facility for **inpatient/outpatient** services/procedures, but the Trinity Health or a Network facility uses a **Non-Network provider** for anesthesia, the interpretation of laboratory tests and x-rays and other **medically necessary** services, the plan will pay benefits at the Network level.

If you or your covered **dependents** are admitted to a Non-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 will pay benefits at the Non-Network level, unless you are transferred to a Trinity Health or Network facility.

If a covered service or supply (other than Chiropractic services) is not available through a Trinity Health or a **Network provider**, the plan will pay benefits at the Network level. It is your responsibility to investigate the availability of a needed provider.

WHAT IS THE PLAN DEDUCTIBLE?

The plan considers the **network rate** allowance for **medically necessary** services and supplies.

When you enroll as an individual your individual **deductible** will apply, when you enroll as a two person your two-person **deductible** will apply, or when you enroll as a family your family **deductible** will apply. The covered expenses that apply to the individual, two person and the family **deductible** for all family members will accumulate until the appropriate **deductible** is reached, such that any individual within the family can meet the family **deductible**.

When you enroll mid-year your **deductible** will be pro-rated based on your date of enrollment.

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**.

The **deductible** is satisfied on a calendar year basis with expenses from January through December. If a **covered individual** incurs expenses in the last three months of the year (October, November and December), and has not satisfied the **deductible** prior to October, the expenses in the last three months will be carried over and applied to the **deductible** for the next calendar year.

Expenses applied toward the Network **deductible** will be used to satisfy the Non-Network **deductible**. Expenses applied to the Non-Network **deductible** will be used to satisfy the Network **deductible**.

WHAT IS YOUR OUT-OF-POCKET MAXIMUM EXPENSE?

This plan shares with you the expense for certain services. Your co-payment is the balance that you must pay of the covered charge for covered benefits when plan payment is at a percentage other than 100%.

This plan is designed to limit your out-of-pocket. The **out-of-pocket maximum** expense limits are for covered services rendered during each calendar year.

For services rendered during the remainder of the calendar year after a **covered individual** reaches their **out-of-pocket maximum** expense limit, this plan will pay 100% of the **reasonable and customary** charges for subsequent expenses.

Out-of-pocket expenses not included in the **out-of-pocket maximum** expense limit and not eligible for 100% payment even if the **out-of-pocket maximum** expense limit is met is:

- Amounts over the usual, customary, and reasonable charges (UCR)
- Applicable Penalties
- Coinsurance and co-pays for **prescription drugs**
- Co-pays for **inpatient** admissions and emergency room services
- **Outpatient surgery** co-pays
- Coinsurance for services related to Temporomandibular Joint Syndrome
- Coinsurance for infertility drugs

Expenses applied toward the Non-Network **out-of-pocket maximum** will be used to satisfy the Network **out-of-pocket maximum**, and expenses applied to the Network **out-of-pocket maximum** will be applied to the Non-Network **out-of-pocket maximum**

HEALTH MANAGEMENT SERVICES

The services outlined in this section of the Plan 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.

CASE MANAGEMENT

Case management is a service designed to develop a quality plan of care. Aetna **nurses and other clinicians** will partner with you and your **physician** to coordinate your care. They will ensure that you receive high quality, cost-effective care by accessing your condition, evaluating your needs, and monitoring your progress.

If you are diagnosed with a serious **illness** or suffer a serious **injury**, an Aetna **nurse** will review your treatment plan with your **physician**, and will clarify questions that you may have regarding your treatment. You can contact an Aetna **nurse** any time you have a question or concern regarding your treatment. The **nurse** will provide you with information about the treatment and will assist you in evaluating your options.

When the patient chooses to follow the recommendations made through case management, the Plan may, at its discretion, cover additional expenses of alternative care and supplies when recommended by medical case managers.

If the **Plan Administrator** determines through case management that the treatment plan submitted is appropriate, then the Plan participant must follow this plan of treatment in order to receive benefits under this Plan.

PRE-CERTIFICATION OF SERVICES

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 medical identification 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.

Aetna's **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 medical necessity of the **hospital** admission and length of stay against generally accepted medical standards,
- suggests alternative treatment settings, if appropriate, and
- assist with discharge planning.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on medical necessity.

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. You, a family member, or your physician may make the contact.

PERSONAL CARE ACCOUNT (PCA)

The Personal Care Account PPO Plan is a totally new Plan option. The Personal Care Account PPO Plan requires that an individual meet a high **deductible**, and then pays covered expenses at the percentages outlined in your Plan Provisions for Trinity Facility, **Network** and **Non-Network providers** until your annual **out-of-pocket maximum** is met. In order to help you meet your **deductible** and **out-of-pocket maximum**, the Personal Care Account PPO Plan allocates dollar credits to a Personal Care Account (PCA), and you can apply those dollars to any covered expenses, regardless of whether they are incurred by a Trinity Health **Network** or **Non-Network provider**.

When you enroll mid-year your PCA amount will be pro-rated based on your date of enrollment.

The amount of your **deductible**, PCA dollars and annual **out-of-pocket maximum** will vary depending on whether you have single, two person, or family coverage.

You may use the amount credited to your PCA to pay 100% of covered expenses of any covered family member, regardless of whether the provider is Network or Non-Network, until the PCA is exhausted.

You may apply costs from either **Network** or **Non-Network providers** to your PCA, but you will find that you can often stretch your PCA account dollars farther by using **Network providers**.

For many people, the amount in the PCA will be enough to cover annual health care expenses. Any unused remaining balance in your PCA at the end of the year will roll over for you to use in the future.

If, however, your annual health care expenses exceed the amount in your PCA you must meet your remaining annual **deductible** out of your own pocket before the Personal Care Account PPO Plan pays any more covered expenses. After your deductible has been satisfied, covered expenses will be paid at the percentage outlined in your Plan Provisions until your annual **out-of-pocket maximum** is met. After that, covered expenses will be paid at 100% except for services related to **mental disorders**, substance abuse, or Temporomandibular Joint Syndrome, and infertility drugs. These services are not included in the out-of-pocket maximum and will continue to be covered at the percentage outlined in your specific Plan Provisions.

SPECIAL RULES

- If you terminate employment with Trinity Health and elect **COBRA**, those premiums are not payable under the PCA.
- If you terminate employment claims payment under the PCA 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 PCA provided they are filed no later than the plan's filing date.
- If due to a family status change you move from single coverage to family coverage, an increase in the amount of PCA funds available will be pro-rated for the remainder of the calendar year.
- If due to a family status change, you move from family coverage to single coverage, your available PCA funds will not be reduced for the remainder of the **plan year**.
- If, at open enrollment or due to a family status change, you elect to move from the PCA to another plan offered by Trinity Health or another division of Trinity Health, or another division that does not offer a PCA, claims payment under the PCA will continue for expenses incurred during the coverage period, up to the plan filing date.
- Prescription medications will not be subject to the annual **deductible** and **out-of-pocket maximum**. Your **prescription drug** co-pays and out-of-pocket expenses will not be reimbursed by any PCA dollars. Please see the section titled PRESCRIPTION DRUGS for additional information.
- Trinity Health will provide a credit of \$25 each in your PCA when you and/or your covered spouse complete the Health Risk Appraisal on the Health A to Z website. No more than the \$25 per **employee** or spouse will be deposited in a lifetime.

NOTE: To make the best use of your PCA 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 Aetna website <http://www.aetna.com/docfind/custom/trinity/> includes information on your benefits, your PCA, general medical information and other information designed to help you make wise decisions regarding your health care.

MENTAL DISORDERS AND/OR SUBSTANCE ABUSE

All **inpatient** services (including partial hospitalization), intensive **outpatient** services, and **outpatient** psychiatric testing for **mental disorders** and/or substance abuse 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
(800) 544-5108

Benefits available under this Plan for the treatment of **mental disorders** and/or substance abuse are payable as described in Plan Provisions Appendix.

COVERED MEDICAL EXPENSES

The following pages describe more specifically the benefits that are covered under the Plan for particular services.

Benefits are only payable when they are **medically necessary** for a **covered individual** (up to the applicable maximums as defined in the Plan Provisions Appendix).

Plan payment is made according to whether you choose to have services rendered by a Trinity Health facility, **Network** or **Non-Network provider**. For detailed information regarding benefit payment levels, please see the Plan Provisions Appendix.

Covered Medical Expenses are the expenses for certain **hospital** and other medical services and supplies. Covered Medical Expenses must be for the treatment of an injury or disease.

Only charges for **Preferred Care** are included as Covered Medical Expenses.

GENETIC TESTING/SCREENING AND COUNSELING

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

Benefits may be reimbursable by the Personal Care Account (PCA). Please refer to the Plan Provisions 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.

1. **Covered individual** is referred by a **physician** to a **genetic counselor** before testing
2. Informed written consent is obtained before and after testing/screening
3. The test has been proven valid (regulatory agency approval).
4. Factors exist to justify that a **covered individual** is at increased risk.
5. Knowledge of presence or absence of condition would directly affect medical care, where:
 - a. the disease is treatable or preventable
 - b. the test 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/screening is performed:

1. to determine whether a person has a disorder caused by a genetic defect,
2. to determine whether a person is a carrier of a disorder caused by a genetic abnormality,
3. to determine a person's risk of developing a disease,
4. to predict response to therapy,
5. if there is a history of spontaneous abortions,
6. if a **covered individual** gave birth to a child with a **genetic disorder** or chromosomal abnormality,
7. if there is a family history of certain inherited disorders, or the **covered individual** has symptoms of certain inherited disorders and requires a **diagnosis**,
8. for a dependent child if there is an increased risk of developing a childhood malignancy,
9. for an adopted child(ren), 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 screen may be covered for non-covered individuals when BRCA testing is required to assess the need for Prophylactic Mastectomies or Oophorectomies for a **covered Individual**.

All of the following criteria must be met:

- a. the information is needed to adequately assess risk in the **covered individual**;
- b. the information will be used in the immediate care of the **covered individual**;
- c. the non-**covered individual's** plan (if any) will not cover the test (proof required).

NOT COVERED:

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

Genetic testing/screening for any individual who is not an eligible **employee** or **dependent** as defined in the section titled ELIGIBILITY of this Plan

Genetic testing for:

Huntington's Chorea Disease,
Li-Fraumeni syndrome,
Melanoma and melanoma-associated syndromes,
Ataxia Telanglectasia-associated susceptibilities.

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)

HOSPITAL EXPENSES

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **room and board** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

If a private room is used, the daily **room and board charge** will be covered if:

the person's **Preferred Care Provider** requests the private room; and the request is pre-approved by Aetna.

If the above procedures are not met, any part of the daily **room and board charge**, which is more than the Private Room Limit is not covered.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies, which are given to a person who is not confined as a full-time inpatient.

OUTPATIENT SURGICAL EXPENSES

Covered Medical Expenses include charges for outpatient surgical expenses to the extent shown below.

Covered Medical Expenses include charges made:

- in its own behalf by:

a **surgery center**;
the outpatient department of a **hospital**; or
an office based surgical facility of a **physician** or a **dentist**.

- on behalf of a salaried staff **physician** by the outpatient department of a hospital.

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a **hospital**. The procedure must meet these tests:

- 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** or in a hospital or in 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**.

Outpatient Services and Supplies

These are services and supplies furnished by the **surgery center** or by a **hospital** on the day of the procedure.

Limitations

No benefit is paid for charges incurred while the person is confined as a full-time inpatient in a **hospital**.

CONVALESCENT FACILITY EXPENSES

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease 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 Private Room Limit.
- 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.

Limitations to Convalescent Facility Expenses

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

HOME CARE EXPENSES

Home 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 person 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 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R.N.** or **L.P.N.** if the person’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 person 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 person for Home Care Expenses.

As to skilled nursing care:

- Each visiting nurse shift or private duty nursing shift of 4 hours or less counts as one visit;
- Each such shift of over 4 hours but less than 8 hours counts as 2 visits.

As to home health care:

- Each visit by a nurse or therapist is one visit;
- Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Care Expenses

Covered Medical 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; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:
 - for no more than one 4 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 Medical 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.
- 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.

ROUTINE PHYSICAL EXAM EXPENSES

The charges made by your **Primary Care Physician** or a **Preferred Care Provider** for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:

- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a dependent child:

To qualify as a covered physical exam, the **physician's** exam must include at least:

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

For all exams given to your child under age 17, Covered Medical Expenses will not include charges for:

- seven exams in the first 12 months of life;
- three exams in the second 12 months of life;
- three exams in the third 12 months of life; and
- one annual physical examination thereafter.

For all exams given to your child age 18 and over, Covered Medical Expenses will not include charges for more than one exam per calendar year.

For you and your spouse:

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than:

- one exam in per calendar year for a person under age 65; and
- one exam in per calendar year for a person age 65 and over.

Also included, as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam. Included, as part of the exam is a routine Pap smear.

Limitations to Routine 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 disease;
- exams given while the person 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 a **Non-Preferred Care Provider**.

ROUTINE HEARING EXAM EXPENSES

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by:

1. a **physician** certified as an otolaryngologist or otologist; or

3. 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.

Covered Medical Expenses will not include charges for more than one hearing exam in per calendar year.

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease 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 covered;
- any exams given while the person 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 a **Non-Preferred Care Provider**.

HOSPICE CARE EXPENSES

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- hospice facility;
- hospital; or
- convalescent facility;

which are for:

Inpatient Care

- **Room and Board** and other services and supplies furnished to a person 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 Private Room Limit.

Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care

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 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:
 - assessment of the person's:
 - social, emotional, and medical needs; and
 - the home and family situation;

- identification of the community resources which are available to the person; and
- assisting the person to obtain those resources needed to meet the person's 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 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an associate of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant 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 8 hours in any one day; these consist mainly of caring for the person;
 - medical supplies;
 - drugs and medicines prescribed by a **physician**; and
 - psychological and dietary counseling.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care in excess of 60 days per calendar year. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

OUTPATIENT SHORT-TERM REHABILITATION EXPENSE COVERAGE

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is 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;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy, or
- speech therapy.

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

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 person 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 person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from:
 - disease;
 - injury; or
 - congenital defect.
- Special education, including lessons in sign language, to instruct a person 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 Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

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.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

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. Drugs furnished during a **hospital confinement** will be payable as described in the section of this handbook titled HOSPITAL SERVICES AND SUPPLIES.

Prescription drugs purchased in a participating pharmacy are covered by the **prescription drug** benefit administered by Medco Health Solutions, Inc. 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 **co-insurance** shown in the Plan Provisions Appendix. When 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 (to treat long-term or chronic medical conditions) can be obtained by mail through the Medco Health Solutions, Inc. This program allows you to save money by receiving a 90-day supply of medication for a low copayment or co-insurance.

COVERED DRUGS:

The following are covered benefits 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 and Syringes
- OTC Diabetic Test Strips and Lancets
- Retin-A through age 25
- Tazorac cream through age 25
- Zostavax from age 60
- Pediatric Fluoride Vitamins through age 13
- Legend Pediatric Fluoride Vitamin Drops up to a 50-day supply
- Inhalers, Assisted Devices
- Rhogam

TRADITIONAL PRIOR AUTHORIZATION:

- Retin-A/Avita/Altinac (cream only) age 26 and older
- Tazorac cream age 26 and over
- Growth hormones/Growth Hormone Releasing Hormones
- IVRU – Oral Contraceptives (except Emergency Contraceptives) for females only
- 91 day Pre-packaged Oral Contraceptives up to a 91-day supply for females only
- PDST (Preferred Drug Step Therapy) - For a list of drugs that require PDST, contact Medco customer service
- Transdermal and Intravaginal Contraceptives for females only
- Legend Anti-Obesity Preparations
- Erythroid Stimulants
- Myeloid Stimulants
- Platelet Proliferation Stimulants
- MS Agents
- Tysabri
- Interferons
- Xolair
- Provigil

Note: Drugs for cancer therapy and the reasonable cost of administering them are usually covered. The prescription plan 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 jellies, creams, foams, devices, implants or injections
- Emergency Contraceptives
- Retin-A (except cream) age 26 and older
- Non-Sedating Antihistamines/Non-Sedating Antihistamine Combo Products(SPECs: Z2O, Z2Q)
- Zostavax through age 59
- Drug to Treat Impotency
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Allergy Sera
- Biologicals, Immunization agents or Vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the 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 member.

- Medication which is to be taken by or administered to an 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 hospital, 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 smoking cessation drugs

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.

If you or your **dependent** purchases a drug at a pharmacy that does not participate in the Medco Health Solutions, Inc. program, you or your **dependent** must pay for the prescription in full and submit a claim for reimbursement to Medco Health Solutions, Inc. You will be reimbursed the amount that would have been paid to the pharmacy minus the cash co-payment you would have paid at a participating pharmacy. Controlled drugs cannot be purchased through the mail order program.

Your **prescription drug** co-payments are not eligible expenses in this Plan and may not be applied to any **deductible** or **out-of-pocket maximum** expense limits.

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 plan, contact Medco Health Solutions Customer Service at 800-849-9080.

SMOKING CESSATION/NON-SURGICAL WEIGHT LOSS PROGRAMS:

Coverage is provided at 100% up to an annual benefit maximum of \$500 individually for Weight loss non-surgical and Smoking cessation. These benefits are not subject to **deductible** and **out-of-pocket maximums**. The following wellness benefits include as follows:

Covered Medical Expenses include:

- Outpatient counseling
- Outpatient therapy
- Office visits rendered by a licensed physician for the treatment of smoking cessation or weight loss
- Lab services for weight loss, performed during a course of treatment (refer to the section titled Diagnostic Laboratory and X-Ray Services for requirements)
- Services for weight loss, rendered by nationally recognized programs, such as Jenny Craig, Weight Watchers, Nutri-System and LA Weight Loss.

Not covered are:

- Services administered exclusively in a Web-based forum.
- Pharmacotherapy and/or injection expenses associated with smoking cessation or weight loss, unless otherwise covered for an unrelated medical condition.
- Charges for food and/or nutritional supplements, unless included in the initial program fee
- Charges for over-the-counter diet aids and/or smoking cessation aids
- Health clubs, exercise equipment
- Services and/or programs not approved in the United States
- Charges in connection with acupuncture, hypnotism, and/or biofeedback training

Not more than the Smoking Cessation/Weight Loss Programs Maximum in the Plan Provisions Appendix will be paid.

SPINAL DISORDER TREATMENT BENEFIT

Covered Medical 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.

The Chiropractic maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

OTHER MEDICAL EXPENSES

- Charges made by a **physician**.
- Charges for the following:
 - Diagnostic lab work and X-rays.
 - X-ray, radium, and radioactive isotope therapy.
 - 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 Aetna is shown 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 Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.
 - Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

- Artificial limbs and eyes.

Not included are such things as:

- eyeglasses;
- vision aids;
- hearing aids;
- communication aids; and

COMPLEX IMAGING SERVICES

Covered Medical Expenses include charges for Complex Imaging Services received by a covered person on an outpatient basis when performed in:

1. a physician's office
2. a Hospital outpatient department or emergency room; or
3. a Hospital confinement
4. a licensed radiological facility

Complex Imaging Services include:

1. C.A.T. Scans;
2. Magnetic Resonance Imaging (MRIs);
3. Positron Emission Tomography (PET Scans); and
4. any other outpatient diagnostic imaging service costing over \$500.

Deductibles, copayments and other cost sharing features; maximum benefit amounts; and exclusions apply.

NATIONAL MEDICAL EXCELLENCE PROGRAM ® (NME)

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 area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described in the Plan Provisions Appendix. See Plan Provisions Appendix for the Plan Lodging and Travel Expenses Maximums.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or

- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

one year after the day the procedure is performed; and
the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Maximum Benefit.

Limitations

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

WEIGHT MANAGEMENT

The plan provides for services as described below. For plan coverage specifics please refer to the summary of benefits.

COVERED:

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). For purposes of determining these benefits, the Plan will base the determination of morbid obesity on the patient's Body Mass Index (BMI) or overweight status. A BMI greater than 40, or more than 80 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 has one or more of the following co-morbid conditions; severe sleep apnea, Pickwickian syndrome, Congestive heart failure, cardiomyopathy, Insulin dependent diabetes or severe musculoskeletal dysfunction, that are either life threatening or which significantly impair a major life function (e.g. mobility, ability to work, ability to self care). Documentation of the medical treatment of the co-morbid conditions that demonstrates the patient meets these criteria must be provided.

Additionally, the Plan will review 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 patient has been unable to lose weight through non-surgical, conventional measures and whether the 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 patient 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 patient 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 patient.

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

Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of morbid obesity will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.
2. 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.
3. Bariatric Surgical intervention beyond one course of treatment per lifetime.

NOTE: Please refer to the sections titled CONSULTATIONS, LABORATORY/PATHOLOGICAL TESTING, X-RAY AND X-RAY INTERPRETATION and OFFICE VISITS for information regarding coverage for consultations, laboratory/pathological tests, x-rays and office visits related to covered weight management procedures.

NOT COVERED:

Prescription drugs without prior authorization

EXPLANATION OF SOME IMPORTANT PLAN PROVISIONS

INPATIENT FACILITY COPAY

This is the amount of Inpatient Facility Expenses you pay for each **hospital**, each **convalescent facility**, or each **treatment facility** confinement of a person.

The Inpatient Hospital Copay will only be applied once to all **hospital** confinements, regardless of cause, which are separated by less than 90 days.

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Copay

A separate Hospital Emergency Room Copay applies to each visit for emergency room care, by a person to a **hospital's** emergency room, unless the person is admitted to the **hospital** as an inpatient immediately following a visit to a **hospital** emergency room.

Urgent Care Copay

A separate Urgent Care Copay applies to each visit for urgent care by a person to an **Urgent Care Provider** unless the person is admitted to the **hospital** as an inpatient immediately following a visit to an **Urgent Care Provider**.

Lifetime Maximum Benefit

This is the most that will be payable for any person in his or her lifetime.

LIMITATIONS

ROUTINE MAMMOGRAM

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram, for a person age 35 but less than 40.
- One mammogram each calendar year, for a person age 40 or over.
- Also covers one sigmoidoscopy each calendar year, for a person age 40 or over.

ROUTINE SCREENING FOR CANCER

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for:

- One digital rectal exam and a prostate specific antigen (PSA) test each calendar year, for a male age 40 or over; and
- One colorectal cancer screening every 10 years, for persons age 50 or over, for routine screening for cancer.

MOUTH, JAWS AND TEETH

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

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;
 - 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:

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone 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); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical 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.

Except as provided for injury, not included are 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;
- for routine tooth removal (not needing cutting of bone).

Not included are 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;
- for myofunctional therapy; this is:
 - muscle training therapy; or
 - training to correct or control harmful habits.

EMERGENCY ROOM TREATMENT

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

Benefits will be payable at the payment percentage.

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** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

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

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits. If a claim for treatment of an urgent condition is paid at the Non-Preferred level and you believe that it should have been paid at the Preferred level, please contact Members Services at the toll-free number on your I.D. card.

Non-Urgent Care

For benefit coverage reference Plan Provision Appendix for Covered Medical Expenses for charges made by an **Urgent Care Provider** to treat a non-urgent condition.

Non-urgent care 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.

TREATMENT OF ALCOHOLISM, DRUG ABUSE, OR MENTAL DISORDERS

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **residential treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means such as cirrhosis of the liver, delirium tremens, or hepatitis.
- Effective treatment of alcoholism or drug abuse.
- Effective treatment of **mental disorders**.

Residential Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **room and board** in a private room over the Private Room Limit.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Calendar Year Maximum Days applies to the **hospital** and **residential treatment facility** expenses described above.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **residential treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital, residential treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one calendar year.

GENERAL EXCLUSIONS

GENERAL EXCLUSIONS APPLICABLE TO HEALTH EXPENSE COVERAGE

Coverage is not provided for the following charges:

- Those for services and supplies not **medically necessary**, as determined by Aetna in accordance with the terms of the Plan, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational 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 disease or injury involved; or
 - if required by the FDA, approval has not been granted for marketing; or
 - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, 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, investigational, or for research purposes.

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

- the disease can be expected to cause death within one year, in the absence of effective treatment; and
- the care or treatment is effective for that disease or shows promise of being effective for that disease 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 disease.

- 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 person's disease 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 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 person 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.

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 in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. 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 provided in your Plan Provision Appendix.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Plan Provision Appendix.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in-vitro fertilization, fertility drugs (refer to the section titled PRESCRIPTION DRUGS), or embryo transfer procedures.
- GIFT (Gacmete Intrafallopian Transfer). ZIFT
- Charges 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 provided in your Plan Provision Appendix.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease 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.
- **Claims filed later than one year from the date the charge was incurred.**
- Charges incurred by a surrogate mother.
- Termination of pregnancy (abortion).
- Charges incurred as a result of committing an assault, felony or any illegal or criminal activity.
- Services rendered for treatment of any **injury** or **illness** for which benefits are available under Workers' Compensation or Employer Liability Law, and such coverage must be purchased by 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 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:
 - disease; or
 - surgery performed to treat a disease 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, reversal of a sterilization procedure, or abortion.
- 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 **Preferred Care 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.

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 person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Coordination of Benefits - Other Plans Not Including Medicare

Benefits Subject To This Provision: This Coordination of Benefits (“COB”) provision applies to This Plan when an associate or the associate’s covered dependent has medical and/or dental coverage under more than one Plan. “Plan” and “This Plan” are defined herein.

The Order of Benefit Determination Rules below determines which Plan will pay as the Primary Plan. The Primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total **Allowable Expense**.

Definitions. When used in this section, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a **semi-private** room in the **hospital** and the private room (unless the patient’s stay in the private **hospital** room is medically necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of **hospital** private rooms) is not an allowable expense.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense, unless the Secondary Plan’s provider’s contract prohibits any billing in excess of the provider’s agreed upon rates.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the Primary Plan’s payment arrangements shall be the allowable expense for all the Plans.
5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Claim Determination Period means the Calendar Year.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any arrangement providing health care benefits or services, including but not limited to:

- A. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- B. Other prepaid coverage under service plan contracts, or under group or individual practice;
- C. Uninsured arrangements of group or group-type coverage;

- D. Labor-management trustee plans, labor organization plans, employer organization plans, or associate benefit organization plans;
- E. Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- F. Medicare or other tax supported or governmental programs;
- G. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate Plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy Plans. In turn, the dental coverage will be coordinated with other dental Plans.

This Plan is the Medical Benefit Program under component Plan 504 of the Trinity Health Corporation Welfare Benefit Plan.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Order Of Benefit Determination.

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- A. The Primary Plan pays or provides its benefits as if the Secondary Plan or plans did not exist.
- B. A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use:
 - (1) **No Coordination of Benefits.** If a Plan has no coordination of benefits provision, it will always be primary.
 - (2) **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an associate, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired associate); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an associate, member, subscriber or retiree is secondary and the other Plan is primary.
 - (3) **Child Covered Under More Than One Plan.** When a child is covered by more than one Plan:
 - (a) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not legally separated; or

- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

If a dependent is covered by two Plans and the other Plan does not coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the other Plan will determine the Primary and Secondary Plan.

- (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the Plan is given notice of the court decree.
- (c) If the parents are not married, or are legally separated or are divorced, the order of benefits is:
- The Plan of the Custodial Parent;
 - The Plan of the spouse of the Custodial Parent;
 - The Plan of the noncustodial parent; and then
 - The Plan of the spouse of the noncustodial parent.

If the Custodial Parent has remarried, his/her Plan is primary, his/her spouse's Plan is secondary and the Plan of the parent without custody pays last.

- (4) **Active or Inactive Associate.** The Plan that covers a person as an associate, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as an associate who is neither laid off nor retired. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(2).
- (5) **Continuation Coverage.** If a person whose coverage under This Plan is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an associate, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. However This Plan will be primary for expenses incurred in connection with pre-existing condition exclusion under the other Plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (6) A plan covering the child as a **CHIP** participant.
- (7) **Longer or Shorter Length of Coverage.** The Plan that covered the person as an associate, member, subscriber longer is primary.
- (8) **If the preceding rules do not determine the Primary Plan,** the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

Effect On Benefits Of This Plan.

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this plan will:
- (1) Determine its obligation to pay or provide benefits under its contract;
 - (2) Determine whether a benefit reserve has been recorded for the covered person; and
 - (3) Determine whether there are any unpaid Allowable Expenses during that claims determination period.

- B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that plan and other Closed Panel Plans.

Right To Receive And Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under This Plan and other Plans. To the extent consistent with the HIPAA Business Associate Agreement between Aetna and the Trinity Health Corporation Welfare Benefit Plan, Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility Of Payment.

Any payment made under another Plan may include an amount, which should have been paid under This Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

EFFECT OF MEDICARE

The following provisions explain how the benefits under This Plan interact with benefits available under Medicare.

Medicare, when used in this provision, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

A person is "**eligible for Medicare**" if he or she:

- is covered under it by reason of age, disability, or End Stage Renal Disease;
- is not covered under it because of:

having refused it;
having dropped it; or
having failed to make proper request for it.

If a person is eligible for Medicare, This Plan will pay for such benefits as for such person as the Primary Payor or Secondary Payor, as follows:

If your coverage under This Plan is based on your or your spouse’s current employment with the Employer, This Plan will be the Primary Payor:

- (a) if you are eligible for Medicare due to age (i.e., age 65 or over) and This Plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more associates).
- (b) if you are eligible for Medicare due to end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits; 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.
- (c) if you are eligible for Medicare solely due to any disability other than end stage renal disease; but only if This Plan meets the definition of a large group health plan (i.e., generally a plan of an employer with 100 or more associates).

Otherwise, This Plan will cover the benefits as the Secondary Payor. This Plan will pay the difference between the benefits of This Plan and the benefits that Medicare pays, up to 100% of “Plan Expenses.” “Plan Expenses” means any **necessary** and reasonable healthcare expenses, part or all of which are covered under this Plan.

Charges used to satisfy a person's Part B deductible under Medicare will be applied under This Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.

Any rule for coordinating "other plan" benefits with those under This Plan will be applied after This Plan's benefits have been figured under the above rules.

Exclusions

Those charges for non-emergency care or treatment furnished by a covered person's physician under a Private Contract are excluded. A Private Contract is a contract between a Medicare beneficiary and a **physician** who has decided not to provide services through Medicare.

This exclusion applies to services an "opt out" physician has agreed to perform under a Private Contract signed by the covered person. Physicians who have decided not to provide services through Medicare must file an "opt out" affidavit with all carriers who have jurisdiction over claims the physician would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into with a Medicare beneficiary.

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under This Plan and Medicare. To the extent consistent with the HIPAA Business Associate Agreement between Aetna and the Trinity Health Corporation Welfare Benefit Plan, Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

EFFECT OF PRIOR COVERAGE - TRANSFERRED BUSINESS

If the coverage of any person under any part of this Plan replaces any Prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like Prior coverage. Any benefits provided under such Prior coverage may reduce benefits payable under this Plan.

PHYSICAL EXAMINATIONS

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom pre-certification or benefits have been requested. This will be done at reasonable times while pre-certification or a claim for benefits is pending or under review. This will be done at no cost to you.

ADDITIONAL PROVISIONS

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because more than one Employer employs you.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from the Plan Administrator.

Trinity Health and your Employer hope to continue this Plan indefinitely but reserve the right to amend or terminate the Plan at any time and for any reason as to all or any class of associates.

Assignments

Coverage under the Plan may be assigned only with the written consent of Aetna.

SUBROGATION AND RIGHT OF RECOVERY PROVISION

Definitions

As used throughout this section, the term “Responsible Party” means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person’s injury, illness, or condition. The term “Responsible Party” includes the liability insurer of such party or any Insurance Coverage.

For purposes of this provision, the term “Insurance Coverage” refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers’ compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a “Covered Person” includes anyone who is eligible for coverage under the Plan (including eligible associates, spouses and dependent children) and who is actually enrolled for coverage under the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person’s injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

By filing a claim for and/or accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) under this Plan, a Covered Person is deemed to have consented to such subrogation 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 subrogation agreement with the Plan upon the request of the Plan Administrator or Employer. .

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

By filing a claim for and/or accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) under this Plan, a Covered Person is deemed to have consented to such 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.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she 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 the Covered Person’s fiduciary duty to the Plan.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury, or condition for which the Plan paid benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider). The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person’s representative or agent; Responsible Party; Responsible Party’s insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole or to compensate the Covered Person in part, or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of reimbursement provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan's subrogation and reimbursement rights are not limited by the stated purposes of the payment from the Responsible Party or how it is characterized in any agreement, or judgment and is not subject to offset or reduction by reason of any legal fees or other expenses incurred by the Covered Person in securing such recovery. As a result, the Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of coverage under the Plan for the Covered Person or the institution of court proceeding against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The Plan reserves the right to notify a Responsible Party and his, her or its agents of the Plan's lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery 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.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees 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, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

RECOVERY OF OVERPAYMENT

If a benefit payment is made, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the Plan, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

ADJUSTMENT RULE

If, for any reason, a person is entitled to a different amount of coverage under the Plan than the amount that is paid, coverage will be adjusted in accordance with your Employer policy.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised Plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

REPORTING OF CLAIMS

A claim for benefits must be submitted to Aetna in writing. It must give proof of the nature and extent of the expense. Your Employer has claim forms.

All claims for benefits should be reported promptly. The deadline for filing a claim for any benefits is 12 months after the date the expense is incurred.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

PAYMENT OF BENEFITS

Benefits will be paid as soon as administratively practicable following Aetna's determination that the benefits set forth in a claim are eligible for coverage under the Plan.

All benefits covered under the Plan are payable to you. However, this Plan has the right to pay any benefits directly to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

This Plan may pay up to \$1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of each Covered Expense incurred by you, your spouse and your dependent child (ren). They will be required when a claim is made.

Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

LEGAL ACTION

No legal action can be brought to recover any benefit under the Plan after 3 years from the date you have exhausted our internal review procedure.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions, which apply only to a specific benefit, appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Associate

An individual who is a regularly scheduled benefit eligible associate as defined in your Employer's policy.

Behavioral Health Provider

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Room and Board Charges

Charges made by an institution for room and board and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Claims Administrator

Your 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. Your **Claims Administrators** are as follows:

Pre-service claims and post-service claims: (Medical) Aetna, P.O. Box 981107, El Paso, TX 79998-1107, (800) 544-5108

Post-service claims: (Pharmacy) Medco Health Solutions, Inc., P.O. Box 14711, Lexington, KY 45012.

Each **Claims Administrator** shall have final discretionary authority to construe the terms of the plan, for purposes of final claims determinations, for those **pre-** and **post-service claims** listed above for which they are designated as the **Claims Administrator**.

COBRA

Continuation coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Administrator

The organization responsible for administering COBRA continuation.

Aetna
Individual Billing Administration
151 Farmington Ave., MB 52
Hartford, CT 06156-7522
(800) 429-9526

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:

professional nursing care by a **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and

physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

Coverage Effective Date

The date on which the **associate's** and/or his or her **dependent's** eligibility for benefits begins.

Covered Individual

An eligible **associate** or **dependent** who is enrolled in the Plan.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes **room and board** and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Plan, which is given to your Employer for distribution to all associates covered under this Plan. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse 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 organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Effective Treatment of A Mental Disorder

This is a program that:

- is prescribed and supervised by a **physician**; and
- is for a disorder that can be favorably changed.

Emergency Care

This means the treatment given in a **hospital's** 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; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition

This means a recent and severe medical condition, 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; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Genetic Counselor

Health care professional with specialized graduate degrees and experience in medical genetics and counseling. It is the genetic counselor's role to provide information to the individual or family regarding the genetic disorder.

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 abnormally.

Health care professional

A **physician** or other **health care professional** licensed, accredited, or certified to perform specified health services consistent with state law.

Home Health Care Agency

This is an agency that:

- mainly provides skilled 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.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment of a disease or injury.

The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
 - skilled nursing services; and
 - medical social services; and
 - psychological and dietary counseling.
- Provides or arranges for other services which will include:
 - services of a **physician**; and
 - physical and occupational therapy; and
 - 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.
- Has personnel which include at least:
 - one **physician**; and
 - one **R.N.**; and
 - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.

- Utilizes volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
 - a **physician** attending the person; and
 - appropriate personnel of a **Hospice Care Agency**.
- Is designed to provide:
 - palliative and supportive care to **terminally ill** persons; and
 - supportive care to their families.
- Includes:
 - an assessment of the person's medical and social needs; and
 - a description of the care to be given to meet those needs.

Hospice Facility

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of a **R.N.**
- Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

Illness

The condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9).

L.P.N.

This means a licensed practical nurse.

Late Enrollee

This is an associate in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the associate did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible associate or dependent may not be considered a Late Enrollee under certain circumstances. See the Special Enrollment Periods section.

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. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

Morbid Obesity

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or

- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

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 Provider

A facility or practitioner who has a signed, effective contract with Trinity Health.

Non-Preferred Care Provider

A health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Out-of-pocket Maximum

The maximum amount of out-of-pocket expenses you have to pay each calendar year for certain covered medical expenses. The limit varies based on your choice of providers.

Physician

This means a legally qualified physician.

Plan

The Medical Benefit Program under component Plan 504 of the Trinity Health Corporation Welfare Benefit Plan.

Plan Administrator

Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

Plan Year

Begins on January 1 and ends on December 31.

Post-service claim

Any claim for a benefit under this plan that is not a **pre-service claim**. In other words, a claim that is a request for payment under the plan for covered medical services that a **claimant** has already received.

Preferred Care

This is a health care service or supply furnished by:

- A person's **Primary Care Physician** or any other Preferred Care Provider.
- **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care, which is recommended and approved by the BHCC.

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 **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of associates of which you are member.

Prescription Drug

Those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a **physician** or **dentist** and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

Pre-service claim

Any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- **Urgent Care Claim:** A **pre-service claim** may be an urgent care claim if it is for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **claimant**; or jeopardize the ability of the **claimant** to regain maximum function; or in the opinion of a **physician** with knowledge of the **claimant's** medical condition, would subject the **claimant** to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim and the plan conditions receipt of the benefit for the service, in whole or in part, on approval in advance of obtaining medical care.

A **health care professional** with knowledge of the **claimant's** medical condition may determine if a claim is one involving urgent care. If there is no such **health care professional**, an individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, may make the determination.

Primary Care Physician

This is the Preferred Care Provider who is:

- selected by a person from the list of Primary Care Physicians in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician.

R.N.

This means a registered nurse.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- 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
- 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; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the 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.

Referral

When a course of treatment or procedure cannot be performed by a **Preferred Care Provider**, a written **referral** may be made to another provider. An approved written **referral** from a **Preferred Care Provider** must be obtained prior to receiving the services from a **Non-Preferred Care Provider**. Failure to obtain an approved **referral** prior to receiving services will result in no benefits being paid.

Residential Treatment Facility - Alcoholism and Drug Abuse

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 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 RN or Masters-Level Health 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 individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and 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.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **Physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or substance abuse professionals 24 hours per day/7 days a week.

Residential Treatment Facility - Mental Disorders

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health 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 individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and 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.

Semi-private Rate

This is the **charge for room and board**, which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by Aetna in which **Preferred Care Providers** for this Plan are located.

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 CPT.

Terminally Ill

This is a medical prognosis of 6 months or less to live.

Urgent Care Provider

This is:

- A freestanding medical facility which:

Provides unscheduled medical services to treat an urgent condition if the person's **physician** is not reasonably available.

Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

Makes charges.

Is licensed and certified as required by any state or federal law or regulation.

Keeps a medical record on each patient.

Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.

Is run by a staff of **physicians**. At least one **physician** must be on call at all times.

Has a full-time administrator who is a licensed **physician**.

- A **physician's** office, but only one that:

has contracted with Aetna to provide urgent care; and
is, with Aetna's consent, included in the **Directory** as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- does not require the level of care provided in the emergency room of a **hospital**; and
- requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

ADDITIONAL INFORMATION PROVIDED BY

Trinity Health Corporation

The following information is provided to you in accordance with the Associate Retirement Income Security Act of 1974 (ERISA). The Plan Administrator has determined that this information together with the information contained in the Handbook is the Summary Plan Description required by ERISA.

This Summary Plan Description describes the Plan. It does not interpret, extend or change the Plan in any way. The full provisions of the Plan can only be determined precisely by consulting the applicable Plan documents. In the event of any discrepancy between this summary and the actual provisions of the Plan documents, the Plan documents will govern.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan

The Medical Program under component Plan 504 of the Trinity Health Corporation Welfare Benefit Plan

Employer Identification Number:

35-1443425

Plan Number:

504

Type of Plan:

The Plan is a welfare benefit plan providing medical benefits.

Type of Administration:

Benefits under the Plan are self-insured. The following entity is responsible for the day-to-day administration of the Plan, including claims processing:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Trinity Health Corporation
34605 Twelve Mile Road
Farmington Hills, MI 48331

Agent for Service of Legal Process:

Trinity Health Corporation
34605 Twelve Mile Road
Farmington Hills, MI 48331

Plan Year:

January 1 - December 31

Source of Contributions:

Employer and Associate

HIPAA PRIVACY COMPLIANCE

The Plan may have access to certain 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.

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Trinity Health Corporation Welfare Benefit Plan ("Welfare Plan") has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information ("PHI"). You will receive a copy of the 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 Corporation
34605 Twelve Mile Road
Farmington Hills, MI 48331

The Welfare Plan has appointed one or more individuals 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.

ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Associate Retirement Income Security Act of 1974. 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, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Associate Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health 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. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the associate benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of 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 a 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 materials 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 up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- the nearest office of the Associate Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Associate 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 Associate Benefits Security Administration.

Claim Procedures

Your handbook contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

FILING HEALTH CLAIMS UNDER THE PLAN

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (“Aetna”). The notice (also called an “Explanation of Benefits”) will contain: (a) specific reasons for the claim’s denial, (b) specific reference to pertinent Plan provisions, (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, (d) information as to the steps to be taken if you wish to submit an appeal, including the address where the appeal can be sent, (e) any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination, and (f) if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided upon written request at no charge.

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

Urgent Care Claims - within 72 hours after receipt of your claim, unless you do not provide enough information for Aetna to determine what benefits are payable under the Plan. 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 the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Pre-Service Claims - within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of Aetna, 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.

A **pre-service claim** is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. An example of a pre-service claim is pre-authorization for hospital stays.

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 a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's 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 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.

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

Ongoing Course of Treatment – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an adverse benefit determination. Aetna must 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 receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

FILING AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

HEALTH CLAIMS – STANDARD APPEALS

You have the right to file an appeal if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Pre-certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

You or your authorized representative may file an appeal in writing to Aetna. If your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your Identification ("ID") Card. Your request should include the name of your Employer, your name, Plan ID number or other identifying information shown on the front of the Explanation of Benefits, 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.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. If your appeal is received by the appropriate deadline, Aetna will independently review your appeal and any additional information that you submit. The Aetna representative who reviews your appeal will not be the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

You will be notified of Aetna's decision regarding your appeal not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. If your appeal is denied, Aetna will send you a statement containing: (a) specific reasons for the denial, (b) specific references to pertinent Plan provisions, (c) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim, (d) a statement describing any voluntary appeal procedures offered by the Plan, including your right to bring an action in federal court under Section 502(a) of ERISA, (e) any information regarding an internal rule, guideline or protocol used in making the appeal decision, and (f) an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Aetna's Member Services Unit. Aetna's Member Services Unit's telephone number is on your ID Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, 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.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If your second level appeal is denied, Aetna will send you a statement containing: (a) specific reasons for the denial, (b) specific references to pertinent Plan provisions, (c) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim, (d) a statement describing any voluntary appeal procedures offered by the Plan, including your right to bring an action in federal court under Section 502(a) of ERISA, (e) any information regarding an internal rule, guideline or protocol used in making the appeal decision, and (f) an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge.

Exhaustion of Process

You must exhaust the applicable claims procedures, including both levels of appeal, before you establish any:

litigation; or

arbitration; or

administrative proceeding;

regarding any claim for benefits under the Plan .

ADDITIONAL INFORMATION

Retrospective Record Review

Aetna conducts a retrospective review to analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to individuals covered under the Plan includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by a person covered under the Plan upon discharge from an inpatient stay.

Provider Networks

If Plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your Employer, or by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at www.aetna.com.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this Plan, benefits will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about the Plan's coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

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, solely to the extent of its responsibilities specified in the Plan and Service Agreement between the Trinity Health Corporation Welfare Benefit Plan, Trinity Health and Aetna ("Services Agreement"). Trinity Health shall exercise all discretionary authority and control with respect to management of this Plan, which is not specifically granted to the Aetna or another fiduciary.

Trinity Health may delegate certain of its fiduciary responsibilities under the Plan to persons who are not named fiduciaries. 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 execution of the Services Agreement been designated as the named fiduciary with respect to 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 claim determinations. Aetna shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

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 of 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 the Plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

Trinity Health may modify, amend, or terminate the Plan at any time in its sole discretion.

Any such modification, amendment, or termination that affects **covered individuals** will be communicated to them. If the Plan is terminated, benefits will only be paid for claims incurred before the date of termination.

ADMINISTRATION OF THE PLAN

The **Plan Administrator**, Trinity Health, is required to supply you with this Summary Plan Description and to file various reports and documents with government agencies. In its role of administering the Plan, the **Plan Administrator** also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive and review financial information of the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering the Plan.

The **Plan Administrator** shall have any and all powers and authority which shall be proper to enable it to carry out its duties under the Plan, including by way of illustration and not limitation (i) the powers and authority contemplated by ERISA Associatewith respect to associate welfare plans, and (ii) full discretionary authority to make regulations with respect to the Plan not inconsistent with the Plan or ERISA and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The **Plan Administrator** will determine eligibility for benefits under the Plan. The **Plan Administrator** has delegated fiduciary responsibility for claims decisions to Aetna. The Plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code of 1986, as amended, and, where not preempted by federal law, the laws of the state of Michigan.

PLAN FUNDING AND ASSET DISTRIBUTION UPON TERMINATION

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.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

The Associate 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 the Plan for any reason, the individuals covered by this Plan may be liable for those expenses.

The **Claims Administrator**, Aetna, merely processes benefit claims and does not insure that any benefits 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 **Claims Administrator**, Aetna, than as otherwise afforded by law.