SHORT-TERM DISABILITY PLAN

Summary Plan Description

JANUARY 1, 2002

INTRODUCTION

This booklet is a summary plan description of Short Term Disability benefits for Trinity Health as it applies to eligible employees. Short Term Disability (STD) is a partial wage replacement plan designed to assist employees financially while they are disabled. STD is provided to eligible employees of Trinity Health at no cost to them.

The Trinity Health Short Term Disability Plan, herein referred to as the "Plan" is self-funded. The Plan shall assign a Claims Administrator to process claims, but the Claims Administrator or your employer does not insure that any claims for covered individuals will be paid. Complete and proper claims for benefits provided by the Plan will be promptly processed, but in the event there are delays in processing, the covered individual shall have not greater rights to interest or other remedies against the Claims Administrator or your employer than as otherwise afforded them by law.

Coverage under the Plan is not a guarantee of employment.

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MERCY HEALTH SERVICES NORTH
PLAN OUTLINE

Description of Eligible Classes

You are eligible to participate in the Short Term Disability Plan if you are a regularly scheduled employee, and eligible to participate in the benefits program as a full-time employee as defined by your employer.

Amount of Coverage

60% of basic weekly earnings.

Maximum Benefit Period

Twenty-six (26) weeks from the date of disability.

Elimination Period

Seven (7) calendar days or the expiration of sick leave, whichever occurs later.

Minimum Requirement for Active Employment

Sixty-four (64) scheduled hours per week.

Definition of Basic Weekly Earnings

"Basic weekly earnings" means the amount of regular weekly salary or wages paid by your employer. This does not include commissions, bonuses, overtime, incentive pay or any other extra compensation.

Waiting Period

Each eligible employee shall be automatically covered by the Plan the first day of the month following thirty (30) days of active employment. If an employee is not actively at work on the date their coverage would otherwise be effective, they will be eligible for benefits on the first day they return to active work.

Contributions

The cost of this coverage is paid entirely by your employer.

TERMS YOU SHOULD KNOW

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows:

"**Active employment**" means you must be working:

1. for your employer and paid regular earnings;
2. at least the minimum number of hours shown in the plan outline; and either
3. at your employer's usual place of business or
4. at a location to which your employer's business requires you to travel.

"**Basic Weekly Earnings**" - as defined in the Plan Outline.

"**Disability**" and "**disabled**" means that:

X you are completely unable to perform any and every material and substantial duty of your regular occupation due to your sickness or injury. Furthermore, you are not considered disabled or under a disability unless you are under the regular care and treatment of a licensed physician, who is practicing within the scope of his/her license during the entire period of disability.

"**Deductible Sources of Income**" means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

"**Disability Benefits**" means money that is paid as a weekly benefit when your claim for disability benefits has been approved.

"**Disability Earnings**" means the earnings which you receive while you are disabled and working.

"**Elimination Period**" means a period of consecutive days of disability for which no Short Term Disability benefit is payable. The elimination period is shown in the Plan outline and begins on the first day of disability.

"**Employer**" means Trinity Health and includes any division, subsidiary, or affiliated company named in the Plan.

"**Gross Disability Payment**" means the disability benefit amount before deductible sources of income and disability earnings are subtracted.

"**Hospital or Institution**" means an accredited facility licensed to provide care and treatment for the condition causing your disability.

"**Illness**" means sickness, disease or other medical conditions including pregnancy.

"Complications of pregnancy" means that part of pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management.

A complication may exist:
- during the pregnancy;
- during the delivery; or
- after the delivery

"**Injury**" means a bodily injury that is the direct result of an accident and not related to any other cause. The disability resulting from the injury must begin while you are covered under the Plan.

"Material and Substantial Duties" means duties that:

X are normally required for the performance of your regular occupation and
X cannot be reasonably modified or omitted.

"**Physician**" means a person (other than you, your spouse, child, brother, sister, or parent, or the child, brother, sister, or parent of your spouse) who is/has:

X performing tasks that are within the limits of his or her medical license; and
X licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
X with a doctoral degree in Psychology (PH.D. or Psy.D.) whose primary practice is treating patients; or
X a legally qualified medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

"**Regular Care**" means:

X you personally visit a doctor as frequently as is medically required, according to standard medical practice, to effectively manage and treat your disabling condition(s); and
X you are receiving appropriate treatment and care of your disabling condition(s) by a doctor whose specialty or experience is appropriate for your disabling condition(s).

"**Net Weekly Benefit**" means the disability benefit amount after any reduction for other income benefits and earnings (subject to the maximum benefit).

"**Weekly Payment**" means your payment after any sources of income and weekly disability

earnings have been subtracted from your gross disability payment.

"**You**" and "**Your**" means you, the employee.

DISABILITY

When do disability benefits become payable?

The Claims Administrator approves payment of a weekly benefit after the end of the elimination period and only when you and your physician provide proof that you:

1. are "disabled" due to illness or injury, and
2. are under appropriate treatment and care of a physician.

What conditions must be met for benefit payments to continue?

You will be paid a weekly benefit as long as you remain disabled or partially disabled and are under the appropriate treatment and care of a physician. You will not be paid longer than the maximum benefit period shown in the Plan outline.

The Claims Administrator or your employer may require that you be examined by an independent physician specialist. If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not disabled under the definition of the Plan.

You will be required to file a claim with the Claims Administrator or your employer in order to be considered for benefits. You will also be required to give the Claims Administrator or your employer periodic proof that your disability continues. Such proof will be provided at your expense.

How much will I be paid if I am "disabled"?

The following process will be used to figure your payment

1. Multiply your weekly earnings by the amount of coverage shown in the Plan Outline; this amount is your **gross disability payment**.

2. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in item 2 is your **weekly payment**.

After the elimination period, if you are disabled for less than 1 full week, you will receive 1/7th

of your payment for each day of disability.

How much will I be paid if I am "disabled" and working?

If you are unable to return to a normal work schedule, but the condition allows for a reduced work schedule as part of a rehabilitation program, you will continue to receive a weekly benefit. The following process will be used to figure your payment.

1. Subtract your "disability earnings" from your weekly earnings.

2. Divide the answer in item 1 by your weekly earnings. This is your percentage of lost earnings.

3. Multiply your weekly payment as shown above in "(How much will I be paid if I am "disabled"?", by the answer in item 2.

The amount figured in item 3 is your weekly payment.

What are "Deductible Sources of Income"?

The following deductible sources of income will be subtracted from your gross disability payment:

1. Any amount provided under federal maritime law;

2. Any amount you are entitled to, under any group insurance plan of your employer, that provides disability income benefits;

3. Any benefits you are entitled to receive under the provisions of any retirement or pension plan, excluding lump sum distributions, regardless of whether your employer sponsored or maintained the plan.

4. Any benefits you are entitled to receive under No Fault Insurance award or through Third Party Subrogation.

5. Any benefits you or your dependents are eligible to receive because of your disability or age under the United States Social Security Act or similar plan or act. If benefits from these programs are denied for any reason (except your non-insured status), you will be required to appeal the denial to the full extent permitted. You will continue to be considered eligible to receive these benefits until all appeal processes are exhausted.

6. Any benefits you are eligible to receive under any plan or provision providing periodic payments for disability, or providing benefits for loss of time or income, to which your

employer, union, trade, or professional organization directly or indirectly sponsored or contributed;

7. Any benefits payable under any state compulsory benefit act or law.

What if I receive a lump sum payment from these other income sources?

The Claims Administrator or your employer will prorate lump sum income benefits (excluding distributions from any retirement or pension plan) on a weekly basis over the time period for which the sum is given. If no time period is given, the lump sum amount will be prorated over your expected lifetime, as determined by the Claims Administrator or your employer.

When do these benefits stop?

Benefits will stop on the earliest of:

1. The date you are determined to be no longer disabled;

2. The end of the Plan's maximum benefit period;

3. The date of your death.

4. The date when you are able to work in your regular occupation on a part-time basis but you choose not to. Part Time basis means the ability to work and earn between 20% to 80% of your weekly earnings.

5. The date the disability earnings exceed the amount allowable under the plan.

6. The date you fail to submit proof of continuing disability.

7. The date you die.

What happens if my claim is overpaid?

The Claim Administrator or your employer has the right (on behalf of Trinity Health) to recover any overpayments due to:

X fraud:
X any error the Claim Administrator makes in processing a claim; and
X your receipt of deductible sources of income.

You must reimburse the plan in full. The Claim Administrator or your employer will determine the method by which the repayment is to be made. The Claim Administrator or your employer will not recover more money than the amount that was paid to you under the Plan.

What happens if I return to work and become disabled again?

If you are disabled, return to work, and become disabled again due to the same or a related cause, the second disability will be considered a continuation of the first period of disability, as long as you had returned to work for less than two weeks.

If your second disability is unrelated to the first, or if you have returned to work for more than two weeks, the second period of disability will be considered a separate claim and a new Elimination Period must be satisfied before benefits will become payable.

GENERAL EXCLUSIONS

What disabilities aren't covered?

This Plan will not cover any disabilities caused by, contributed to by or resulting from your:

1. intentionally self-inflicted injuries or attempted suicide, while sane or insane;

2. attempt to commit or commission of a crime under state or federal law;

3. commission of a crime for which you have been convicted under state or federal law;

4. war or act of war, unless you are a United States expatriate or on temporary assignment in a war area on employer business, or while you are in the military service of any country which is at war;

5. any injuries sustained while you are on a personal leave of absence, excluding jury duty and vacations (see also "Active employment" in Terms You Should Know, above).

6. a vague or undefinable condition (such as "tiredness" or "pain"), for which your physician cannot provide a medical diagnosis;

7. cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan.

8. Any occupational illness or injury. Occupational illness or injury means a illness or injury that was caused by or aggravated by any employment for pay or profit.

TERMINATION

When does coverage terminate?

You will cease to be covered on the earliest of the following dates:
1. the date your employer discontinues the Plan;
2. the date your employment with the Trinity Health ends;
3. the date you retire under any normal retirement plan of your employer;
4. the date you cease to be an eligible employee;
5. the date of your death.

SOME GENERAL INFORMATION TO KNOW

When must you submit a claim?

You must advise your Human Resource Department of a Medical Leave of Absence if you expect to be absent from work for more than three consecutive days. Upon your notification of an impending Short Term Disability claim, your Benefits Representative will forward a completed Employer's Statement to the Disability Benefits Specialist at the Claims Administrator, who in turn will begin processing your application for benefits. *Your Short Term Disability claim must be filed with the Claims Administrator within 30 days after the date your disability begins.*

The Disability Benefits Specialist will first review the Employer Statement, and then contact you by telephone within three days of receipt of the notice. The Disability Benefits Specialist will answer your questions regarding the claim application process, as well as gather additional information about your claim, including your attending physician's name and telephone number. If you are required to complete a separate claim application, as determined by the Disability Benefits Specialist, you must provide the information in a timely manner to avoid any delays in processing your claim.

Your attending physician will be contacted directly by the Disability Benefits Specialist, and instructed to provide medical documentation and related information. This information must also be provided in a timely manner.

Once the claim has been approved, Short Term Disability benefit payments will be issued directly to you by the Claims Administrator or your employer on a weekly basis. In order to continue to receive a weekly benefit you must provide the Claims Administrator with proof of continued disability and regular treatment by a physician within two weeks of the date the

Claims Administrator requests such proof.

You must notify your Human Resource Department and the Claims Administrator immediately when you return to work in any capacity.

What constitutes proof of claim?

Your proof of claim must show:

X that you are under the ***regular care*** of a ***qualified physician***

- ***regular care*** means that you personally visit a physician as frequently as is medically required, according to standard medical practice, to effectively manage and treat your disabling condition(s); and that you are receiving appropriate treatment and care of your disabling condition(s) by a physician whose specialty or experience is appropriate for your disabling condition(s).

X current medical evidence;
X the appropriate documentation of your weekly earnings;
X the date your disability began;
X the cause of your disability;
X the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
X the name and address of any ***hospital or institution*** where you received treatment, including all attending physicians.

In some cases, the Claims Administrator may require additional medical evidence in support of your claim. Such evidence may consist of records from your physician, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the appropriate care and treatment of a physician. In the absence of such proof, the Claims Administrator or your employer may elect to suspend benefits until such proof is received.

If your physician cannot substantiate your disability by objective findings, you may be required to see a physician selected by the Claims Administrator for an independent evaluation. Failure to cooperate with such requests may result in an interruption in benefits.

When are claims paid?

When the Claims Administrator receives satisfactory proof of claim, and your claim for disability benefits is approved, benefits payable under the Plan will be paid weekly or in accordance with your normal payroll schedule during any period that you remain disabled under the terms of the Plan.

To whom are benefits paid?

All benefits are payable to you. However, if benefits are payable to your estate or if you are not competent, the plan administrator has the right to pay up to $1,000 to any of your relatives whom the plan administrator considers entitled. If benefits are paid in good faith to a relative, the administrator will not be obligated to pay such benefits again.

SUBROGATION

Subrogation means that the Plan has the same rights as you to recover benefits for time you have lost from work for which another person, organization, or plan is legally liable. To the extent that the Plan provides benefits in that situation, the Plan is subrogated to the amount of benefits provided.

You or your representative will execute and deliver to the Plan any instruments and documents and undertake all actions necessary to enable the Plan to exercise the right of subrogation.

If a suit brought by the Plan on your behalf results in a monetary award in excess of the benefits provided by the Plan, the Plan shall have the right to recover its legal fees and expenses out of the excess.

At its election, the Plan shall have a lien, or the right to recover, any sums you receive from a person, organization, or plan, including reimbursement, settlement, judgment, or compromise, for benefits which have been provided by the Plan.

You shall not compromise or settle a claim or take any action which would prejudice the rights and interest of the Plan Sponsor pursuant to this section without the prior written consent of the Plan.

When benefits have been rendered by the Plan and responsibility for payment is with another plan or person, the Plan has the right to recover the cash value of the benefits. You shall cooperate in those efforts.

PLAN TERMINATION, MODIFICATION OR AMENDMENT

The Plan Administrator reserves the right to terminate, modify or amend the Plan at any time (with respect to Employees and/or Retirees). Upon termination, modification or amendment, the right of covered individuals to benefits are limited to claims incurred and filed prior to the date of termination, modification or amendment. Any termination, modification or amendment which could affect covered individuals of the Plan will be communicated to the covered individuals.

YOUR RIGHTS UNDER ERISA

1. As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

   ERISA provides that all plan participants shall be entitled to:

   A. Examine, without charge, at the Plan Administrator's office, and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

   B. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for such copies.

   C. 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 report.

2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the disability Plan.

3. The people who operate the Plan, who are called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

4. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

5. If your claim for benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 per day until you receive the materials, unless the materials were not sent due to circumstances beyond the Administrator's control.

7. 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, after filing the appeal process outlined below. 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 these costs and fees. If you lose the suit, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

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

9. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed on page 12, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Disability Claim Determinations

The claims administrator will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if it is determined that such an extension is necessary due to matters beyond the control of the Plan and notify you of the circumstances requiring the extension of time and the date by which we expect to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the claims administrator may make a determination on your claim without that information.

If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the Plan will
(a) state the specific reason(s)for determination;
(b) reference specific Plan provision(s)on which the determination is based;
(c) describe additional material or information necessary to complete the claim and why such information is necessary;
(d) describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and
(e) disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).
Notice of the determination may be provided in written or electronic form. Electronic notices

will be provided in a form that complies with any applicable legal requirements.

Claim Appeal Procedure

You have 180 days from the receipt of Notice of an adverse benefit determination to file an appeal.

Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the claims administrator determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). The claims administrator will notify you in writing if an additional 45 day extension is needed. If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you provided that information. If you fail to deliver the requested information within the time specified, the claims administrator may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. The review will be conducted by the claims administrator and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker 's subordinate. In the case of a claim denied on the grounds of a medical judgment, the claims administrator will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, the claims administrator will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:
(a) the specific reason(s)for the appeal determination;
(b) a reference to the specific Plan provision(s)on which the determination is based;
(c) a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
(d) a statement describing your right to bring a civil suit under federal law;
(e) a statement that you are entitled to receive upon request, and without charge, reasonable

access to or copies of all documents, records or other information relevant to the determination; and
(f) a statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

PLAN ADMINISTRATION INFORMATION

Name of Plan:
Trinity Health Short-Term Disability Plan

Name and Address of Employer:
Trinity Health
34605 Twelve Mile Road
Farmington Hills, MI 48331

Employer Identification Number:
35-1443425

Who Pays for the Plan:
The cost of this Plan is paid entirely by your employer.

Type of Plan: Welfare

Plan Number:
581

Plan Year: The year ends on each June 30

Plan Administrator:
Trinity Health
34605 Twelve Mile Road
Farmington Hills, MI 48331
(248) 489-6736

Claims Administrator:
UNUMProvident Corporation
Glendale Customer Care Center
655 N. Central Avenue #800
Glendale, CA 91203
1-800-424-2008

Agent for Service of Legal Process:
Plan Administrator as stated above.

Department of Labor:
SPD
Office of Reporting and Disclosure
Pension & Welfare Benefit Programs
U.S. Department of Labor
Washington, D.C. 20216

The Plan's benefits are self-insured. Claim payments are made by the Claim Administrator or your employer. If the plan should terminate, there are no specific assets set aside which will be used for any purpose other than for payment of claims incurred prior to the date of such termination.