Summary Plan Description

for the

Trinity Health Corporation
Welfare Benefit Plan

An Overview of Your Health and Welfare Benefit Programs

Effective as of January 1, 2022

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INTRODUCTION

Trinity Health Corporation (the ***"Company"***) has established the Trinity Health Corporation Welfare Benefit Plan (the ***"Plan"***) in order to provide health and welfare benefits and programs for eligible colleagues of the Company and its affiliates that adopt the Plan and their dependents and other beneficiaries. The Company and its affiliates that have adopted the Plan are individually and collectively referred to in this summary plan description as the ***"Employer."***

Plan Overview

The Plan is a welfare benefit plan providing medical, prescription drug, dental, vision, disability, life, accidental death and dismemberment, employee assistance, severance and legal benefits, a health care flexible spending account program, a dependent care flexible spending account program, a health reimbursement account program (***"HRA Program"***), and a health savings account program (***"HSA Program"***). The Plan constitutes two separate welfare benefit plans for purposes of the Employee Retirement Income Security Act of 1974, as amended (***"ERISA"***) – Plan 504 and Plan 505.

The Plan also includes a ***"Cafeteria Plan"*** under Section 125 of the Internal Revenue Code of 1986, as amended (the ***"Code"***), which allows eligible colleagues to pay for certain benefits on a pre-tax basis including the Health Care Flexible spending account program, the dependent care flexible spending account program, and the HSA Program. Examples of benefits that are not included in the Cafeteria Plan and that you may not pay for with pre-tax dollar are the HRA Program and benefits for dependents who are not your Tax Dependents. In general, except as otherwise provided in an incorporated document for a Benefit Program, for Plan purposes your ***"Tax Dependents"*** are: (i) your spouse, (ii) your Eligible Dependent who is your biological child, stepchild, legally adopted child, eligible foster child (as defined in Code Section 152(f)(1)(C)) or child lawfully placed with you for legal adoption by you, and (iii) your Eligible Dependent who is your dependent within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) for purposes of benefits under Code Sections 105 and/or 106.

Except where the context clearly indicates otherwise, references to "you" and "your" in this summary plan description are intended to be references to the Eligible Colleague.

Funding Medium and Type of Administration

Some benefits under the Plan are fully-insured and others are self-funded. The medical and prescription drug program for certain Employers and the life, accidental death and dismemberment, vision, long term disability, short term disability for certain Employers, employee assistance, and legal benefit programs are fully-insured. These fully-insured benefits are provided under insurance contracts entered into between the Employer and an insurance company. Claims for fully-insured benefits must be sent to the insurance company who is responsible for paying claims, not to the Employer or Plan Administrator. Insurance premiums are generally paid by the Employer from its general assets, although you may share the cost, or may be responsible for the entire cost, of certain Benefit Programs. For example, you are required to pay the entire cost of coverage for the voluntary life, voluntary accidental death and dismemberment, and legal programs. The Employer will provide you with detailed information about any required contributions you must make toward the cost of your coverage under the Plan.

The Health Care Flexible Spending Account Program and the Dependent Care Flexible Spending Account Program are funded through your pre-tax contributions, if you choose to participate. Your claims under the flexible spending account programs are processed through a third-party administrator, which assists in administering each flexible spending account. Please

refer to Appendix A for additional information regarding the Health Care Flexible Spending Account Program and Appendix B for additional information regarding the Dependent care Flexible Spending Account Program.

If you are eligible for and elect to participate in a high-deductible health plan that is an ***"HSA Medical Benefit Program"*** (as designated by the Plan Administrator), you may be able to establish a health savings account (***"HSA"***). Although you may establish an HSA wherever you like, if you establish an HSA with the HSA trustee or custodian that has contracted with the Employer to offer HSAs to Eligible Colleagues (defined below) of the Employer, and you are HSA-eligible (as determined under Code Section 223), you may elect to make pre-tax payroll deduction contributions to your HSA and the Employer may make contributions to your HSA under the HSA Program. You are only eligible to participate in the HSA Program if you participate in an HSA Medical Benefit Program. A description of the HSA Program is set forth in Appendix C and may be amended or terminated in the future.

If you are eligible for and elect to participate in a plan that is an ***"HRA Medical Benefit Program"*** (as designated by the Plan Administrator), you are eligible to participate in the HRA Program and the Employer will establish a health reimbursement account (***"HRA"***) for you under the HRA Program and may credit amounts to your HRA. You are only eligible to participate in the HRA Program if you participate in an HRA Medical Benefit Program. You cannot make contributions to your HRA. A description of the HRA Program is set forth in Appendix D and may be amended or terminated in the future.

The medical and prescription drug program for certain Employers and the dental and severance programs, short term disability program for certain Employers,[1] and HRA Program are self-insured by the Employer. The Employer may hire certain providers to process claims and provide services for self-insured programs under the Plan. These companies do not serve as insurers. If applicable, these companies process claims and request and receive funds from the Employer to pay the claims, and then make payment on the claims to applicable providers. You and the Employer share the cost of the medical and prescription drug, vision, and dental programs. You must make any required contributions for these benefits.

About this Summary

This booklet is a summary plan description (***"Summary"***) prepared in compliance with ERISA. This Summary, including the Appendices and incorporated documents that constitute part of this Summary, provides a general explanation of the Plan. The incorporated documents include the booklets and certificate and evidence of coverage documents for the Benefit Programs. The Plan, together with each benefit, other than the Cafeteria Plan portion of the Plan, the dependent care flexible spending account program, and the HSA Program, is intended to constitute an "employee welfare benefit plan," as defined in ERISA. While we have tried to describe the Plan as completely and accurately as possible, due to the relatively brief nature of this Summary and the complexity of the Plan document, some details may not have been described or have been described only briefly.

We strongly urge you to read this Summary in its entirety. If you have further questions, or if you would like to review the entire Plan document, copies are available from your Employer or Plan Administrator for inspection during normal business hours.

[1] If you are eligible for a State's mandatory short-term or temporary disability coverage (e.g., California, Hawaii, New Jersey, New York and Rhode Island), you will be eligible for that coverage and, if the Short Term Disability Program under the Plan would provide benefits in excess of that coverage, you may be eligible for the excess coverage from the Short Term Disability Program under the Plan. Please refer to the documents for the Short Term Disability Program for additional information.

THIS SUMMARY PLAN DESCRIPTION DESCRIBES THE PLAN. IT DOES NOT INTERPRET, EXTEND OR CHANGE THE PLAN IN ANY WAY. THE FULL PROVISIONS OF THE PLAN CAN ONLY BE DETERMINED PRECISELY BY CONSULTING THE APPLICABLE PLAN DOCUMENTS. IN THE EVENT OF ANY DISCREPANCY BETWEEN THIS SUMMARY AND THE ACTUAL PROVISIONS OF THE PLAN DOCUMENTS, THE PLAN DOCUMENTS WILL GOVERN.

AVAILABLE BENEFIT PROGRAMS

The Company has established the following benefits (the ***"Benefit Programs"***) under the Plan.

Benefit Programs

A. **Plan 504**

1. **Medical Benefit Program (including Prescription Drug Program)** -- covers a variety of health-related services and supplies and prescription drugs and medications for you and your dependents.

   a. HRA Medical Benefit Program – Essential PPO Assist or another HRA health plan option.

   b. HSA Medical Benefit Program – Health Savings PPO or another high deductible health plan option.

2. **Dental Benefit Program** -- covers a variety of dental expenses for you and your dependents.

3. **Health Reimbursement Account Program or HRA Program** -- if you are eligible for and elect to participate in an HRA Medical Benefit Program, the Plan Administrator will establish a health reimbursement account ("HRA") for you under the HRA Program. You do not make a separate election to enroll in the HRA Program.

B. **Plan 505**

1. **Vision Benefit Program** -- covers a variety of vision expenses for you and your dependents.

2. **Life Insurance Program**

   a. **Basic Life Insurance Program** -- provides you with basic life insurance coverage.

   b. **Voluntary Life Insurance Program** -- provides you the opportunity to purchase additional life insurance coverage for yourself and/or your dependents.

3. **Accidental Death and Dismemberment (*"AD&D"*) Program**

   a. **Basic AD&D Insurance Program** -- provides you with AD&D insurance coverage related to the loss of life, limb, sight, hearing or speech.

   b. **Voluntary AD&D Insurance Program** -- provides you with the opportunity to purchase additional AD&D insurance coverage for yourself and/or your dependents.

4. **Short Term Disability Program**

   a. **Basic Short Term Disability Program** -- provides you with temporary income protection if you become disabled. This program is not available to all Eligible Colleagues.

b. **Voluntary Short Term Disability Program** -- provides you the opportunity to purchase temporary disability insurance. This program is not available to all Eligible Colleagues.

5. **Long Term Disability Insurance Program**

a. **Basic Long Term Disability Insurance Program** -- provides you with long-term income protection if you become disabled.

b. **Voluntary Long Term Disability Insurance Program** -- provides you the opportunity to purchase additional long term disability insurance coverage for yourself and/or your dependents. This program is not available to all Eligible Colleagues.

6. **Health Care Flexible Spending Account Program** -- a flexible spending arrangement that allows you to pay with pre-tax dollars for eligible healthcare expenses not covered under the Medical, Dental, Prescription Drug, Vision or HRA Programs; the Health Care Flexible Spending Account Program provides for limited-use health care flexible spending accounts for participants in the Health Savings Account Program.

7. **Dependent Care Flexible Spending Account Program** -- a flexible spending arrangement that allows you to pay with pre-tax dollars for eligible dependent care expenses.

8. **Employee Assistance Program** -- provides access to health professionals and other services to assist you and your dependents in dealing with various life events.

9. **Legal Benefits Program** -- allows you to obtain legal services and legal advice. This program is not available to all Eligible Colleagues.

C. **Health Savings Account Program or HSA Program** -- if you are eligible for and elect to participate in an HSA Medical Benefit Program (each of which is a high-deductible health plan), the HSA Program allows you to establish an HSA; you and your Employer may make contributions to your HSA under the HSA Program if you are HSA-eligible. The HSA Program is not subject to ERISA and is included only in the Cafeteria Plan portion of the Plan to permit you and your Employer to make pre-tax contributions to your HSA if you are HSA-eligible.

Each Benefit Program is further described in a benefit description, certificate of insurance, benefits booklet or other governing documents. This Summary incorporates by reference the documents applicable to the Benefit Programs listed above. Copies of the booklets, summaries or other governing documents can be obtained by accessing the HR4U colleague portal at https://hr4u.trinity-health.org or by contacting the HR Service Center by phone at 1-877-750-HR4U (4748). If your ministry is not supported by the HR Service Center you may reach out to your ministry HR department.

Please refer to the incorporated documents applicable to a Benefit Programs for specific information concerning the Benefit Program, your eligibility for such Benefit Program, the specific benefits offered, and the circumstances which may result in your disqualification or ineligibility or in the denial, loss, forfeiture or suspension of your benefits.

ELIGIBILITY

You are eligible to participate in the Plan if you are an ***"Eligible Colleague"*** who has met all of the eligibility and participation requirements under the Plan. An Eligible Colleague's ***"Eligible Dependent"*** who has met all of the eligibility and participation requirements under the Plan is eligible to be covered under the Plan.

When Are You Eligible?

Eligible Colleagues

You must be part of the group of colleagues who are eligible to participate according to the provisions of a Benefit Program before you may participate in that Benefit Program. In general, you must be a regular full-time or regular part-time common law employee of your Employer, as defined in the Trinity Health Human Resources System-Wide Eligibility for Coverage Under the Trinity Health Corporation Welfare Benefit Plan Procedure (***"Eligibility Procedure"***), to participate in the Plan except the following individuals are not eligible to participate:

- Leased employees;
- Self-employed individuals;
- Employees who are non-resident aliens with no income from sources within the United States;
- Any individual who has been classified by the Employer as an independent contractor, notwithstanding a contrary determination by any court or governmental agency; and
- Union employees who are members of a collective bargaining unit that has bargained in good faith over benefits like those available under the Plan, but whose participation in the Plan is not provided for in the union agreement.

In addition, with respect to the Medical Benefit Program and any other Benefit Program that is a group health plan for purposes of the employer mandate requirements of the Affordable Care Act (each an ***"ACA Group Health Plan"***), you are considered an Eligible Colleague of an Employer for a stability period (as determined under the Trinity Health Human Resources System-Wide ACA Employee Eligibility Procedure, as amended from time to time) if you averaged at least 30 hours of service per week (130 hours of service in a calendar month) for the Employer during the applicable measurement period for that stability period (as determined under the Trinity Health Human Resources System-Wide ACA Employee Eligibility Procedure, as amended from time to time) or you are hired by the Employer during a Plan Year and you are expected to work an average of at least 30 hours per week (130 hours of service in a calendar month) when you are hired.

If you are covered by a collective bargaining agreement that provides for your participation in the Plan and the terms of the collective bargaining agreement conflict with the terms of this SPD, the terms of the collective bargaining agreement control.

A former Eligible Colleague may be eligible to continue participation in the Plan for the limited purpose of allowing continued eligibility for specific Benefit Programs for the remainder of the Plan Year in which the Eligible Colleague ceases to be employed by the Employer. In addition, former Eligible Colleagues who are receiving severance benefits from an Employer may be entitled to continued eligibility for specific Benefit Programs in accordance with the terms of the applicable severance agreement, plan or policy.

If you are an Eligible Colleague, you become a participant in accordance with the ***"Participating In The Plan"*** section of this Summary (below).

Eligible Dependents
Whether and to what extent dependents are eligible for coverage under a particular Benefit Program depends on the terms of that Benefit Program. Except as otherwise provided in a Benefit Program, a collective bargaining agreement that governs your participation in the Plan, or as required by applicable law, if you are an Eligible Colleague, your Eligible Dependents include:

- One Eligible Adult (as defined below); and
- Each of your Dependent Children.

The Administrator has the sole discretion to determine whether a person satisfies the requirements to be an Eligible Dependent.

Your Eligible Dependent(s) can be enrolled in a Benefit Program under the Plan only if you are enrolled in (i.e., a participant in) that Benefit Program. If a colleague and the colleague's Eligible Dependent are both Eligible Colleagues, neither may be covered under the Plan as both an Eligible Colleague and an Eligible Dependent. In addition, coverage will not be duplicated for an Eligible Dependent of more than one Eligible Colleague.

You are required to provide proof of your dependents' eligibility. False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for colleague discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or misrepresentation, you will forfeit any contributions made.

Except as required by COBRA, former spouses are not eligible for benefits under this Plan even if you have a divorce decree stipulating you must provide health and/or other coverage to your former spouse.

Eligible Adult
An "Eligible Adult" is a person who satisfies the criteria to be a Pre-Tax Eligible Adult or Post-Tax Eligible Adult set forth below.

a. Criteria for Pre-Tax Eligible Adult:

A person is an Eligible Colleague's Pre-Tax Eligible Adult if the person satisfies all of the requirements of 1. or 2., below:

1. Spouse:

i. The person is the Eligible Colleague's legally married husband or wife under the law of the state or foreign jurisdiction where the Eligible Colleague and person were married; a spouse by common law marriage is not considered an Eligible Colleague's spouse for purposes of the Plan;

ii. The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities; and

iii. The person is not legally married to someone other than the Eligible Colleague.

2. Non-Spouse:

i. The person satisfies the requirements set forth below to be the Eligible Colleague's Post-Tax Eligible Adult;

ii. The person is the Eligible Colleague's dependent for federal tax purposes;

iii. The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities; and

iv. The person is not legally married to anyone.

In order for a person who is not the Eligible Colleague's spouse to be treated as a "Non-Spouse Pre-Tax Eligible Adult," the Eligible Colleague will need to complete the Trinity Health Corporation Welfare Benefit Plan Certification Regarding Tax Dependent Status of a Non-Spouse Eligible Adult and submit it to the HR Service Center or the Eligible Colleague's local HR: (i) within 30 days of the Eligible Colleague's benefits eligibility date (if the Eligible Colleague is a new employee or a newly benefits eligible employee); (ii) within 30 days of the Eligible Colleague's qualified change in status event; or (iii) within two (2) weeks of the close of the open enrolled period, as applicable.

An Eligible Colleague's contributions for the cost of a Pre-Tax Eligible Adult's coverage under the Plan for any benefits that may be paid for on a pre-tax basis will be withheld from the Eligible Colleague's compensation on a pre-tax basis.

b. Criteria for Post-Tax Eligible Adult:

A person is an Eligible Colleague's Post-Tax Eligible Adult if the person satisfies ***all*** of the following:

1. The person is not the Eligible Colleague's spouse or dependent for federal tax purposes;

2. The person is not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities

3. The person is not legally married to anyone; and

4. The person satisfies the requirements of either i. or ii. below:

i. The person has a current, valid domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry with the Eligible Colleague; or

ii. The person satisfies ***all*** of the following requirements:

I. The person shares the Eligible Colleague's permanent residence;

II. The person is financially interdependent with the Eligible Colleague; and

III. The person is not the Eligible Colleague's:

(i) Parent/Step-parent;

(ii) Parent's/Step-parent's other descendants (i.e., the Eligible Colleague's siblings, nieces, nephews);

(iii) Grandparent's/Step-Grandparent's and their descendants (e.g., the Eligible Colleague's aunt, uncle, cousin, etc.);

(iv) In-law;

(v) Renter, boarder, tenant, or employee; or

(vi) Child* or grandchild.
*Dependent Children are separately eligible for coverage as described below.

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

Dependent Children

"Dependent Children" are the following who are not otherwise covered under the Plan or any other group health plan offered by the Employer or one of its related or affiliated entities:

a. Natural children of the (1) Eligible Colleague or (2) Eligible Colleague's Pre-Tax Eligible Adult, or (c) Eligible Colleague's Post-Tax Eligible Adult who is enrolled in the Plan ("Covered Post-Tax Eligible Adult");

b. Legally adopted children of or children placed for adoption with the Eligible Colleague, Eligible Colleague's Pre-Tax Eligible Adult or Covered Post-Tax Eligible Adult; or

c. Children for whom the Eligible Colleague, Eligible Colleague's Pre-Tax Eligible Adult or Covered Post-Tax Eligible Adult are the court-appointed legal guardian.

In general, except as otherwise provided in a Benefit Program, a collective bargaining agreement that governs the Eligible Colleague's participation in the Plan, or as required by applicable law, an Eligible Colleague's Dependent Children are eligible for coverage under the Plan until the end of the Plan Year in which they turn age 26. However, except as otherwise provided in a Benefit Program, a collective bargaining agreement that governs the Eligible Colleague's participation in the Plan, or as required by applicable law, an Eligible Colleague's Dependent Children are eligible for coverage under the Plan after the end of the Plan Year in which they turn age 26 if they meet all of the following criteria:

d. They are incapable of self-sustaining employment because of mental or physical incapacitation ("Disabled") and became Disabled prior to the end of the Plan Year in which they attained age 26;

e. They are unmarried;

f. They are continuously enrolled prior to their 26th birthday in a plan applicable to the coverage in which they are being enrolled; and

g. They either:

1. Live in the same house as the Eligible Colleague for more than half of the Plan Year and do not provide more than half of their own support for the Plan Year; or

2. Are not anyone's "qualifying children" for the year (as defined in Internal Revenue Code Section 152(c)) and the Eligible Colleague, Eligible Colleague's Pre-Tax Eligible Adult or Covered Post-Tax Eligible Adult provides over half of their support for the Plan Year.

If you wish to continue coverage for a child who is Disabled, you must notify the Administrator and/or insurance provider within 30 days of the date the child reaches age 26 (or limiting age for dependent coverage under the Benefit Program, if different). In order for the child to continue to be an Eligible Dependent, you may be required to show the child's continued dependency and Disability on an annual basis.

Notwithstanding the above, your unmarried child who is a full-time student will not cease to be an Eligible Dependent for purposes of the Medical Benefit Program solely due to the fact that the child takes a medically necessary leave of absence (or reduces his or her hours to part-time status for a medically necessary reason) from an accredited college or university. The medically necessary leave of absence (or reduction of hours) must be verified by written certification from the child's treating physician. The child must be enrolled in the Medical Benefit Program as an Eligible Dependent immediately prior to the medically necessary leave of absence (or reduction of hours) and the absence must otherwise cause the child to lose coverage under the Medical Benefit Program. The child will continue to be an Eligible Dependent for one year after the first day of any verified medically necessary leave of absence or, if earlier, the date coverage would otherwise terminate under the Medical Benefit Program (e.g., because the child attains age 26).

In general, an Eligible Colleague's contributions for the cost of a Dependent Child's coverage under the Plan for any benefits that may be paid for on a pre-tax basis will be withheld from the Eligible Colleague's compensation on a pre-tax basis and the Employer contribution for such coverage will not be taxable income to the Eligible Colleague. However, an Eligible Colleague's contributions for the cost of coverage for a Dependent Child who is not the Eligible Colleague's Tax Dependent (generally a Covered Post-Tax Eligible Adult's Dependent Child who is not also the Eligible Colleague's child) under the Plan will be withheld from the Eligible Colleague's compensation on a post-tax basis, and the Employer contribution for such coverage will be taxable income to the Eligible Colleague.

Participation Conditions

Generally, if you are an Eligible Colleague, you will be eligible to participate in the Plan and the Benefit Program(s), unless stated otherwise in the documents governing the specific Benefit Program. You must satisfy the participation conditions under each Benefit Program before you will be eligible to receive benefits under that program. For instance, you must satisfy any eligibility service or waiting period for a Benefit Program before your participation in the Benefit Program will begin.

Pre-existing Conditions (if applicable)

You will be informed (via applicable incorporated documents) if certain Benefit Programs apply a pre-existing condition limitation or exclusion. A Benefit Program that is a group health plan will not apply any pre-existing condition limitation to any Eligible Colleague, participant or Eligible Dependent.

Qualified Medical Child Support Orders

With respect to Benefit Programs that are group health programs, the Plan will also provide coverage for your Dependent Child as required by the terms of a Qualified Medical Child Support Order (***"QMCSO"***). This coverage applies even if you don't have legal custody of the child, the child is not dependent on you for support, and regardless of any enrollment restrictions that may otherwise exist for dependent coverage. If the Employer receives a valid QMCSO and you don't enroll the Dependent Child, the custodial parent or state agency may enroll the affected child (and you will also be enrolled). Additionally, the Employer may withhold from your paycheck any contributions required for such coverage.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the Employer to cover a child under the Plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Plan Administrator follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the child support order qualification procedures, you may do so by accessing the HR4U colleague portal at https://hr4u.trinity-health.org, by contacting the HR Service Center by phone at 1-877-750-HR4U (4748) or contacting your local HR department if not supported by the HR Service Center.

PARTICIPATING IN THE PLAN

Enrollment

As an Eligible Colleague who has satisfied the eligibility and participation conditions, you will need to enroll formally before you may participate in certain Benefit Programs. However, certain Benefit Programs will be provided to you automatically, and no enrollment will be required subject to your satisfaction of any waiting periods or eligibility requirements, as specified in the applicable incorporated documents.

In general, you will need to enroll online in order to participate in the Plan and the Benefit Programs and to enroll your Eligible Dependents. The Plan Administrator will make all of the information you need to properly enroll in each Benefit Program available to you.

Initial Enrollment

If you are a new Eligible Colleague, you may obtain enrollment materials and information by accessing the HR4U colleague portal at https://hr4u.trinity-health.org or by contacting the HR Service Center by phone at] 1-877-750-HR4U (4748). If your ministry isn't supported by the HR Service Center you may reach out to your ministry HR department. If you desire to enroll in one or more Benefit Programs for the Plan Year (or remaining portion thereof), you must enroll online no later than the 30th day following the later of your date of hire by the Employer or the date you become an Eligible Colleague (or by such other enrollment date established by the Plan Administrator, which will be no later than the beginning of the first pay period in which contributions will be deducted from your pay) and agree to a reduction in your compensation to pay the required contributions toward the purchase of benefits or coverage under the Benefit Program(s). If you do not enroll by the specified enrollment deadline, except with respect to any Benefit Program that does not require an election in order for you to participate (for example, the Basic Life Insurance Program), you will be deemed to have elected not to participate in the Plan or any Benefit Program. In this case, you will not be eligible to enroll in any Benefit Program under the Plan until the next Plan Year unless you experience a qualified change in status event or qualify for special enrollment, as discussed below.

If you are a new Eligible Colleague and you enroll on or before the established enrollment deadline and elect coverage under one or more Benefit Programs, unless otherwise provided in an incorporated document, a collective bargaining agreement, or the Eligibility Procedure, the effective date of your coverage under each Benefit Program in which you elect to participate will be the first day of your active employment with your Employer (prior to January 1, 2022, the first day of the month coinciding with or following 30 days from your date of hire by your Employer) or, if later, the date you become an Eligible Colleague. In addition, unless otherwise provided in an incorporated document, a collective bargaining agreement or the Eligibility Procedure, the effective date of your coverage under each Benefit Program that is provided to you automatically will be the first day of your active employment with your Employer (prior to January 1, 2022, the first day of the month coinciding with or following 30 days from your date of hire by your Employer) or, if later, the date you become an Eligible Colleague.

If you elect coverage for your Eligible Dependents, you will have 30 days to provide documentation to verify the eligibility of each of the Eligible Dependents. The required documentation is set forth in the Trinity Health Dependent Verification Documentation Requirements, a copy of which can be obtained accessing the HR4U colleague portal at https://hr4u.trinity-health.org or by contacting the HR Service Center by phone at 1-877-750-HR4U (4748). If your ministry isn't supported by the HR Service Center you may reach out to your ministry HR department.Coverage for your Eligible Dependents will remain in an "ineligible" status until appropriate documentation is provided. Failure to provide appropriate documentation within 30 days will result in the voluntary termination of your election for coverage for your Eligible Dependents. In addition, certification of eligibility may be required periodically for your covered Eligible Dependents.

Annual Enrollment

Prior to the beginning of each Plan Year, during the "annual open enrollment period," Eligible Colleagues choose Benefit Programs for the next Plan Year. If you are an Eligible Colleague, each year you have the opportunity to decide if you want to elect coverage, opt out of coverage or change your participation (*i.e.*, switch between single and family coverage) in one or more of the Benefit Programs by completing an election online on or before the last day of the annual open enrollment period or such later date as established by the Plan Administrator. You may obtain open enrollment materials and information by accessing the HR4U colleague portal at https://hr4u.trinity-health.org or by contacting the HR Service Center by phone at 1-877-750-HR4U (4748). If your ministry isn't supported by the HR Service Center you may reach out to your ministry HR department. The Plan Administrator will not accept enrollments for a Plan Year after the end of the annual open enrollment period for the Plan Year (or such later date as established by the Plan Administrator). Note that if you elect coverage, opt out of coverage, make no election or change your participation effective for the Plan Year that follows the end of an annual open enrollment period, you may not change or revoke your election after the end of the annual open enrollment period (or such later date as established by the Plan Administrator) or during that Plan Year unless you have a qualified change in status or qualify for special enrollment, as discussed below (except with respect to your pre-tax contributions under the HSA Program, if applicable).

Generally, if you fail to make any elections during the annual open enrollment period, your election to participate (or not to participate) in the Benefits Program(s) will remain in effect until you choose to opt out of such coverage. You will be deemed to have agreed to a reduction in your compensation to pay the required contributions for coverage under the Benefit Program(s). If a Benefit Program that you elected for the prior Plan Year is no longer available, you will be deemed to have elected the Benefit Program most comparable to the option previously in effect or such other option as communicated to you by the Employer and you will be deemed to have agreed to a reduction in your compensation for such coverage.

Notwithstanding the foregoing, the Health Care Flexible Spending Account Program and Dependent Care Flexible Spending Account Program require a new election prior to each Plan Year. If you do not re-enroll in the Health Care Flexible Spending Account Program and Dependent Care Flexible Spending Account Program each year, your participation in such Benefit Program(s) will cease at the end of the Plan Year, or such earlier date provided under the terms of the Plan or the Benefit Program(s).

In addition, if you participate in a an HRA Medical Benefit Program (as designated by the Plan Administrator) for a Plan Year, your participation in the HRA Medical Benefit Program will cease at the end of the Plan Year, or such earlier date provided under the terms of the Plan or the Benefit Program, and you must make a new election to participate in a Medical Benefit Program for the next Plan Year.

Paying for your Benefits as a Colleague

Participation in certain Benefit Programs requires cost-sharing between your contributions and the Employer's contributions (e.g., the Medical Benefit Program). Alternatively, other Benefit Programs are provided by the Employer without any cost to you (e.g., the Basic Life Insurance Program). Finally, some Benefit Programs provide additional optional coverage as elected and paid for by you (e.g., the Voluntary Life Insurance Program). Each variation of Benefit Program is discussed below.

In general, your contributions will be made by payroll deduction on a pre-tax basis unless otherwise permitted and elected by you. However, as explained below, your contributions for coverage under certain Benefit Programs (e.g., the Voluntary Life Insurance Program) are made on an after-tax basis. In addition, your contributions for coverage under a Benefit Program for your Eligible Dependent who is not your Tax Dependent (generally, a Post-Tax Eligible Adult or Covered Post-Tax Eligible Adult's Dependent Child who is not also your child) will be made on an after-tax basis unless otherwise permitted and elected by you. Also, the portion of the cost for the coverage for your Eligible Dependent who is not your Tax Dependent that is paid by the Employer will be imputed in your income. In addition, if your contributions for coverage under a Benefit Program for your Eligible Dependent who is not your Tax Dependent are not made on after-tax basis, the cost of the Eligible Dependent's coverage will be imputed in your income.

Required Colleague Contributions

Medical, Dental and Vision Benefit Programs. Eligible Colleagues are currently required to make payroll deduction contributions to help cover the cost of the Medical Benefit Program, Dental Benefit Program and Vision Benefit Program. Before the beginning of each Plan Year (or during your initial enrollment period if you are a new Eligible Colleague), the Plan Administrator will inform you of the amount of the required contributions for these Benefit Programs. By completing the online enrollment necessary to participate in these Benefit Programs, you are agreeing to pay the required contributions rather than receiving such amounts in cash. Thus, when enrolling in these Benefit Programs, you will (a) designate whether you are electing colleague only, colleague + spouse/eligible adult*, colleague + child(ren) or family coverage, (b) provide information on any Eligible Dependents, if applicable, and (c) authorize the deduction of the required colleague contributions from your paycheck.

Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and HSA Programs. The Health Care Flexible Spending Account Program and the Dependent Care Flexible Spending Account Program are funded solely through colleague contributions. In addition, the HSA Program permits colleague contributions. Under these Benefit Programs, you select the dollar level at which you want to participate (within certain identified limits). Your election to contribute to your Health Care Flexible Spending Account or Dependent Care Flexible Spending Account will be made on a Plan Year basis.

Prior to each Plan Year (or during your initial enrollment period if you are a new Eligible Colleague), you must complete an online enrollment and specify the dollar amount you wish to defer into the applicable reimbursement account. Your election to contribute to your HSA through the Plan may be changed or revoked on a prospective basis at any time in accordance with the procedures established by the Plan Administrator.

No Colleague Contributions -- Automatic Colleague Enrollment

The Employer does not currently require any colleague contributions for the following Benefit Programs:

- Basic Life Insurance Program
- Basic AD&D Program
- Long Term Disability Program
- Basic Short Term Disability Program (not offered by all Employers)
- Employee Assistance Program

The Plan Administrator will automatically enroll you in each of the above Benefit Programs when you become an Eligible Colleague and satisfy the eligibility and participation conditions (described above). You will still need to complete an online enrollment in order to select a beneficiary for certain insurance benefits.

In addition to the above, if you timely enroll in a Medical Benefit Program for a Plan Year, timely apply for the HRA Program for the Plan Year, and satisfy the eligibility requirements for the HRA Program for the Plan Year, the Plan Administrator will automatically enroll you in the HRA Medical Benefit Program and HRA Program for that Plan Year.

Optional Additional Colleague Coverage

You may also elect to purchase additional coverage under the Voluntary Life Insurance Program, Voluntary AD&D Program, Voluntary Short Term Disability Program (no offered by all Employers), Voluntary Long Term Disability Program (certain Eligible Colleagues only), and Legal Benefits Program. You pay for this coverage on an after-tax basis through payroll deductions.

Other Enrollment Features/Rights

Pre-Tax Contributions

An important feature of the Plan is that each Eligible Colleague may elect to have the contributions that are required under some of the Benefit Programs to be made with “pre-tax” dollars, in accordance with the applicable Treasury Regulations. This means that your share of the cost of these Benefit Programs is deducted from your wages or salary paid by the Employer before federal income and social security taxes are applied. Because your share of the benefit cost is deducted first, you do not pay taxes on that portion of your gross income from the Employer. This will result in a real tax savings to you that help offset your share of the cost of such benefits. However, your pre-tax contributions will reduce the amount of your gross taxable income. Accordingly, there could be a decrease in your social security benefits by reducing the total taxable income used to calculate your social security benefit and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

As explained above, coverage under a Benefit Program for an Eligible Dependent who is not an Eligible Colleague’s Tax Dependent (generally, an Eligible Colleague’s Post-Tax Eligible Adult or a Covered Post-Tax Eligible Adult’s Dependent Child who is not also the Eligible Colleague’s child) cannot be paid for with pre-tax dollars and will be paid for with after-tax dollars by and/or result in imputed income to the Eligible Colleague.

Special Enrollment for Coverage Under the Medical Benefit Program
Under the Health Insurance Portability and Accountability Act (***"HIPAA"***), special enrollment rights are available to certain Eligible Colleagues who previously declined coverage under the Plan's Medical Benefit Program and wish to enroll themselves and/or one or more of their Eligible Dependents. You will have a special enrollment right regardless of when you would otherwise be eligible to enroll under the Plan. Therefore, these provisions supplement any other enrollment period otherwise available to you.

Special Medical Benefit Program Enrollment for Loss of Coverage
You are entitled to special enrollment if <u>all</u> of the following conditions are met:

A. You (the Eligible Colleague) did not elect health coverage for yourself and/or your Eligible Dependent when you were first eligible to do so, because at that time:

   1. You and/or your Eligible Dependent were covered under a group health plan or had insurance at the time coverage was previously offered; and

   2. If required to do so, you stated in writing at the time you declined coverage that the reason you were declining was because you and/or your Eligible Dependent had other similar coverage; and

   3. You and/or your Eligible Dependent lost coverage under the group health plan because of a loss of eligibility for that coverage due to:

      - Termination of employment in a class eligible for such coverage;
      - Reduction in hours of employment;
      - Death;
      - Divorce or legal separation;
      - The exhaustion of COBRA continuation coverage;
      - The employer that maintains the group health plan no longer contributing toward the cost of such coverage;
      - The exhaustion of applicable lifetime benefits under the coverage;
      - An individual ceases to be a dependent under the plan;
      - The plan terminates a benefit package option;
      - If your coverage is provided through an HMO, you no longer live or work in the HMO's service area (and there is no other coverage available under the plan); or
      - The plan no longer offers coverage to a class of similarly situated individuals that includes you and/or your Eligible Dependent (e.g., the plan terminates coverage for all part-time colleagues); and

B. You elect coverage not later than 30 days after the date of the loss of coverage for one of the reasons stated above[2].

You will also be a special enrollee if you did not elect coverage under the Plan's Medical Benefit Program when you were first eligible to do so, even though you and your Eligible Dependents did not have other coverage, if you again decline coverage under the Plan's Medical Benefit Program during any subsequent annual open enrollment period because of other coverage

[2] The special enrollment period is extended by the COVID-19 "<u>Outbreak Period</u>," which began on March 1, 2020 and ends on the earlier of: (i) one year from the date of the special enrollment event, or (2) 60 days after the announced end of the National Emergency for COVID-19.

under your Eligible Dependent's employer's plan, and you later lose the coverage through the Eligible Dependent's employer's plan.

Coverage under the Plan's Medical Benefit Program for a special enrollee will become effective on the date of the loss of coverage that entitles the person to special enrollment if you timely complete your online enrollment. Any required contributions for the retroactive coverage must be paid with after-tax dollars. If you do not complete your online enrollment within 30 days[3] after the date of the loss of coverage, enrollment for the person must wait until the next annual open enrollment period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow the Eligible Colleague to enroll the person prior to such time).

Special Medical Benefit Program Enrollment for New Dependents

These special enrollment provisions also apply with respect to the Plan's Medical Benefit Program if you acquire an Eligible Dependent through marriage, birth, adoption or placement for adoption. You will be entitled to special enrollment if you meet one of the following conditions:

A. ***Non-Enrolled Colleague***: If you are an Eligible Colleague but have not enrolled in the Plan's Medical Benefit Program, you may enroll upon your marriage, or upon the birth, adoption, or placement for adoption of your Dependent Child.

B. ***Non-Enrolled Spouse***: If you are an Eligible Colleague who is already enrolled in the Plan's Medical Benefit Program, you may enroll your spouse at the time of his or her marriage to you. You may not enroll your spouse due to your acquisition of a child through birth, adoption, or placement for adoption.

C. ***New Dependents of an Enrolled Colleague***: If you are an Eligible Colleague who is already enrolled in the Plan's Medical Benefit Program, you may enroll a child who becomes your Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption.

D. ***New Dependents/Spouse of a Non-Enrolled Colleague***: If you are an Eligible Colleague but you are not enrolled in the Plan's Medical Benefit Program, you may enroll your spouse or child, as applicable, who becomes your Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption. However, you (the non-enrolled Eligible Colleague) must also be eligible to enroll, and actually enroll at the same time.

To enroll yourself and/or your new Eligible Dependent(s), you (the Eligible Colleague) must complete online enrollment no later than 30 days[4] after the date of the event that entitles you and/or your Eligible Dependent(s) to the special enrollment period. If you are entitled to special enrollment and you complete your online enrollment within 30 days of the date of the event[5], coverage will become effective as of the date of the event. Any required contributions for the retroactive coverage must be paid with after-tax dollars unless the event is the birth, adoption or placement for adoption of a child. If you do not timely complete online enrollment, enrollment for the person must wait until the next annual open enrollment period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your new Eligible Dependent(s) prior to such time).

HIPAA special enrollment rights also apply if (1) you and/or your Eligible Dependent lose Medicaid or Children's Health Insurance Program (***"CHIP"***) coverage due to no longer being eligible for those benefits, or (2) you and/or your Eligible Dependent become eligible for

[3] The special enrollment period is extended by the Outbreak Period set forth in footnote 2.
[4] The special enrollment period is extended by the Outbreak Period set forth in footnote 2.
[5] The special enrollment period is extended by the Outbreak Period set forth in footnote 2.

premium assistance in the Plan under a Medicaid program or CHIP. You (the Eligible Colleague) must request special enrollment due to one of these reasons by enrolling g no later than 60 days[6] after the date of the event that entitles you and/or your Eligible Dependent to the special enrollment period. If you are entitled to special enrollment and complete your online enrollment within 60 days[7] of the date of the event, coverage will become effective no later than the first day of the first calendar month beginning after the date of the event. If you do not timely complete online enrollment, enrollment for the person must wait until the next annual open enrollment period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to enroll yourself and/or your Eligible Dependent(s) prior to such time).

Irrevocable Election

Once you make your election for a Plan Year (or, in your initial year of eligibility, for the remaining portion of the Plan Year), you generally cannot change or revoke your election until the beginning of the next Plan Year unless you have a qualified change in status. This rule applies whether your election was to opt out of coverage, to begin participation, or to continue coverage by making no other affirmative election. However, in addition to the HIPAA special enrollment rights described above, an Eligible Colleague may enroll himself or herself and/or the Eligible Colleague's Eligible Dependent(s) in the Plan within 30 days after a qualified change in status event if such enrollment is as a result of and is consistent with the qualified change in status event. If proper enrollment is not completed during this time, enrollment of such an Eligible Colleague or Eligible Dependent(s) must wait until the next annual open enrollment period, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow enrollment prior to such time).

Qualified Change in Status

A ***"qualified change in status"*** includes the following events that may impact your (the Eligible Colleague's) or your Eligible Dependent's eligibility for coverage under the Plan:

A. ***Marital Status*** - An event that changes your legal marital status, including your:
   1. marriage;
   2. divorce;
   3. legal separation;
   4. annulment; or
   5. the death of your spouse.

   The commencement of a relationship with a Non-Spouse Eligible Adult (e.g., entering into or terminating a domestic partnership, civil union, or other similar arrangement that is currently recognized and registered with a state or local government registry with an Eligible Adult who is your Tax Dependent) is an event which permits an election to add coverage for the Non-Spouse Eligible Adult and the Non-Spouse Eligible Adult's children who are not also your children but are your Eligible Dependents only in accordance with Section F.3., below (i.e., a change in coverage under an employer plan). The termination of a relationship with or death of a Non-Spouse Eligible Adult will automatically result in the termination of coverage for the Non-Spouse Eligible Adult and the Non-Spouse Eligible Adult's children who are not also your children but is not an event that allows an election to revoke coverage or add coverage for you or you other Eligible Dependents; an election to add coverage for you and your Eligible Dependents would only be permitted if you and your Eligible Dependents have a loss of coverage that is a HIPPA special

[6] The special enrollment period is extended by the Outbreak Period set forth in footnote 2.
[7] The special enrollment period is extended by the Outbreak Period set forth in footnote 2.

enrollment event (and only for the Medical Benefit Program) or in accordance with Section F.3., below (i.e., a change in coverage under an employer plan).

B. ***Number of Dependents*** - An event that changes the number of your Eligible Dependents, including a:
   1. birth;
   2. death;
   3. adoption;
   4. placement for adoption;
   5. legal guardianship; or
   6. a change in the number of qualifying dependents under the Dependent Care Flexible Spending Account Program.

C. ***Employment Status*** – An event that changes the employment status of you or your Eligible Dependent who is your Tax Dependent and that causes you or your Eligible Dependent who is your Tax Dependent to either gain or lose eligibility for Benefit Program, such as:
   1. the commencement or termination of employment;
   2. a strike or lockout;
   3. the commencement or termination of an unpaid leave of absence;
   4. a change in work site location that removes the affected individual from a benefit plan's service provider area; or
   5. any employment status change that affects the eligibility of the individual to participate in a benefit program or plan of an employer, including a change from full-time to part-time, hourly to salaried, union to non-union status, or the reverse of any such change.

D. ***Residence*** - A change in your residence or the residence of your Eligible Dependent. Such a change entitles you to select another coverage option, but generally does not permit you to opt out of coverage entirely unless, as a result of the move, you and/or your Eligible Dependent(s), as applicable, are no longer eligible for coverage. In addition, coverage under the Medical Benefit Program (including Prescription Drug Program), Dental Benefit Program, and Vision Benefit Program may be added for an Eligible Dependent if a change in the Eligible Dependent's residence results in the Eligible Dependent being able to benefit from coverage under the Medical Benefit Program (including Prescription Drug Program), Dental Benefit Program, and Vision Benefit Program, respectively; coverage under the Medical Benefit Program (including Prescription Drug Program), Dental Benefit Program, and Vision Benefit Program may be dropped for an Eligible Dependent if a change in the Eligible Dependent's residence results in the Eligible Dependent no longer being able to benefit from the coverage under the Medical Benefit Program (including Prescription Drug Program), Dental Benefit Program, and Vision Benefit Program, respectively.

E. ***Dependent Eligibility*** - A change that causes an individual to satisfy or cease to satisfy the requirements to be an Eligible Dependent, including:
   1. the attainment of a particular age;
   2. gaining or losing student status, if applicable; or
   3. a change in Plan and/or Benefit Program eligibility requirements.

F. ***Cost or Coverage*** - A significant change in the cost or coverage of a Benefit Program offered to you, your spouse or other Eligible Adult or your Dependent Child, such as:
   1. a new benefit option being added;
   2. a benefit option being eliminated or significantly curtailed;

3. a change in coverage made under a plan offered by your Employer or the employer of your spouse or other Eligible Adult or Dependent Child, if the other employer's plan allows participants to make mid-year election changes allowed under the Code Section 125 Treasury Regulations;
4. a significant increase in the cost of a benefit (such a qualified change in status permits you to make a new benefit selection, but does not allow you to revoke coverage entirely, unless no other similar coverage is available); further, in the case of the Dependent Care Flexible Spending Account Program, where the provider is your relative, no election change is permitted for this change in status reason; or
5. a change in dependent care provider (for purposes of elections made under the Dependent Care Flexible Spending Account Program).

G. ***Medicare/Medicaid*** – You or your Eligible Dependent becomes covered or loses benefit coverage under Part A or Part B of Medicare or Medicaid, other than for pediatric vaccines (for the purpose of elections made under any available Benefit Program that is a health plan).

H. ***Court Order*** - A duly executed judgment, decree or order (including a qualified medical child support order ("QMCSO")), resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for your child (including your adopted or foster child) who is your Eligible Dependent (for the purpose of any elections made under any available Benefit Program that is a health plan, coverage previously elected by you may be dropped only if the other individual actually provides coverage for the child).

I. ***HIPAA*** - A special enrollment right you or your Eligible Dependent may be entitled to under the provisions of HIPAA (for the purpose of any elections made under any available accident or health plan, including the Health Care Flexible Spending Account Program if it is subject to the provisions of HIPAA).

J. ***COBRA*** – You or your Eligible Dependent who is your Tax Dependent becoming eligible for COBRA continuation coverage but only for the purpose of allowing an election to increase any pre-tax contributions to pay for the COBRA premium.

K. ***Federal Family and Medical Leave Act ("FMLA")*** - You commence or return from an unpaid leave of absence as permitted and regulated by the FMLA (as applied only to elections made under any Benefit Program that is a health plan).

L. ***Open Enrollment*** - An election of coverage by you or your Eligible Dependent another employer plan during an open enrollment period that differs in time from the Plan's annual open enrollment period offered by the Plan Administrator; provided, however, that you are not permitted to change your pre-tax contributions under the Plan due to the election of coverage by your Eligible Dependent that is not your Tax Dependent.

In addition to the above, consistent with the regulations under the Uniformed Services Employment and Reemployment Rights Act, if you gain eligibility for TRICARE during a Plan Year, you may drop your coverage under the Medical Benefit Program and, if you lose eligibility for TRICARE during a Plan Year you may elect coverage under the Medical Benefit Program.

Any election change or revocation you make must be consistent with the qualified change in status. **You must change or revoke your election within 30 days of the date of the qualified change in status event**. The change or revocation will be effective as of the date of the event. If a qualified change in status event occurs on the first day of the Eligible Colleague's

payroll period, any payroll deduction change will begin in the payroll period in which the event took place, and, if the event occurs after the first day of the Eligible Colleague's payroll period, any deduction change will begin in the next following payroll period. Payroll deductions will not be taken for any benefit coverage change that is effective before payroll deductions begin.

The terms of certain Benefit Programs may either not permit you or limit your right to change or revoke your election due to a qualified change in status event. Please refer to the specific Benefit Program materials for more details.

You are not permitted to reduce your election for the Health Care Flexible Spending Account Program or the Dependent Care Flexible Spending Account Program to an amount where your annualized contributions for such program is less than the amount already reimbursed. In addition, any change you make in your election which affects contributions to the Health Care Flexible Spending Account Program, Dependent Care Flexible Spending Account Program, HSA Program and HRA Program also will change the maximum reimbursement benefit available for the remaining portion of the Plan Year. Please see the Appendices to this Summary for additional information regarding the Health Care Flexible Spending Account Program, Dependent Care Flexible Spending Account Program, HSA Program and HRA Program.

If you become entitled to an increase in your coverage amount under the Voluntary Life Insurance Program and/or Voluntary AD&D Insurance Program (which are paid for with after-tax dollars) during a Plan Year as a result of an increase in your compensation from the Employer, you may elect to increase your contributions towards the cost of such coverage without experiencing a qualified change in status event if the new election is on account of and consistent with the increase in your compensation; provided, however, that you may not otherwise change your election with respect to such Benefit Program during the Plan Year unless you experience a qualified change in status.

If you are a participant in the HSA Program, you may elect to increase, decrease, or revoke your election to make contributions to your HSA through the Plan on a prospective basis at any time in accordance with the procedures established by the Plan Administrator. Any such election shall be effective as soon as administratively practicable following the date you make such an election in accordance with the procedures established by the Plan Administrator.

If your employment status changes but the employment status change does not cause you to lose eligibility for coverage under a Medical Benefit Program that is an ACA Group Health Plan, you may revoke or change your (and your Eligible Dependents', if any) coverage under the ACA Group Health Plan as well and the corresponding contributions election under the Plan, within 30 days of the date of your employment status change if you intend to enroll in other health coverage that is "minimum essential coverage," as defined in the Affordable Care Act (e.g., Health Insurance Marketplace coverage or your Eligible Adult's employer's group health plan or a lower cost group health plan option under this Plan) with the new coverage effective no later than the first day of the second month following the month that includes the date the ACA Group Health Plan coverage is revoked or changed. If you do not complete enrollment documents (or the online enrollment process, if directed by your Employer) to revoke or change your (and your Eligible Dependents', if any) ACA Group Health Plan coverage and corresponding contribution election within 30 days of the date of your employment status change, you must wait until the next election period to revoke or change the ACA Group Health Plan coverage, to be effective at the beginning of the next Plan Year (unless another event occurs which would allow you to revoke or change your coverage prior to such time).

You may cancel your (and your Eligible Dependents', if any) ACA Group Health Plan coverage and corresponding contributions election under the Plan in order to purchase coverage through

the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period (i.e., November 15 through the following February 15). In order to cancel ACA Group Health Plan coverage and corresponding contributions election, the Health Insurance Marketplace coverage must be effective immediately after the day the ACA Group Health Plan coverage is cancelled. You must complete enrollment documents (or the online enrollment process, if directed by your Employer) to revoke your (and your Eligible Dependents', if any) ACA Group Health Plan coverage and corresponding contributions election to purchase coverage through the Health Insurance Marketplace during a special enrollment period or during the Marketplace's annual enrollment period.

Participation During Leave of Absence

Subject to any specific limitations for a particular Benefit Program, if you are not at work with the Employer due to an unpaid FMLA leave, an unpaid period of military service, or another unpaid leave of absence pursuant to the Employer's policies, or any other reason that creates a legal obligation for the Employer to extend certain benefit coverages while you are not being paid by the Employer, your and your Dependents', if any, coverage under all of the Benefit Programs under the Plan that you and your Dependents, if any, were receiving at the date your unpaid leave of absence commenced will continue during the period of absence. However, with respect to any fully insured Benefit Program, such continued coverage is subject to the terms of the insurance contract or policy and approval by the applicable insurance carrier. In addition, this does not apply to HSA contributions, if any, which stop during your leave of absence and will restart at the pre-leave amount unless you elect to change the amount of these contributions in accordance with the applicable plan documents and procedures.

You will not be required to pay the required cost of coverage or premiums for the coverage under the Benefit Programs under the Plan that continues during your unpaid leave of absence until you return to employment following your unpaid leave of absence. As a result, you will have unpaid benefit contribution amounts that you are responsible for repaying. Upon your return from your unpaid leave of absence in the same Plan Year in which the leave began, your contributions will be increased to "make up" for contributions you missed during your leave period and, by accepting the continuation coverage during the leave, you consent to such deductions from your pay. If you do not return to employment with the Employer following the unpaid leave, you still must pay your Employer for the cost of coverage that was continued during the leave.

If you are absent from work for any paid leave of absence you must continue coverage under any and all Benefit Programs under the Plan (to the extent permitted by the terms of the Benefit Program) and your contributions (if any) for those Benefit Programs will continue to be deducted from your paychecks during the absence.

If you do not return to work at the end of an FMLA leave of absence, you may be entitled to purchase COBRA continuation coverage. See the "COBRA Continuation Coverage" Section of this Summary below for more details. In addition, if you do not return to work at the end of a military leave of absence, you may be entitled to purchase continuation coverage under any a "health plan" (as defined in 38 USCS Section 4303(7)) to the extent required by the Uniformed Services Employment and Reemployment Rights Act (***"USERRA"***). In order to be entitled to this continuation coverage, you must comply with USERRA. For example, you must give your Employer advance notice of the leave (unless military necessity prevents prior notice or providing prior notice is otherwise impossible or unreasonable) and your total leave, when added to any prior periods of military leave from the Employer does not exceed 5 years (with certain exceptions including certain types of service that are not counted toward the 5-year limit). Your military leave benefits continuation period runs concurrently with your COBRA Continuation Coverage period. This means that COBRA coverage and USERRA coverage

begin at the same time. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation coverage period to which you and your dependents may be eligible. See the ***"COBRA Continuation Coverage"*** Section of this Summary below for more details.

Rehired Colleagues

If you terminate employment with all of the Employers and you are subsequently reemployed by an Employer, you will become a participant as provided in the document(s) for each Benefit Program. Except as provided in the document(s) for a Benefit Program or the Trinity Health Human Resources Ministry-Wide Rehire Policy No. 1022.

Employment Transfers

If you transfer employment positions with the same Employer or transfer from one Employer to another Employer, your benefits may be affected. Except as provided in the document(s) for a Benefit Program or the Trinity Health Human Resources Ministry-Wide Employment Transfers Policy No. 1023.

Ceasing Participation

Except as specifically provided in any Benefit Program, you will cease to be a participant in each Benefit Program as of the earliest of:

- If your employment with all of the Employers terminates, except as otherwise provided under the Trinity Health Corporation Severance Pay Plan, the Trinity Health Corporation Severance Pay Policy or another severance policy or separation, employment, severance or similar agreement:
    - The effective date of the termination of your coverage under the Life Insurance, AD&D Insurance, Short-Term Disability, Long-Term Disability, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account and another voluntary Benefit Programs is the date your employment terminates;
        - The effective date of the termination of your coverage under the Medical, Dental and Vision Programs is the last day of the month in which your employment terminates;
    - The effective date of the termination of your coverage under the EAP is 18 months after the date your employment terminates;
- The date you cease to be an Eligible Colleague (except with respect to the EAP because all colleagues are eligible for the EAP);
- The date the Benefit Program terminates;
- The date the Plan terminates;
- The date you elect to terminate your participation in the Benefit Program (whether pursuant to your annual open enrollment elections or pursuant to a qualified change in status);
- The date you fail to make any required contribution (other than in connection with certain leaves of absence, as described above); or
- The date of your death.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (e.g., exclusions for certain medical procedures) are described in the incorporated documents.

If you are a full-time Eligible Colleague of an Employer for a Plan Year (i.e., you averaged at least 30 hours of service per week for the Employer during the applicable measurement period for that Plan Year or you are hired by the Employer during the Plan Year and you are expected to work an average of at least 30 hours per week when you are hired), as determined under the Trinity Health Human Resources ACA Employee Eligibility Procedure, you will not cease to be eligible for coverage under any ACA Group Health Plan until the later of the earliest date set forth above or the last day of the applicable stability period.

Note that when you terminate employment during a Plan Year, under the Health Care Flexible Spending Account Program, the final date that you can incur eligible medical expenses is the date of your termination of employment (unless you elect COBRA coverage); however, you have until the March 31 following your termination (or, if March 31 falls on a Saturday, Sunday, or holiday, the next following business day) to file claims for reimbursement from your Health Care Flexible Spending Account. Under the Dependent Care Flexible Spending Account Program, you have until the date of your termination of employment to incur dependent care expenses and until the March 31 following your termination of employment (or, if March 31 falls on a Saturday, Sunday, or holiday, the next following business day) to file claims for reimbursement of dependent care expenses.

Except as specifically provided in any Benefit Program or under the Trinity Health Corporation Severance Pay Plan, the Trinity Health Corporation Severance Pay Policy or another severance policy or separation, employment, severance or similar agreement, coverage for your Eligible Dependents terminates on the earliest of:

- The date your coverage terminates except that:
    - If your coverage terminates due the termination or reduction in your hours of employment, the effective date of the termination of coverage under the EAP is 18 months after the date your employment terminates or your hours of employment are reduced; and
    - In the event of your death, coverage under the Medical, Dental and Vision Programs terminates 60 days from the date of your death and coverage under the EAP terminates 36 months following the date of your death;
- The date the individual ceases to be an Eligible Dependent;
- The date any required contribution for the Eligible Dependent's coverage is not made in a timely manner;
- The date you elect to terminate the Eligible Dependent's coverage (whether pursuant to your annual open enrollment election or pursuant to an election following a qualified change in status event);
- For a child covered pursuant to a QMCSO, the date the child is no longer covered under a QMCSO; or
- With respect to any Benefit Program, the date specified in the incorporated documents for the Benefit Program.

If you fail to notify the Plan Administrator that your Eligible Dependent has ceased to be an Eligible Dependent, the Eligible Dependent's coverage under the applicable Benefit Program(s) will still be terminated effective as of the date of the event making them ineligible. However, applicable deductions changes will only be made on a go forward basis.

Under certain circumstances, even though your participation in (or your Eligible Dependent's coverage under) a Benefit Program has terminated, the provisions of the specific Benefit Program may permit you (and/or your Eligible Dependent, if applicable) to continue to be covered under the Benefit Program at your own cost (called ***"COBRA Continuation***

Coverage"). See the ***"COBRA Continuation Coverage"*** Section of this Summary below for more details.

CONTINUATION OF COVERAGE

COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (***"COBRA"***). COBRA Continuation Coverage is a temporary extension of health coverage, available to you and to other members of your family who are covered under the Plan, at group rates, in certain instances where coverage under the Plan would otherwise end. **This information is intended to provide notice and explain, in a summary fashion, COBRA Continuation Coverage, when it may become available to you and your family, what you must do to continue your health care coverage under the Plan, including what to do to protect the right to receive it.** This information gives you only a summary of your COBRA Continuation Coverage rights. Both you and your spouse, if any, should take the time to read this information carefully. For more information about your COBRA rights and obligations under the Plan and under federal law, please see the additional incorporated summaries prepared for each Benefit Program to which COBRA applies.

The COBRA Continuation Coverage described in this section of the Summary does not apply to a Post-Tax Eligible Adult or Dependent Children who are a Post-Tax Eligible Adult's children but who are not also the Eligible Colleague's children. However, pursuant to a voluntary program, such individuals may be eligible to continue coverage under the Plan when they would otherwise lose coverage. The terms of such continuation coverage are generally the same as the COBRA Continuation Coverage described in this section.

The Plan Administrator, as listed at the end of this Summary, is responsible for administering COBRA Continuation Coverage. The Plan Administrator has contracted with the third-party administrator listed at the end of this Summary to assist with the Plan's COBRA administration. The Plan Administrator may terminate or modify its contract with the third-party administrator at any time in its discretion.

COBRA Continuation Coverage is a continuation of group health coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose group health coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, colleagues, spouses of colleagues and dependent children of colleagues may be qualified beneficiaries. In addition, Post-Tax Eligible Adults of colleagues and their dependent children may be treated as qualified beneficiaries. Under the Plan, qualified beneficiaries (including Post-Tax Eligible Adults of colleagues and their dependent children, if applicable) who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you are a colleague of the Employer covered by the Plan (the ***"Participant"***), you will become a qualified beneficiary if you lose your group health coverage under the Plan because of a reduction in your hours of employment or the termination of your employment with your Employer (for reasons other than gross misconduct on your part).

If you are the Eligible Adult of the Participant, you will become a qualified beneficiary if you lose group health coverage under the Plan for any of the following reasons:

A. The death of the Participant;

B. A termination of the Participant's employment (for reasons other than his or her gross misconduct) or reduction in the Participant's hours of employment;

C. Divorce or legal separation from the Participant or otherwise ceasing to be the Participant's Eligible Adult; or

D. The Participant becomes enrolled in Medicare (Part A, Part B or both).

In the case of a dependent child of the Participant, he or she will become a qualified beneficiary if the child's group health coverage under the Plan is lost for any of the following reasons:

A. The death of the Participant;

B. The termination of the Participant's employment (for reasons other than the Participant's gross misconduct) or reduction in the Participant's hours of employment with the Employer;

C. Parents' divorce or legal separation (or a Participant's Eligible Adult ceasing to be the Participant's Eligible Adult);

D. The Participant becomes enrolled in Medicare (Part A, Part B or both); or

E. The dependent ceases to be an Eligible Dependent under the Plan.

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

If there is a choice among types of coverage under the Plan, each person eligible for COBRA Continuation Coverage is entitled to make a separate election among the types of coverage. Thus, an Eligible Adult or Dependent Child is entitled to elect COBRA Continuation Coverage even if the Participant does not make that election. Similarly, an Eligible Adult or Dependent Child may elect a different coverage from the coverage elected by the Participant.

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the colleague, commencement of a proceeding in bankruptcy with respect to the Employer or enrollment of the colleague in Medicare (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events[8].

For the other qualifying events (divorce or legal separation of you and spouse, an individual ceasing to be a Participant's Eligible Adult or a Dependent Child's loss of eligibility for coverage as a Dependent Child), you must notify the third-party administrator or Plan Administrator. The Plan requires you to notify the third-party administrator or Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the third-party administrator or Plan Administrator at the address listed at the end of this Summary. Your notice must be in writing and must

[8] The COBRA notification periods set forth in this section are extended by the Outbreak Period set forth in footnote 2.

include: (1) the Plan name, (2) the name of the Participant and each qualified beneficiary impacted by the qualifying event, (3) the type of qualifying event, and (4) the date of the qualifying event. The notice to the third-party administrator or Plan Administrator can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.

Once the third-party administrator or Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the colleague, the colleague's enrollment in Medicare (Part A, Part B or both), the colleague's divorce or legal separation, an individual ceasing to be an Eligible Adult or a dependent child losing eligibility as an Eligible Dependent, COBRA Continuation Coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the colleague's hours of employment, COBRA Continuation Coverage lasts for up to 18 months. However, if the qualifying event is the colleague's termination of employment or reduction in hours of employment and the qualifying event occurs within the 18-month period after the colleague becomes enrolled in Medicare, the colleague's Eligible Adult and Dependent Children are entitled to COBRA Continuation Coverage for up to 36 months from the date the colleague enrolled in Medicare.

There are two additional ways in which this 18-month period of COBRA Continuation Coverage can be extended.

F. **Disability Extension of 18-Month Period of Continuation Coverage**. If you or anyone in your family who has COBRA Continuation Coverage under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA Continuation Coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator or third-party plan administrator is notified of the Social Security Administration's determination within 60 days of the later of: (i) the date of the qualifying event (the colleague's termination of employment or reduction in hours); (ii) the date of the Social Security Administration determination; and (iii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In addition, you must notify the Plan Administrator or third-party plan administrator of the Social Security Administration determination before the end of the 18-month period of COBRA Continuation Coverage. This notice should be sent to the Plan Administrator or third-party plan administrator at the address listed for the Plan Administrator or third-party plan administrator at the end of this Summary. The notice must be in writing and must include: (1) the Plan name, (2) the name of the Participant and the disabled qualified beneficiary, if different, (3) the date of the Social Security Administration's determination of disability, and (4) a copy of the Social Security Administration's determination of disability. The notice can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.

G. **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**. If your family experiences another qualifying event while receiving COBRA Continuation Coverage, the spouse or other Eligible Adult and Dependent Children in your family can

get additional months of COBRA Continuation Coverage, up to a maximum of 36 months. This extension is available to the spouse or other Eligible Adult and Dependent Children if the former colleague dies, gets divorced or legally separated (or the individual otherwise ceases to be an Eligible Adult, if applicable) or enrolls in Medicare Part A and/or Part B (and the former colleague's enrollment in Medicare Part A and/or Part B would have been a qualifying event if it occurred before the former colleague's termination of employment or reduction in hours of employment). The extension is also available to a Dependent Child when that child stops being eligible under the Plan as a Dependent Child. **In all of these cases, you must make sure that the Plan Administrator or third-party plan administrator is notified of the second qualifying event within 60 days of the date of the second qualifying event. This notice must be sent to the Plan Administrator or third-party plan administrator at the address listed for the Plan Administrator or third-party plan administrator at the end of this Summary. The notice must be in writing and must include: (1) the Plan's name, (2) the name of the Participant and each qualified beneficiary impacted by the second qualifying event, (3) the nature of the second qualifying event, and (4) the date of the second qualifying event. The notice can be provided by the Participant, the qualified beneficiary or any representative on behalf of the Participant or the qualified beneficiary.**

If you have questions about your COBRA Continuation Coverage, you should contact the Plan Administrator, third-party plan administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (***"EBSA"***). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

If you are a colleague's Post-Tax Eligible Adult or the child of a colleague's Post-Tax Eligible Adult (who is not also the colleague's child) and you have questions about your COBRA-like Continuation Coverage, you should contact the Plan Administrator or third-party plan administrator.

In order to protect your family's rights, you should keep the Plan Administrator and third-party plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or third-party plan administrator.

COBRA Continuation Coverage Under the Trade Act of 2002

Section 605(b) of ERISA, as amended by the Trade Act of 2002, provides for a second 60-day COBRA Continuation Coverage election period for individuals who become eligible for trade adjustment assistance or alternative trade adjustment assistance (collectively ***"TAA"***) under the Trade Act of 1974. An eligible TAA recipient or an eligible alternative TAA recipient (collectively, a ***"TAA-eligible individual"***) is a worker whose employment is adversely affected by international trade through increased imports or a shift in production to another country and who receives TAA.

If you become certified as a TAA-eligible individual and you did not elect COBRA Continuation Coverage during the initial 60-day COBRA election period that was a direct result of the TAA-related loss of coverage, you may elect COBRA Continuation Coverage during a second 60-day election period that begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided that your election is made not later than six months after the date of the initial loss of group health coverage that triggered the initial COBRA Continuation Coverage eligibility.

COBRA Continuation Coverage elected during the second 60-day election period begins on the first day of the second election period and not on the date of the original loss of coverage. Further, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether you have had a 63-day break in coverage under HIPAA's pre-existing condition rules.

Continuation Coverage -- Health Care Flexible Spending Account Program

Regardless of the COBRA Continuation Coverage provisions outlined above and in the applicable incorporated documents, you will be eligible to elect continuation coverage under the Health Care Flexible Spending Account Program only if your health care flexible spending account balance at the time of a COBRA qualifying event equals or exceeds the amount of COBRA premiums required to maintain coverage under the Health Care Flexible Spending Account Program for the balance of the calendar year in which the qualifying event occurs. If you are eligible to elect COBRA Continuation Coverage under the Health Care Flexible Spending Account Program, the COBRA Continuation Coverage will be available only until the end of the Plan Year in which the qualifying event occurs.

Eligible Dependents who are not Tax Dependents of a colleague or former colleague are not eligible to elect COBRA-like Continuation Coverage under the Health Care Flexible Spending Account Program.

Continuation Coverage -- Health Reimbursement Account Program

Regardless of the COBRA Continuation Coverage provisions outlined above and in the applicable incorporated documents, you must be eligible to elect COBRA Continuation Coverage under an HRA Medical Benefit Program and you must actually elect COBRA Continuation Coverage under an HRA Medical Benefit Program to receive COBRA Continuation Coverage under the HRA Program. If you elect COBRA Continuation Coverage under an HRA Medical Benefit Program, you may also elect COBRA Continuation Coverage under the HRA Program. COBRA Continuation Coverage under the HRA Program will automatically end when COBRA Continuation Coverage under the HRA Medical Benefit Program ends (or such earlier date as described above).

Eligible Dependents who are not Tax Dependents of a colleague or former colleague are not eligible for COBRA-like Continuation Coverage under the HRA Program.

USERRA Continuation of Coverage

If you perform service in the uniformed services, you may elect continuation of coverage for any Benefit Program under the Plan that is considered to be a “health plan” (as defined in 38 USCS Section 4303(7)), as required by the USERRA. See ***“Coverage During Military Leave,”*** above, for additional information.

ADDITIONAL PLAN FEATURES

Maternity Hospital Stays

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

Women's Health And Cancer Rights Act

If you are a participant or dependent receiving benefits under the Medical Benefit Program in connection with a mastectomy and you elect breast reconstruction, the Medical Benefit Program will cover benefits consistent with the Women's Health and Cancer Rights Act. These benefits are coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of the mastectomy, including lymphedemas.

These benefits are subject to the deductibles and coinsurance limitations, if any, applicable to the medical coverage available under the Medical Benefit Program option that you choose under the Plan.

HIPAA Privacy Compliance

The medical, prescription drug, dental, vision, employee assistance and health care flexible spending account programs and the HRA Program portions of the Plan (the identified ***"health care components"***) may have access to certain health information about you and your covered dependents. This information is necessary to administer claims and provide benefits under the Plan. The Plan understands and recognizes the confidentiality and sensitivity of your health information and is committed to protecting this information from inappropriate uses and disclosures.

As required by HIPAA, the Plan has adopted certain privacy policies and procedures related to the use and disclosure of your protected health information (***"PHI"***). You will receive a copy of the Plan's Notice of Privacy Practices (the ***"Notice"***) that outlines how and when the Plan can use or disclose your PHI as well as your rights and protections under the law. If there are material changes made to the Plan's practices and procedures regarding the use and protection of your PHI, you will receive a revised Notice. In addition, you may receive a copy of the Notice at any time by contacting the Plan's Privacy Official listed in the Notice.

The Plan has appointed one or more individuals to oversee the Plan's compliance with the HIPAA privacy rules and to address complaints. If you have any questions about how the Plan protects your PHI and your question is not answered by reviewing the information in the Notice, if you would like more information about the Plan's privacy practices or if you want to make a complaint about the Plan's privacy activities, contact the individual(s) identified in the Notice.

CLAIMS PROCEDURES

You should follow the procedures under each Benefit Program to request benefits under such program. If your request is denied, you may appeal your claim under the claims procedures provided under the specific Benefit Program.

If the Benefit Program does not have a claims procedure and you believe you are being denied any rights or benefits under the Plan and you wish to seek those benefits or you have a claim regarding eligibility to participate in the Plan or a Benefit Program, you, or your authorized representative on your behalf, must file a written claim with the Administrator at the address listed in the back of this Summary. The Administrator will review your claim and notify you of its determination under the procedures set forth below. The procedures set forth below also apply to claims regarding eligibility to participate in the Plan.

Claims Notification

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

- For all claims:

  (a) the specific reason(s) for the claim's denial;
  (b) the specific reference to pertinent Plan provisions on which the decision is based;
  (c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and
  (d) a description of the Plan's review or appeal procedures and time limits applicable to such procedures, including a statement of your right to bring an action in federal court under Section 502(a) of ERISA with respect to any adverse benefit determination on review or appeal (i.e., after the Plan's appeal procedures have been exhausted).

- If your claim is a medical benefit claim, the notice will also contain:

  (e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse benefit determination, either the specific rule, guideline, protocol or other criterion or a statement that a copy of such information will be provided free of charge upon request; and

  (f) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment used in the determination or a statement that such explanation will be provided free of charge upon request. Notice of a denial of an urgent care claim will also contain a description of the expedited review process; this notice can be provided orally within the timeframe for the expedited review process if a written notice is provided no later than three days after the oral notice;

  (g) information sufficient to identify the claim involved, including the date(s) of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and the corresponding meaning of these codes*;

  (h) the denial code, if any, and its corresponding meaning and a description of the standard, if any, that was used in denying the claim*;

(i) a description of the available internal appeal and external review processes, including instructions on how to initiate an appeal; and

(j) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes*.

*Not applicable to claims with respect to HIPAA "excepted benefits" such as the Dental Benefit Program and Health Care Flexible Spending Account Program.

- If your claim is a disability benefit claim, the notice will also contain:

(k) either the specific internal rules, guidelines, protocols, standards or other similar criteria that were relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;

(l) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(m) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by you to the Plan of health care professionals treating the claimant and vocational professionals who evaluated you;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination regarding you presented by you to the Plan made by the Social Security Administration; and

(n) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

This notification will be given within the following timeframes, depending on the type of claim[9]:

Urgent Care Claims – within 72 hours after receipt of your claim, unless you do not provide enough information for the Administrator to determine what benefits are payable under the Plan. If this occurs, the Administrator will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Administrator will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An ***"urgent care claim"*** is a claim for medical care or treatment where a delay in making a determination could jeopardize the life or health of you or your dependent or the ability of you or

[9] The notification periods set forth in this section are extended by the Outbreak Period set forth in footnote 2.

your dependent to regain maximum function, or, in the opinion of your or your dependent's physician, would subject you or your dependent to severe pain that cannot be adequately managed without the requested treatment.

Pre-Service Claims – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Administrator, but only if the Administrator notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the Administrator expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A ***"pre-service claim"*** is a request for approval of a medical benefit where receipt of the benefit is conditioned, in whole or in part, on approval in advance of obtaining medical care. Examples include pre-authorization for hospital stays, second surgical opinions, etc.

Post-Service claims – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Administrator's control if the Administrator notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the Administrator expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

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

Ongoing treatment – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an adverse benefit determination. The Administrator must notify you within a reasonable time prior to the reduction or termination of services. If you request to extend urgent care treatment beyond the approved period of time or number of treatments, the Administrator will notify you of its decision as soon as possible, but no later than 24 hours after receiving your claim, provided that your request was made at least 24 hours in advance of the end of the approved ongoing treatment. If you do not make your claim at least 24 hours before the expiration of the ongoing treatment, then the time frames for urgent care claims (discussed above) will apply. If your request to extend ongoing treatment does not involve urgent care, your claim will be treated as either a pre-service or post-service claim, as applicable.

Disability claims – within a reasonable time, but no later than 45 days after receipt of your claim. The review period may be extended for an additional 30 days due to matters beyond the Administrator's control if the Administrator notifies you of the extension before the end of the 45-day period, the circumstances requiring the extension and the date by which the Administrator expects to make a decision. If, prior to the end of the first 30-day extension, the Administrator determines that a decision cannot be made within the 30-day extension, the period for making a decision may be extended another 30 days, as long as the Administrator notifies you of the reasons requiring the extension and the date by which the Administrator expects to make a decision.

Other claims – the Administrator will notify you within 90 days. An extension of an additional 90 days is available if written notice is given to you before the initial 90-day period ends.

Generally, if notice of an adverse benefit determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period. However, if your claim is for group health benefits and the Administrator does not comply with the procedures set forth above, the Plan's internal claims and appeal process will be deemed exhausted and you may initiate an external review of the claim (described below) or bring an action under Section 502(a) of ERISA with respect to the claim unless the violation is minor and does not cause (and is not likely to cause) prejudice or harm to you, occurs in the context of an ongoing, good faith exchange of information between the Administrator and you, is due to good cause or matters beyond the control of the Administrator, and is not reflective of a pattern or practice of non-compliance. You may make a written request to the Administrator for an explanation of the Administrator's basis for asserting that it meets these requirements.

Plan Appeals

If your claim is denied or deemed to be denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal in writing (except in the case of an urgent care claim appeal) and request a review of your claim. Your appeal must be received by the Plan Administrator within the following time frames[10]:

- Medical benefit claims (including urgent care, pre-service, post-service and ongoing treatments) = 180 days
- Disability claims = 180 days
- All other claims = 60 days

You may submit written issues, comments, records, documents and other information related to your claim to the Plan Administrator. You may also, upon request and at no charge, be provided reasonable access to and copies of all documents, records and other information relevant to your claim. In the case of medical care and disability claim appeals, review on appeal will not take into consideration the initial claim determination and will be completed by a fiduciary of the Plan other than the individual that made the original claim determination or the subordinate of such individual.

Appeal Notification

If your appeal is received by the appropriate deadline, the Plan Administrator will independently review your appeal and any additional information that you submit. The Plan Administrator will notify you of its decision regarding your appeal within the following timeframes:[11]

Urgent-care claims – as soon as possible, but no later than 72 hours after receipt of your appeal.

Pre-Service claims – within a reasonable period, but no later than 30 days after receipt of your appeal.

Post-Service claims – within a reasonable period, but no later than 60 days after receipt of your appeal.

Disability claims – within a reasonable time, but no later than 45 days after receipt of your appeal. If special circumstances require, the time period may be extended for 45 days. The Plan Administrator will notify you of the necessary extension before the initial 45-day period ends.

[10] The timeframes set forth in this section are extended by the Outbreak Period set forth in footnote 2.
[11] The timeframes set forth in this section are extended by the Outbreak Period set forth in footnote 2.

Other claims – within a reasonable time, but no later than 60 days after receipt of your appeal. If special circumstances require, the time period may be extended for 60 days. The Plan Administrator will notify you of the necessary extension before the first 60-day period ends.

If your appeal is denied, the Plan Administrator will send you a notice with respect to the final internal adverse benefit determination that contains:

- For all claims:

  (a) the specific reason(s) for the claim's denial;
  (b) the specific reference to pertinent Plan provisions on which the decision is based;
  (c) a statement that you may receive, upon request and at no charge, reasonable access to and copies of all documents, records and information relevant to your claim, and
  (d) a statement describing any voluntary appeal procedures offered by the Plan or specific Benefit Program, your right to bring an action in federal court under Section 502(a) of ERISA, and, with respect disability benefit claims, a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

- If your claim is a medical benefit claim, the notice will also contain:

  (e) if an internal rule, guideline, protocol or other similar criterion was relied on in making the adverse benefit determination, either the specific rule, guideline, protocol or other criterion or a statement that a copy of such information will be provided free of charge upon request;

  (f) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment used in the determination including applying the terms of the Plan to the request or a statement that a copy of the information will be provided free of charge upon request.

  (g) The following statement: "You and 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."

- If your claim is a disability benefit claim, the notice will also contain:

  (g) either the specific internal rules, guidelines, protocols, standards or other similar criteria that were relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist;
  (h) if the denial is based on medical necessity, experimental or investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment used in the determination , applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided free of charge upon request;
  (i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination made by the Social Security Administration regarding you and presented by you to the Plan.

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

Generally, if notice of an adverse benefit determination is not given to you within the applicable time period, your appeal will be considered denied as of the last day of the applicable review period. However, if your appeal is of a claim for group health benefits and the Plan Administrator does not comply with the procedures set forth above, the Plan's internal appeal process will be deemed exhausted and you may initiate an external review of the claim (described below) or bring an action under Section 502(a) of ERISA with respect to the claim unless the violation is minor and does not cause (and is not likely to cause) prejudice or harm to you, occurs in the context of an ongoing, good faith exchange of information between the Plan Administrator and you, is due to good cause or matters beyond the control of the Plan Administrator, and is not reflective of a pattern or practice of non-compliance. You may make a written request to the Plan Administrator for an explanation of the Plan Administrator's basis for asserting that it meets these requirements.

External Review

There is an external review process for certain group health benefit claim reviews and appeal denials. An external review may be requested only for an adverse benefit determination with respect to a Claim Involving Medical Judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer, or a rescission of coverage (i.e., a cancellation or discontinuance of coverage under group health plan that has a retroactive effect). A ***"Claim Involving Medical Judgment"*** is a claim for group health benefits involving, but not limited to, decisions based on the group health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational. Information regarding the external review process is available by contacting the Administrator.

Statute of Limitations

For purposes of filing any civil action against the Plan upon the exhaustion of all other available administrative remedies, you may bring a legal action no later than one year from the date of completion of the Plan's claims appeal process, or if earlier, three years from the time "proof of

loss" for the applicable benefit is required under the applicable Benefit Program. If a "proof of loss" timeframe does not otherwise exist under the applicable Benefit Program(s), the proof of loss timeframe will be deemed to be a submission within 90 days following the date you experience an event entitling you to the applicable benefit under the Plan.

Misrepresentation and Fraud

If, for the purpose of obtaining or continuing to obtain benefits under the Plan and/or a Benefit Program, an Eligible Colleague, dependent or anyone acting on behalf of such person makes, or causes to be made, a false statement or misrepresentation, conceals or withholds information, commits fraud against the Plan and/or a Benefit Program, or otherwise misleads the Plan, Benefit Program, Employer, Administrator or Plan Administrator, the Plan and/or Benefit Program shall be entitled to recover its damages, including benefits paid and legal fees, from the Eligible Colleague, dependent or from any other person responsible for misleading or committing fraud against the Plan and/or Benefit Program, and from the person for whom the benefits were provided.

COORDINATION OF BENEFITS

Certain types of plans coordinate the payment of benefits. Benefits for medical and healthcare related expenses paid by a Benefit Program under this Plan will be coordinated with benefits payable under other plans, including:

A. Plans provided by an employer, union, trust or similar plan;

B. Other group health plans that cover you or your dependents; and

C. Governmental programs or coverage required by law (*i.e.*, Medicare and no-fault automobile insurance).

The Plan does not coordinate benefits with individual, privately-paid coverage except no-fault automobile insurance. The Medical Benefit Program coverage is "qualified health coverage" for purposes of Michigan's no-fault insurance law (MCL 500.3107d(7)(b)(i)).

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a benefit (if any). When benefits are coordinated, the plans decide which plan pays first (*i.e.*, primary), which pays second (*i.e.*, secondary), etc. Below are the guidelines the Plan uses to determine which plan is primary.

1. A plan is considered primary if the plan: (a) has no coordination of benefits provision; (b) coordinates benefits according to different rules; (c) is a plan required by law (*i.e.*, Workers' Compensation); or (d) constitutes a no-fault motor vehicle insurance or third party liability policy.

2. The plan covering the person as an employee, rather than as a dependent, is primary and pays benefits first. The plan covering an active employee pays first before the plan covering a laid-off or retired employee.

3. If both parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the birthday rule, then the rules of that plan determine the order of benefits. If the other plan uses the gender rule, the father's plan is primary.

4. In the case of a divorce or separation, the plan of the parent (who hasn't remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan is always primary.

5. If the parent with custody remarries, his or her plan pays benefits first, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan is always primary.

If a determination can't be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

SUBROGATION AND REIMBURSEMENT

The Plan does not cover expenses for which another party may be responsible as a result of having caused or contributed to an injury, sickness or other loss. Notwithstanding any other subrogation or right of reimbursement provisions contained in any Benefit Program or applicable incorporated document, if you or your dependent or your or your dependent's heir, legatee, administrator, executor, personal representative, beneficiary, or assignee (collectively, the ***"Claimant"***), has any claim, right, or cause of action against any other person for payment of expenses covered under this Plan other than:

A. Another benefit plan, as described in the ***"Coordination of Benefits"*** Section of this Summary; or

B . In the case of a colleague, one or more of his or her dependents; or

C. In the case of a dependent, the colleague upon which he or she is dependent and any other dependents of such colleague;

benefits may be withheld under the Plan when a party other than the participant may be liable for such expenses until such liability is legally determined.

In certain circumstances, you, your dependent, or another Claimant may have an obligation to reimburse the Plan for payments made to or on behalf of you or your dependent. In particular, if you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant (such as under a policy of insurance), then payments made by the Plan are only made on the condition that the Plan will be reimbursed by you, your dependent, and/or other Claimant to the extent of any amounts received from the third party. It does not matter whether the amounts received from the third party are as a result of a judgment rendered in a lawsuit, as a settlement of a claim, or otherwise.

If you, your dependent, or another Claimant is entitled to any benefits under the Plan as a result of an injury or illness for which a third party is legally responsible or obligated to indemnify you, your dependent, or another Claimant, the Plan shall, to the extent of its payment of benefits, be subrogated to all of your, your dependent's, and any other Claimant's rights of recovery arising out of any claim or cause of action that may accrue because of the alleged negligent, willful or other conduct of a third party. As a result, if a Claimant does not pursue recovery from a liable third party, the Plan may pursue the claim on the Claimant's behalf. In addition, a Claimant agrees to reimburse the Plan for any benefits paid under the Plan, and any out-of-pocket expenses incurred by the Plan, Plan Administrator, Administrator, Company, or any Employer in pursuing such recovery, out of any monies recovered from a third party as the result of judgment, settlement or otherwise.

The subrogation and reimbursement obligation applies to any full or partial recovery from a third party, even if the Claimant has not been "made whole" for the loss accruing because of the alleged negligent, willful or other conduct of the third party. Further, the Plan's right of reimbursement applies on a first-dollar basis. In other words, the reimbursement right shall be in first priority over you, your dependent, and any other Claimant to the extent of any benefits paid hereunder. The reimbursement obligation applies to any amounts paid by a third party, is not limited by the stated purpose of the payment from the third party or how it is characterized in any agreement or judgment, and is not subject to offset or reduction by reason of any legal fees or other expenses incurred by the Claimant in securing such recovery.

By filing a claim for and accepting benefits under this Plan, any Claimant shall be deemed to have consented to the Plan's rights of subrogation and reimbursement and to have agreed to cooperate with the Company, Employer, Administrator and/or Plan Administrator in any respect necessary or advisable to make, perfect or prosecute such claim, right or cause of action, regardless of whether the Claimant chooses to pursue such claim, right or cause of action. A Claimant may not do anything that would prejudice the rights of the Plan to this right of reimbursement or subrogation, and payment of any claims to or on behalf of you or your dependents may be delayed, withheld, or denied unless the Claimant cooperates fully and, upon the request of the Company, Employer, Administrator or Plan Administrator, enters into a subrogation and reimbursement agreement with the Plan. The Plan's right to subrogation and reimbursement do not apply, however, to a recovery obtained by you or your dependent from an insurance company on a policy under which you or your dependent is entitled to indemnity as a named insured person.

The Plan shall have an equitable lien against any right the Claimant may have to recover any payments made by the Plan from any other party. Recovery shall be limited to the amount of payments made from this Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment, settlement or otherwise, where the Plan has paid expenses otherwise eligible as covered expenses under the Plan prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or programs or the Employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anyone (including, but not limited to, the Claimant, the Claimant's attorney, and/or a trust) as a result of an exercise of the Claimant's rights of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future benefit payments otherwise available to the Claimant under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien. The Plan's provisions regarding subrogation, reimbursement, equitable liens or other equitable remedies are intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

ADMINISTRATIVE AND LEGAL OVERVIEW

Administrative Information

About the Plan

The official name of the Plan is the ***"Trinity Health Corporation Welfare Benefit Plan."*** The Plan was originally effective January 1, 2002. The Plan contains two ERISA Plans that have plan number designations Plan 504 and 505.

Plan Administrator

Trinity Health Corporation is the Plan Administrator and named fiduciary for purposes of ERISA. The "***Administrator***" of the Plan is the person, persons or entity appointed by the Plan sponsor or the Plan Administrator, in accordance with its delegated authority, from time to time to assist in the day-to-day administration of the Plan. The ***"Benefits Committee"*** is the Trinity Health Benefits Committee. The Benefits Committee assists Trinity Health Corporation in the administration of the Plan. Accordingly, all references in the SPD to the "Plan Administrator," are references to the Trinity Health Corporation, as assisted in discharging its duties by the Benefits Committee, in accordance with the Benefits Committee's Charter and By-Laws and its delegated authority, and only to the extent it does not detract from the Benefits Committee's principal purpose of administration of the church plans, or the Administrator, in accordance with its delegated authority in the Trinity Health Corporation Table of Authority for Welfare Benefit Plans.

The Plan Administrator is responsible for maintaining all individual and Plan records, filing Plan tax returns and reports, authorizing payments, and resolving questions of Plan interpretation. Certain responsibilities of the Plan Administrator with respect to the Plan have been delegated to the Administrator. In addition, the Plan Administrator may utilize the services of insurance companies and/or professional third-party administrators to assist with administration of the Plan. You can contact the Administrator or Plan Administrator as follows:

Trinity Health Corporation
Attn: Total Rewards Benefits & Well-Being
20555 Victor Parkway
Livonia, MI 48152
Phone Number: 734-343-1000

The third-party administrator with respect to COBRA Continuation Coverage is WageWorks, Inc.. You can contact WageWorks® regarding COBRA Continuation Coverage at: 877-502-6272 or https://www.wageworks.com.

The third-party administrator for the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account and is Health Equity. You can contact Health Equity regarding the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account at: 888-678-4881 or memberservices@healthequity.com.

The HSA Vendor is Health Equity. Please contact Health Equity regarding the HSA Program at: 866-212-4721 or memberservices@healthequity.com.

Type of Plan

The Plan is a welfare benefit plan as described in the Plan Overview in the Introduction to this Summary.

Funding Medium and Type of Administration

See the description provided in the Plan Overview in the Introduction to this Summary.

Plan Year
The Plan maintains a Plan Year of January 1 through December 31.

Required Participant Information
You must provide the Plan Administrator and Administrator with the information that is requested of you from time to time for the purpose of the Plan's administration. The Plan Administrator and Administrator will rely on the information you provide.

Source of Financing
Except with respect to the HSA Program, all of the benefits provided under this Plan will be paid from the general assets of the Employer and by any insurance policies purchased by the Employer. Participants may be required to make contributions to the Plan based on the Benefit Programs elected. To the extent permitted by applicable law, the Employer is not obligated to establish a separate trust or fund under the Plan; however, the Employer may elect to fund Benefits through a voluntary employees' beneficiary association (***"VEBA"***).

Recovery of Overpayment
Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits
Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a QMCSO. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, Plan Administrator and Employer to the extent of such payment.

No assignment currently in effect or prospective, may be made for the payment of benefits to a provider, including physicians, hospitals or other providers of services covered by the Plan or any benefit under the Plan. Plan payments directly to a provider for covered expenses shall not be construed as a waiver of this anti-assignment requirement. Further, any assignment recognized or accepted by the Plan or a Benefit Program shall be limited to the right to receive payment or benefits for covered expenses and shall not include the right to pursue claims or litigation of any other nature against the Plan or a Benefit Program, including, but not limited to, fiduciary claims or acting on behalf of a Claimant in pursuing benefit claims under the Plan or a Benefit Program, or confer to the provider any specific rights under the Plan, a Benefit Program, or ERISA.

Misstatement of Fact
In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Legal Information/Issues

No Enlargement of Employment Rights

Nothing contained in the Plan is to be construed as a contract of employment between the Employer and you. The Plan shall not be deemed to give you the right to be retained in the employ of the Employer, nor shall it limit the right of the Employer to employ or discharge you or to discipline you, for any reason or for no reason.

No Guarantee of Tax Consequences

The Company, Employer and the Plan Administrator do not make any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from your gross income for federal or state income tax purposes. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes.

Authority to Construe and Apply Plan Documents

To the full extent permitted by law, the Company, the Administrator, the Plan Administrator and their designees under the terms of the Plan (the ***"Decision-makers"***) shall have the discretionary authority to:

A. Construe any uncertain or disputed term or provision in the Plan and related documents, and this Summary (collectively, ***"Plan Documents"***), and

B. Decide all questions of law and fact concerning the Plan Documents and their application (including, but not limited to, determining questions concerning eligibility and benefits).

The exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to you, your estate and your beneficiaries, and shall be subject to review only if it is arbitrary or capricious or otherwise inconsistent with applicable law.

Standard of Judicial Review

Any review of an exercise of this discretionary authority shall be based only on such evidence presented to or considered by the Decision-maker at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Decision-maker makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described in this Section and in the Plan.

Agent for Service of Legal Process

Any legal process against the Plan in the event of an unresolved dispute over the Plan provisions may be made on The Corporation Company, which may be served with process at 40600 Ann Arbor Road East, Suite 201, Plymouth, Michigan 48170.

Amendment and Termination

The Company has the right to amend the Plan or any Benefit Program in the Plan, in whole or in part, at any time with an instrument in writing executed by an officer of the Company. In addition, the Administrator and the Benefits Committee are authorized to approve amendments to the Plan in accordance with the Table of Authority for the Plan. Anyone claiming an interest under the Plan will be bound by any such amendment. While the Company expects the Plan to be continued, future conditions affecting the Company cannot be anticipated. Therefore, the Company has reserved the right to terminate the Plan or to discontinue permanently paying benefits under the Plan, a Benefit Program, or any portion thereof. Moreover, the Plan Administrator has the specific discretionary authority to determine eligibility for benefits or to

construe the terms of the Plan. If a benefit is paid in error, that error does not amend the Plan nor obligate the Plan to continue to pay the same benefit in the future.

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

Your Rights Under ERISA

Statement of ERISA Rights

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for an ERISA welfare benefit is denied or ignored, in whole or in part, you have a 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

IMPORTANT PLAN INFORMATION	
Name of Plan	Trinity Health Corporation Welfare Benefit Plan
Company/Plan Sponsor/ Plan Administrator	Trinity Health Corporation 20555 Victor Parkway Livonia, MI 48152 Phone Number: -734-343-1000
Employer Identification Number	35-1443425
Effective Date of Plan	January 1, 2020, as amended
Plan Numbers	504 and 505
Type of Plan	The Plan is a welfare benefit plan and a cafeteria plan under Section 125 of the Internal Revenue Code.
Plan Year	January 1 to December 31

APPENDIX A – HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

The Health Care Flexible Spending Account ("HFSA") Program allows Eligible Colleagues to pay for certain medical expenses with pre-tax dollars. The HFSA Program is intended to qualify as a "self-insured medical reimbursement plan" under Section 105 of the Internal Revenue Code ("Code"), and the eligible medical expenses reimbursed under the HFSA Program are intended to be eligible for exclusion from participating colleagues' gross incomes under Code Section 105(b).

The HFSA Program is beneficial to you because amounts that you elect to have withheld from your pay for qualified benefits are withheld *before* any federal income and employment taxes (e.g., FICA tax) are applied, and in most cases, before any applicable state taxes are applied. Thus, participation in this HFSA Program will actually increase your take home pay over what your net take home would be if you paid for eligible medical expenses with after-tax dollars.

ELIGIBILITY AND PARTICIPATION

Please refer to the "Eligibility" and "Participating in the Plan" sections of the Summary in order to determine who is an Eligible Colleague and how to enroll in the HFSA Program. If you are an Eligible Colleague, you must enroll formally before you may participate in the HFSA Program.

IMPORTANT: If you want tax-free reimbursement of unreimbursed medical expenses, you must affirmatively elect to participate in the HFSA Program every Plan Year.

If you are an Eligible Colleague and you elect to participate in the HFSA Program during your initial enrollment period, the election is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. Similarly, if you are an Eligible Colleague and you elect to <u>not</u> participate in the HFSA Program during your initial enrollment period, the election is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

If you are a current participant in the HFSA Program and you fail to complete and submit an election form during the annual enrollment period, you will be deemed to have elected <u>not</u> to participate in the HFSA Program during the next Plan Year. You will not be able to participate during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. Similarly, if you are a current participant in the HFSA Program and, during the annual enrollment period, you elect to participate in the HFSA Program during the next Plan Year, you will not be able to change your election during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change.

Please refer to the "Irrevocable Election" Section of the Summary for information regarding the qualified change in status events.

The HFSA Program is required to meet certain nondiscrimination provisions as outlined by the Code. Although you may not change your election with respect to the HFSA Program during a Plan Year unless you have a qualified change in status event, your Employer reserves the right to modify the amount of your election with respect to the HFSA Program during a Plan year if necessary to allow the HFSA Program to satisfy these nondiscrimination requirements. In

addition, your election to participate in the HFSA Program will automatically terminate if you cease to be an Eligible Colleague.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the HFSA Program. For instance, participation in the HFSA Program may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in the HFSA Program.

CEASING PARTICIPATION

Please refer to the "Ceasing Participation" Section of the Summary for information regarding when your coverage under the HFSA Program terminates.

Note that when you terminate employment or otherwise cease to be an Eligible Colleague during a Plan Year, under the HFSA Program, the final date that you can incur eligible medical expenses is the date of your termination of employment or the date you otherwise cease to be an Eligible Colleague (unless you elect COBRA Continuation Coverage); however, you have until the March 31 following your termination or ceasing to be an Eligible Colleague (or, if March 31 falls on a Saturday, Sunday, or holiday, the next following business day) to file claims for reimbursement from your HFSA Account.

Under certain circumstances, even though your participation in the HFSA Program would otherwise terminate, you may be able to continue to participate in the HFSA Program through the end of the Plan Year in which your participation would terminate. This continuation coverage is called *"COBRA Continuation Coverage"*. Please refer to the "COBRA Continuation Coverage" Section of the Summary for additional information regarding COBRA Continuation Coverage.

HFSA PROGRAM BENEFITS

When you become a participant in the HFSA Program, the Plan Administrator (or the third party administrator identified in the Administrative and Legal Overview Section of the Summary) will establish a Health Care Flexible Spending Account in your name. Your Health Care Flexible Spending Account is a non-interest bearing bookkeeping account that is credited with your contributions and reduced by any payments made on your behalf. No actual account is established; it is merely a bookkeeping account.

Your Health Care Flexible Spending Account will be credited with your contributions and will be reduced by any payments made on your behalf.

The Medical Benefit Program options available to you under the Plan may include an HSA Medical Benefit Program option. If you elect coverage under an HSA Medical Benefit Program, you are eligible to participate in the Health Savings Account Program ("HSA Program") if you are HSA-eligible. If you are eligible to participate in the HSA Program and elect to participate in the HSA Program, you are not eligible to participate in the HFSA Program.

Contributions

When you enroll in the HFSA Program for a Plan Year, you specify the amount of pre-tax contributions that you would like to make to your Health Care Flexible Spending Account for the Plan Year. You may make any amount of pre-tax contributions you desire under the HFSA Program for a Plan Year, subject to the maximum contribution/reimbursement amount for the Plan Year, as adjusted from time to time. In addition, if you are a highly paid colleague, federal

law may impose limits on the amount you may contribute to a Health Care Flexible Spending Account for a Plan Year. The Plan Administrator will notify you if any such limits are applicable to you for a Plan Year.

An equal, pro-rata portion of the pre-tax contribution amount you elect to make to your Health Care Flexible Spending Account for the Plan Year will be withheld on a pre-tax basis from each of your paychecks for the Plan Year. If you go on a paid leave of absence for any reason, your pre-tax contributions will continue to be withheld from your paychecks. If you go on an unpaid leave of absence for any reason, your missed pre-tax contributions will be placed in arrears and collected when your pay resumes in the same Plan Year in which the leave of absence began. The amount available for reimbursement from your Health Care Flexible Spending Account at any time during a Plan Year is the full amount you elected to contribute for the Plan Year less any reimbursements already disbursed, without regard to how much you have contributed to your Health Care Flexible Spending Account. However, any change in your HFSA Program election during a Plan Year (as a result of a qualified change in status event) that affects your contributions will change the maximum available reimbursement amount under your Health Care Flexible Spending Account for the remainder of the Plan Year. Such maximum available reimbursement amount will be determined on a prospective basis only by a method determined by the Plan Administrator (or the third party administrator) that is in accordance with applicable law. The Plan Administrator (or the third party administrator) will notify you of the applicable method when you make your election change.

Eligible Medical Expenses

An "Eligible Medical Expense" is an expense that has been incurred by you, your legal spouse or other Pre-Tax Eligible Adult or your other eligible dependent (defined below) that satisfies the following conditions:

- The expense is for "medical care" as defined by Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator (or the third party administrator); and

- The expense has not been reimbursed by any other source and you, your legal spouse and your eligible dependent will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, prescription drugs and over-the-counter ("OTC") drugs and medicines and menstrual care products.

Not every health-related expense you, your legal spouse or other Pre-Tax Eligible Adult or your other eligible dependent incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the Code, if it is merely for the beneficial health of you, your legal spouse and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Administrator (or the third party administrator), be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Also, "stockpiling" of OTC drugs, products and devices is not permitted and expenses resulting from stockpiling are not reimbursable. There must be a reasonable expectation that such drugs, devices and products could be used during the Plan Year (as determined by Plan Administrator or the third party administrator).

In addition, certain expenses that might otherwise constitute "medical care" are not reimbursable under the HFSA Program, including:

- Health insurance premiums under any health insurance plan whether or not sponsored by your Employer;
- Expenses incurred for qualified long term care services;
- Expenses which are reimbursable under any other health insurance plan, whether or not sponsored by your Employer and whether insured, through a health maintenance organization, preferred provider organization or otherwise; and
- Any other expenses that are specifically excluded by the Plan Administrator as set forth in the enrollment materials or other materials regarding this Benefit Program.

For additional information regarding Eligible Medical Expenses, please call 1-888-678-4881, Monday – Friday, 8 am – 8 pm EST, or check Health Equity's website at memberservices@healthequity.com.

When Eligible Medical Expenses Must Be Incurred

In order for your Eligible Medical Expenses to be paid or reimbursed from your Health Care Flexible Spending Account, the Eligible Medical Expenses must be incurred during the Plan Year and while you are a participant. In order for your legal spouse's, other Pre-Tax Eligible Adult's or your other eligible dependent's Eligible Medical Expenses to be paid or reimbursed from your Health Care Flexible Spending Account, the Eligible Medical Expenses must be incurred during the Plan Year, while you are a participant, and while the individual is your legal spouse, other Pre-Tax Eligible Adult or other eligible dependent. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the service or treatment. Notwithstanding the preceding, if you pay for the ongoing care of orthodontia, your Eligible Medical Expenses will be reimbursable if payment for the current year's services is made by you during the current Plan Year, even if full treatment will not be performed until a future date within that current Plan Year.

You may not be reimbursed for any Eligible Medical Expenses incurred before your HFSA Program election becomes effective or after your termination of employment with the Employers (except for expenses incurred during an applicable COBRA Continuation Coverage period).

You are also able to use amounts credited to your Health Care Flexible Spending Account for a Plan Year that are unused at the end of the Plan Year for Eligible Medical Expenses incurred during a "grace period" following the end of the Plan Year. The grace period begins on the first day of the next Plan Year and ends on March 15 of the next Plan Year.

In order to take advantage of the grace period, you must be:

- A participant in the HFSA Program on the last day of the Plan Year to which the grace period relates; or

- A qualified beneficiary who is receiving COBRA coverage under the HFSA Program on the last day of the Plan Year to which the grace period relates.

If the Eligible Medical Expenses you, your legal spouse or other Pre-Tax Eligible Adult and your other eligible dependents incur during the Plan Year (plus the grace period) are less than the amount you elected to contribute to your Health Care Flexible Spending Account for the Plan Year, the excess amount will be forfeited. Amounts so forfeited shall be used to offset

administrative expenses and future costs, and/or applied in a manner that is consistent with applicable law.

Any reimbursements under the HFSA Program that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Medical Expense was incurred shall be forfeited.

Claims

You are entitled to receive reimbursement from your Health Care Flexible Spending Account for Eligible Medical Expenses incurred by you, your legal spouse or other Pre-Tax Eligible Adult and your eligible dependents, if any. An "eligible dependent" for purposes of the HFSA Program is generally someone who you may claim as a dependent on your federal tax return. Your son, daughter, stepson, stepdaughter, and eligible foster child, if any, may be an eligible dependent for purposes of the HFSA Program through the year in which he or she turns age 26.

You may receive reimbursement for Eligible Medical Expenses incurred at a time when you are actively participating in the Plan. You may receive reimbursement for Eligible Medical Expenses incurred by your legal spouse or other Pre-Tax Eligible Adult or eligible dependent while you are a participant and while the individual is your legal spouse or other Pre-Tax Eligible Adult or eligible dependent. Coverage under the HFSA Program for your legal spouse or other Pre-Tax Eligible Adult ends on the earlier of the date you cease to be a participant or the date he/she ceases to be your legal spouse or other Pre-Tax Eligible Adult (subject to his/her right to elect COBRA Continuation Coverage). Coverage under the HFSA Program for your eligible dependent under the HFSA Program ends on the earlier of the date you cease to be a participant or the date he/she ceases to be your eligible dependent (subject to his/her right to elect COBRA Continuation Coverage).

You have multiple reimbursement options under the HFSA Program: (1) you may use an electronic payment card ("Electronic Payment Card" or the "Card") to pay Eligible Medical Expenses from your Health Care Flexible Spending Account, (2) you or your authorized representative may file a claim with the third party administrator, Health Equity, online by logging in to your account at www.healthequity.com/wageworks, (3) you may use the Health Equity EZ Receipts® mobile app on your iPhone, Android or Blackberry smartphone, or (4) you or your authorized representative may file a claim with Health Equity by completing a reimbursement request form faxing it to 877-353-9236 or mailing it to: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512. However, a claim that is not for reimbursement of medical expenses (for example, a general eligibility claim or a dispute involving a mid-year election change due to a qualified change in status event) must be filed with the Plan Administrator in accordance with the procedures set forth in the "Claims Procedures" Section of the Summary. A request for prior approval of an Eligible Medical Expenses is not a claim for purposes of the HFSA Program. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the HFSA Program is not a claim, unless it is determined that your inquiry is an attempt to file a claim. In order for an authorized representative to file a claim on your behalf, you must provide written notice to the Plan Administrator or Health Equity designating the individual as your authorized representative.

In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement"), including any fees applicable to participate in the Program, limitations as to Card usage, the HFSA Program's right to withhold and offset for ineligible claims, etc. The following is a summary of how the Electronic Payment Card option works.

(a) *Eligibility for a Card.* When you enroll in the HFSA Program you will receive an Electronic Payment Card. You elect whether or not to activate the Card. By activating the Card you agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the Program, limitations as to Card usage, the HFSA Program's right to withhold and offset for ineligible claims, etc. A Cardholder Agreement will be provided to you when you enroll in the HFSA Program. The Card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program. The Cardholder Agreement is part of the terms and conditions of the HFSA Program and this SPD.

(b) *The Card will be turned off when employment or coverage terminates.* The Card will be turned off when you terminate employment with each Employer or coverage under the HFSA Program otherwise ends. You may not use the Card during any applicable COBRA Continuation Coverage period.

(c) *You must certify proper use of the Card.* By enrolling in the HFSA Program, you certify that (i) the Card will be used only for the Eligible Medical Expenses of you, your legal spouse or other Pre-Tax Eligible Adult and your eligible dependents, (ii) any Eligible Medical Expense paid with the Card has not been reimbursed and you will not seek reimbursement for the expense from any other source, and (iii) you will acquire and retain sufficient documentation (described in (f), below) for any Eligible Medical Expense paid with the Card. Failure to abide by this certification will result in termination of Card use privileges.

(d) *Reimbursement under the Card is limited to certain merchants.* Use of the Card for Eligible Medical Expenses is limited to merchants identified by the Plan Administrator or its designee as an eligible merchant. The Card will be administered in accordance with applicable IRS guidance.

(e) *You swipe the Card at the merchant like you do any other credit or debit card.* When you incur an Eligible Medical Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the Card at the merchant much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available in your Health Care Flexible Spending Account. Every time you swipe the Card, you certify to the HFSA Program that the expense for which payment is being made is an Eligible Medical Expense, you have not been reimbursed from any other source for the Eligible Medical Expense, you will not seek reimbursement from another source for the Eligible Medical Expense, and you will acquire and retain sufficient documentation (described in (f), below) for the Eligible Medical Expense.

(f) *You must obtain and retain a receipt/third party statement each time you swipe the Card.* You must obtain a third party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the Card:

- The nature of the expense (e.g., what type of service or treatment was provided);

- If the expense is for an over-the-counter product or device or insulin, the written statement must indicate that the drug is insulin or indicate the name of the product or device;

- The date the expense was incurred; and
- The amount of the expense.

You should retain this statement for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made under the Card arrangement, a written third party statement is generally required to be submitted (except as otherwise set forth in the applicable law and/or related guidance). You will receive a letter from the third party administrator that a third party statement is needed. You must provide the third party statement to the third party administrator within 45 days (or such longer period provided in the letter from the third party administrator) of the request. In accordance with applicable guidance, there may be situations in which the third party administrator does not ask for substantiation related to a Card swipe.

(g) *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the third party administrator, you must repay the HFSA Program. The deadline for repaying the HFSA Program is set forth in the Cardholder Agreement. If you do not repay the HFSA Program within the applicable time period, the Card will be turned off and you will be requested to repay an amount equal to the unsubstantiated expense. If you do not repay this amount, your Employer or the Plan Administrator will withhold the amount from your compensation, to the fullest extent permitted by applicable law. If an unsubstantiated amount is still outstanding, it will be offset against future Eligible Medical Expenses. If no claims are submitted prior to the date you terminate coverage in the HFSA Program, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then, the amount may be treated by your Employer as any other bad debt, which will result in additional gross income for you.

Claims for which the Electronic Payment Card has been used cannot be submitted to the third party administrator or by completing a reimbursement request form.

In order to substantiate your claim, you must submit a written statement from the service provider (e.g., a receipt or explanation of benefits ("EOB")) associated with each expense for which you are requesting reimbursement that indicates the following:

- The nature of the expense (e.g., what type of service or treatment was provided). If the expense is for an OTC drug prescribed by a physician, the written statement must indicate the name of the drug;
- The date the expense was incurred; and
- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. The third party administrator will process the claim once it receives a reimbursement request form from you.

To the extent that the third party administrator approves a claim, your Employer or the third party administrator may either (i) reimburse you, or (ii) pay the service provider directly. Any payment or reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after the third party administrator receives the claim and

processes it. The third party administrator may provide that payments or reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments or reimbursements outstanding on the March 31st following the end of a Plan Year will be reimbursed without regard to the minimum payment amount.

You must submit all claims for reimbursement of Eligible Medical Expenses incurred during a Plan Year (or during the grace period) by the March 31 of the following Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day).

For additional information regarding how to file a claim reimbursement, please go to memberservices@healthequity.com or call a Health Equity Customer Service professional at 1-888-678-4881, Monday – Friday, 8 am – 8 pm EST.

Timing of Notice of Denied Claim

If the third party administrator determines that an expense for which you have submitted a claim is not an Eligible Medical Expense, you will receive written notice from the third party administrator that your claim is denied. The notice will contain:

1. The specific reason(s) for the claim's denial;

2. Specific reference to the pertinent HFSA Program provisions on which the denial is based;

3. A description of any additional material or information needed to perfect your claim and an explanation of why the information is necessary;

4. A description of the HFSA Program's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring an action in federal court under Section 502(a) of ERISA with respect to *any adverse benefit determination on review or appeal* (i.e., after the Plan's appeal procedures have been exhausted); and

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

The third party administrator will provide a claim denial notice to you within a reasonable period of time, but not later than 30 days after the third party administrator receives the claim[12]. This period may be extended one time for up to 15 days, provided that the third party administrator both determines that such an extension is necessary due to matters beyond its control and notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which it expects 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 shall specifically describe the required information, and you will have 45 days from receipt of the notice of the extension to provide the specified information. The time period during which the third party administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

[12] The notification periods set forth in this section are extended by the Outbreak Period set forth in footnote 2.

Appeal of Denied Claim

If you do not agree with the decision of the third party administrator, you or your authorized representative may file a written appeal. You or your authorized representative must file an appeal with the third party administrator on or before the 180th day after you receive the third party administrator's notice that your claim has been wholly or partially denied. You lose the right to appeal if the appeal is not timely made. An appeal must identify the reason for the appeal and the specific HFSA Program provisions upon which the appeal is based.

As part of your appeal, you or your authorized representative have the right to:

1. Submit written comments, documents, records and other information relating to your claim for benefits that you wish to have considered;
2. Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
3. A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination; and
4. A review that does not defer to the initial claim determination and that is conducted by someone other than the individual who made the adverse determination, and who is not such person's subordinate.

The third party administrator will notify you and your authorized representative, if applicable, of its benefit determination on appeal within 60 days after its receipt of your or your authorized representative's request for review of an adverse benefit determination. If an appeal is wholly or partially denied, the third party administrator shall provide you and your authorized representative with a notice identifying:

1. The specific reason(s) for the claim's denial;
2. Specific reference to the pertinent HFSA Program provisions on which the denial is based;
3. A statement that you or your authorized representative are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
5. A statement describing your right to bring an action under section 502(a) of ERISA.

Qualified Reservist Distributions

If you (the Eligible Colleague who is a participant in the HFSA Program) are a "Qualified Reservist," you may elect to take a "Qualified Reservist Distribution" from your Health Care Flexible Spending Account. You are a "Qualified Reservist" if, by reason of being a member of a reserve component, as defined in Section 101 of Title 37 of the United States Code, you are ordered or called to active duty for a period in excess of 179 days or for an indefinite period. A "Qualified Reservist Distribution" is a distribution of all or a portion of the unused contributions to

a Qualified Reservist's Health Care Flexible Spending Account (i.e., generally the difference between the amount the Qualified Reservist contributed to his/her Health Care Flexible Spending Account for the Plan Year and the amount reimbursed from the Qualified Reservist's Health Care Flexible Spending Account as of the date of the request for the Qualified Reservist Distribution) that is made during the period beginning on the date the Qualified Reservist is ordered or called to active duty and ending on the last day that reimbursements for Eligible Medical Expenses could otherwise be made for the Plan Year which includes the date the Qualified Reservist is ordered or called to active duty. If you receive a Qualified Reservist Distribution, you are not entitled to any additional benefits under the HFSA Program for the Plan Year in which you receive the Qualified Reservist Distribution. Please contact the third-party administrator if you would like additional information regarding Qualified Reservist Distributions and/or to request a Qualified Reservist Distribution.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse your Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Employer or Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Anti-Assignment

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the HFSA Program.

APPENDIX B – DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

The Dependent Care Flexible Spending Account ("DFSA") Program allows Eligible Colleagues to pay for certain dependent care expenses with pre-tax dollars. The DFSA Program is intended to qualify as a "dependent care assistance plan" under Code Section 129, and the eligible dependent care expenses reimbursed under the DFSA Program are intended to be eligible for exclusion from participating colleagues' gross incomes under Code Section 129(a).

The DFSA Program is beneficial to you because amounts that you elect to have withheld from your pay for qualified benefits are withheld *before* any federal income and employment taxes (e.g., FICA tax) are applied, and in most cases, before any applicable state taxes are applied. Thus, participation in the DFSA Program will actually increase your take home pay over what your net take home would be if you paid for eligible dependent care expenses with after-tax dollars.

ELIGIBILITY AND PARTICIPATION

Please refer to the "Eligibility" and "Participating in the Plan" sections of the Summary in order to determine who is an Eligible Colleague and how to enroll in the DFSA Program. If you are an Eligible Colleague, you must enroll formally before you may participate in the DFSA Program.

IMPORTANT: If you want tax-free reimbursement of dependent care expenses, you must affirmatively elect to participate in the DFSA Program every Plan Year.

If you are an Eligible Colleague and you elect to participate in the DFSA Program during your initial enrollment period, the election is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. Similarly, if you are an Eligible Colleague and you elect to not participate in the DFSA Program during your initial enrollment period, the election is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

If you are a current participant in the DFSA Program and you fail to complete and submit an election form during the annual enrollment period, you will be deemed to have elected not to participate in the DFSA Program during the next Plan Year. You will not be able to change this election not to participate during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change. Similarly, if you are a current participant in the DFSA Program and, during the annual enrollment period, you elect to participate in the DFSA Program during the next Plan Year, you will not be able to change your election during the Plan Year unless you experience a qualified change in status event that will allow a mid-year election change.

Please refer to the "Irrevocable Election" Section of the Summary for information regarding the qualified change in status events.

The DFSA Program is required to meet certain nondiscrimination provisions as outlined by the Code. Although you may not change your election with respect to the DFSA Program during a Plan Year unless you have a qualified change in status event, your Employer reserves the right to modify the amount of your election with respect to the DFSA Program during a Plan year if necessary to allow the DFSA Program to satisfy these nondiscrimination requirements. In

addition, your election to participate in the DFSA Program will automatically terminate if you cease to be an Eligible Colleague.

Please note that while you may enjoy certain tax benefits, there may be some drawbacks to participation in the DFSA Program. For instance, participation in the DFSA Program may lower your social security benefits. You should consult with your professional tax/financial advisor to determine the consequences of your participation in the DFSA Program.

CEASING PARTICIPATION

Please refer to the "Ceasing Participation" Section of the Summary for information regarding when your coverage under the DFSA Program terminates.

Note that when you terminate employment or otherwise cease to be an Eligible Colleague during a Plan Year, under the DFSA Program, the final date that you can incur eligible medical expenses is the date of your termination of employment or the date you otherwise cease to be an Eligible Colleague; however, you have until the March 31 following your termination or ceasing to be an Eligible Colleague (or, if March 31 falls on a Saturday, Sunday, or holiday, the next following business day) to file claims for reimbursement from your HFSA Account.

DFSA PROGRAM BENEFITS

When you become a participant in the DFSA Program, the Plan Administrator (or the third party administrator identified in the Administrative and Legal Overview Section of the Summary) will establish a Dependent Care Flexible Spending Account in your name. Your Dependent Care Flexible Spending Account is a non-interest bearing bookkeeping account that is credited with your contributions and reduced by any payments made on your behalf. No actual account is established; it is merely a bookkeeping account.

Your Dependent Care Flexible Spending Account will be credited with your contributions and will be reduced by any payments made on your behalf.

Contributions

When you enroll in the DFSA Program for a Plan Year, you specify the amount of pre-tax contributions that you would like to make to your Dependent Care Flexible Spending Account for the Plan Year. You may make any amount of pre-tax contributions you desire under the DFSA Program for a Plan Year, subject to the maximum DFSA contribution/reimbursement amount for the Plan Year. The maximum you may contribute to a Dependent Care Flexible Spending Account for a Plan Year is $5,000 ($2,500 if you are married and filing a separate return). This maximum amount is established by the Internal Revenue Service and may be adjusted from time to time. In addition, the amount you elect to contribute for a Plan Year cannot exceed the lesser of your or your spouse's earned income (as defined in Code Section 32). For purposes of the DFSA Program, your spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals), for each month that your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

If you are a highly paid colleague, federal law may impose limits on the amount you may contribute to a Dependent Care Flexible Spending Account for a Plan Year. The Plan Administrator will notify you if any such limits are applicable to you for a Plan Year.

An equal, pro-rata portion of the pre-tax contribution amount you elect to make to your Dependent Care Flexible Spending Account for the Plan Year will be withheld on a pre-tax basis

from each of your paychecks for the Plan Year. If you go on a paid leave of absence for any reason, your pre-tax contributions will continue to be withheld from your paychecks. If you go on an unpaid leave of absence for any reason, your missed pre-tax contributions will be placed in arrears and collected when your pay resumes in the same Plan Year in which the leave of absence began. The amount available for reimbursement from your Dependent Care Flexible Spending Account at any time during a Plan Year is the amount you have contributed for the Plan Year at the time the request for reimbursement is processed less any reimbursements already disbursed.

Eligible Dependent Care Expenses

You will be entitled to receive reimbursement from your Dependent Care Flexible Spending Account for work-related dependent care expenses ("Eligible Dependent Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

1. The expense is incurred for services rendered after the date of you become a participant.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

   - An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in Code Section 152(a)(1)) and who is age 12 or under, or

   - A spouse or other tax "dependent" (as defined generally in Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of the DFSA Program only, a "dependent" under Code Section 21 means an individual who is your tax dependent as defined in Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in Code Section 151(d); (ii) the individual is a child of a participant who is a tax dependent of another taxpayer under Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on his or her tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Dependent Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care.

Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps (not overnight) are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The day care is not provided by a "child" (as defined in Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent. Moreover, the day care cannot be provided by your (the participant's) spouse or the parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the Internal Revenue Service ("IRS") with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 for further guidance as to what is or is not an Eligible Dependent Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for Eligible Dependent Care Expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

Please note that participation in the DFSA Program may prevent you from taking a tax credit for the same Eligible Dependent Care Expenses. You should consult with your professional tax/financial advisor to determine the consequences of your participation in the DFSA Program.

When Eligible Dependent Care Expenses Must Be Incurred

In order for your Eligible Dependent Care Expenses to be paid or reimbursed from your Dependent Care Flexible Spending Account, the Eligible Dependent Care Expenses must be incurred during the Plan Year and while you are a participant. You may not be reimbursed for any Eligible Dependent Care Expenses incurred before your DFSA Program election becomes effective. An expense is "incurred" when the service giving rise to the expense has been performed and not in advance of the service.

If you terminate employment with your Employer during a Plan Year, you automatically cease to participate in the DFSA Program. However, you may receive reimbursement for Eligible Dependent Care Expenses incurred during the Plan Year in which your employment terminates through the date your employment terminates.

If the Eligible Dependent Care Expenses you incur during the Plan Year (plus the grace period, if applicable) are less than the amount you elected to contribute to your Dependent Care Flexible Spending Account for the Plan Year, the excess amount will be forfeited. Amounts so forfeited shall be used to offset administrative expenses and future costs, and/or applied in a manner that is consistent with applicable law.

Any reimbursements under the DFSA Program that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Dependent Care Expense was incurred shall be forfeited.

Claims

You are entitled to receive reimbursement from your Dependent Care Flexible Spending Account for your Eligible Dependent Care Expenses. When you incur an Eligible Dependent Care Expense, you file a reimbursement request claim with the third party administrator, WageWorks®, by: (1) filing the claim online by logging in to your account at www.wageworks.com, (2) using the WageWorks® EZ Receipts® mobile app on your iPhone, Android or Blackberry smartphone, or (3) completing a reimbursement request form faxing it to 877-353-9236 or mailing it to: CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512.

You must include with your reimbursement request a written statement (or photo or copy of a written statement, where applicable) from the service provider (e.g., an invoice) associated with each expense for which you are requesting reimbursement that indicates the following:

- The nature of the expense;
- The date or dates the services were provided; and
- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. The third party administrator will process the claim once it receives a reimbursement request form from you. To the extent that the third party administrator approves a claim, your Employer or the third party administrator may either (i) reimburse you, or (ii) pay the service provider directly. Any payment or reimbursement for expenses that are determined to be Eligible Dependent Care Expenses will be made as soon as possible after the third party administrator receives the claim and processes it. The third party administrator may provide that payments or reimbursements of less than a certain amount will be carried forward and aggregated with future claims until the reimbursable amount is greater than a minimum amount. In any event, the entire amount of payments or reimbursements outstanding on the March 31st following the end of a Plan Year will be reimbursed without regard to the minimum payment amount.

You must submit all claims for reimbursement of Eligible Dependent Expenses incurred during a Plan Year (or during the grace period, if applicable) by the March 31 of the following Plan Year (or, if March 31 falls on a Saturday, Sunday or holiday, the next following business day).

For additional information regarding how to file a claim reimbursement, please go to www.wageworks.com or call a WageWorks® Customer Service professional at 1-877-WageWorks (877-924-3967), Monday – Friday, 8 am – 8 pm EST.

Timing of Notice of Denied Claim

If the third party administrator determines that an expense for which you have submitted a claim is not an Eligible Dependent Care Expense, the third party administrator shall notify you of the adverse benefit determination in writing. The adverse benefit determination notice will set forth:

1. The reason(s) for such denial;

2. The pertinent DFSA Program provisions on which the denial is based;

3. Any material or information needed to grant the claim and an explanation of why the additional information is necessary; and

4. An explanation of the steps that you must take if you wish to appeal the denial.

The third party administrator will provide an adverse benefit determination notice to you within a reasonable period of time, but not later than 90 days after the third party administrator receives the claim. This period may be extended one time for up to 90 days, provided that the third party administrator both determines that such an extension is necessary due to matters beyond its control and notifies you, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which it expects to render a decision. If notice of an adverse benefits determination is not given to you within the applicable time period, your claim will be considered denied as of the last day of the applicable review period.

Appeal of Denied Claim

If you wish to appeal the denial of a claim, you or your authorized representative must file an appeal with the third party administrator on or before the 60th day after you receive the third party administrator's notice that your claim has been wholly or partially denied. You lose the right to appeal if the appeal is not timely made. The written appeal must identify both the grounds and specific DFSA Program provisions upon which the appeal is based. You or your authorized representative will be provided, upon request and free of charge, documents and other information relevant to your claim. A written appeal may also include any comments, statements or documents that you or your authorized representative may desire to provide.

The third party administrator shall consider the merits of your or your authorized representative's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the third party administrator may deem relevant. The third party administrator will ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the third party administrator furnishes you or your authorized representative with a written extension notice during the initial period, the third party administrator may take up to 120 days to rule on an appeal.

If an appeal is wholly or partially denied, the third party administrator will provide you and your authorized representative with a notice identifying the reason or reasons for such denial and the pertinent DFSA Program provisions on which the denial is based.

The determination rendered by the third party administrator shall be binding upon all parties.

Tax Issues

You will not normally be taxed on a reimbursement you receive under the DFSA Program for Eligible Dependent Care Expenses, provided that your family's aggregate dependent day care reimbursements (under this DFSA Program and/or another employer's dependent care spending account program) do not exceed the limits set by law. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

You may not claim any other tax benefit for the tax-free amounts received by you under the DFSA Program, although the balance of your Eligible Dependent Care Expenses not reimbursed under the DFSA Program may be eligible for the child and dependent care credit.

The child and dependent care credit is an allowance for a percentage of your annual child and dependent care expenses against your federal income tax liability under the Code.

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements or any payments/reimbursements that are taxable to you. You must reimburse your Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Employer or Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Anti-Assignment

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the DFSA Program.

APPENDIX C – COLLEAGUE AND EMPLOYER CONTRIBUTIONS TO HSA PROGRAM

Background

The HSA Program is intended to permit an Eligible Colleague who enrolls in an HSA Medical Benefit Program for a Plan Year and who is HSA-eligible to make contributions to a health savings account (***"HSA"***). In addition, if a participant in the HSA Program establishes an HSA with the HSA trustee or custodian that has contracted with the Employer to offer HSAs to Eligible Colleagues (***"HSA Vendor"***), the HSA Program is intended to permit the participant to make pre-tax contributions to his/her HSA and to permit Employer contributions to the participant's HSA, if any, if the participant is HSA-eligible. Only an Eligible Colleague may receive an Employer contribution to an HSA, if any (i.e., no Eligible Dependent will receive an Employer contribution to an HSA). If an Eligible Colleague is enrolled in the HSA Medical Benefit Program as the Eligible Dependent of another Eligible Colleague he or she may not make pre-tax contributions to an HSA and will not receive any Employer contributions to his or her HSA. An HSA is a tax-favored, IRA-type trust or custodial account that may be contributed to by, or on behalf of eligible individuals who are covered by certain high-deductible health plans (**"*HDHPs"***) to pay for certain medical expenses of the eligible individuals and their spouses and Tax Dependents.

Participation

When you enroll in an HSA Medical Benefit Program under the Plan for a Plan Year in the manner described in the Summary, you will automatically be enrolled in the HSA Program. This does not apply to an individual who is an Eligible Colleague but who is enrolled in an HSA Medical Benefit Program as an Eligible Dependent. If you open an HSA with the HSA Vendor and provide any verification required by the HSA Vendor in a timely manner for a Plan Year (or you already have an HSA with the HSA Vendor at the beginning of the Plan Year), your Employer may make one or more contributions to your HSA for the Plan Year. If you do not open an HSA with the HSA Vendor and provide any verification required by the HSA Vendor in a timely manner for a Plan Year (or already have an HSA with the HSA Vendor at the beginning of the Plan Year), your Employer will not make contributions to your HSA for the Plan Year (or any future Plan Year unless you open an HSA with the HSA Vendor in a timely manner for that Plan Year) any Employer contribution which would have otherwise been made to your HSA for the Plan Year is forfeited. An ***"HSA Medical Benefit Program"*** is a Medical Benefit Program under the Plan that is intended to be an HDHP and is designated by the Plan Administrator as an HSA Medical Benefit Program. The HSA Medical Benefit Program(s) may be changed from time to time.

Notwithstanding the above, if you are a participant in the Health Care Flexible Spending Account Program for a Plan Year and you first enroll in an HSA Medical Benefit Program for the next Plan Year, you must exhaust your health flexible spending account by the end of the Plan Year in order for any contributions to be made to your HSA before April 1 of the next Plan Year. For example, if you are a participant in the Health Care Flexible Spending Account Program for the 2016 Plan Year and you first enroll in an HSA Medical Benefit Program for the 2017 Plan Year, you must exhaust your health flexible spending account by December 31, 2016, in order for any contributions to be made to your HSA before April 1, 2017.

In general, you are ***"HSA-eligible"*** if:

- You are covered under a qualifying HDHP and not covered by any impermissible non-HDHP health coverage (e.g., an HRA or health flexible spending account that provides benefits without regard to whether the HDHP deductible is met

unless it is a limited purpose or post-deductible HRA or health flexible spending account); and

- You are not eligible for and enrolled in Medicare and you cannot be claimed as a tax dependent by another taxpayer (beginning with the month in which you become eligible for and enrolled in Medicare, you are no longer HSA-eligible).

Only an HSA-eligible individual can establish an HSA and make HSA contributions or have contributions made to an HSA on his/her behalf. An individual's status as an HSA-eligible individual is determined monthly as of the first day of the month.

An HSA is an established between you and a qualified HSA trustee or custodian. Although you may be able to make contributions to your HSA under the Cafeteria Plan, your HSA is not part of the Plan. Please refer to your HSA documents and other information regarding your HSA from your HSA trustee or custodian or contact your HSA trustee or custodian for additional information regarding your HSA (e.g., how much you may contribute, what is impermissible non-HDHP health coverage, what expenses may be paid and reimbursed from your HSA, how to request a payment or reimbursement from your HSA, what happens when you are no longer HSA-eligible, etc.).

Employer Contributions

If, for a Plan Year, you are HSA-eligible, enroll in an HSA Medical Benefit Program for the Plan Year and open an HSA with the HSA Vendor and provide any verification required by the HSA Vendor in a timely manner for the Plan Year (or already have an HSA with the HSA Vendor at the beginning of the Plan Year), the Employer may, in its discretion, make contributions to your HSA. If you become a participant in the HSA Program after the first day of a Plan Year, the amount of Employer contributions, if any, that will be made to your HSA for the Plan Year will be prorated in accordance with the procedures established by the Plan Administrator. The amount of Employer contributions, if any, for the Plan Year will be determined by the Plan Administrator prior to the beginning of the Plan Year. However, the amount of Employer contributions may be modified from time to time in the sole discretion of the Plan Administrator. All Employer contributions made to participants' HSAs under the HSA Program are made under the Cafeteria Plan contained in the Plan. However the HSA Program is not subject to ERISA.

No Employer contribution will be made to your HSA unless you are an HSA-Eligible Colleague at the time the Employer contribution will be made. As a result, for example, no Employer contribution will be made to your HSA if you are covered under the HSA Medical Benefit Program as a result of COBRA coverage.

APPENDIX D - HEALTH REIMBURSEMENT ACCOUNT PROGRAM

The HRA Program is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the Treasury Regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and will be interpreted accordingly. The medical expenses reimbursed under the HRA Program are intended to be eligible for exclusion from a participant's gross income under Code Section 105(b). The HRA Program is not offered under or through the Cafeteria Plan contained in the Plan.

When you enroll in an HRA Medical Benefit Program under the Plan in the manner described in the Summary, you will automatically be enrolled in the HRA Program and a health reimbursement account (***"HRA"***) will be established for you to receive benefits in the form of reimbursements for eligible medical expenses. Participation in the HRA Program will begin at the same time as your participation in the HRA Medical Benefit Program under the Plan. An ***"HRA Medical Benefit Program"*** is a Medical Benefit Program under the Plan that is designated by the Plan Administrator as an HRA Medical Benefit Program. The HRA Medical Benefit Program(s) may be changed from time to time.

An HRA is a bookkeeping account established and maintained by the Plan Administrator (or third-party administrator) for each participant in the HRA Program that reflects the amount of Employer contributions (defined below) credited to the account less the amount of Eligible Medical Expenses reimbursed from the account on behalf of the participant or the participant's eligible Dependents.

Please see the summary plan description and other documents describing the HRA Medical Benefit Program in which you are enrolled for additional information regarding the HRA Program.