



**Saint Mary's Health Care  
Short Term Disability Benefits  
Under the Trinity Health  
Short-Term Disability Plan  
January 1, 2004**

**INTRODUCTION**

This document describes the short-term disability benefits for eligible non-management employees of Saint Mary's Health Care ("Saint Mary's") under the Trinity Health Corporation Short-Term Disability Plan ("Plan"). The Plan is a part of the Trinity Health Corporation Welfare Benefits Plan and intended to constitute an "employee welfare benefit plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Although part of the Plan, the benefits for Saint Mary's employees described in this summary plan description are sometimes referred to as Saint Mary's Short Term Disability ("STD"). The STD, however, is not a separate benefit plan.

The STD is a partial wage replacement plan designed to assist employees financially while they are disabled. **The STD does not cover work-related illness or injury.** STD benefits are provided to eligible employees of Saint Mary's Health Care at no cost to them. The benefits described in this summary are effective June 1, 2003, and **replace all previous short-term disability plans, programs or policies of Saint Mary's (or its predecessors) in their entirety.**

Please retain a copy of this summary for your reference. The written terms of the Plan will always govern whether any employee is entitled to benefits under the Plan and the amount and nature of those benefits. **Therefore, you should not rely on any oral explanation, description or interpretation of the Plan by any employee of Saint Mary's. No employee of Saint Mary's, not even management, has the authority to vary the terms of the Plan.** The Plan is intended to be interpreted consistently and uniformly for all eligible employees.

The Plan is self-funded. Claims under the STD will be administered by Occupational Health Services and Human Resources.

Coverage under the Plan is not a guarantee of continued employment.

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## **PLAN OUTLINE**

- **Description of Eligible Classes**

All full-time employees engaged in Active Employment who are budgeted to work 72 hours or more per pay period and who have been employed and available for work for at least six months since their most recent hire date prior to the beginning of their leave. Employees who change status to full time will be eligible the first of the month following their status change, provided that such employee has been employed and available for work for at least six months since their current hire date prior to the change. Employees working in the Saint Mary's Staffing Center or classified as resource, temporary, seasonal, executive, director or manager employees are not covered under this plan.

- **Amount of Disability Benefit**

Sixty (60) percent of Base Earnings up to a maximum of \$10,000 per month.

- **Maximum Benefit Period**

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

- **Elimination Period**

Forty (40) scheduled work hours.

- **Minimum Requirement for Active Employment**

Seventy-two (72) budgeted hours per pay period.

- **Definition of Base Earnings**

"Base Earnings" means the amount of regular bi-weekly salary or wages paid by Saint Mary's. Base Earnings does not include commissions, bonuses, overtime, incentive pay, shift premium or any other extra compensation.

- **Waiting Period**

Each eligible employee shall be automatically covered by the Plan after six months of continuous active employment. Employees transferring from certain employers affiliated with Trinity Health Corporation will be eligible for the STD benefits the first of the month following the transfer date, provided they meet the other eligibility requirements.

- **Medical Disability Guidelines**

**Medical disability guidelines will be used by Saint Mary's to determine the duration of STD benefits by diagnosis. If the employee's request for time off exceeds those guidelines, a Personal Leave of Absence may be granted.**

- **Contributions**

The cost of this coverage is paid entirely by Saint Mary's. No employee contributions are required or permitted.

### **TERMS YOU SHOULD KNOW**

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

- **“Active Employment”** means you must be working:
  - for Saint Mary's and paid Base Earnings;
  - at least the minimum number of hours shown in the Plan Outline; and either:
    - at Saint Mary's usual place of business; or
    - at a location to which Saint Mary's assigns you to work
- **“Base Earnings”** - as defined in the Plan Outline.
- **“Disability”** (or **“Disabled”**) means that you are completely unable to perform any 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 Physician.
- **“Disability Benefits”** means money that is paid as a bi-weekly benefit under the Plan when your claim for these benefits has been approved.
- **“Elimination Period”** means a period of consecutive scheduled work hours of Disability for which no Disability Benefit is payable. The elimination period is shown in the Plan Outline and begins on the first day of Disability.
- **“Illness”** means non-work related sickness, disease or other medical conditions, including pregnancy.
- **“Injury”** means non-work related bodily harm that is the direct result of an accident and not related to any other cause.
- **“Material and Substantial Duties”** means duties that:
  - are normally required for the performance of your regular occupation; and

- cannot be reasonably modified or omitted.
- **“Occupational Health Services” or “OHS”** means the staff employed in the Occupational Health Services Department of Saint Mary’s.
- **“Physician”** means a person (other than you, your spouse, child, brother, sister, aunt, uncle or parent, or the child, brother, sister, aunt or uncle or parent of your spouse) who:
  - is performing tasks that are within the limits of his or her medical license; and
  - is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
  - has with a doctoral degree in Psychology (PhD or PsyD) whose primary practice is treating patients; or
  - is a legally qualified medical practitioner required to be recognized as such under the insurance statutes or the insurance regulations of the governing jurisdiction.
- **“Regular Care”** means:
  - 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
  - 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).

In either case, documentation must be provided by the treating Physician.

- **“You” or “Your”** means the employee eligible for benefits under the Plan.

## **DISABILITY**

- **When do Disability Benefits become payable?**

OHS approves payment of Disability Benefits after the end of the Elimination Period and only when you and your Physician provide proof that you:

- are Disabled due to Illness or Injury, and
- are under appropriate treatment and care of a Physician.

The Disability resulting from Illness or Injury must begin while you are an eligible employee under the Plan.

- **What conditions must be met for Disability Benefit payments to continue?**

You will be paid Disability Benefits 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.

OHS may require that you be examined by its occupational health Physician and/or an independent Physician specialist. If you fail to comply with such a request, the result may be an interruption in or suspension of your Disability Benefits. Disability Benefits may also be suspended if the results of the independent examination determine that you are not Disabled under the definition of the STD.

You will be required to file an application with OHS in order to be considered for Disability Benefits. Upon request, you will also be required to give OHS periodic proof if your Disability continues. Such proof will be provided at your expense.

- **How much will I be paid if I am Disabled?**

To calculate your Disability Benefits:

- Multiply your hourly Base Earnings times sixty percent. This amount is your **Gross Disability Payment**.
- Subtract from your Gross Disability Payment any **Deductible Sources of Income** (as defined below).

- **How much will I be paid if I am Disabled and working?**

If you are unable to return to a normal work schedule, but your Disability allows for a reduced work schedule as part of a rehabilitation program, you will continue to receive a Disability Benefit. To determine the amount of your payment in this situation, OHS will subtract Base Earnings during your reduced schedule from your regular Base Earnings amount and pay sixty percent of the difference.

- **What are “Deductible Sources of Income?”**

The following deductible sources of income will be subtracted from your Gross Disability Payment:

- Any amount payable under any group insurance plan of Saint Mary’s or any other employer affiliated with Trinity Health Corporation that provides disability income benefits;
- Any benefits you are entitled to receive under the provisions of any retirement or pension plan, excluding lump sum distributions, regardless of whether Saint Mary’s, another employer affiliated with Trinity Health Corporation or any other company sponsored or maintained plan;
- Any benefits you are entitled to receive under a no fault insurance award or through third party subrogation as compensation for lost earnings;
- 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 Saint Mary’s, or your union, trade or professional organization, directly or indirectly sponsored or contributed; and
- Any benefits payable under any state compulsory benefit act or law.

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

OHS will prorate lump sum benefits (excluding distributions from any retirement or pension plan) on a bi-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 OHS.

- **When do my Disability Benefits stop?**

Disability Benefits will stop on the earliest of:

- The date you are determined to be no longer Disabled;
- The end of the Plan's Maximum Benefit Period;
- The date of your death;
- The date when you are able to work in your regular occupation on a part-time basis but you choose not to do so. For this purpose, "part-time basis" means the ability to work and earn from 20% to 80% of your Base Earnings, calculated based on your Base Earnings immediately prior to the start of your Disability leave;
- The date your Base Earnings attributable to work performed during your period of Disability equals or exceeds the amount of your regular Base Earnings;
- The date you fail to submit proof of continuing Disability after such proof is requested by OHS;
- The date the Plan is discontinued for all employees.

- **What happens if I am overpaid?**

Saint Mary's has the right to recover any overpayments of Disability Benefits due to:

- fraud
- any error Saint Mary's makes in processing a claim; and
- your receipt of Deductible Sources of Income.

You must reimburse Saint Mary's in full. OHS will determine the method by which the repayment is to be made. Saint Mary's 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 within a 12-month period due to the same or a related cause, the second period of Disability will be considered a continuation of the first period of Disability. You would not be required to fulfill a new Elimination Period, and benefits may resume to provide up to a maximum twenty-six weeks of payment. For example, if you started receiving Disability Benefits on March 1, received eight weeks of Disability Benefits, returned to work on May 1 and became Disabled again on May 5 due to the same Disability, you would be entitled to receive up to 18 more weeks of Disability Benefits.

If your second Disability is unrelated to the first, the second period of Disability will be considered a separate claim and a new Elimination Period must be satisfied before benefits will become payable.

- **May I supplement Disability Benefits with available vacation/bonus time?**

During the benefit period, you are required to receive the other 40% of the your Base Earnings by using earned vacation or bonus hours (determined at the time of your application). This additional amount will be paid during the benefit period until exhausted.

- **What happens when a holiday occurs while being paid Disability Benefits?**

If a legal holiday occurs during the benefit period, you will receive 60% of your Base Earnings that would be payable for that day; no additional holiday pay or hours in the holiday bank will be provided.

- **How does the Elimination Period work?**

Disability Benefits will be available to eligible employees after the Elimination Period. Eligible employees will qualify for Disability Benefits after 40 hours of scheduled work time is missed due to their Disability.

- **Is the Disability Benefit Period counted under FMLA?**

Any absence from work during which Disability Benefits are received, as well as your absence during the Elimination Period, is included in the twelve-week leave of absence entitlement under the Family and Medical Leave Act of 1993 (FMLA).

- **Will Saint Mary's require me to see an occupational health Physician?**

Saint Mary's reserves the right to obtain a second opinion from its occupational health Physician and/or an independent medical examination from an examiner of its choice.

## **GENERAL EXCLUSIONS**

- **What disabilities are not covered?**

The Plan will not cover any Disabilities caused by, contributed to or resulting from your:

- intentionally self-inflicted injuries or attempted suicide, while sane or insane;
- attempt to commit or commission of a crime under state or federal law;
- commission of a crime for which you have been convicted under state or federal law;
- war or act of war, unless you are a United States expatriate or on temporary assignment in a war area on employer business;

- any injuries sustained while you are on a leave of absence, excluding jury duty and vacations;
- a vague or undefinable condition (such as “tiredness” or “pain”), for which your Physician cannot provide a medical diagnosis;
- cosmetic surgery, except surgery made necessary by Injury incurred while covered under the Plan; and
- any occupational illness or injury. Occupational illness or injury means an 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 by the Plan on the earliest of the following dates:

- the date Trinity Health Corporation discontinues the Plan;
- the date your employment with Saint Mary’s ends;
- the date you retire under the normal retirement provisions of any retirement plan made available to employees of Saint Mary’s;
- the date you cease to be an eligible employee;
- the date of your death.

## **ADMINISTRATION AND CLAIMS PROCEDURES**

- **Plan Administration**

Trinity Health Corporation is the Plan Administrator. The Plan Administrator shall be responsible for the general administration and management of the Plan. In its role of administering the Plan, the Plan Administrator shall have all powers and duties necessary to fulfill its responsibilities including, but not limited to, the following powers and duties:

- To interpret and apply the Plan as the Plan Administrator, in its sole discretion, determines to be appropriate;
- To determine all questions relating to the eligibility of persons to participate or receive benefits under the Plan as the Plan Administrator, in its sole discretion, deems to be appropriate; and
- To appoint individuals to assist in any administrative function and generally do all other things which need to be handled in administering the Plan as the Plan Administrator, in its sole discretion, deems appropriate.

- **When must you submit an application for Disability Benefits?**

You must advise OHS of an anticipated medical leave of absence for which Disability Benefits should be paid if you expect to be absent from work for more than five consecutive days. An application form to file a claim is available from Human Resources. *Your application should be filed in advance of requesting*

***benefits when practical, and must be filed with OHS within seven (7) days after the date your Disability begins to ensure timely processing.***

OHS will first review your application and then contact you by U.S. mail, generally mailed within three (3) business days of receiving your claim. OHS 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 OHS requests that you provide additional information about your claim, 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 OHS and requested to provide medical documentation and related information to support your claim. This information must also be provided in a timely manner.

Once the application for benefits has been approved, disability benefits will be paid directly to you by Saint Mary's on a bi-weekly basis. In order to continue to receive Disability Benefits, you must provide OHS with proof of continued Disability and regular treatment by a Physician within two weeks of the date OHS requests such proof. ***You must notify OHS immediately when you return to work in any capacity.***

- **What constitutes proof of claim?**

Your application must show:

- that you are under the Regular Care of a qualified Physician;
- current medical information about your Illness or Injury, diagnosis and treatment;
- the date your Disability began;
- the cause of your Disability;
- the estimated duration of disability,
- the extent of your Disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending Physicians.

In some cases, OHS 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, OHS 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 Saint Mary's for an independent evaluation. Failure to cooperate with such requests may result in an interruption in benefits.

- **Claims and Claim Review Procedures**

If you do not believe that you have received the benefits to which you are entitled under the Plan, or believe that the Plan is not being managed properly, or that your legal rights are being violated with respect to the Plan, you must file a formal claim under the procedures set forth below. A formal claim must be filed within 90 days of the date upon which you first knew (or should have known) of the facts upon which the claim is based. The Plan Administrator may consent, in writing, to a different time period during which to make a formal claim. These procedures shall apply to all claims that any person has with respect to the Plan, including claims against fiduciaries and former fiduciaries.

- A claim must be presented to the Plan Administrator in writing. A claims official appointed by the Plan Administrator shall, within 45 days of receiving the claim, consider the claim and issue his or her determination of the claim in writing. The claims official may extend the determination period by 30 days two times (for a total of 105 days after receipt of the claim) if he or she determines that special circumstances require additional time to process the claim. Written notice will be given to you each time if an extension is needed.
- If the claim is wholly or partially denied, the claims official shall, within 45 days (or such longer period as described above), provide you with written notice of the denial. The notice will set forth:
  - the specific reason or reasons for the denial;
  - specific references to pertinent Plan provisions on which the denial is based;
  - a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary; and
  - an explanation of the Plan's claim review procedure.

With your consent, this determination period can be extended further. If the claims official fails to respond to the claim in a timely manner you may treat the claim as having been denied by the claims official. If the claims official determines that more information is necessary, you will have 45 days from the notice to submit the requested information to the claim official.

- If the claim is wholly or partially denied, you shall have the opportunity to appeal in writing the claims official's denial of a claim. The appeal shall be submitted to a review official (which may be a person or a committee) designated by the Plan Administrator for a full and fair review. You must request review of a denied claim within 180 days after you received written notice of denial of the claim or within 180 days after such written notice was due if the written notice was not sent. In connection with the review proceeding, you or your authorized representative may review pertinent documents and may submit issues and comments in writing. Any claims which are not in good faith pursued through the review stage of the procedure shall be treated as having been irrevocably waived.
- The decision by the review official upon review of a claim shall be made not later than 45 days after the written request for review is received by the Plan Administrator, unless special

circumstances require an extension of time for processing. If such special circumstances exist, a decision shall be rendered as soon as possible, but not later than 90 days after receipt of the request for review. You may, however, agree to an extension of that deadline. The decision on review shall be in writing and shall include specific reasons for the decision. The decision will be written in a manner calculated to be understood by the claimant with specific references to the pertinent Plan provisions on which the decision is based. All actions taken and all determinations made in good faith by the Plan Administrator shall be final and binding upon all persons claiming any interest in or under the Plan. No court action concerning a claim for benefits may be filed more than six 6 months after the date of the final written decision.

## **SUBROGATION**

Subrogation means that Saint Mary's 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 Saint Mary's any instruments and documents and undertake all actions necessary to enable Saint Mary's to exercise the right of subrogation.

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

At its election, Saint Mary's 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 Saint Mary's or the Plan sponsor pursuant to this section without the prior written consent of Saint Mary's or the Plan sponsor.

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

## **PLAN TERMINATION, MODIFICATION OR AMENDMENT**

Trinity Health Corporation, as sponsor of the Plan, reserves the right to terminate, modify or amend the Plan at any time. Saint Mary's may also amend or terminate STD benefits under the Plan. Upon termination, modification or amendment, the right of covered individuals to benefits is 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.

## **AN ELIGIBLE EMPLOYEE'S RIGHTS UNDER ERISA**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- **Receive Information about the Plan and its Benefits.**

You may:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- **Prudent Action by Plan Fiduciaries.**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including the Employer, a union or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent the employee from obtaining a benefit from the Plan or exercising his or her rights under ERISA.

- **Enforce Your Rights.**

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such 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 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. 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 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 the claim frivolous.

- **Assistance with Your Questions.**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 988-7542.

### **APPLICABLE LAW; SEVERABILITY**

The Plan shall be construed, administered and governed in all respects under and by the laws of the State of Michigan, except where such laws are preempted by ERISA or other applicable federal law. If any provision of the Plan shall be held illegal, invalid or unenforceable for any reason, such illegality, invalidity or unenforceability shall not affect the remaining provisions of the Plan. The Plan shall be construed and interpreted as if such illegal, invalid or unenforceable provision had never been a part of it.

### **IMPORTANT INFORMATION**

ERISA requires that you be provided with certain information about the Plan and the people and organizations involved with the Plan. This information is summarized for you below:

- **Plan Sponsor.** ERISA calls the organization that establishes and sponsors a plan a “Plan Sponsor.” **Trinity Health Corporation** (“Trinity Health”) is the Plan Sponsor. Any correspondence to Trinity Health in this capacity should be addressed as follows:

Short-Term Disability Plan Sponsor  
Senior Vice President, Human Resources  
Trinity Health Corporation  
27870 Cabot Drive  
Novi, MI 48377-2920

- **Plan Administrator/Named Fiduciary.** Under ERISA, a **Plan Administrator must** be named for every plan. **Trinity Health** is the Plan Administrator. The Plan Administrator has the authority to

control and manage the operation and administration of the Plan, and the duty to deliver various reports and other documents to you and to file them with government agencies. Inquiries or requests to the Plan Administrator under the Plan should be addressed as follows:

Plan Administrator/Short Term Disability Plan  
Attn: Director of Corporate Benefits  
Trinity Health Corporation  
34605 Twelve Mile Road  
Farmington Hills, MI 48331-3221

- **Employer Identification Number (“EIN”).** The Internal Revenue Service (“IRS”) assigns identifying numbers to employers and other taxpayers. The identifying number or EIN assigned by the IRS to Trinity Health is **35-1443525**.
- **Plan Name and Plan Number.** The Plan is part of the **Trinity Health Corporation Welfare Benefit Plan**. The plan number assigned to the Welfare Benefit Plan is **505**. You should not think that this number distinguishes this Plan from plans maintained by other employers. The number merely distinguishes this Plan from any other plans which Trinity Health or its affiliates maintain or may create in the future.
- **Agent for Service of Process.** The law requires someone to be named as Agent for Service of Process, that is, someone to whom court papers may be given officially if a court dispute does arise. The person currently named as the Agent for Service of Process is **CT Corp**, which may be served with process at 30600 Telegraph Road, Bingham Farms, Michigan 48025. Process also may be served upon the Plan Administrator at the address given above.
- **Plan Year.** The Plan records are maintained and reports are filed with the government for the 12-month period ending on each December 31.
- **Type of Plan.** The Plan is a welfare benefit plan.
- **Plan Funding.** Benefits are paid from the general assets of the Employer.