



FLEXIBLE SPENDING ACCOUNT PROGRAM

SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

Highlights	3
Types of Accounts	3
Eligibility and Participation	3
How the Program Works	4
The Before-Tax Advantage -- An Example.....	5
Costs	5
The Health Care Account	5
The Dependent Care Account.....	6
Deciding Your Contribution Amount	7
The Federal Dependent Care Tax Credit.....	7
Changes in Status	7
Use It or Lose It.....	8
Claim Procedures.....	8
Your Choice.....	9
Administrative Information	10
Notice of an Adverse Benefit Determination	10
Appeals	10
Employee Rights and Protections (ERISA).....	11
State of Michigan Notification Requirement.....	12
Loss of Benefits.....	12
COBRA Continuation of Benefits.....	12
Plan Termination, Modification, or Amendment	14
Plan Administrative Information.....	15
Health Care Account Reimbursable Items.....	16
Dependent Care Tax Savings	17

HIGHLIGHTS

A flexible spending account (FSA) provides important tax advantages that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income. Cash that you now spend on health care (e.g., deductibles, copayments, the employee portion of medical and dental coverage, and expenses not covered under the health plan) and dependent care (e.g., child care, nanny, and elder care services) may be deducted from your paycheck and placed in your designated FSAs.

TYPES OF ACCOUNTS

You have the option of establishing two types of accounts. The accounts are separate; therefore, money placed in one account cannot be transferred to another account.

- ✓ **Health Care Account** - You can pay for certain medical, dental, and vision services and supplies not covered under your medical or dental plan, or if applicable, the services not covered by your spouse's health plan on a tax-free basis.
- ✓ **Dependent Care Account** - Pays dependent and childcare expenses on a tax-free basis.

An additional pre-tax feature, referred to as the **"Premium Account"** in this summary, provides that employee contributions for medical and dental coverage are automatically deducted from your pay before taxes are withheld. This applies when you elect to participate in the medical and/or dental plan and authorize the appropriate deduction from your pay.

ELIGIBILITY AND PARTICIPATION

You are eligible to participate in the plan provided you meet the employment requirements defined by your Trinity Health Ministry Organization (MO). Coverage will become effective after you satisfy the waiting period as defined by your Trinity Health MO.

Below is a list of dependents who are eligible for coverage under the plan. Upon enrollment in the plan, you will have 31 days to provide documentation to verify the eligibility of each of your covered dependents. 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 coverage for your covered dependents.

You do not have to be covered under the medical or dental plan to enroll in a Health Care or Dependent Care Flexible Spending Account; participation in either program is strictly voluntary.

Please note: If you and your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded) are employed with any Trinity Health MO in a benefits-eligible position, you may either carry individual coverage as employees 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 employee and a dependent under any Trinity Health plan. In addition, if both you and your spouse are covered as employees under a Trinity Health plan, only one of you may cover dependent children.

Dependent Spouse

A dependent spouse is eligible for coverage under the plan provided they meet of the following criteria:

- The person is legally married to you. Legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded.
- The person is not otherwise covered under any Trinity Health plan.

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 age 19, provided they meet all of the following criteria:

- They are unmarried.
- They are the natural, legally adopted or court appointed dependent child of either you and/or your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded).
- They are not otherwise covered under any Trinity Health plan.

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

- They meet the IRS definition of a Qualifying Child (does not include qualified child(ren) who are not otherwise covered as described above). A Qualifying Child is one who:
 - Is enrolled as a full-time student at least five months of the year.
 - Has the same principal residence as the **employee** for more than half of the tax year (exceptions apply in certain cases, such as divorce / separation situations, college attendance, etc.), and
 - Is receiving more than one-half of his / her support from you or your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded).

Please note: Dependent children at or over age 13 are not eligible to participate in the Dependent Care Spending Account program unless they are a disabled dependent claimed by you or your spouse for federal income tax purposes.

Dependent children who are legally disabled are eligible for coverage beyond age 24, provided they *also* meet all of the following criteria:

- They are enrolled in a creditable plan prior their 19th or 24th birthday, and
- They are deemed legally disabled by mental or physical incapacity prior to their 19th or 24th birthday.

Who Is Not Eligible For Coverage

- Your common law spouse;
- Your legal spouse and/or dependent child(ren) if covered under any Trinity Health plan as an employee or dependent;
- 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
- Any individual who does not meet the definition of an employee or dependent as described in the section of the Summary Plan Description titled WHO IS ELIGIBLE FOR COVERAGE.

HOW THE PROGRAM WORKS

The Flexible Spending Account Program enables you to pay your share of uncovered medical, dental, and vision expenses, as well as dependent care expenses with before-tax dollars. You contribute a portion of your salary to a spending account on a pre-tax basis to reimburse yourself for eligible health care and dependent care expenses. That means, the money you contribute to these accounts to pay for expenses is deducted from your pay **before** federal, state or local income and Social Security taxes are withheld. As a result, your taxable income -- that is, the amount on which you pay taxes -- is reduced, and you pay less in taxes. After you have paid for an eligible expense, you submit a request for reimbursement from your health care or dependent care account. The reimbursement is made to you on a tax-free basis. Specific procedures for reimbursement are explained later in this summary plan description.

Your employer might offer to you a credit if you decide not to elect coverage in the employer sponsored medical plan. You can use this credit to participate in either the Health Care or Dependent Care Spending Account programs. If you elect to receive these credits as cash back each pay period, the amount you receive is considered taxable.

THE BEFORE-TAX ADVANTAGE -- AN EXAMPLE

The amount you save in taxes by participating in a flexible spending account depends on several factors, such as the amount you set aside in each account and your tax bracket. The following example demonstrates the tax savings for an employee required to make premium contributions and who participates in both spending accounts.

	With Spending Accounts	Without Spending Accounts
Gross Income	\$25,000	\$25,000
Dependent Care Account	- 1,000	0
Health Care Account	- 400	0
Premium Account	- <u>1,075</u>	<u>0</u>
Taxable Income	\$22,525	\$25,000
Less:		
FICA (7.65%)	- 1,723	- 1,913
Federal Income Taxes (15%)	- <u>3,379</u>	- <u>3,750</u>
Net Income	\$17,423	\$19,337
Dependent Care Expenses	0	- 1,000
Health Care Expenses	0	- 400
Insurance Premium	<u>0</u>	- <u>1,075</u>
Spendable Income	\$17,423	\$16,862
Increase in Spendable Income	\$561	

NOTE: This example assumes the employee is married, files income taxes jointly and has one dependent. This example does not include the State income tax savings through the Flexible Spending Accounts. State taxes should be included in your individual comparison.

COSTS

The employee contribution amount each pay period will depend on how much money you choose to contribute on a yearly basis. The employee, however, determines participation in a Health Care Account and Dependent Care Account. Your employer assumes all administrative costs for the plans.

THE HEALTH CARE ACCOUNT

THE PREMIUM ACCOUNT - Employees who elect to participate in the medical or dental benefit plans may be required to share in the cost through premium contributions. The completion of your enrollment process serves as authorization for your employer to deduct your share of medical or dental premium contributions from each pay before federal, state, local and Social Security taxes are withheld.

HEALTH CARE EXPENSE ACCOUNT - You can contribute any dollar amount up to the maximum (as defined by your Member Organization) per year, to the Health Care Expense Account. You receive reimbursement for eligible expenses not covered under your benefit plan. Eligible expenses are those, which the IRS and Trinity Health consider legitimate, tax-deductible health care items including, but not limited to, orthodontia, physical exams, certain over-the-counter drugs, durable medical equipment, eyeglasses, or mental health care. However, expenses related to abortion, infertility procedures, and voluntary sterilization are specifically excluded for reimbursement under the Health Care Account. In addition, you can use the account to receive reimbursement for deductibles and copayments required under your medical or dental plans.

A more detailed list of reimbursable items can be found at the back of this document. Please note that you cannot receive reimbursement for the same expense for which you take a deduction on your federal income taxes, so you will need to choose between taking the tax deduction or participating in the health care spending account.

January 1, 2006 Enhancement - 2 1/2 Month Extension on Claims

Effective January 1, 2006 contributions made to the HCSA will be eligible for reimbursement on services incurred from January 1 through March 15. The claim submission deadline will continue to be March 31st. This 2-½ month extension is allowed under new IRS guidelines. It does not apply to contributions made in 2005.

THE DEPENDENT CARE ACCOUNT

The Dependent Care Account allows you to reimburse yourself after you have paid an individual or child/dependent care center to take care of a dependent so that you or your spouse can work or attend school full time. To participate in the Dependent Care Account, you must either be single, or if you're married, your spouse must work or be a full-time student. Your dependent must be:

- a child who is under age 13 or a disabled child of any age and is claimed as a dependent by you or your spouse for federal income tax purposes.
- an IRS recognized dependent such as a spouse or parent who regularly resides at least 8 hours a day in your home.

The types of care are eligible for reimbursement through a Dependent Care Account include:

- care provided in your home or someone else's home. Under this arrangement, you must submit the care provider's Social Security number when you request reimbursement.

Care provided in a licensed dependent care facility such as a day care center or nursery. In this case, you must submit the care provider's taxpayer identification number when you request reimbursement.

- Housekeeping services provided in your home that include dependent care. In this case, you must submit the provider's Social Security number when you request reimbursement.
- Food and education provided as part of preschool care services.

You cannot use your Dependent Care account to reimburse payments for childcare services provided by:

- someone you claim as a dependent for federal income tax purposes.
- one of your children who is under age 19.
- your spouse.
- a non-spouse parent of the child.

DECIDING YOUR CONTRIBUTION AMOUNT - The annual maximum amount you can contribute to the Dependent Care Account under IRS guidelines depends on your federal tax filing status:

- If you are single and file under single or head of household status, the maximum contribution is \$5,000 per year,
- If you are married and file a joint tax return, the maximum contribution is \$5,000 per year,
- If you are married and file a single tax return, the maximum contribution is \$2,500. This means that, together you and your spouse can contribute a maximum of \$5,000 per year.

NOTE: If either the employee or spouse earns less than \$5,000, the tax-free maximum is the lesser earnings.

If you and your spouse both work for Trinity Health and file a joint return, you have the option of deciding how to split the \$5,000 contribution between your two paychecks.

NOTE: The IRS requires that on an annual basis the Dependent Care Spending Account satisfy the requirements of Section 129 nondiscrimination testing. If it is determined that the plan has not met the requirements of the Section 129 testing, elections of highly compensated participants will be adjusted to satisfy the requirements.

THE FEDERAL DEPENDENT CARE TAX CREDIT

The Internal Revenue Service (IRS) also provides a tax credit on your dependent care expenses. You can either use the Dependent Care Account or the tax credit, but you cannot use both for the same expense. Also, whatever you contribute to the Dependent Care Account reduces dollar for dollar the amount of your dependent care expenses eligible for the Federal Dependent Care Tax Credit. You should decide which alternative is best for you. Calculate your tax break under the Federal tax credit and under the Dependent Care Account using the tax comparison chart. Then, select the method that saves you the most in taxes. Keep in mind however, that the tax comparison table does not take into account other income and/or additional deductions.

CHANGES IN STATUS

Under IRS guidelines, an election to participate in a flexible spending account cannot be changed until an annual enrollment period. However, you can change your deductions if you have a qualified change in your family status. The change you request must be consistent with the change in your family status. For example, if you gain a dependent through marriage, birth or adoption, you may want to increase your health care reimbursement account. You must complete your new election within 31 days of a change in family status. If you are currently a participant in the Health Care Account, you may not reduce your contribution below the amount of claims reimbursed up to the point of your new election. Qualified family status changes include:

- marriage;
- divorce;
- birth or adoption of a child;
- death of a covered dependent;
- termination of your spouse's employment and/or loss of medical coverage;
- a change in your status from full-time to part-time or part-time to full-time;
- taking a paid or unpaid leave of absence that qualifies as family or medical leave under the Family and Medical Leave Act (FMLA); or
- for health care coverage, a significant change to the health care coverage provided by the employer of the employee's spouse that affects the coverage provided to the employee or the employee's spouse.

You have an opportunity to change your contribution amount, elect to participate, or drop out of any account for the next plan year during the annual enrollment period.

USE IT OR LOSE IT

The Health Care and Dependent Care accounts are regulated by IRS guidelines. These guidelines require that money directed into the account(s) during a plan year may be used only for health care and dependent care expenses incurred during that plan year. That means you forfeit any money remaining in these accounts after being reimbursed for all eligible expenses for that plan year.

There is a three-month grace period following the end of the plan year in which to submit claims for eligible expenses incurred during the plan year (all claims must be received by March 31st). If you terminate your employment during the plan year, you may only be reimbursed for expenses incurred while you were employed, unless you elect to extend your coverage under the health care spending account through COBRA. You may submit eligible expenses for reimbursement until the end of the three-month grace period.

January 1, 2006 Enhancement - 2 1/2 Month Extension on Health Care Expense Account Claims

Effective January 1, 2006 contributions made to the HCSA in any plan year may be used to reimburse participants for services incurred from January 1 of that plan year through March 15 of the following plan year (a total of fourteen and one-half months). The claim submission deadline will continue to be March 31st.

While the Premium Account is also covered under these same IRS guidelines, the exact amount for medical or dental premiums is deducted from your pay, and you will not forfeit any money.

CLAIM PROCEDURES

You must complete a reimbursement request form and submit it to the claims administrator (either Aetna or your Human Resources Department) in order to receive reimbursement under the Flexible Spending Account.

Health Care Expense Account - You can request a reimbursement equal to the full amount of your annual contribution election. No additional payments will be issued once you have used up your annual HCRA contribution amount. You must also supply documentation, such as an Explanation of Benefits (EOB), to show which charges have been denied, excluded, or applied as deductible or co-payments under a health plan. If you are enrolled in an Aetna administered medical plan and an Aetna flexible spending account program, unpaid medical expenses can be automatically submitted to your health care reimbursement account. You must complete an authorization form in order to initiate these automatic claims submissions. Please see your Human Resources Representative for more information. If eligible expenses are not covered by a health plan, you must submit itemized bills, statements, or receipts along with your claim form. Information shown on the receipt must include the date of service, the type of service, and the amount charged for the service. If you are on a monthly payment schedule you must submit claims on a monthly basis. You will not be reimbursed for expenses on a lump sum amount unless the payment for service was made in full. If you terminate coverage under the plan you will only be reimbursed for expenses incurred during the time frame in which you were covered. You can be reimbursed only for expenses incurred during the same year you put money into your Health Care Spending Account. You are required to submit claims by March 31st of the following year for dates of service from January 1st (current plan year) – March 15th (following plan year).

Improper Payment Procedures

Trinity Health has adopted the following correction procedures with respect to payments that are identified as ineligible for reimbursement under the FSA and/or HRA programs.

- 1) Upon identifying an improper payment, Trinity Health will require the employee to pay the plan an amount equal to the improper payment.
- 2) Where this proves unsuccessful, Trinity Health will have the amount of the improper payment withheld from the employee's wages or other compensation to the extent consistent with applicable law.

- 3) If the improper payment still remains outstanding, Trinity Health will utilize a claims substitution or offset approach to resolve improper claims. For example, if Employee A has received an improper reimbursement of \$200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement will be made until the improper payment is fully recouped.
- 4) In addition to the above, Trinity Health will take other actions as needed, to ensure that further violations of the terms of the card do not occur, including denial of access to the card until the indebtedness is repaid by the employee.
- 5) If these correction efforts prove unsuccessful, or are otherwise unavailable, and the employee remains indebted to Trinity Health for the amount of the improper payment. In that event and consistent with its business practices, Trinity Health will treat the payment as it would any other business indebtedness.

Dependent Care Account - You can request reimbursement up to the amount that has been contributed and currently resides in your account. You must submit a claim form and appropriate documentation in order to receive payment from the Dependent Care Account. Examples of acceptable documentation include a receipt from a licensed day care center showing dates of service and the amount charged, a cancelled check showing the dates of service and the name of your dependent care provider. Dependent care reimbursement check will always be made payable to you.

You can only be reimbursed for expenses incurred during the same year you put money into your Dependent Care Account. You are required to submit claims by March 31st of the following year for expenses incurred from January 1st through December 31st of the current plan year.

YOUR CHOICE

Keep in mind that although participating in a flexible spending account can result in reduced Social Security benefits when you retire, the actual effect on your benefit is usually minimal, typically less than 1%. For income purposes, the spending accounts do not affect your other pay-related benefits. All benefits will continue to be calculated on your full base pay. However, amounts contributed to these accounts may affect your Tax Sheltered Annuity exclusion allowance maximum.

ADMINISTRATIVE INFORMATION

The following procedures apply to your Flexible Spending Account Program.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

The Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse benefit determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion which was relied on will be provided free of charge to the claimant upon request.
7. If the adverse benefit determination is based on medical necessity or experimental or investigational treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge to the claimant upon request.

APPEALS

If a claimant receives an adverse benefit determination, the claimant may appeal the decision within 180 days of date of the adverse benefit determination. The claimant may submit written comments, documents, records, and other information relating to the claim. Appeals may be filed with the Claims Administrator. If the claimant requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual employed by the Claims Administrator who is neither the individual who made the adverse benefit determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator shall consult with a Health Care Professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a review on appeal will be identified.

YOUR RIGHTS UNDER ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit 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 Claims Administrator review and reconsider your claim. 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 31 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, or bring a civil action under section 502A of ERISA. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the 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.

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, you should contact the nearest office of Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

Under Michigan law, the Plan Supervisor is required to make the following disclosure:

The Trinity Health, Inc. Employee Medical Benefit Plan as Amended and Restated Effective January 1, 2004, is a self-funded plan. Covered individuals in this plan are not insured. In the event this plan does not ultimately pay expenses that are eligible for payment under this plan for any reason, the individuals covered by this plan may be liable for those expenses.

The Claims Administrator, merely processes claims and does not insure that any expenses of individuals covered by this plan will be paid.

Complete and proper claims for benefits made by covered individuals will be promptly processed. In the event of a delay in processing, the covered individual shall have no greater right or interest or other remedy against the Plan Supervisor, than as otherwise afforded by law.

LOSS OF BENEFITS

Under certain circumstances, you may lose your entitlement to your flexible spending account benefits as outlined below:

- The plan is terminated;
- The plan is modified to eliminate benefits for the class of employees to which you belong.
- You terminate your employment. No additional pre-tax contributions can be made to the plan. You can continue to submit claims incurred while you were a participant until the end of the grace period for the plan year in which you terminate.

COBRA - CONTINUATION OF BENEFITS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended requires that employers of 20 or more employees, continue to provide employees and certain family members, the opportunity to continue coverage under the medical and/or dental plans, in certain instances where coverage under the group health plan would otherwise be terminated.

Continuation coverage for your *health care spending account* is available through the end of the current plan year only if the unused amount available in your account exceeds the amount of the contribution amount required under COBRA and if your coverage or a covered dependent's coverage would otherwise end because:

- your employment ends for any reason other than your gross misconduct.
- your hours of work are reduced so that you are no longer an eligible employee.
- you are divorced or legally separated.
- you die.
- your child is no longer eligible to be a covered dependent (for example, because he or she reaches the limited age).

HOW TO CONTINUE COVERAGE - If your coverage would end because of divorce or legal separation, or because your child is no longer eligible to be a dependent, you or your covered dependent must notify the Human Resources Department. If the Human Resources Department is not notified within 60 days after coverage would otherwise end, coverage cannot be continued.

When the Human Resources Department receives this notice (or when your employment ends, your hours of work are reduced so you are no longer an eligible employee, or your death), you and your covered dependents will be notified about your/their right to continue coverage. If you or a covered dependent want to continue coverage, you, he or she must elect to do so within 60 days of the date the notice was received. (You and each of your covered dependents can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be considered to be an election by all covered individuals, unless another covered individual rejects coverage.)

Continuation coverage is identical to the coverage provided to similarly situated active employees and their family members. If coverage for similarly situated active employees and their family members is modified, your continuation coverage will also be modified in the same manner. You will be notified of any such change in advance.

PREMIUMS - Continuation of coverage is at your expense, the monthly costs of this continued coverage will be included in the notice sent to you.

For coverage to continue, the Cobra Administrator must receive the first premium in full, within 45 days after continuation of coverage is elected. Premiums for every subsequent month of coverage must be paid in full each month, on or before the premium due date stated in the notice sent to you.

There is a 30-day grace period for the monthly premium. If it is not paid within 30 days after the due date, continuation of coverage will end as of the first day of that period of coverage and cannot be reinstated.

LENGTH OF COVERAGE - If coverage would otherwise end because your employment ends or your hours are reduced so you are no longer an eligible employee, continuation of coverage for you and/or your covered dependents may continue until the earliest of the following:

- the end of the current Plan year
- the date on which a premium payment was due but not paid.
- the date a covered person becomes covered by another group health plan, which does not contain a pre-existing condition limitation affecting eligibility for coverage.
- the date a covered person becomes entitled to Medicare.
- the date Trinity Health terminates its group health plan.

If coverage would otherwise end for a covered dependent (spouse or child) because of divorce, legal separation, death or a child's loss of dependency status, continuation of coverage may continue until the earliest of the following:

- the end of the current Plan Year
- the date on which a premium payment was due but not paid.
- the date a covered person becomes covered by another group health plan, which does not contain a pre-existing condition limitation affecting eligibility for coverage.
- the date Trinity Health terminates its group health plan.

UNPAID LEAVES OF ABSENCE – You can maintain coverage while on an unpaid leave of absence, such as leaves under the Family and Medical Leave Act of 1993 (“FMLA”) or the Uniformed Services Employment and Reemployment Rights of Act of 1994 (“USERRA”). To do this, you must:

- continue to have an employment relationship with your employer;
- remain eligible to participate in an employer-sponsored health plan; and
- make the required contributions described below.

If you are on an unpaid leave of absence, you shall be entitled to continue to participate in the Plan in either of the following manners or any other manner that is part of a leave policy of your employer and does not violate the FMLA or USERRA:

Pre-Pay – Before the unpaid leave begins, you may pre-pay on a pre-tax basis your required contributions for the duration of the leave or until the end of the Plan Year, whichever is earlier. If the leave extends beyond the Plan Year, the participant may continue to make his or her required contributions on an after-tax basis. In no event, however, may you pre-pay any contributions due for the following Plan Year. If the leave extends beyond the end of the Plan Year, you shall be entitled to re-enroll in the Plan. If you elect to continue participation, you will need to pay any required contributions due for the following Plan Year on an after-tax basis under the pay as you go option set forth below.

Pay-As-You-Go – You may also elect to pay your required contributions during the unpaid leave of absence on an after-tax, pay as you go basis. Under this option, you will need to remit the required contributions on or before each pay period for which the contributions would have been deducted from your paycheck if you were not on a leave of absence, provided that any delinquent payments shall be paid within 30 days of their due date.

SPECIAL RULES IN CASE OF BANKRUPTCY - If you have plan coverage as a retiree from a participating company and if that participating company substantially eliminates the coverage you or your covered dependents would otherwise have within one year before or after the date the participating company begins a bankruptcy proceeding, you and/or your covered dependents also have the right to continue coverage in the plan, at your expense. The procedure for continuing coverage and your cost is the same as stated above. Coverage will continue until the earliest of the following:

- the end of the current Plan Year.
- the date on which a premium payment was due but not paid.
- the date a covered person becomes covered by another employer's group health plan.
- the date a covered person dies.
- the date coverage is permitted to end under ERISA or the Internal Revenue Code.

PLAN TERMINATION, MODIFICATION OR AMENDMENT

The Plan Administrator may terminate, modify or amend the Plan at any time (with respect to Employees and/or Retirees). Whenever there is a discrepancy between this plan and the Plan Document the Plan Document will prevail. 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 of which will affect Covered Individuals of the Plan will be communicated to the Covered Individuals.

PLAN ADMINISTRATIVE INFORMATION

Plan Name

Trinity Health Welfare Benefit Plan

Employer Identification Number

EIN: 35-1443425

Plan Sponsor

Trinity Health

Plan Number

Health – 505
Dependent – 505

Plan Administrator

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

Type of Plan

Welfare

Plan Benefits and Assets

Administered by:

Aetna, Inc.
151 Farmington Ave.
Hartford, CT 06156

Agent for Service of Legal Process

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

Department of Labor

Office of Reporting and Disclosure
Pension and Welfare Benefit Programs
U.S. Department of Labor
Washington, DC 20216

Plan Year Ends

December 31

Plan Costs

The plan is funded solely by employee contributions.

HEALTH CARE SPENDING ACCOUNT REIMBURSABLE ITEMS

Outlined below is a list of health-related expenses incurred by you and/or your dependents that are reimbursable under your Health Care Spending Account. The expenses listed below are examples of reimbursable expenses that often are not covered or only partially covered under your medical or dental plan. The final determination of reimbursable expenses is subject to approval under IRS guidelines.

REIMBURSEABLE EXPENSES*

- Acne treatments
- Acupuncture
- Alcoholics Anonymous
- Alcoholism or substance abuse centers (inpatient only)
- Ambulance
- Artificial limbs and teeth
- Chiropractors
- Christian Science practitioners
- Contact lenses
- Medical expenses – co-payments, deductibles, etc.
- Dental expenses – co-payments, deductibles, orthodontia, etc.
- Doctor's or dentist's fees not payable under the medical / dental plan due to reasonable & customary cutbacks or other non-covered services
- Eyeglasses and eye exams
- Hearing aids and tests
- Home improvements or special equipment installed in home related to medical care (certain restrictions apply)
- Laboratory fees
- Lasik surgery
- Learning disability tuition fees (certain restrictions apply)
- Nursing home expenses for medical care
- Over-the-counter drugs used to aid illness / injury
- Physical exams
- Prescription drugs or drug co-payments, including insulin and supplies
- Prescription medications used to suppress nicotine addiction
- Psychiatric fees, psychologist or psychiatrist
- Smoking cessation programs and products, including patches and nicotine gum
- Transplants
- Transportation expenses to and from medical care, except ambulance
- Wheelchairs

NON-REIMBURSEABLE EXPENSES

- Abortion
- Cosmetic surgery, unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease**
- Diaper care
- Electrolysis or hair removal
- Funeral expenses
- Future medical care
- Health club dues
- Household help while under medical care
- Massage therapy (unless for treatment of a specific medical condition)**
- Maternity clothes
- Medicines / prescriptions obtained outside the United States
- Personal use items, such as toothpaste
- Sterilization
- Retin-A (unless for treatment of acne)**
- Swimming and dancing lessons
- Veterinary fees, except for the care of guide dogs for the seeing or hearing impaired
- Insurance premiums
- Teeth whitening
- Weight loss programs (unless recommended by a physician for treatment of a medical condition)**
- Nutritional supplements, vitamins, herbal supplements, "natural medicines," etc. unless they are recommended by a medical practitioner as treatment for a specific medical condition diagnosed by a physician**
- Expenses incurred prior to your enrollment in the plan
- HCSA requests for reimbursement for services, care, treatment, and referrals rendered by the covered individual's family, including (but not limited to) spouse, mother, father, grandmother, grandfather, in-laws, son, daughter, stepchildren or any person who resides with the covered individual

* This is not an all-inclusive list of covered expenses.

**These expenses will require a physician's note be included in reimbursement request indicating the medical necessity for expense.

DEPENDENT CARE TAX SAVINGS

FEDERAL TAX CREDIT vs. DEPENDENT SPENDING ACCOUNT

<u>* ADJUSTED GROSS FAMILY INCOME</u>	<u>ANNUAL DEDUCTIBLE DEPENDENT CARE EXPENSES</u>	<u>ANNUAL TAX SAVINGS UNDER FED TAX CREDIT</u>	<u>ANNUAL TAX SAVINGS UNDER SPEND ACCT.</u>	<u>ADVANTAGE WITH SPENDING ACCOUNT</u>
14,000	3,000	1,050	680	(370)
14,000	6,000	2,100	1,133	(967)
16,000	3,000	1,020	680	(340)
16,000	6,000	2,040	1,133	(907)
18,000	3,000	990	680	(310)
18,000	6,000	1,980	1,133	(847)
20,000	3,000	960	680	(280)
20,000	6,000	1,920	1,133	(787)
22,000	3,000	930	680	(250)
22,000	6,000	1,860	1,133	(727)
24,000	3,000	900	680	(220)
24,000	6,000	1,800	1,133	(667)
26,000	3,000	870	680	(190)
26,000	6,000	1,740	1,133	(607)
29,000	3,000	840	680	(160)
29,000	6,000	1,680	1,133	(547)
34,000	3,000	750	680	(70)
34,000	6,000	1,500	1,133	(367)
38,000	3,000	690	680	(10)
38,000	6,000	1,380	1,133	(247)
45,000	3,000	600	680	80
45,000	6,000	1,200	1,133	(67)
50,000	3,000	600	935	335
50,000	6,000	1,200	1,475	275
60,000	3,000	600	935	335
60,000	6,000	1,200	1,475	275
70,000	3,000	600	935	335
70,000	6,000	1,200	1,475	275

- Adjusted gross income is your gross pay less any eligible tax deductions. It also assumes that the spouse's annual earnings are sufficient to earn the maximum tax credit; \$3,000 for one dependent, or \$6,000 for two or more dependents.

This comparison is based on applicable laws and tax rates, which may change in the future. The comparison is not intended as tax advice. You should consult your own personal tax advisor before electing either option. Tax savings include federal, FICA, and state taxes. Contributions to your spending account reduce dollar for dollar the expenses you can claim for the Federal Tax Credit.

Reimbursement is provided for expenses on eligible dependents under age 13, a disabled spouse or disabled parent. If your child turns age 13 during the year you must file a status change, as the expenses are no longer eligible for reimbursement after age 13.