

**SUMMARY PLAN DESCRIPTION OF
TRINITY HEALTH
TCCS RETIREE HRA PLAN
EFFECTIVE JANUARY 1, 2005**

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INTRODUCTION

This booklet or **Summary Plan Description** includes information describing your plan benefits, first in general, and then specifically, including how each type of service is covered by this Plan. Specific services that are not covered are listed in the section of this booklet titled WHAT IS NOT COVERED BY THIS PLAN?

You will notice that certain words in this **Summary Plan Description** have been highlighted. These words have a special meaning in this Plan and are defined in the section titled WHAT IS MEANT BY...? in this booklet.

Your medical Plan is governed by a legal document referred to as the **Plan Document**. This booklet, referred to as a **Summary Plan Description**, is written in a manner meant to be easily understood as an explanation of the medical benefits provided for you in the **Plan Document**.

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

You will find information on the following pages which describes your benefits. If you have any questions, please contact your local Trinity Health Retirement Office professional.

The plan is intended to comply with all provisions of any Federal acts or Supreme Court decisions which set forth precedence. Any provision of this plan found to be in conflict with these acts or Supreme Court precedence is amended to comply.

WHAT IS MEANT BY...?

Whenever one of the following words and phrases appears highlighted, they shall have the meaning explained below unless the context otherwise requires. Please, refer to the section titled WHAT ARE THE PLAN SPECIFICS? for information regarding benefits coverage.

Adverse benefit determination: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a participant's or beneficiary's eligibility to participate in the Plan. This includes a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review (if applicable), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental** or **investigational** or not **medically necessary** or appropriate.

Authorized representative: a **physician** rendering the service for which a bill is submitted (but not a designee of the **physician**), or a person who a covered **retiree** or covered **dependent** has authorized in writing to act on his/her behalf. If the claim is an urgent care **pre-service claim**, the plan will consider a **health care professional** with knowledge of a **claimant's** medical condition as an **authorized representative**.

If a covered **retiree** or covered **dependent** wish to authorize another person (e.g., family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the **Plan Administrator** of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from the Trinity Health Retirement Office Department.

Benefit service: this is one of the standards used to determine eligibility for participation in the Trinity Health Retiree Health Care Plan. For most participating employers, accrued **benefit service** is determined in the same fashion for the Trinity Health Retiree Health Care Plan as for the pension plan.

Claimant: an eligible **retiree**, a covered **dependent** or an **authorized representative**.

Claims Administrator: Your plan has different **Claims Administrators** based on the type of claim. The **Claims Administrator** for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an **adverse benefit determination**. Each is independently, responsible for notifying you of the **adverse benefit determination**, based on the type of claim, as well as reviewing any appeal you may make. Your **Claims Administrators** are as follows:

Post-service claims: (HRA) NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800)-521-1555.

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

WHAT IS MEANT BY...? (Continued)

Company: Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331, (248) 489-6150.

Concurrent claims decision: a decision by the Plan relating to an ongoing course of treatment.

Covered individual: an eligible **retiree** or **dependent** who is enrolled in the Trinity Health Retiree HRA Plan Effective January 1, 2005. (This includes only those people who qualify for enrollment as indicated in the section titled WHO IS ELIGIBLE FOR BENEFITS?)

Dependent(s): a **retiree's** current legal spouse or unmarried child as described in detail in the section titled WHO IS ELIGIBLE FOR BENEFITS?

Illness: the condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9) which is a standard originated by the World Health Organization for classifying and coding diseases and medical conditions.

Injury: a sudden, unexpected and unforeseen bodily harm which occurs solely through external bodily contact. (Strains and spasms are considered an **illness** rather than an **injury**.)

Medicare: a federal program through the Social Security System which provides benefits for **hospital** and **physician** care. This includes a Health Maintenance Organization (HMO) which participates with **Medicare** and receives payment from **Medicare**. (**Medicare** is available on an enrollment basis to individuals either receiving hemodialysis treatment beyond 30 months, or eligible for Social Security benefits if they are age 65 or older, or those individuals who have qualified for Social Security disability benefits and have received such disability benefits for 24 months.)

Plan Administrator: Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331, (248) 489-6150.

Plan Document: the legal description of the plan coverage, exclusions and limitations that is the governing document for this plan.

Plan Supervisor: NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

Plan year: begins on January 1 and ends on the following December 31.

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

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

WHAT IS MEANT BY...? (Continued)

Pre-service claim: any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

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

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

This plan does not condition benefit payment whether an Urgent Care Claim or a Non-Urgent Care Claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, or by calling (800) 521-1555.

Retiree: a former employee of Trinity Health TCCS who is eligible to participate as described in the section titled WHO IS ELIGIBLE FOR BENEFITS?

Summary Plan Description: this summary of your benefits, which introduces key features of medical benefits.

ELIGIBILITY

WHO IS ELIGIBLE FOR BENEFITS?

Eligible employees are active employees of Trinity Health TCCS as of August 1, 2004, who retained **retiree** medial eligibility during the one time election period on or before December 31, 2001, who have at least 65 points (adding together age and years of **benefit service**) as of August 1, 2004, and who meet eligibility requirements when they terminate employment .

Eligibility requirements at the time of termination (after 08/01/04) are that you:

- Are age 58 at your termination date,
- Have 10 or more years of **benefit service** accrued after the age of 45,
- Have begun your pension benefit from the Trinity Health Retirement Plan; and
- Have participated in a health plan sponsored by your Trinity Health employer for at least five continuous years immediately before retirement.

If you are eligible for medical benefits as an active employee with any Trinity Health member facility, you are not eligible to be on any Trinity Health sponsored **retiree** medical plan.

When you are eligible and enroll in this plan, an individual who qualifies as your **dependent** may enroll in the TCCS Retiree HRA Plan. To be eligible, your **dependents** must have participated in your employer's health plan, or in their own employer's health plan, for at least five continuous years immediately before you retire.

WHAT IS YOUR COST TO PARTICIPATE IN THE PLAN?

All contributions will be made by Trinity Health.

HOW DO YOU ENROLL FOR COVERAGE?

The Trinity Health Retirement Office will provide you with an enrollment form. If you complete, sign and return this form within 30 days of your retirement, you and your eligible **dependents** will be enrolled in this plan as described in WHEN WILL COVERAGE BEGIN?

If you do not enroll for coverage, your **dependents** are not eligible for coverage through this plan.

HOW DO YOU ENROLL DEPENDENTS?

At the time of your original enrollment you must enroll your eligible **dependents** in order for them to be covered under this plan.

If you do not enroll your **dependents** at this time, you will not be given the opportunity to enroll them at a later date.

Additionally, after your original enrollment in this plan, new **dependents** may not be added to your **retiree** coverage.

WHEN WILL COVERAGE BEGIN?

You become eligible for coverage on the day after you retire. If you complete your enrollment form within 30 days of your date of retirement, your coverage under this plan will be effective on the date of your retirement.

WHAT CHANGES SHOULD I REPORT?

Whenever any of the information you reported on your **enrollment form** changes, you should immediately advise the Trinity Health Retirement Office. As benefits are administered on the basis of the information provided during enrollment, your records must be kept up to date. Those changes include:

- change of address;
- change of name due to marriage or divorce;
- change in your spouse's employment status or employer;
- your divorce or legal separation
- changes in the eligibility status of your **dependent**

WHEN WILL COVERAGE END?

Your **retiree** coverage will end when:

- You die;
- The Plan ends or is amended so that you or your **dependents** are no longer eligible to participate; or
- The funds in the HRA account are depleted.

If you die, your **dependents** will continue to be covered as long as they continue to meet the eligibility requirements and as long as funds are available in the HRA.

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

COBRA CONTINUATION COVERAGE

WHAT IS COBRA?

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

WHEN WOULD I QUALIFY FOR COBRA?

Continuation coverage is available if coverage would otherwise end due to:

- for your dependent spouse – divorce or legal separation from you; or
- for your dependent spouse or child(ren) – your death; or
- for your dependent child(ren), loss of eligibility as a covered **dependent** (for example, because he or she reaches the maximum age provided by the plan); or
- for a **retiree**, if the former employer files for bankruptcy under Chapter 11.

WHAT MUST I DO TO NOTIFY MY EMPLOYER OF AN EVENT THAT WOULD TRIGGER COBRA COVERAGE?

If coverage would end because of divorce or legal separation, or because a child is no longer eligible to be a **dependent**, the retiree or covered **dependent** MUST notify the Trinity Health Retirement Office in writing. If the Trinity Health Retirement Office is not notified within 60 days after the coverage would otherwise end, and the person is no longer eligible as a **dependent**, continuation coverage cannot be offered.

HOW CAN I ELECT COBRA?

When the employer receives notification of one of the above events, or when any other qualifying event occurs, you or the individual losing coverage will be notified of the right to continue coverage. If continuation is desired, the participant must elect to do so within 60 days of the date the notice was sent. Each covered member of the family may individually decide whether or not to continue coverage, but an election of coverage by the retiree or spouse will be considered to be an election by all **covered individuals**, unless another **covered individual** rejects coverage.

WHAT IS THE COST FOR COBRA COVERAGE?

Continuation is at the participant's expense. The monthly cost of this continued coverage will be included in the notice. Premiums are the same for all individuals who are in the same type of classification – adult single individuals have the same cost and family groups have the same cost.

Should a qualifying event occur (e.g. divorce) the qualified beneficiary would be permitted to elect COBRA. The balance in their account would be the balance in the account on the day prior to the qualifying event. The **retiree** would maintain the balance that is in his/her account as well.

The amount of the COBRA premium would be the anticipated claims cost per person, plus a 2% surcharge for administrative expenses.

WHEN MUST I MAKE PREMIUM PAYMENTS?

For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated.

HOW LONG CAN I CONTINUE COBRA?

If coverage would otherwise end because employment ends or hours are reduced so you are no longer eligible for group benefits, continuation coverage may continue until the earliest of the following:

- The date on which a premium payment was due but not paid.
- The date the person continuing the coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects a **covered individual's** pre-existing condition.
- The date, after continuation coverage has been elected, the person becomes eligible for **Medicare**.
- The date the employer terminates all of its group health plans.

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

- 36 months from the date the covered **dependent's** coverage would have otherwise ended.
- The date on which the premium payment was due but not paid.
- The date the person continuing coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects a **covered individual's** pre-existing condition.
- The date, after continuation coverage has been elected, the person continuing coverage becomes eligible for **Medicare**.
- The date the employer terminates all of its group health plans.
- The **funds** in the Trinity Health HRA plan are **depleted**.

CAN THE LENGTH OF COBRA COVERAGE BE EXTENDED?

Second Qualifying Event

If continuation coverage was elected by a covered **dependent** because your employment ended or your hours were reduced and, if during the period of continued coverage, another event occurs which is itself an event which would permit continuation coverage to be offered, the maximum period of continued coverage for the covered **dependent** is extended for 18 months to a maximum of 36 months from the date of the initial event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

CAN THE LENGTH OF COBRA COVERAGE BE EXTENDED? (Continued)

Spouse and Dependents of Medicare-Eligible Retirees

If continuation coverage was elected by your spouse or dependent child and you became entitled to **Medicare** while an employee, the maximum period of continuation coverage for spouse or child is the greater of 36 months from the date you became entitled to **Medicare** or 18 months from the date you lost coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals

If a **covered individual** is disabled, according to the Social Security Act, at the time he or she first becomes eligible for continuation or within 60 days of that date, the maximum period of continuation coverage is extended to 29 months. (Coverage will still end for any other reason listed above, such as failure to pay premiums when due, etc.) The **covered individual** must notify the employer within 60 days of the date he or she is determined to be disabled under the Social Security Act and within 30 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning 30 days after the **covered individual** is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage, and may be adjusted from time to time when group rates are adjusted.

NOTE: Once the funds in the HRA plan are depleted, the plan will no longer be available for COBRA benefits.

Trade Act Of 1974

Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a 'trade readjustment allowance' or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Trinity Health Retirement Office for additional information. You must contact the Trinity Health Retirement Office promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

SPECIAL PROVISIONS FOR RETIREES

If your plan provides coverage for **retirees**, sometimes, filing a proceeding in bankruptcy under Title 1 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the **company** and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

WHAT OTHER FACTS SHOULD I KNOW REGARDING MY RIGHTS UNDER COBRA?

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members who are or may become eligible for COBRA. You should also keep a copy of any notices you send the **Plan Administrator** for your records.

WHO SHOULD I CONTACT FOR FURTHER INFORMATION AND TO WHOM SHOULD I PROVIDE NOTICE OF COBRA EVENTS?

If you need more information regarding continuation of coverage, please feel free to contact NGS American, Inc. or contact the **Plan Administrator**. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

The **company** is responsible for administering COBRA continuation. The **company** has contracted with Mongoose Administrators to perform certain administrative functions on its behalf. These functions may include mailing of COBRA notices, collection of premium payments and reporting of paid participants to applicable vendors.

MEDICAL BENEFITS

WHAT IS THE HEALTH REIMBURSEMENT ACCOUNT (HRA)?

The Health Reimbursement Account (HRA) is new in 2005 and is a very different type of plan option. The HRA contains an annual amount which you may apply to any covered expenses.

You can use the HRA to reimburse yourself for medical, dental, vision and hearing care expenses that qualify as Federal income tax deductions under Section 213 of the Internal Revenue Code as described in the Department of the Treasury, Internal Revenue Service Publication 502.

Generally, eligible HRA expenses are physicians' or dentists' services, or related supplies, that are not covered by or only partially covered by any employer sponsored benefit plan or personal insurance policy.

THE HRA BENEFIT FOR ELIGIBLE EXPENSES

Trinity Health will provide a one time only contribution of \$1,000 for each year of credited service after age 45, up to a maximum of \$15,000.

You may use the amount credited to your HRA to pay 100% of allowable expenses of any covered family member.

Any unused remaining balance in your HRA at the end of the year will roll over for you to use in the future.

HRA SPECIAL RULES

- Premiums (e.g. COBRA, **Medicare** Part B) may be submitted for reimbursement under the HRA.
- The HRA will make payment after any other source of coverage available (including **Medicare**).
- To make the best use of your HRA funds, you will want to become involved in the cost of the care you receive. You should become a savvy health care consumer so your funds will last as long as possible. The NGS American website (www.ngsameric.com) includes information on your benefits, your HRA, general medical information and other information designed to help you make wise decisions regarding your health care.

WHAT ARE ELIGIBLE EXPENSES?

Generally, eligible HRA expenses are physicians' or dentists' services, or related supplies, that are not covered by or only partially covered by any employer sponsored benefit plan or personal insurance policy. Examples of eligible expenses may include:

- Acupuncture services
- Alcoholism or substance abuse
- Ambulance
- Chiropractors
- Christian Science practitioners
- Contact lenses and related solutions
- Deductibles and co-payments under medical, dental and **prescription drug** plans
- Doctor's or dentist's fees not payable under the medical plan due to reasonable and customary cutbacks or other non-covered services
- Eye examinations, frames and lenses
- Hearing exams and hearing aids
- Home improvements or special equipment installed in home related to medical care (certain restrictions apply)
- Insurance premiums
- Laboratory fees
- Lasik Surgery
- Learning disability tuition fees (certain restrictions apply)
- Nursing home expenses for medical care
- Orthodontia expenses
- Over the counter drugs used to aid **illness/injury**
- Physical exams
- **Prescription drugs** or drug copays, including Insulin and supplies
- Prescription medications used to suppress nicotine addiction
- Psychiatric fees, psychologist or psychiatrist
- Smoking cessation programs
- Transplants
- Weight Loss Programs – if recommended by a physician for treatment of a medical condition
- Wheelchairs

You can obtain additional information about eligible expenses under the Internal Revenue Code by calling the Internal Revenue Service directly at 1-800-829-FORM, and requesting a copy of Publication #502: Medical and Dental Expenses.

WHAT IS NOT COVERED?

The following expenses are not eligible for HRA reimbursement:

Abortion

Health club dues

Household help while under medical care

Sterilization surgery

Weight loss programs – if not medically necessary

Transportation expenses to and from medical treatment except ambulance

Acne treatments, vitamins, dietary and herbal supplements, hair growth products, smoking cessation products, toiletries, weight loss drugs

NOTE: You can obtain additional information about eligible expenses under the Internal Revenue Code by calling the Internal Revenue Service directly at 1-800-829-FORM, and requesting a copy of Publication #502: Medical and Dental Expenses.

PHYSICAL EXAMINATION

This plan, at its own expense, will have the right and opportunity to have any individual whose treatment is the basis of a claim under this plan, examined by a **physician** designated by this plan when and as often as it may reasonably require during the review of a claim under this plan.

REIMBURSEMENT OF PLAN PAYMENTS

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
2. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **Plan Administrator**, the Plan may reduce any future covered expenses otherwise available to the covered person 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.

REIMBURSEMENT OF PLAN PAYMENTS (Continued)

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, ___ US ___ (1/8/2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Plan's Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the **Plan Administrator** to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **Plan Administrator** to enforce the Plan's rights.
4. Overpayments. This plan will have the right to recover any payments that were made to, or on behalf of, a **covered individual** and which causes an overpayment to be made.

Failure by a covered person to follow the above terms and conditions may result, at the discretion of the **Plan Administrator**, in a reduction from future benefit payments available to the covered person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Plan.

HIPAA PRIVACY COMPLIANCE

Section 6.17 HIPAA Privacy Compliance. The plan shall comply with applicable requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, (collectively “HIPAA”) with respect to the programs under the Plan which meet the definition of a “group health plan” as defined by HIPAA (including the medical, dental, vision, **prescription drug**, mental health and health care flexible spending account). Accordingly, this Section 6.17 shall apply only to those programs constituting “group health plans” under HIPAA. With respect to the medical, dental, vision, **prescription drug**, mental health and health care flexible spending account programs under the Plan, such compliance shall include, but not be limited to the following:

- A. Plan Sponsor Uses and Disclosures. The Plan shall establish and determine the permitted and required uses and disclosures of protected health information (“PHI,” as defined by HIPAA) by the Plan Sponsor, provided that such permitted and required uses and disclosures may not be consistent with the HIPAA regulations.
- B. Plan Sponsor Obligations. The Plan shall disclose PHI to the Plan Sponsor only upon the Plan Sponsor’s agreement that the Plan Sponsor shall:
1. Not use or further disclose PHI other than as permitted or required by the **Plan Document** or as required by law;
 2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
 3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or **employee** benefit plan of the Plan Sponsor;
 4. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by HIPAA of which the Plan Sponsor becomes aware;
 5. Make PHI available in accordance with the provisions of HIPAA granting individuals access to their own PHI contained in the Plan’s designated record set;
 6. Make PHI available for amendment by the individual who is the subject of the PHI and incorporate any amendments to such person’s PHI in accordance with relevant HIPAA provisions;
 7. Make available the information required to provide an accounting of PHI disclosures to an individual covered by the Plan in accordance with relevant HIPAA provisions;
 8. Make the Plan Sponsor’s internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

HIPAA PRIVACY COMPLIANCE (Continued)

B. Plan Sponsor Obligations (Continued)

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Provide for adequate separation between the Plan and the Plan Sponsor, as set forth below

The Plan Sponsor hereby agrees to abide by the above obligations and to certify to the Plan that it has been amended to incorporate the foregoing provisions.

C. Adequate Separation.

1. Only those **employees** or classes of **employees** or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to the PHI to be disclosed, including any **employee** or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.
2. The Plan shall restrict the access to and use by such **employees** or classes of **employees** or other persons under the control of the Plan Sponsor to plan administrative functions that the Plan Sponsor performs for the Plan.
3. The Plan shall provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Section 6.17 by such **employees** and other persons under the control of the Plan Sponsor.

D. Plan Disclosures. The Plan may:

1. Disclose PHI to the Plan Sponsor for purposes of the Plan's administrative functions that the Plan Sponsor performs consistent with the provisions of this Plan Section 6.17;
2. Not permit a health insurance issuer or health maintenance organization ("HMO") with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this Section 6.17.D;
3. Not disclose, and not permit a health insurance issuer or HMO to disclose, PHI to the Plan Sponsor as otherwise permitted by this Section 6.17.D unless the disclosure is included in the Plan's Notice of Privacy Practices distributed to Plan Participants; and
4. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or **employee** benefit plan of the Plan Sponsor.

HIPAA PRIVACY COMPLIANCE (Continued)

- E. Summary Information. The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:
1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 2. Modifying, amending or terminating the Plan.
- F. Enrollment Information. The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.

GENERAL PLAN INFORMATION

PLAN NAME

The name of the plan is the Trinity Health TCCS Retiree HRA Plan Effective January 1, 2005.

TYPE OF PLAN

This plan is a welfare benefits plan providing medical benefits.

PLAN NUMBER

The plan number is 504.

PLAN ADMINISTRATOR AND NAMED FIDUCIARY

The **Plan Administrator**, named fiduciary and agent for service of legal process is Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

EMPLOYER IDENTIFICATION NUMBER

The employer identification number for the Trinity Health is 35-1443425.

COST OF THE PLAN

All contributions are will be made by Trinity Health.

PLAN EFFECTIVE DATE

This plan is effective January 1, 2005.

PLAN YEAR

The fiscal year of this plan commences on the first day of January and ends on the last day of the following December.

PLAN SUPERVISOR

The **Plan Supervisor** is NGS American, Inc., 27575 Harper, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

PLAN IS NOT A CONTRACT OF EMPLOYMENT

Neither this **Summary Plan Description** nor the plan constitutes or provides a promise or guarantee of employment or continued employment, to any **employee** of the Plan Sponsor or of any participating employer. Nor do these documents change any such employment relationship to be other than employment "at will".

YOUR RIGHTS UNDER ERISA

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

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the **employee** benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the **Claims Administrator** review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the plan and do not receive them within 31 days, you may file suit in a Federal court. In such a case, the court may require the **Plan Administrator** to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the **Plan Administrator**. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, or bring a civil action under section 502A of ERISA. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

YOUR RIGHTS UNDER ERISA (Continued)

If you have any questions about your plan, you should contact the **Plan Administrator**. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Trinity Health is the named fiduciary with respect to this plan, within the meaning of Section 402(a)(1) of ERISA, solely to the extent of its responsibilities specified in the plan and service agreement. Trinity Health shall exercise all discretionary authority and control with respect to management of this plan which is not specifically granted to the **Plan Supervisor**, NGS American, Inc., or another fiduciary.

Trinity Health may delegate certain of its fiduciary responsibilities under this plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility shall be made by written instrument executed by Trinity Health, a copy of which will be kept with the records of this plan.

NGS American, Inc. has, by written instrument been designated as the Fiduciary for Final Claims Determination for medical, **post-service claims** submitted to the plan. By making this designation, it is Trinity Health's intention that NGS American, Inc. makes final claim determinations and has final discretion in construing the terms of the plan with respect to final claim determinations. NGS American, Inc. shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

Each fiduciary under this plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

Trinity Health, by a duly **authorized representative**, may modify, amend, or terminate the Plan at any time in its sole discretion.

Any such modification, amendments, or terminations that affect **covered individuals** in or beneficiaries of the Plan will be communicated to them. If the Plan is terminated, benefits will only be paid for claims incurred before the date of termination up to the time funds are no longer available.

ADMINISTRATION OF THE PLAN

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

The **Plan Administrator** shall have any and all powers of authority which shall be proper to enable him to carry out his duties under this plan, including by way of illustration and not limitation (i) the powers and authority contemplated by the Employee Retirement Income Security Act of 1974 (ERISA) with respect to **employee** welfare plans, and (ii) full discretionary authority to make regulations with respect to this plan not inconsistent with this plan or ERISA and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The **Plan Administrator** will determine eligibility for benefits under the Plan. The **Plan Administrator** has delegated fiduciary responsibility for medical and **post-service claim** decisions to NGS American, Inc. The plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not preempted by federal law, the laws of the state of Michigan.

PLAN FUNDING AND ASSET DISTRIBUTION UPON TERMINATION

The Plan is funded through the general assets of Trinity Health and contributions as required. In the event of Plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Plan should be terminated, only claims incurred prior to the date of such termination would be paid by the Plan up to the time funds are no longer available.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

The Trinity Health TCCS Retiree HRA Plan Effective January 1, 2005, is a self-funded plan. **Covered individuals** in this plan are not insured. In the event this plan does not ultimately pay expenses that are eligible for payment under this plan for any reason, the individuals covered by this plan may be liable for those expenses.

The **Claims Administrator**, NGS American, Inc., merely processes claims and does not insure that any medical, dental or disability expenses of individuals covered by this plan will be paid.

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

APPENDIX A

HOW TO FILE A CLAIM

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a **claimant** that complies with the Plan's reasonable procedure for making benefit claims.

There are different types of claims. Reasonable claim filing procedures, which are different for each type of claim, are described below. Each type of claim has a specific timetable for approval, payment, and request for further information, denial of the claim and for review of any **adverse benefit determination**.

The times listed below for response and appeals are maximum times only. A period of time begins at the time the claim is received, as explained in the claim filing procedures for each type of claim. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

WHAT YOU SHOULD KNOW ABOUT PRE-SERVICE CLAIMS

This plan does not condition benefit payment whether an Urgent Care Claim or a Non-Urgent Care Claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, or by calling (800) 521-1555.

WHAT YOU SHOULD KNOW ABOUT POST-SERVICE CLAIMS

Plan Procedures For Filing A Medical Post-Service Claim

In most cases, you must submit a claim form and documentation in order to receive payment from the HRA plan. Examples of acceptable documentation include the following:

If eligible expenses result from charges which have been denied, excluded or applied as deductibles or copayments under a health plan, you must submit the explanation of **benefits** form showing these denied or excluded charges along with your claim form.

If eligible expenses are not covered by a health plan, you must submit itemized bills, statements or receipts along with your claim form. When submitting a medical claim, the following information must be presented:

- The **retiree's** name, name of the employer and four-digit division code; this information is embossed on your NGS American, Inc. identification card.
- The **retiree's** social security number.
- The name of the patient and relationship to the **retiree**.
- The date of service.
- The provider's name and degree.
- The medical condition for which treatment was provided.
- The charge for each specific service.

WHAT YOU SHOULD KNOW ABOUT POST-SERVICE CLAIMS (Continued)

Plan Procedures For Filing A Medical Post-Service Claim (Continued)

Unless you submit proof that you have paid for the services billed, payment will be made to the provider as your **authorized representative**.

Additional information provided at the time of the claim will help in making a determination. For example, if the bill is for your covered **dependent** who has other medical coverage, send a copy of the other coverage's proof of payment or denial.

Completed claim forms and supporting documentation should be sent to NGS American, Inc., P.O. Box 7676, St. Clair Shores, Michigan 48080-7680.

Things you need to know...

For medical claims, your **Claims Administrator** is NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

This Plan intends, through NGS American, Inc., to promptly acknowledge and make a claims determination on claims submitted. In order to do this, the Plan needs your cooperation. When you send a bill or receipt to NGS American, Inc., you should be sure the above claim information is given.

The **Claims Administrator** must reply to a claim request within a certain time period. The **claimant** must also respond to the request for additional information from the **Claims Administrator** within certain time periods.

When a **post-service claim** is filed, and all information needed to make a claim determination is present, the **Claims Administrator** must notify the **claimant** of a claim decision within 30 days from the date the claim is received.

If a **post-service claim** is filed and additional information is needed, the **Claims Administrator** must notify the **claimant** within 30 days.

The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied 60 days after the request for information.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. The appeal must be in writing. It should be addressed to the **Claims Administrator**. The appeal must be made within 180 days from the receipt of the notification. The **Claims Administrator** will review the appeal and respond within 60 days. Please see the section titled APPEALS for further information.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

Except with Urgent Care Claims, when the notification may be given orally followed by written or electronic notification within three days of the oral notification, the **Claims Administrator** shall provide written or electronic notification of any **adverse benefit determination**. The notice will state, in a manner calculated to be understood by the **claimant**:

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

APPEALS

If a **claimant** receives an **adverse benefit determination** for a Non-Urgent **pre-service claim** or a **post-service claim**, the **claimant** may appeal the decision within 180 days of date of the **adverse benefit determination**. The **claimant** may submit written comments, documents, records, and other information relating to the claim. If the **claimant** requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

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

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

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

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

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