Signature Copy: October 29, 2025

AGREEMENT

Between

CHARTER TOWNSHIP OF BLOOMFIELD

and

BLOOMFIELD TOWNSHIP ASSOCIATION OF PROFESSIONAL FIREFIGHTERS IAFF LOCAL 3045

FROM: April 1, 2025
THROUGH: March 31, 2028

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AGREEMENT

AGREEMENT made this _____ day of October, 2025, by and between the Charter Township of Bloomfield (hereinafter "Township" or "Department" or "Employer") and the Bloomfield Township Association of Professional Firefighters IAFF Local 3045 (hereinafter "Union" or "Association").

PURPOSE AND INTENT

The general purpose of this Agreement is to set forth the terms and conditions of employment, and to promote orderly and peaceful labor relations for the mutual interest of the Township, the Employees, and the Association.

The parties recognize that the interest of the community and the job security of the Employees depends upon the continued existence of a quality fire service for the community.

To these ends, the Township and Association encourage to the fullest degree friendly and cooperative relations between the Township, the Employees and the Association at all levels.

ARTICLE 1 - RECOGNITION

Section 1 - General

Pursuant to and in accordance with all applicable provisions of Act 379 of the Public Acts of 1965 as amended, the Charter Township of Bloomfield does hereby recognize the Bloomfield Township Association of Professional Firefighters as the exclusive representative for the purpose of collective bargaining in respect to rates of pay, wages, hours of employment and other conditions of employment for full time uniformed Firefighters and Command Officers. The township shall continue to have a total of three Command Officers excluded from the bargaining unit. Those exclusions shall be the Fire Chief, Assistant Chief and either an additional Assistant Chief or an Operations Officer, at the discretion of the Fire Chief.

Section 2 – Sole Bargaining Rights

The employer will not aid, promote, or finance any other labor group or organization which purports to engage in collective bargaining or make any agreement with any other such group or organization for the purpose of undermining the Bloomfield Township Association of Professional Firefighters.

Section 3 – Gender Disclosure

The pronouns and relative words used in this agreement are written in the masculine form. If members of the bargaining unit are of feminine gender, such words shall be read in the feminine form.

ARTICLE 2 - DEPARTMENT EMPLOYEES

The following sections describe some of the Employees in the Department. These descriptions are not formal job descriptions.

Section 1 – Fire Chief

The Fire Chief is the highest-ranking officer in the Department and the Fire Chief is in charge of all Department operations.

Section 2 – Unit Officer in Charge

The Unit Officer in Charge is a Battalion Chief. They are the highest-ranking unit officer on duty. There shall be one (1) Battalion Chief for each unit and each shall be promoted from within the Union's bargaining unit. For contractual comparison purposes they will be compared to the Shift Commander Level.

Section 3 – Unit Officers

A Unit Officer Captain is responsible for the fire ground operations and daily Fire Department operations. There shall be one Captain scheduled at Central Fire Station for each unit, if the Captain is on leave an acting Lieutenant will fill the position (see ARTICLE 10 - WAGES/ACTING PAY, Section 3). All Captains shall be promoted from within the Bloomfield Township Fire Department.

A Unit Officer Lieutenant is responsible for the fire ground operations and daily Fire Department operations. There shall be one Lieutenant at each fire outstation for each unit. All Lieutenants shall be promoted from within the Bloomfield Township Fire Department. If any fire stations are added, there shall be an agreement between the Township and Union as to whether there must be a Lieutenant, however if the station has 3 or more persons assigned there shall be a Lieutenant added for each unit.

Section 4 – Day Employee

A. A Day Employee is a firefighter or officer, assigned to a ten (10) hour shift, four (4) days per week, Monday through Thursday.

1. Fire Marshal
2. EMS Captain
3. Lt./Fire Inspector(s)

B. Temporary Day Employee- Work hours and workdays may vary at the discretion of the Fire Chief or his designee, depending on needed schedule.

1. Temporarily for disciplinary reasons.
2. Special seminars, conferences, etc.
3. EMS Academy/Fire Academy.

4. Other specialized fire services positions as determined by the Fire Chief.

C. Probationary Day Employee (New Hire)

1. Will be assigned to day shift Monday through Friday (8:00 AM to 4:30 PM)

Section 5 – Unit Employee

A Unit Employee is a firefighter or officer who is assigned to a unit for a twenty-four (24) hour shift.

Section 6 – Class "A" Firefighter

Notwithstanding any other provision of this Agreement, all employees shall achieve and maintain "Class A Firefighter" rating as follows:

A. All employees hired after April 1, 1983, shall in order to become "Class A Firefighters":

1. Achieve a Basic EMT classification and a Fire Science Certificate at no cost (including tuition fees and books) to the Township within the first four (4) years of employment to attain a "Class A Firefighter" rating.
2. Have four (4) years of continuous service with the Fire Department.
3. Employees hired under this section may attain probationary "Class A Firefighter" rating without completing their Fire Science Certificate under the following conditions:
   a. They have been enrolled in the Medical Academy and successfully completed the requirements for Paramedic status.
   b. They are actively enrolled in Fire Science classes.
   c. Satisfactory proof of A & B shall be provided to the Fire Chief.
   d. In any event a Fire Science Certificate must be attained within eighteen (18) months from date of probationary "Class A Firefighter" rating.

B. All Employees hired after May 1, 2011, shall in order to become "Class A Firefighters":

1. Possess and maintain a State of Michigan Issued Paramedic license while employed by the Department.
2. Complete 60 College semester credit hours.
3. Possess Fire Fighter I and II State of Michigan certifications.
4. Have four (4) years of continuous service with the Department.

C. All Employees hired after April 1, 2020, shall in order to become" Class A Firefighters":

1. Possess a State of Michigan Issued Paramedic license.
2. Complete 60 College semester credit hours or accepted equivalences in conjunction with semester credit hours. (15 total credits for FF I and FFII and 30 Credits for a Paramedic License.)
3. Possess Fire Fighter I and II State of Michigan certifications.
4. Have four (4) years of service with the Department.

D. Failure of any Employee who has achieved "Class A Firefighter" rating pursuant to 6(B) or 6(C), to maintain Paramedic classification as required, will result in the following steps:

1. Immediate cessation Paramedic classification pay when notification from the State of Michigan licensing agency confirms the de-certification.
2. The decertified Paramedic is given a six (6) month grace period to complete the re-certification process. The grace period begins when notification is received from the State of Michigan licensing agency. This period of grace re-certification shall coincide with the first available class and continuing education credit availability.

E. Failure of any Employee, who achieved "Class A Firefighter" rating pursuant to 6(B), 6(C) or 6(D) and fails to utilize said grace period, to maintain the Paramedic classification, shall be cause for termination.

Section 7 – Probationary Employees

Employees shall be considered on probation for a period of one (1) year of employment from the date of their original hire or re-hire. During the probationary period, an Employee may be suspended, discharged, or otherwise disciplined without recourse to the grievance-arbitration procedure. At the expiration of an Employee's probationary period, the Employee shall be deemed a regular Employee, and the Employee's seniority shall relate back to the Employee's date of hire or re-hire. Probationary Employees will accrue vacation time and sick bank as described in other sections of this Agreement. Vacations, Trade Time, Personal Leave and Floating Holiday will be allowed after the probationary Employee is being used as staffing on their assigned shift and approved by their Battalion Chief. Any time off prior to being counted on as staffing will be at the discretion of the Fire Chief.

EMT Basics hired after October 1, 2025, shall remain on probation until they become a fully licensed State of Michigan Paramedic.

ARTICLE 3 - MANAGEMENT RIGHTS

Section 1- General Statement of Rights

Except only as restricted by the express terms of this Agreement, the Township retains the sole and exclusive right to manage the affairs of its business and to direct its working forces, including, but not limited to, the right to determine; the means, method, and manner of providing services; the number, size and location of any buildings, facilities, equipment, divisions, or parts thereof and the extent to which they shall be operated, relocated, or shut down; the selection of machinery and equipment to be acquired and utilized; the work to be handled and to outsource any work; the number of employees; and to establish, change, and enforce quality standards; and to maintain order and efficiency in its operation; and to establish, change, and enforce safety and security rules and rules of conduct; and to hire, select train, assign, and lay off employees; and to suspend, discharge, or otherwise discipline or demote employees for just cause. The failure of the Township to exercise any rights, functions, powers, and authority retained by it, or the exercise in a particular way, shall not be deemed a waiver of such, nor shall it preclude the Township from exercising the same in some other way not in conflict with the express provisions of this Agreement. The Union agrees the only limitation on the Township's rights are those expressly set forth in this Agreement or those set forth in Public Acts or State and Federal Laws.

ARTICLE 4 - SENIORITY

Section 1 – Seniority Lists

A. Newly hired employees shall acquire seniority on the day following satisfactory completion of a one (1) year probationary period from the date of hire into the Fire Department. The seniority of the newly hired employees will date back to their respective dates of hire and their names shall be placed on the seniority list in order of their respective individual seniority dates.

B. The Township agrees to provide to the Association a current seniority list of Association members upon request, for Association purposes.

Section 2 – Loss of Seniority

An Employee shall lose their seniority for the following reasons:

A. Employee quits, unless they are rehired.

B. Employee is discharged and the discharge is not reversed through the grievance procedure.

C. Employee is classified as a Day Employee and is absent for three (3) consecutive working days or is a Unit Employee and is absent for two (2) consecutive working days without prior notification to the Township. In proper cases, exceptions may be made by the Township.

D. Employee fails to return to work on their scheduled shift from Long Term Sick Leave.

E. For any other reason stated in this agreement.

Section 3 – Layoff and Recall

If and when it becomes necessary for the Township to reduce the number of employees in the workforce, the employees will be laid off in seniority order, starting with the least seniority and shall be recalled in reverse order.

ARTICLE 5 - GRIEVANCE – ARBITRATION PROCEDURE

Section 1 – Grievance – Arbitration Procedure

A. Any grievance or dispute which may arise between the parties concerning the application, meaning or interpretation of this Agreement, shall be settled using the Steps below.

B. Township Business Day. "Township Business Day" means any weekday excluding Friday, Saturday, Sunday, and holidays identified in this Agreement.

Step I – Verbal:

Any Employee having a grievance shall first take up the matter with the Fire Chief or Assistant Chief.

Step II – Written:

If the verbal grievance cannot be satisfactorily adjusted between the Employee and the Fire Chief or Assistant Chief and no later than ten (10) Township business days after the facts occurred which gave rise to the grievance, or no later than ten (10) Township business days after the grievant or the Association President shall have reasonably known of such facts, whichever is later, the grievance shall be reduced in writing, on forms provided by the Association, and presented by the Association President or his designee to the Chief or his designated representative. Within five (5) Township business days thereafter, the Chief or his designated representative shall furnish to the Association President or his designee his written answer to the grievance. Should the Chief or his designated representative fail to furnish a written answer within the said five (5) Township business days, the grievance shall be processed in accordance with Step III.

Step III – Written:

If the grievance still remains unadjusted, then within five (5) Township business days after receipt of the answer of the Chief or his designated representative, or within five (5) Township business days of the date on which said answer should have been furnished, the Association President or his designee shall present the grievance to the Township Supervisor. Within ten (10) Township business days thereafter, the Township Supervisor or his designated representative shall furnish to the Association President or his designee his written answer to the grievance. Should the Township Supervisor or his designated representative fail to furnish a written answer within the said ten (10) Township business days, the parties shall proceed to Step IV – Arbitration.

Step IV – Arbitration:

If the grievance cannot be satisfactorily adjusted in Step III, within fifteen (15) business days after receipt of the answer of the Township Supervisor or his designated representative, or within fifteen (15) business days of the date on which said answer should have been furnished, either the Township or the Association by the Association President or his designated representative may to proceed to arbitration by filing a demand with either the Federal Mediation

and Conciliation Service (FMCS) or the Michigan Employment Relations Commission (MERC) and the Township Supervisor.

In no event shall an individual be permitted to invoke arbitration under the Agreement; only the Union and management may invoke arbitration.

Either party shall have the option of requesting a second panel from the arbitrating service at the requesting party's sole expense. The arbitrator shall be selected from said panel or panels by an alternate striking of names.

Upon acceptance of the commission by the arbitrator, he shall, after hearings consistent with fair play and the law, render his award which shall be final and binding upon the parties. Each party shall bear its own expenses in connection with the arbitration; however, the expense of the arbitrator shall be borne equally by both parties. Where one party arranges for the transcription of the arbitration hearing by a court reporter, and the other party orders a copy of the record made, the parties shall share the costs of the record. The arbitrator shall not, in any way, provide said other party with the original or a copy of the transcript unless the party shares equally in the total costs of obtaining the transcript and a copy thereof. A single arbitrator will be selected for each grievance going to arbitration. The arbitrator shall have no power to alter, modify, or amend any provisions of this agreement. The arbitrator shall be bound by the express provisions of this Agreement. Nor shall the arbitrator have the authority to set any wage rates.

The Association shall not be required to process an Employee's grievance, if, in the opinion of the Association, said grievance lacks merit. No grievance shall be considered if not filed or processed within the time limits set forth in this Article and any grievance not appealed from a decision in one of the steps of the grievance procedure to the next step shall be considered dropped and the last answer shall be final and binding.

Section 2 – Grievance Time Extension

The Association or the Township may request, and mutually agree, in writing, to a time period extension of any step of the grievance procedure.

Section 3 – Grievance Committee

The names of the Association's officers shall be certified in writing to the Township by the Association, and the individuals so certified shall constitute the Association Grievance Committee.

The Township shall meet as required, at a mutually convenient time, with the Association Grievance Committee. All Grievance Committee meetings shall be held at reasonable hours, on the Township's premises, and without loss of pay to those committee members on duty.

The purpose of the Grievance Committee meetings will be to adjust pending grievances and to discuss procedures for avoiding future grievances. In addition, the Committee may discuss with the Township other issues which would improve the relationship between the parties.

Section 4 – Staffing Coverage

In order for the Fire Department to arrange staffing coverage, the Association will give, not less than forty-eight (48) hours before the arbitration, advance written notice to the Fire Chief of the names of the Fire Department employees that will testify as witnesses at any arbitration hearing.

ARTICLE 6 - STUDY COMMITTEE

Section 1 – Study Committee

A Study Committee shall be formed consisting of four (4) persons: the Township Supervisor or his designee, the Chief or the Chief's designee, the President of the Association or the President's designee, and another Association designee. Either the Township or the Association may refer to the Study Committee for review and discussion of matters which affect the employees of the bargaining unit. The Study Committee shall decide by majority rule. Any decision of the Study Committee shall be without precedent or prejudice. Meetings of the Study Committee shall be scheduled at the discretion of the Fire Chief or the Fire Chief's designee.

ARTICLE 7 - NO STRIKE/NO LOCKOUT

Section 1 – Uninterrupted Operations

The Association and the Township agree that both desire uninterrupted operations. Each party agrees, in consideration of the provisions of this Agreement, that the parties shall look to the grievance-arbitration procedure contained in this Agreement as the sole and exclusive method for resolving their contract disputes. The Association for its part agrees that it will not cause, permit, authorize, sanction, encourage or condone any strike, work stoppage, slowdown, sympathy strike, unfair labor practice strike, or any other interruption of work or interference with the operations of the Township.

Section 2 - Obligation and Duty

In the event activity prohibited by this Article occurs during the life of this Agreement, the Association, its officers, agents, and each of them, shall have an affirmative obligation and duty, and in connection therewith, shall exercise whatever powers they possess and take whatever steps are necessary and proper to end such improper activity, including but not limited to immediately instructing the involved Employees, in writing, that their conduct is in violation of the labor contract and that all such persons shall immediately cease their offending conduct. The Association agrees that the Township is entitled to expect and rely upon this Article as providing the Township with uninterrupted operations during the life of this Agreement.

Section 3 - Disciplinary

Any Employee, who shall participate in any strike, work stoppage, slowdown, or any other interruption of work in violation of this Article, shall subject himself to immediate disciplinary action up to and including discharge without recourse to the grievance-arbitration procedure except to establish the fact of the offense.

Section 4 - Lockout agreement

The Township for its part agrees that it will not engage in any lockout.

ARTICLE 8 - MAINTENANCE OF CONDITIONS

The Employer and Employee agree to honor and maintain the wages, terms and conditions of employment expressly set forth in this Agreement during the term of this Agreement as required by the specific provisions of this Agreement.

ARTICLE 9 - UNION ACTIVITIES

Section 1 - Union Business

A. Officers and representatives of the Union shall be afforded reasonable time without loss of pay to fulfill their Union responsibilities, including negotiations with the Township, processing of grievances, and administration and enforcement of this Agreement upon approval of the Fire Chief. It is understood that approval will not be arbitrarily withheld and all reasonable requests shall be granted.

B. The Executive Board consists of the President, Vice Presidents, Secretary/ Treasurer or their designee.

C. The Union shall advise the Township in writing as to the officers and representatives and shall report any changes promptly.

D. The Union shall be provided with suitable bulletin boards at each Fire Station for the posting of Union notices and other materials. All posted notices and other materials are the sole responsibility of the Union. The Township maintains the right to remove inappropriate material.

E. The Union may schedule meetings on Fire Department property, providing such meetings are not disruptive of the duties of the Employees or the efficient operation of the department. The Union must obtain the Fire Chief's approval prior to scheduling meetings on Fire Department property.

F. The Township will guarantee uncharged leave time for the three (3) Union Executive Board members to attend the MPFFU State Convention, IAFF National Convention, and 6th District meetings. Sixth District meeting leave time is for attendance at the meeting time only. Executive Board members shall give thirty (30) days' notice. Neither party can cancel without mutual agreement. Time will be charged to one of the following leave banks to attend all other Union meetings, IAFF seminars and classes Vacation bank (Union Executive Board members can utilize up to 12 odd days per year), personal business (Union Executive Board members may use up to 60 hours per year from personal business), or leave without pay. (Trade Time can also be used). Maximum yearly aggregate for union business for all Board members is 144 hours. The 144 aggregate hours include vacation, personal business, and leave without pay. Board members shall decide which bank to be used.

ARTICLE 10 - WAGES/ACTING PAY

Section 1 – Wages

Attached hereto as Appendix "A" is the wage schedule for employees covered by this Agreement, which has been agreed upon by the parties and is made a part of this Agreement.

Section 2 – Lateral Hires

Any firefighter-paramedic currently employed in another community with a full-time professional fire department, who is in good standing there, holds all required firefighting and paramedic certifications, and is otherwise qualified to serve as a firefighter-paramedic, shall be offered the following lateral transfer incentives:

A. A lateral transfer candidate shall move directly into the established wage scale as outlined in ARTICLE 10 - WAGES/ACTING PAY, based on their number of prior years of service as a firefighter-paramedic, up to three years, as defined in Section 2B below. For instance, if a lateral transfer has two (2) years of previous firefighter-paramedic experience, they would be offered a starting salary at Year 2 on this Agreement's wage schedule.

B. A "year of service", as described in Section 2A above, shall be defined as twelve (12) months of service by a firefighter-paramedic who works full-time for a professional fire department.

C. Lateral transfer candidates must complete all current pre-employment testing and evaluations, including an oral board interview, background check, and physical exam/drug screen, prior to being hired.

D. Any lateral transfer candidate's use of previous years of service is limited to the wage scale. Accordingly:

1. Any lateral transfer hired by the Township shall be considered a new employee in terms of either Department or Township-wide seniority. Any years of service that a lateral transfer earned in another community shall not count toward Township seniority once the lateral transfer becomes a firefighter/paramedic with the Township.
2. Any lateral transfer shall be considered a new employee for purposes of earning credit toward vacation time and personal time, as outlined in the schedule found in ARTICLE 17 – VACATION of this Agreement.
3. Any prior years of service from a lateral transfer in another community will not count toward Retention Pay eligibility, nor other benefits offered based on length of service with the Township. Furthermore, lateral transfers will not be eligible to purchase previous years of service from another fire department.
4. Any lateral transfer's years of service in another community shall not negate the required service time in the Department for promotional testing.

5. Lateral hires will progress up the wage schedule yearly on their anniversary date and may receive "Class A" pay even if they have not met the requirements of ARTICLE 2, SECTION 6C.

Section 3 – Acting Pay

In the event that there is no Officer on duty at a station, the Township shall pay the senior fire fighter on duty at the station base wages equivalent to a Lieutenant Paramedic and the senior Lieutenant (time in rank) for Battalion Chief's Acting Pay.

The following procedure will be used to determine which senior firefighter at the station will be used as an acting officer:

A. For Acting Battalion Chief, the on-duty Captain will be selected first. If no Captain is on duty, the Department will select from top-to-bottom order an on-duty Lieutenant who is on the current promotional Battalion Chief/Captain list. If no Lieutenant is on the current promotional Battalion Chief/Captain list, then it will default to the Lieutenant with highest time in rank.

B. For Acting Captain, the position will be filled by an acting Lieutenant at Lieutenant wages. If there is a vacant Captain position, and there is no Lieutenant on the current promotional Battalion Chief/Captain list, then the vacancy will be temporarily filled by the Lieutenant on the vacant Unit, with highest time in rank, until a new list is established. The Lieutenant filling the vacancy shall receive Acting Captain Pay for those hours worked.

C. For Acting Lieutenant, the Department will first select in top-to-bottom order from the on-duty firefighters at the station who are on the current promotional Lieutenant list with a Fire Officer Certificate.

D. If no on-duty firefighter at the station is on current promotional list, the Department shall select by seniority from the on-duty unit firefighters at the station who have obtained a Fire Officer II Certificate.

E. If no on-duty firefighter at the station has a Fire Officer II Certificate, then the Department shall select by seniority from on-duty firefighters at the station who have a Fire Officer I Certificate.

F. If there are no firefighters on duty at the station with a Fire Officer certification, a Firefighter with a Fire Officer Certificate will be sent out from another station at the discretion of the Unit Officer in Charge. If there are no firefighters on duty with any of the above certifications, then the senior firefighter on duty at the station will be the acting officer.

The employee shall receive compensation at the rate of Lieutenant Paramedic or Battalion Chief (whatever the case may be) for the entire duration of time worked in the acting position.

Station 1 shall have one (1) Battalion Chief and one (1) Unit Captain on duty at all times. In the event there is no Battalion Chief and Unit Captain on duty at Station 1, the Township shall pay Acting Pay.

The senior Lieutenant/Fire Inspector shall receive compensation at the rate of Fire Marshal when the Fire Marshal is absent for more than four (4) consecutive workdays. Acting pay will be paid beginning on day five (5).

Light Duty employees and Day employees, other than Lieutenant/Fire Inspector acting as Fire Marshal, are not eligible for Acting Pay.

The Township shall keep record of all hours worked by employees “acting in higher rank”. Acting Pay will be paid in the work period in which it is worked.

ARTICLE 11 –RETENTION PAY

Employees hired May 1, 2011 and after, and with at least five (5) years' credited service with the Department, are eligible for Retention Pay as set forth herein:

Credited Service Time	Percentage of Base Wage
More than five (5) years	2%
More than ten (10) years	3%
More than fifteen (15) years	4%
More than twenty (20) years	5%

Retention Pay will be a one-time annual payment on the final payroll of October and will not be included in hourly rates for regular or overtime compensation, or acting pay. The first year's Retention Pay will be paid as soon as practicable after the ratification of this Agreement.

In order to receive a full Retention payment, an employee must have accrued a full twelve months' credited service time from November 1 through October 31 of the applicable year. An employee shall accrue credited service time only if they meet the following criteria:

1. The employee is on active duty for the current year (November 1 to October 31) receiving bi-weekly paychecks from the Township.

2. The employee is receiving service-related disability (worker's compensation) checks from the Township but only for the first twenty-six (26) week period of the disability.

3. The employee is on sick leave and has not yet exhausted their sick leave bank.

Employees who do not have a full twelve (12) months of credited service time during the applicable twelve-month period (November 1 through October 31), but are otherwise eligible for Retention Pay, shall have their payment prorated based on the amount of credited service time from November 1 through October 31 as determined by the criteria set forth above. Payment for prorated Retention Pay will be calculated by taking the amount of the employee's non-credited service time and dividing by 365.

If an Employee receives Retention Pay, and quits the employment of Bloomfield Township prior to October 31, the Retention Pay shall be deducted from his separation pay.

Any Employee who retires on a service disability retirement shall be paid a prorated Retention Pay payment. Any eligible employee who dies while employed, their heirs shall be paid a prorated Retention Pay payment.

Any Employee who retires shall be paid a prorated Retention Pay payment at time of retirement.

Employees hired before May 1, 2011 are not eligible for Retention Pay.

ARTICLE 12 - FOOD ALLOWANCE

Section 1 – Increments

All Employees will receive a food allowance equal to two percent (2%) of annual base wages paid in two increments, half on the last paycheck of September and half on the last paycheck of March.

As soon as practicable after the ratification of this Agreement, employees will receive the difference between half of the annual food allowance (1% of base wages) and the amount actually received by the employee in September 2025.

Section 2 - Proration

Those Employees on short-term or long-term disability, or after six months of Workers Compensation will receive a prorated food allowance amount.

ARTICLE 13 - OVERTIME

Section 1 - General

Overtime shall be paid on the basis of hours actually worked pursuant to the Fair Labor Standard Act as amended 1985. Except that the Township will pay those overtime hours pursuant to Section 207(K) of the Fair Labor Standard Act (1986) and 29 Code of Federal Regulations, Part 553 (Garcia Act) for those hours over 212 in a pay period for actual hours worked, for vacation time, sick time, personal business, workers compensation, bereavement and jury duty. Provided, however, that the 212-hour threshold for payment of overtime when vacation, sick time, personal business, workers compensation, bereavement and jury time is involved shall not change even if Section 207 (K) and the regulations are amended or changed in the future, to require the payment of overtime for less than 212 hours in a pay period. In such case, overtime shall not be paid based on, or caused by any vacation, sick time, personal business, workers compensation, bereavement and jury duty hours until the 212-hour threshold is reached.

Section 2 - OT Rate and Authorization

Overtime must be authorized by the Fire Chief or the Unit Officer in Charge at Fire Station One on each unit. Overtime will be paid at one and one- half (1 ½) times the Wage Scale, prorated in one-quarter (1/4) hour increments. It shall be the Employee's responsibility to notify the Unit Officer in Charge when overtime is worked, and the amount of overtime worked. The Unit Officer in Charge shall verify the Employee's overtime and forward the amount of overtime on a Fire Department overtime form to the Fire Chief's office.

Section 3 - Held Over OT

If an Employee is held over beyond their regularly scheduled work hours, the Employee shall be paid at the overtime rate, prorated in one quarter (1/4) hour increments.

Section 4 - Call Back OT

An Employee who is called back into work, outside their regularly scheduled hours, will receive a minimum of three (3) hours show up time paid at the overtime rate. Call Back Pay will be prorated in one quarter (1/4) hour increments, after the first three (3) hours of work. Call back shall commence at time of call. Call Back Pay will be designated by the Fire Chief or his designee.

Section 5 - Overtime Procedures

The following procedure shall be followed in the hiring or call back of overtime.

A. Unit Selection

1. Only personnel who can fill the requirements according to Sub-Section (B) will be contacted.

2. When off-duty unit is on "Kelly Day";

i. The unit on "Kelly-Day" will be the first unit contacted.
ii. If all personnel on "Kelly-Day" are not available, the "other unit" that was on the previous 24 hours shift will be contacted next.
iii. If both of the above units cannot fill the shift the day shall be split into one half (1/2) of the original time needed for the staffing coverage and follow above procedure i. and then ii.

3. When both off duty units are on "Kelly Days" (one unit on their last day of "Kelly", the other unit going off duty on their first day of "Kelly");

i. The unit going off duty will be called first.
ii. In the instance where neither unit can fill the vacant classification for the entire time needed, the above order will be repeated beginning with step one, and requesting personnel for one-half (1/2) the original time needed for the manpower coverage.

4. When overtime is required beginning at 0800 hours with a requested duration of less than 12 hours, then the shift that is going off duty at that time will be the first to be called.

5. If an Employee is already on duty on overtime, and the need arises for additional overtime, then the Employee currently working shall have first chance at accepting the additional overtime.

B. Personnel Selection

1. Employees must live in Oakland County or any county that touches Oakland County (Lapeer, Livingston, Genesee, Washtenaw, Macomb, and Wayne) to be hired for when being asked to report to work immediately.

2. To fill any vacancy after unit selection has been made, use the unit overtime roster.

3. The unit overtime roster will be laid out in seniority order. On the date of ratification of this Agreement, overtime will be called in order of the seniority. Once an employee has taken the overtime shift a notation will be made on that employee's name. Then next time the list is used the employee under the notation will be the first to be called. When the end of the list is reached, the order goes back to the top of the list. When hiring multiple days, designated Employee may choose any one of the open shifts, this continues going down the list until all spots are filled or no more takers.

4. In the event that a specific position is needed, as referenced in other parts of this Agreement, the employees who fit those positions will be called in seniority order. That separate list will be saved, as referenced in the above procedure.

5. In the event that all overtime list procedures have been exhausted probationary employees may be contacted for overtime with the approval of the Fire Chief.

6. Any overtime that is worked less than twelve (12) hours will not affect the notation of person to be called.

C. Use of the Overtime Roster

1. The Department will maintain in good order, a list of all Department overtime lists.

2. An employee shall not work overtime on their actual scheduled vacation day. An employee shall not collect pay for vacation leave and for working overtime on the same day unless approved by the Fire Chief.

3. Fire Department employees who have a signed trade time slip for the day overtime is needed shall not be eligible for overtime.

4. EMT Basics will not be offered overtime unless the Department is unable to fill overtime positions with Paramedics.

5. Employees who are transferred from unit to unit shall be placed on the new list in seniority order at the completion of their final shift before transfer.

6. Overtime hours will begin when the employee reports to work.

7. In the event that overtime has to be filled and a vacancy in coverage exists, the crew at that station, in seniority order, shall have the opportunity to cover that time and be paid at the overtime rate.

8. Overtime shall be offered in person or through another communication platform. Examples but not limited to are, telephone, text message, specific program.

   i. When a group text is used, interested employees will be given time parameters to respond, as instructed in the text, if they are interested in working the overtime. Following the list after the notation the employee that responds that is closest to the notation is awarded the overtime.

   ii. If contacted by telephone, the list will be called in order from the “line” down. The first employee to respond with a yes is awarded the overtime.

D. Emergency Overtime

1. In the event that there is an emergency situation that causes a need for more manpower, the Fire Chief or their designee, shall authorize an overtime call back, in whatever mass message means are available to them.

2. It is understood that due to the immediate need of manpower, the first members to respond shall get the overtime, as long as they are currently in Oakland County or a county that touches Oakland County. Any employee taking call back overtime will not be affected on their unit overtime list.

3. In the event that an emergency requires specific personnel, the chief may be able to call specific individuals in for that purpose, for example an incident commander, technical rescue team, hazmat team, etc.

Section 6 - Overtime on a Holiday

A. Fire Department employees called into work Overtime on a Holiday shall be paid two and one-half (2 ½) times of the wage schedule and shall be paid in that pay period in which the Overtime was worked.

B. If an employee is held over for one (1) hour or more beyond their regularly scheduled work hours on a Holiday, the employee shall be paid at two and one-half (2 ½) times of the wage schedule for the entire time the employee is held over, prorated in one-quarter (1/4) hour increments. Employees held over for less than one (1) hour shall be paid at one and one-half (1 ½) times of the wage schedule, prorated in one-quarter (1/4) hour increments.

Section 7- Record

The Township shall submit to the Union a record of all overtime hours paid to fire department bargaining unit employees.

ARTICLE 14 - FAMILY MEDICAL LEAVE ACT

See Family Medical Leave Act Policy at Attachment "I."

ARTICLE 15 – LONGEVITY PAY

Employees hired prior to May 1, 2011, and with at least five (5) years' seniority prior to November 30th of each year shall be eligible for Longevity Pay as set forth herein:

Credited Service Time	Percent of Base Wage for Classification
Five (5) Years	2%
Ten (10) Years	4%
Fifteen (15) Years	6%
Twenty (20) Years	8%
Twenty-five (25) Years	10%

In order to receive a full Longevity payment, an employee must have accrued a full twelve months' credited service time from December 1 through November 30 of the applicable year. An employee shall accrue credited service time only if they meet the following criteria:

1. The employee is on active duty for the current year (December 1 to November 30) receiving bi-weekly paychecks from the Township.

2. The employee is receiving service-related disability (worker's compensation) checks from the Township but only for the first twenty-six (26) week period of the disability.

3. The employee is on sick leave and has not yet exhausted their sick leave bank.

Employees who do not have a full twelve (12) months of credited service time during the applicable twelve-month period (December 1 through November 30), but are otherwise eligible for Longevity Pay, shall have their Longevity payment prorated based on the amount of credited service time from December 1 through November 30 as determined by the criteria set forth above. Payment for prorated Longevity will be calculated by taking the amount of the employee's non-credited service time and dividing by 365. The Longevity Pay shall be paid in the last paycheck in November of each year.

If an employee receives Longevity Pay, and quits the employment of Bloomfield Township prior to November 30th, the Longevity payment shall be deducted from his separation pay.

Any employee who retires on a service disability retirement shall be paid a prorated Longevity payment. Any eligible employee who dies while employed, their heirs shall be paid a prorated Longevity payment. Any employee who retires shall be paid a prorated Longevity payment at time of retirement.

Employees hired on or after May 1, 2011 shall not be eligible for Longevity Pay as set forth herein.

ARTICLE 16 – HOLIDAYS

Day Employees and Unit Employees shall receive Holiday pay for the contract year (April 1 through March 31) in the pay cycle in which they worked. The balance of any Holiday(s) will be paid in one lump sum payment the last paycheck distributed in March of the contract year. Holiday pay shall be calculated by using the Employee's permanent wage rate at the time payment is made for the Holiday(s). Payment will be made only if the criteria set forth are met.

Section 1- Holidays for Day Employees

A. The following shall be official Holiday(s) for Day Employees:

New Year's Day	Labor Day
Martin Luther King Jr. Day	Veterans' Day
President's Day	Thanksgiving Day
Memorial Day	Christmas Eve
Independence Day	Christmas Day
Employee's Birthday	

Should a Holiday fall on Saturday or Sunday, it shall be observed on the date observed by the Township. Day Employees working a Holiday (except one of the Holidays listed in Section 2A hereof), shall be paid at double their regular hourly rate.

Section 2 – Holiday Pay for Day Employees

Day Employees shall receive pay equal to ninety-eight (98) hours per contract year, if the following criteria set forth are met:

A. The Day Employee must work the following Holidays:

President's Day	Columbus Day
Veteran's Day	Martin Luther King Jr. Day
Employee's Birthday	

Day Employees who are absent on one (1) of the above Holidays (except for Vacation and approved Bereavement Leave) shall have sixteen (16) hours of Holiday pay deducted for each of the above days on which the Day Employee fails to work.

B. The Day Employee must accrue a full twelve (12) months of credited service time during the contract year (April 1 through March 31). A Day Employee shall accrue credited service time only if they meet the following criteria:

1. The Employee was on active duty for the entire contract year (April 1 through March 31) receiving bi-weekly paychecks from the Township.

2. The Employee received service-related disability (Worker's Compensation) checks from the Township (not from a Workers Compensation insurance carrier), but only for the first twenty-six (26) week period of the disability.

3. For the first twenty-six (26) weeks the Employee is on Long-Term Sick Leave and has not yet exhausted their Sick Leave bank.

C. Subject to Section 2D, Day Employees who do not have a full twelve (12) months of credited service time during the contract year (April 1 through March 31) shall have their Holiday pay prorated based on the amount of credited service time from April 1 through March 31 as determined by the criteria set forth in Section 2B 1-3.

D. A Day Employee shall have the following deductions made from the ninety-eight (98) hours holiday pay set forth in Section 2A above:

1. The Day Employee must not have used Short-Term Sick Leave on any of their scheduled Holidays. Any use of Short-Term Sick Leave on a scheduled Holiday will be deducted from their Holiday pay.

Section 3 – Holidays for Unit Employees

The following shall be official Holidays for Unit Employees:

New Year's Eve	New Year's Day
President's Day	Labor Day
Independence Day	Thanksgiving Day
Martin Luther King Jr. Day	Christmas Day
Christmas Eve Day	Memorial Day

Section 4 – Holiday Pay for Unit Employees

Unit Employees shall receive Holiday pay as follows:

A. A Unit Employee shall be paid Holiday pay for each Holiday they actually work. Alternatively, and subject to Section 4C below, a Unit Employee shall receive a total of one hundred sixty-eight (168) hours of Holiday pay (worked or unworked) for the contract year, if the Employee meets the following criteria for earning credited service time:

1. The Unit Employee was on active duty the entire contract year (April 1 through March 31) receiving bi-weekly paychecks from the Township. This includes Employees on approved Vacation or approved Bereavement Leave.

2. The Unit Employee received service-related disability (Worker's Compensation) checks from the Township (not from a Worker's

Compensation insurance carrier), but only for the first twenty-six (26) week period of the disability.

3. For the first (1st) twenty-six (26) weeks the Employee is on Long-Term Sick Leave and has not yet exhausted their Sick Leave bank.

B. Subject to Section 4C below, Unit Employees who do not have a full twelve (12) months of credited service time during the applicable contract year (April 1 through March 31) shall have their Holiday pay prorated based on the amount of credited service time set forth in Section 4, A, 1-3.

C. A Unit Employee shall have the following deductions made from the one hundred sixty-eight (168) hours of Holiday pay set forth in Section 4A above:

1. The Unit Employee must not have used Short-Term Sick Leave on any of their scheduled Holidays. Any use of Short-Term Sick Leave on a scheduled Holiday will be deducted from their Holiday pay.

D. Under no circumstances shall a Unit Employee receive more than one hundred sixty-eight (168) hours of Holiday pay in any contract year (April 1 through March 31) unless they should have actually worked on more than Seven (7) Holidays.

Section 5 – Holiday Trade Time

If Trade Time is utilized on a scheduled Holiday the Unit Employee regularly scheduled for duty shall be credited for attendance as if they were working.

Section 6 – Holiday Routine

Holiday routine will be followed for Unit Employees on all Holidays set forth in this Agreement, or on any days where Township Hall is closed in observance of a Holiday.

ARTICLE 17 – VACATION

Section 1 – Amount of Vacation

Vacation will be granted to all employees according to the amount of service time accumulated prior to April 1st of each fiscal year and credited as follows:

A. Day Employees

	Annual Allowance	Rollover Max	Max in Bank
After one (1) years' service	100 Hours	50 hours	150 hours
After five (5) years' service	120 Hours	60 hours	180 hours
After nine (9) years' service	160 Hours	80 hours	240 hours
After twelve (12) years' service	180 Hours	90 hours	270 hours
After fourteen (14) years' service	200 Hours	100 hours	300 hours
After sixteen (16) years' service	220 Hours	110 hours	330 hours
After eighteen (18) years' service	240 Hours	120 hours	360 hours

B. Unit Employees

	Annual Allowance	Rollover Max	Max in Bank
After one (1) years' service	240 hours (10 unit days)	120 hours	360 hours
After five (5) years' service	288 hours (12 unit days)	144 hours	432 hours
After nine (9) years' service	336 hours (14 unit days)	168 hours	504 hours
After twelve (12) years' service	384 hours (16 unit days)	192 hours	576 hours
After eighteen (18) years' service	432 hours (18 unit days)	216 hours	648 hours

Section 2 - Types of Vacations

There shall be the following types of Vacation:

A. Vacations:

1. Vacations shall be scheduled in increments of three (3) Unit days for Unit Employees or four (4) work days for Day Employees and no Vacation shall be longer than six (6) Unit days for Unit Employees or eight (8) work days for Day Employees, unless at the time the Vacation is scheduled, a Vacation request of more than six (6) unit days or eight (8) work days for Day

Employees is acceptable to all other employees on the Unit or on Days respectively, and approved by the Fire Chief.

2. If the last vacation period of the fiscal year bridges into the next fiscal year, then the vacation or A.O.Ds will be scheduled or available in the current fiscal year. Example: March 29, 31, and April 2 are considered previous year vacation picks.

B. Advanced Odd Day Vacations:

1. Unit Employees may schedule six (6) Advanced Odd Day Vacations and Day Employees may schedule eight (8) Advanced Odd Day Vacations per fiscal year in advance. If unforeseen events arise regarding the scheduling of additional Advanced Odd Days, The Chief and the Union will mutually agree to a new process.

2. Only one Unit Employee and/or Day Employee may schedule an Advanced Odd Day Vacation on the same calendar day.

3. First choice for Advanced Odd Day Vacations shall be listed according to seniority on each Unit and Day Vacation list before February 1st of each fiscal year.

4. Second choice for Advanced Odd Day Vacations shall be listed according to seniority on each Unit and Day Vacation list before March 1st of each fiscal year.

5. Third and fourth choice for Advanced Odd Day Vacations shall be listed according to seniority on each Unit and Day Vacation list before March 15th of each fiscal year.

6. Fifth and sixth choices for Advanced Odd Day Vacations shall be listed according to seniority on each Unit and Day Vacation list by March 30th of each fiscal year.

7. Seventh and eighth choices for Advanced Odd Day Vacations shall be listed prior to March 30th by Day Staff in order of seniority for each round of choices.

8. After March 31st, Unit Employees need only the approval of Unit Officer in Charge to schedule an Advanced Odd Day Vacation and Day Employees need only the approval of the Fire Chief to schedule an Advanced Odd Day Vacation.

9. Advanced Odd Day Vacations must be scheduled prior to 08:00 hours of Unit Maximum Posting Date (previous work cycle) or workweek for Day Employees. After 08:00 hours, it is scheduled as an Odd Day Vacation and

follows the procedure for scheduling an Odd Day Vacation as described in Section 2, Paragraph C (Odd Day Vacation) of this Article.

10. Cancellation of Advance Odd Day Vacation

a. Employees may cancel a posted Advance Odd Day Vacation (A.O.D.) using the following criteria:

1. Unit Employees must request the A.O.D. cancellation to the Unit Officer in Charge at Fire Station One BEFORE 08:00 hours on the first workday of the preceding work period. Day Employees must request the A.O.D. cancellation to the Fire Chief or his designee BEFORE 08:00 hours on the first workday of the preceding workweek.

2. If an Employee meets the criteria set forth in 10.a.1 above, the Employee shall then be allowed to utilize (schedule) another A.O.D. at a later date. The Employee must follow the current language set forth in the Labor Agreement when rescheduling an A.O.D.

3. When the Employee cancels an A.O.D. vacation, they in turn cannot take an Odd Day Vacation for the same day. However, if a Unit three (3) or six (6) day Vacation or a Day shift four (4) day or eight (8) day Vacation becomes available during the time of the A.O.D. the Unit Employee may take the Unit three (3) or six (6) day vacation or the Day Employee make take the Day shift four (4) or eight (8) day Vacation without the loss of the A.O.D. status.

4. This policy can only be used one time per year.

b. If an Employee fails to meet the criteria set forth in 10.a.1 above, the Employee may still cancel their A.O.D., but the Employee shall not be allowed to utilize (schedule) another A.O.D. at a later date. The Employee will have utilized one (1) of their A.O.D. options.

c. Day Employees shall notify the Fire Chief of the A.O.D. cancellation. The Day Employee, via e-mail and the posting of a memo, shall also notify all other Day Employees of the A.O.D. cancellation. Day Employees requesting to fill the open Day Vacation shall notify the Fire Chief or his designee. Those Day Employees requesting to fill the open Day Vacation need only the approval of the Fire Chief.

d. If a Unit Employee cancels their scheduled A.O.D after it has been listed and approved according to this Agreement, the A.O.D then

becomes available and shall be offered to the remaining Unit Employees on the Unit by seniority, beginning with the Unit Employee with the most seniority. Each Unit Employee in descending seniority order shall be offered the A.O.D until a Unit Employee accepts the A.O.D or it has been offered to each Unit Employee. The Unit Officer in charge at Fire Station One or his designee will attempt to notify all Unit Employees of the affected shift of the A.O.D cancellation. Notification may consist of a verbal conversation or verbal message. Once the Unit Officer in Charge has completed notification to all affected Unit Employees, the A.O.D shall be available by seniority for six (6) hours. After the six (6) hours, Unit Employees scheduling the A.O.D need only to have the A.O.D approved by the Unit Officer in Charge. If cancelled A.O.D falls within parameters of ARTICLE 17 – VACATION Section 2-B(10), it shall be scheduled as an Odd Day Vacation by seniority.

e. Employees, who are off duty the day of the cancellation, shall be notified either the next scheduled workday in which they return or by phone call if time parameters require.

EXAMPLE

X=Unit Employee June (any year)

Cancellation prior to 08:00 hours on the 1st, for A.O.D. on the 14th

1. X = cancellation	11.	21. X
2.	12. X	22.
3. X	13.	23. X
4.	14. X = A.O.D.	24.
5. X	15.	25.
6.	16.	26.
7.	17.	27
8.	18.	28. X
9.	19. X	29.
10. X	20.	30. X

C. Odd Day Vacation. An Odd Day Vacation is a single Unit day Vacation for Unit Employees or a single workday for Day Employees. This Odd Day Vacation request may be posted (scheduled off) by the Unit Employee up to three work periods prior to their requested day. Day Employees may request this Odd Day Vacation up to four work weeks prior to the requested day.

1. Unit Employees may have an Odd Day Vacation approved on a “first day for first day, second day for second day, third day for third day” basis three work periods prior. Day employees, “Monday for Monday, Tuesday for

Tuesday", etc., four weeks prior to. This previous work cycle or workweek scheduling is the maximum frame for approval. [known hereafter as: Maximum Posting Date]

Any request for an Odd Day Vacation of less than maximum spread may be approved for both Unit and Day Employees.

Example: Odd Day Vacation may be posted on Monday (cycle #1) for Wednesday or Friday (cycle #1) and Wednesday (cycle #2).

2. Unit Employees may utilize up to eleven (11) Odd Day Vacations per fiscal year. Day Employees' use of an Odd Day Vacation need only the approval of the Fire Chief. Unit Employees may request approval from the Fire Chief to utilize more than eleven (11) Odd Day Vacations. Such approval, if granted, shall be at the Fire Chief's discretion.

3. Carryover of Unit Vacation shall not alter the maximum of eleven (11) Odd Day Vacations per fiscal year.

4. Odd Day Vacations shall be approved by seniority for Unit Employees until 09:00 hours of the Maximum Posting Date. After 09:00 hours of the Maximum Posting Date, Odd Day Vacations shall be approved on a first request basis.

5. For Unit Employees, Odd Day Vacations must be approved by the Unit Officer in charge at Fire Station One. The Fire Chief's office must approve Day Employees' requests.

Section 3 - Scheduling Vacations for Unit Employees:

A. Any Unit Employee who fails to list their Vacation on the specified dates of this Section forfeits their seniority rights for Vacation choices. After March 1st of the fiscal year, Unit Employees scheduling Vacations need only to have the Vacation approved by the Unit Officer in Charge at Fire Station One.

B. First choice for Vacations shall be listed according to seniority on each Unit's Vacation list before February 1st of each fiscal year.

C. Second choice for Vacations shall be listed according to seniority on each Unit's Vacation list before March 1st of each fiscal year.

D. The Unit Officer in Charge shall be responsible for approving, by seniority, first and second choices for Vacations, only when listed as required by B and C of this section.

E. All Vacations shall be listed as the first scheduled working day leaving and the first scheduled working day returning.

F. If a Unit Employee cancels their scheduled Vacation, the Unit Employee forfeits their seniority rights for choice.

G. If a Unit Employee cancels their scheduled Vacation after it has been listed and approved according to this Agreement, the Vacation then becomes available and shall be offered to the remaining Unit Employees on the Unit by seniority, beginning with the Unit Employee with the most seniority. Each Unit Employee in descending seniority order shall be offered the Vacation until a Unit Employee accepts the Vacation or it has been offered to each Unit Employee.

H. Three (3) Unit Employees, may be on Vacation per Unit on the same workday and further provided that:

1. A minimum of eight (8) Unit Paramedics are on duty; and,

2. A minimum of two (2) Unit Officers are on duty at all times.

3. The Fire Department will allow a total of three (3) Unit Employees on each Unit to be on Vacation as follows: A maximum of two (2) scheduled Vacations (either three Unit days or six Unit days) with the remaining Vacation time to be comprised of Advanced Odd Day Vacation or an Odd Day Vacation, floating holiday.

I. Probationary Unit Employees shall be allowed to post a vacation by seniority, while still on probation, providing the scheduled vacation occurs after they have been deemed manpower and have accrued the time.

J. The Association understands that the Fire Chief determines the staffing level for the Units and the Fire Chief may or may not adjust staffing levels at his discretion.

Section 4 - Scheduling Vacation for Day Employees:

A. Any Day Employee who fails to list their Vacation on the specified dates of this Section forfeits their seniority rights for Vacation choices. After March 1st of the fiscal year, Day Employees scheduling Vacations need only to have the Vacation approved by the Fire Chief.

B. First choice for Vacations shall be listed according to seniority on the Days' Vacation list before February 1st of each fiscal year.

C. Second choice for Vacations shall be listed according to seniority on the Days' Vacation list before March 1st of each fiscal year.

D. The Fire Chief shall be responsible for approving, by seniority, first and second choices for Vacations, only when listed as required by B and C of this section.

E. One (1) Day Employee from EMS Division and one (1) Day Employee from Fire and Life Safety Division (FLSD) may be on Vacation per work day. One (1) additional FLSD employees may be on vacation with the approval of the Fire Chief providing one FLSD personnel is on duty during the work day.

F. All vacations shall be listed as the first scheduled working day leaving and the first scheduled working day returning.

G. If a Day Employee cancels their scheduled Vacation, the Day Employee forfeits their seniority rights for choice.

H. If a Day Employee cancels their scheduled Vacation after it has been listed and approved according to this Agreement, the Vacation then becomes available. The Day Employee, via e-mail and the posting of a memo, shall notify all other Day Employees, of its availability. Day Employees requesting to fill the open Day Vacation shall submit the request in writing to the Chief's office for approval.

Section 5 - Vacation Credited/Proration

Vacation shall not be used before it is credited. Vacation time shall not be prorated except for:

A. Probationary Employees with less than one year of service on April 1st of the fiscal year. Time will be rounded up to a full vacation day.

B. Upon separation of employment for any reason the Employee will be paid out on all accrued vacation time.

Section 6 – Vacation Encompass Holiday

When Vacations encompass an approved Unit Holiday, Unit Employees shall receive Holiday pay. When Vacations encompass an approved Holiday that Day Employees receive pay for, according to ARTICLE 16 – HOLIDAYS, Section 2A, of this agreement; the Day Employee shall receive Holiday pay for that day.

Section 7 – Carry Over

Unit and Day Employees may carry over up to one-half (1/2) of their annual Vacation accumulation (see table in Section 1 above) and must be used within the immediately following fiscal year. At no time can an Employee have more than 1.5 times their allotment in their vacation bank (see table in Section 1 above).

Section 8 – Working while on Vacation

No Employee will be permitted to work and draw Vacation pay at the same time without prior consent of the Fire Chief and the Township Supervisor. Vacation days or pay shall not be accumulated without the prior express consent of the Fire Chief and the Township Supervisor.

Section 9 – Effect of Bereavement Leave on Vacation

If an Employee has reason to use Bereavement Leave during a period of Vacation usage, and such Bereavement Leave is documented to the Fire Chief's satisfaction, such time may be considered as Bereavement Leave instead of being deducted from their Vacation accumulation.

Section 10 – Effect of Sick Leave on Vacation

If an Employee has reason to use Sick Leave during a period of Vacation usage, and if such Sick Leave is used to cover an illness of the employee, and if such Sick Leave is documented by a physician's written statement to the Fire Chief's satisfaction, such time may be deducted from the Employee's Sick Leave accumulation instead of being deducted from their Vacation accumulation.

ARTICLE 18 – RETIREMENT PLANS

Section 1 – Defined Benefit Pension Plan (see Attachment E)

During the period of this Agreement, the terms of the existing Defined Benefit Pension Plan, Attachment E and hereby incorporated by reference, shall continue in effect for employees hired before June 17, 2008. The substantive provisions of the pension shall be as follows and as described in the Township of Bloomfield Retirement Income Plan ("Pension Plan"), Attachment E, as in effect on January 1, 2013. The pension shall be as follows:

- The base wage average multiplier shall be 2.75%.

- Final average compensation (FAC) to be computed on the employee's best three (3) May 1st earnings and shall include base wages and Longevity Pay.

- The retirement age for bargaining unit members shall be 52.

- Retirement benefits shall not exceed 80% of FAC.

- Each participant who is receiving retirement income as of March 31, 2025, and each participant who retires on or after April 1, 2025 and prior to March 31, 2028, including the surviving spouse or other payee of deceased retired participant shall be eligible effective as of the January 1 following their retirement and each January 1 thereafter for a 1% increase in their retirement income. Prorated if retired less than one (1) year on January 1.

- The Township, in its sole option, may elect to offer voluntary and irrevocable lump sum "buyouts" to individual members and retirees participating in the Township's Pension Plan. Pension buyouts may be partial (e.g., COLA) or full (e.g., entire pension) in nature and shall not exceed the actuarial present value of the individual's benefit at the time of the buyout as determined by the Pension Plan's actuary. All buyouts shall be formally agreed upon pursuant to a written Buyout Agreement between the Township and the affected individual, the terms of which shall be fully negotiable.

- Pre-Retirement Death Benefit

  For vested participants the Pension Plan will provide the following:

  Participant's Spouse (Married Participants) or contingent Pensioner (Single Participants) will receive 50% of their retirement income based on years of credited service to their date of death.

  There will be no reduction for early retirement, however, this benefit will be reduced if the participant's spouse or contingent pensioner is more than ten years younger than the participant. In the event of a death between the ages of 50-52, the early retirement penalty is waived.

The pre-retirement death benefit payments will start the first day of the month following the participant's death.

When the deceased participant's spouse or contingent pensioner dies, the beneficiary will receive the remainder, if any, of the participant's required contributions with interest.

Future vested separated participants will have this benefit, however, past vested separated participants will not.

Non-vested participants – the plan remains the same.

- The Prudential Guarantee certificates were discontinued as of October 1, 2016, or as soon thereafter as practicable, with respect to participants who retired after such date.

Section 2 – Defined Contribution Plan (see Attachment F)

Employees hired on or after June 17, 2008 shall only be eligible to participate in the Township's Defined Contribution Retirement Plan, including the Duty Disability Benefit pursuant to the amendment adopted by the Bloomfield Township Board of Trustees, a copy of which is attached in Attachment F and hereby incorporated by reference, and shall not be eligible to participate in the Township's Defined Benefit Pension Plan. The defined contribution retirement plan will have the following:

1. Investment in Charter Township of Bloomfield 401(a) Plan and Trust ("Plan").

2. Effective April 1, 2025 through December 31, 2025:

   a. Employer contribution of 14% of base wages per year.
   b. Mandatory Employee contribution of 3.5% of base wages per year.
   c. A cash bonus paid to Plan participants equal to 6% of the employee's base wages from April 1, 2025 through December 31, 2025. Such bonus will be paid as soon as practicable after ratification of this Agreement. The bonus will be taxable since it will be paid as cash to the employee in lieu of additional 401a contributions.

3. Effective January 1, 2026:

   a. Employer contribution of 20% of base wages per year.
   b. Mandatory Employee contribution of 5% of base wages per year.

4. For Employees hired before March 31, 2020, the Employer contributions are 100% vested.

5. For Employees hired on or after April 1, 2020 and before December 31, 2025, the following vesting schedule applies for Employer contributions:

a. 3 years of service: 25%
b. 5 years of service: 50%
c. 7 years of service: 100%

6. For Employees hired on or after January 1, 2026 the following vesting schedule applies for Employer contributions:

a. 5 years of service: 25%
b. 8 years of service: 100%

7. Immediate vesting of Employee contributions.

8. Employee ownership of all assets in individual portfolio after vesting, and Employees may move the assets to another qualified account after separation of service, subject to IRS regulations.

9. Employee directs their investments with education, counseling, and advice from independent third-party plan consultants provided by the Township at no direct cost to Employee.

10. Firefighters who participate in the Defined Contribution Plan will be eligible, if otherwise qualified, to receive disability insurance coverage (both duty-related (workers' compensation) and non-duty-related) until they reach age sixty-five (65) or are eligible to receive social security benefits.

11. A union member shall be provided with a copy of the Plan upon written request.

12. "Moratorium" language for defined benefit plan employees as follows:

Eligibility for participation or benefits under the Defined Benefit Pension Program is limited to those individuals who were already active employee participants, participant spouses, future spouses who subsequent to June 17, 2008 marry pre-June 17, 2008 active employees while they are still active employees, retirees, or beneficiaries as of June 17, 2008. After said date, no other individuals shall be eligible to join the Defined Benefit Pension Program. As to Pre-June 17, 2008 participants, participant spouses, future participant spouses as specified above, retirees and beneficiaries, their individual rights to vested status in the program, accrual of service periods, accrued benefits, benefit options, and benefit payment formulas shall continue for the remainders of each of their respective individual lives, as described in the program/plan document(s) in effect on June 17, 2008. The Employer shall continue to fund the Defined Benefit Pension Program to make it actuarially sound, with respect to such lifetime pension rights. The Township may amend the Defined Benefit Pension Plan to maintain its tax qualified or tax-exempt status and to comply with existing or future laws or regulations.

13. No loans or hardship withdrawals from the Plan.

14. The Qualified Default Investment Alternative in the Plan will be a target-date fund for employees who fail to make an investment election upon hire.

ARTICLE 19 – HEALTHCARE BENEFITS

Section 1 – Medical and Prescription Coverage

A. All employees shall be placed in a High-Deductible Health Plan with a Health Savings Account (HSA) (the "HSA Plan") effective the first of the month following thirty (30) days of employment. The summaries of benefits documents for medical, prescription, dental and vision coverage are attached as part of this Agreement at Attachments A, B, and C. The Bloomfield Township HSA Plan will include (see Attachment A):

1. Healthcare Premium Contribution by employees:

   a. From April 1, 2025 through December 31, 2025, biweekly payroll deduction for 24 pays per year: Single $50 and Family $100.
   b. Beginning January 1, 2026, biweekly (for 24 pays per year) payroll deduction: Single $25 and Family $50.
   c. If two employees are married and choose to enroll, they must choose which person will enroll as a family and the payroll deduction is taken from only one person.

2. The annual deductible is $2,000 for individuals and $4,000 for families.

3. In-network out of pocket maximum (OOPM):

   a. From April 1, 2025 through December 31, 2025, $4,000 for individuals and $8,000 for families.
   b. Beginning January 1, 2026, $3,000 for individuals and $6,000 for families.

4. Employer contribution to the employee's HSA is $1,500 Single and $3,000 Family annually. If two employees are married and choose to enroll, they must be on the same plan and will have one HSA and one Employer contribution.

   a. New hires will receive prorated HSA funds based on the benefit start date:

      i. From 1/1 to 3/31 — Full Amount
      ii. From 4/1 to 6/30 — 75% of allotment
      iii. From 7/1 to 9/30 — 50% of allotment
      iv. From 10/1 to 12/31 — 25% of allotment

   b. If an employee is actively working but nearing Medicare age, they may delay Social Security and Medicare to continue funding an

HSA. Once enrolled in Medicare, even as an active employee, no new HSA funds are permissible.

c. In the year an active employee (or future pre-Medicare retiree) plans to retire and age into Medicare, the Township's HSA annual funding will be prorated for the number of months the member is enrolled in the HSA program and HSA funding will cease when the individual has effectively enrolled in Medicare.

d. The account is owned by each individual even after they separate from active employment, therefore the individual will pay the monthly fee for maintaining the account.

e. IRS Guidelines

i. An additional employee contribution into the HSA is allowable, optional, pre-tax, and the annual maximum contribution is set and limited by the IRS.

ii. It is the responsibility of those enrolled in the HSA to follow any and all tax rules associated with these accounts.

iii. When a retiree reaches age 65 they will be moved to an HRA plan.

5. Employer shall provide the Standard 3 Tier prescription drug list with exclusions for certain over-the-counter prescriptions, proton pump inhibitors, and non-sedating antihistamines. The parties recognize that the carrier may change the name of the drug list.

6. A provision allowing a Dependent Care Flexible Savings Account.

a. The optional Dependent Day Care Reimbursement Accounts for non-medical day care expenses with a maximum employee contribution set by the IRS. Available to active employees only.

7. Active employees who decline the Township's medical coverage will receive an "opt-out payment". Such opt-out payments will be paid out divided across 26 biweekly pays. The annual opt-out amount for Single is $3,000 and Family is $6,000. Payments will not be made for any period in which the employee is enrolled in or covered by a Bloomfield Township plan. If two employees are married and enrolled on the plan, they are not eligible for the opt-out payment. Also, if an employee, is covered by the plan as a dependent, they are not eligible for the opt-out payment. Employees shall be required to show proof of other group health care coverage that includes every member of the employee's tax family before the employee will be eligible to receive the payments. Opt-out payments

will begin on the first day of the month following thirty (30) days of employment.

B. Notwithstanding anything to the contrary as set forth in this Agreement, the Township, at its sole discretion shall have the right to change providers of any and all insurance plans so long as the insurance plans provided by the new provider are equal to or better than the current plans.

C. Current Medicare retirees who have retired prior to April 1, 2020, under the Bloomfield Township HRA healthcare plan are in a closed and grandfathered plan.

D. If, at any time during the term of this Agreement, the Township Board of Trustees fails or refuses, in accordance with MCL 15.568, to exempt the Township from the requirements of Public Act 152 of 2011, for the next medical benefit plan coverage year, all Township employees who are enrolled in the Township provided health insurance plan shall receive equal per pay installments in an amount equal to the annual cost of the provided health insurance plan over the established hard-cap for the particular medical benefit plan coverage year; or, if the Township Board elects to require employees to pay 20% of the annual premium, then employees shall receive equal per pay installments in the amount equal to 20% of the annual premium of provided health insurance. Such payments shall be made in the equal per pay installments for that particular medical benefit plan coverage year. Such payments shall not be included in the employees' base wages and shall have no impact on any other economic benefits, including, but not limited to, Longevity or Retention Pay or pension benefits. As an example, *if the Township Board of Trustees fails to exempt the Township from the requirements of Public Act 152 of 2011, for the 2026 medical benefit plan coverage year, and the overall annual cost of provided health insurance is $4000 over the established hard-cap for the 2026 medical benefit plan coverage year (assuming a family insurance plan), then each employee of the Township shall be paid $4000 in equal per pay installments during 2026.*

E. Effective August 17, 2006: The Township shall continue health insurance coverage for five years with the same healthcare contribution, co-pays, deductibles, etc. as active employees for the spouse and children in the event of duty related death.

F. Dependents for Medical and Prescription Benefits

1. Eligible Dependents are defined as:

a. The HSA Plan Employee's lawful spouse;

b. Any child of an Employee who is less than 26 years old; or

c. 26 or more years old, unmarried, and primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was

covered as a Dependent under this HSA Plan, or while covered as a dependent under a prior plan with no break in coverage. Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

2. The term child means a child born to the Employee or a child legally adopted by the Employee. It also includes a stepchild.

3. Benefits for a Dependent child will continue until the last day of the calendar month in which age 26 is reached.

4. A child under age 26 may be covered as either an Employee or as an Employee's Dependent child. Employees cannot be covered as an Employee while also covered as a Dependent of an Employee.

5. No one may be considered as a Dependent of more than one Employee.

6. After an Employee retires, a new spouse and/or dependent that was not already covered on the plan at the time of retirement cannot be added to the healthcare plan as an eligible spouse and/or dependent.

G. Dependents for Dental and Vision benefits

1. Eligible Dependents are defined as:

   a. Employee's lawful spouse;
   b. Any child of an Employee who is less than 26 years old; or
   c. Student status is not required for children between the ages of 19 and 26 annually.

2. The term child means a child born to an Employee or a child legally adopted by an Employee. It also includes a stepchild.

3. Benefits for a Dependent child will continue until the last day of the calendar month in which age 26 is reached.

4. A child under age 26 may be covered as either an Employee or as an Employee's Dependent child. Employees cannot be covered as an Employee while also covered as a Dependent of an Employee.

5. No one may be considered as a Dependent of more than one Employee.

6. After an Employee retires, a new spouse and/or dependent that was not already covered on the plan at the time of retirement cannot be added to the healthcare plan as an eligible spouse and/or dependent.

Section 2 Retiree Healthcare

A. Employees hired before May 1, 2011 are eligible for the defined benefit retiree healthcare plan.

B. The parties understand, acknowledge and agree that employees and their Eligible Dependents (defined in Section 1(F) and (G), above) who are eligible for the defined benefit retiree health care plan, who retire or separate from service after April 1, 2020, or who have retired or separated from service prior to April 1, 2020 and are on the pre-Medicare age HRA plan, will have the same health care, prescription, dental and vision coverage for themselves, and for their Eligible Dependents, for the remainder of their respective lives (known as "Retiree Health Care for Life"). The health care, prescription, dental and vision plans that a pre-Medicare age retiree on the HRA plan and an employee retiring or separating from service under the April 1, 2020 to March 31, 2025 Collective Bargaining Agreement will have access to for the remainder of their life and/or lives in retirement is the plan that is in place in the final year of the April 1, 2020 to March 31, 2025 Collective Bargaining Agreement; not the year that they retired or separated from service. The health care, prescription, dental and vision plans that an employee retiring or separating from service under a Collective Bargaining Agreement beginning after March 31, 2025 will have access to for the remainder of their life and/or lives in retirement is the plan that is in place as of December 31 of the last full calendar year of that Collective Bargaining Agreement; not the year that they retired or separated from service. For example, if the employee retires or separates from service in 2022, they and their Eligible Dependents shall have the same health care plan, including all employee/retiree cost-sharing obligations, in effect in 2022, 2023, 2024, and 2025 and as set forth in this ARTICLE 19 – HEALTHCARE BENEFITS. Under this example, the plan the employee/retiree will have for the remainder of their life and/or lives, post-2025, will be the same plan that is in place for active employees on December 31, 2024. However, there shall be no retiree cost-sharing premium obligations beyond the existing 15-25-year schedule that was established in 1999 and is within ARTICLE 19 – HEALTHCARE BENEFITS Section 2 (E) and (F). This "Retiree Health Care for Life" provision shall survive the expiration of this Agreement under the terms and conditions immediately set forth above. This "Retiree Health Care for Life" provision shall be subject to the provisions set forth in ARTICLE 19 – HEALTHCARE BENEFITS Section 2 (B) through (H) and Sections 3 and 4. Notwithstanding the forgoing, the parties understand, acknowledge and agree there may be changes to provided insurance that are out of the Township's control; for example protocol changes, network requirements, prescription formulary changes, etc. Any such changes shall be at the sole discretion of the insurance carrier. See also, ARTICLE 40 - TERMINATION.

C. When a benefit eligible retiree, spouse, or dependent reach Medicare age, the Township's healthcare plan becomes secondary to Medicare and the retiree (or spouse/dependent) must enroll in Medicare Parts A and B at their own expense.

D. The calendar year a pre-Medicare retiree (or spouse/dependent) ages into Medicare, their coverage will convert to a HRA. (See plan summary documents in Attachment X). Any HSA funds accumulated are member-owned and may be used to address future healthcare costs. However, no new HSA funds will be permissible once retired with Medicare.

1. The Bloomfield Township HRA healthcare plan includes a provision whereby remaining allotted funds in an Employee's HRA account at the end of each calendar year will roll over into the next calendar year and be in addition to the annual HRA fund allotment of $1,500 for individual plan participants or $3,000 for family plan participants.

E. Subject to the conditions and limitations set forth in Sections 2F and 2G below, the healthcare plan will apply to an eligible employee (spouse and other dependents), who has retired on or after his/her normal retirement date.

F. Qualifications for retiree health insurance, including medical, prescription, dental and vision coverage if hired prior to April 1, 1999.

1. If you retire at age 52 or older and are in active service on your retirement date, then you qualify for retiree health insurance; including medical, prescription, dental and vision coverage as long as you have satisfied the minimum requirements to retire as defined in the Township Defined Benefit Pension Plan.

2. If you retire or your active service ends prior to your normal retirement date, you will still qualify to receive health insurance; including medical, prescription, dental and vision coverage, if you meet the following criteria:

a. If you have 25 or more years of service when your active service ends you will qualify for health insurance; including medical, prescription, dental and vision coverage, on your normal retirement date.

b. If you have between 15 and 25 years of service when your active service ends you will qualify for retiree health insurance; including medical, prescription, dental and vision coverage, once you meet your normal retirement date if you make co- payments of premium based on the following schedule:

Years of Service	Coverage
Less than 15	No Coverage
15	40%
16	36%
17	32%
18	28%
19	24%
20	20%
21	16%
22	12%
23	8%
24	4%
25 or more	0%

c. Years of service shall be based from date of hire to date of termination. Co-payments will be based on the Township's estimated premium before experience adjustments. Years of Service will be credited in full years only; No proration, no rounding. If you have less than 15 years of service when your active service ends you do not qualify to have your health insurance; including medical, prescription, dental and vision coverage reinstated at your normal retirement date.

NOTE: If you have any other employer provided health insurance; including medical, prescription, dental and vision coverage, reinstatement of your Township policy will be delayed until such time as the other insurance is no longer available to you.

G. Qualifications for retiree health insurance; including medical, prescription, dental and vision coverage, if hired after March 31, 1999 and before May 1, 2011.

1. If you have 25 or more years of service and you retire on or after your normal retirement date you will be provided retiree health insurance; including medical, prescription, dental and vision coverage beginning on your retirement date.

2. If you have 25 or more years of service and your active service ends for any reason prior to your normal retirement date, you will be provided retiree health insurance; including medical, prescription, dental and vision coverage beginning at your normal retirement date. If you have any other employer provided health insurance; including medical, prescription, dental and vision coverage this benefit will be delayed until such time as the other insurance is no longer available to you.

3. If you have between 15 and 25 years of service and you retire on or after your normal retirement date, you will be provided retiree health insurance;

including medical, prescription, dental and vision coverage so long as you make co-payments of premium based on the following schedule:

Years of Service	**Coverage**
Less than 15	No Coverage
15	40%
16	36%
17	32%
18	28%
19	24%
20	20%
21	16%
22	12%
23	8%
24	4%
25 or more	0%

4. Years of service shall be based from date of hire to date of termination. Co-payments will be based on the Township's estimated premium before experience adjustments. Years of service will be credited in full years only; no pro-ration, no rounding. Copayments will not end at age 55.

5. If you have between 15 and 25 years of service and your active service ends for any reason prior to your normal retirement date you will be provided retiree health insurance; including medical, prescription, dental and vision coverage beginning at your normal retirement date provided you make premium copayments per the above schedule. If you have any other employer provided health insurance; including medical, prescription, dental and vision coverage this benefit will be delayed until such time as the other insurance is no longer available to you.

6. If you have less than 15 years of service when your active service ends, you do not qualify to have your health insurance; including medical, prescription, dental and vision coverage, reinstated.

H. Termination of Insurance for Spouse/Dependents of Deceased Retirees.

1. If you are retired and covered by Bloomfield Township medical, prescription, dental and optical insurance when you die, your Spouse, if currently insured by Bloomfield Township, will remain so insured as long as any premium co-payment, if required, continues to be made. If any other medical insurance is available to the spouse, medical benefits shall then be coordinated according to the rules of coordination.

   a. If you are retired and insured with medical, prescription, dental and optical insurance when you die, any dependent if currently insured by Bloomfield Township, will remain so insured as long as any

premium co-payment, if required, continues to be made. If any other medical insurance is available to the dependent, medical benefits shall be coordinated according to the rules of coordination or until the date that the dependent ceases to qualify as a dependent for a reason other than lack of primary support by you.

I. Retiree Healthcare for Employees hired on or after May 1, 2011, provided through the IAFF Medical Expense Reimbursement Plan (MERP). (See Attachment D.)

1. As soon as practicable after ratification of this Agreement, all Township contributions and employee withholdings to the Township's Retirement Health Savings Plan (RHS) for bargaining unit members hired on or after May 1, 2011 shall cease. The Township shall enroll all current bargaining unit members hired on or after May 1, 2011 and all future bargaining unit members into the IAFF Medical Expense Reimbursement Plan ("IAFF MERP") of the WSCFF Employee Benefit Trust ("Trust") as set forth below.

2. Defined Classes of Employees Receiving Contributions. Bargaining unit members hired on or after May 1, 2011 shall be divided into three (3) Defined Classes:

   a. Members with 0 to 4 years of service to the Department

   b. Members with 5 to 14 years of service to the Department

   c. Members with 15 or more years of service to the Department

3. Employer Contribution Amount. The Employer shall make mandatory contributions on the first and second paycheck issued by the Employer (not a third-party) of each month, on a pre-tax basis for every employee in the Defined Classes. No employee in the Defined Classes shall be permitted to opt-out of the mandatory contributions or receive any portion of the contribution in cash. The Employer's contribution to each individual account shall be:

   a. 0-4 years of service - $125.00 per pay

   b. 5-14 years of service - $208.33 per pay

   c. 15 years or more of service - $312.50 per pay

   All active employees' prior years of service to the Department will count toward future contribution amounts; there will be no retroactive contributions.

4. Employee Contribution Amount. The Employer and the Union agree that the Employer shall withhold a mandatory contribution of $100 per pay period on the first and second paycheck of each month, on a pre-tax basis from the pay of every Employee in the Defined Classes and shall transmit

such contributions to the IAFF MERP pursuant to the requirements in Section 6 below. No employee in the Defined Classes shall be permitted to opt-out of the mandatory contributions or receive any portion of the contribution in cash.

5. The Employer shall transmit the contributions referenced in this Section to the Trust within 30 days of the date that the payment would have been payable to the Employee.

6. The Employer shall provide an initial report of information for all contributing Employees, as reasonably requested by the Trust; and shall send updates whenever requested from the Trust in the format requested.

7. If now or in the future it is permissible under IRS Codes to transfer the balances of all bargaining unit members' accounts with the Township's Retirement Health Savings Plan to the IAFF MERP Trust then Employees in the Defined Classes may agree to collectively transfer the balances. All balances must be transferred in such case.

J. The Township, in its sole option, may elect to offer voluntary, irrevocable, and potentially taxable lump-sum "buyouts" to individual members and retirees participating in the Township's defined benefit retiree healthcare plan. Retiree healthcare buyouts shall not exceed the actuarial present value of the individual's healthcare benefit at the time of the buyout as determined by the Retiree Healthcare Plan's actuary. All buyouts shall be formally agreed upon pursuant to a written Buyout Agreement between the Township and the affected individual, the terms of which shall be fully negotiable.

Section 3 Dental

A. Dental Plan benefits are in accordance with the attached Dental Plan Summary of Benefits (see attachment C). Effective January 1, 2026, Dental benefits will be offered through a Dental PPO.

B. Orthodontia has no age restriction, and a $4,000 lifetime cap per person.

C. This provision will also apply to retirees who have retired under the proposed Bloomfield Township Dental Plan effective January 1, 2010.

Section 4 Vision

A. Vision Plan Benefits are in accordance with the attached Vision Plan Summary of Benefits (see attachment B).

B. Lasik/Lasec: one Lasik/Lasec procedure per participant to be reimbursed by the Township. $500.00 maximum.

C. This provision will also apply to retirees who have retired under the proposed Bloomfield Township Vision Plan effective January 1, 2010.

ARTICLE 20 - LIFE INSURANCE

The Employer will provide life insurance, inclusive of survivor's benefits, in the face amount of $50,000 with double indemnity for qualified employees as provided in the contract between the Employer and Insurance Carrier. (See Attachment G)

The amount of life insurance will be adjusted to $6,000.00 following the earlier of:

1. Your 70th birthday or

2. Your date of retirement

The Employer shall also provide dependent's life insurance in the amount of:

1. $5,000.00 for the spouse of qualified employees.

2. $2,500.00 for each child between 6 months and 19 years of age.

3. $500.00 for each child between 15 days and 6 months of age.

The Employer shall also provide Accidental Death and Dismemberment policy in the amount of $50,000.

Section 1 – Survivor Income Benefit Insurance

If you die while insured, the Township or the Township's Insurance Carrier will pay monthly transition Survivor Income Benefits and Bridge Survivor Income Benefits to your eligible survivor or survivors.

Section 2 – Duty Related Death Policy

The Township, or the Township's Insurance Carrier shall provide a life insurance policy to the insured in the amount of $500,000.00 for a duty related death, paid to insured beneficiary.

ARTICLE 21 – DISABILITY BENEFITS

Section 1 - Disability Benefits - Short and Long Term (See Attachment H)

A. Employees on short-term disability benefits will receive 70% of their weekly basic earnings up to a maximum benefit of $1,500.00 per week, and employees on long-term disability benefits will receive 66.6667% of their monthly basic earnings up to a maximum benefit of $6,000.00 per month, and these provisions will be incorporated in the Certificate of Coverage provided by the insurance carrier.

Section 2 - Disability Pension Benefits

A. Duty Disability

1. The yearly amount of retirement income payable on account of a duty disability will be equal to that calculated in Section 4.1 of the Retirement Plan and adjusted in accordance with Section 4.3 of the Retirement Plan using Credit Service from employment date to the earlier of the date the Participant is no longer considered disabled, or the Normal Retirement Date and Final Earnings equal to the Rate of Earnings immediately prior to disablement adjusted by the increases negotiated for that job classification between the date of disablement and the earlier of the date the Participant is no longer disabled, or the Normal Retirement Date.

B. Duty Disability for Defined Contribution – 401(a) Plan Employees

1. This amendment revises the 401(a) Plan to provide for continuing contributions to the Plan for those who become totally and permanently disabled and applies only to bargaining members of the Police Department and Fire Department. This amendment excludes dispatchers.

   In this case, total and permanent disability is required to meet a statutory definition which differs from the definition in the 401(a) Plan or the retirement Income Plan. An employee is totally and permanently disabled if the employee "is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last fora continuous period of not less than 12 months."

   For such a totally and permanently disabled participant, the Township will continue to make contributions to the 401(a) Plan until the individual reaches normal retirement age as defined in the Retirement Income Plan. The contribution will be based on the disabled participant's deemed compensation, which is equal to the greater of compensation at the rate the employee was paid when becoming disabled, or the rate of pay the disabled participant would have received if continuously employed under the collective bargaining agreement.

C. Non-Duty Disability

1. The yearly amount of retirement income payable on account of a non-duty disability will be equal to that calculated in Section 4.1 of the Retirement plan and adjusted in accordance with Section 4.3 of the Plan based on Credited Service and Final Earnings as of this date of disablement.

D. Calculating the Retirement Benefit

1. For the purpose of calculating the retirement benefit, employees will be considered disabled only if because of injury or sickness he/she is unable to perform the essential duties of any occupation for which he or she is or may reasonably become qualified for based upon his or her training, education or experience.

E. Doctor Selection Process

1. The determination of whether employees meet the definition of disability will be made by a doctor selected by the employer and a doctor selected by the employee. If the doctors do not agree a third doctor shall be selected by the employer's doctor and the employee's doctor. The third doctor will then make the determination of whether the employee meets the definition of disability. The third doctor will be paid for by the employee.

Section 3 - Additional Benefits

A. Employees on non-duty disability leave will be entitled to reinstatement to their former position at the current rate of pay and benefits for a period of thirty (30) months from the date of disability. Employees on non-duty disability leave shall receive full medical benefits for a period of thirty (30) months from the date of disablement, unless the employees are eligible for medical benefits from another job, through a spouse or from some other source.

B. Employees on duty disability leave will be entitled to reinstatement to their former position at the current rate of pay and benefits for a period of forty-eight (48) months from the date of disability. Employees on duty disability leave shall receive full medical benefits for a period of fifty-four (54) months from the date of disablement, unless the employees are eligible for medical benefits from another job, through a spouse or from some other source.

C. In order to be eligible for reinstatement from duty or non-duty disability, employees must be certified as fit for duty by a doctor selected by the Employer.

ARTICLE 22 - WORK CONNECTED INJURY OR ILLNESS

Section 1 – Reporting

Employees shall report all injuries or illnesses, arising directly from their employment to the Fire Chief immediately.

Section 2 – Treatment

The Fire Chief has the authority to order any employee involved in an on-the-job injury to receive immediate professional medical attention and refusal on any ground other than the employee's religion shall be deemed insubordination. The person or institution rendering the medical treatment shall be informed that it is a possible Worker's Compensation case.

Section 3 – Payment of Medical Bills

If the injury or illness is deemed compensable by the Township, the Township's Workers' Compensation Insurance Company, the First Responders Presumed Coverage Fund, or the Michigan Worker's Compensation Commission, the Township or its insurance company will pay the related medical bills. All medical bills resulting from the case should be sent to the Accounting Department.

Section 4 – Payment for Time Off

If the injury or illness is deemed compensable by the Township, the Township's Workers' Compensation Insurance Company, the First Responders Presumed Coverage Fund, or the Michigan Worker's Compensation Commission, the employee shall be paid directly by the Township in the following manner:

A. An Employee off work due to an injury or illness, shall be paid by the Township their regular normal salary. Payment of the regular normal salary shall continue until the Employee returns to work, or has been paid a total of twenty-six (26) weeks normal salary, whichever occurs first. Payment will be subject to the following conditions:

   1. All normal payroll deductions will be made from each check issued by the Township.

   2. Any payments received by the employee from the insurance company or the First Responders Presumed Coverage Fund, shall be endorsed to, and returned to, the Township. When notification is received by the Township that the employee has received a payment from the insurance company or the First Responders Presumed Coverage Fund, and if such payment has not been returned to the Township, the amount of the payment shall be deducted from the employee's next Township paycheck. Deductions will continue until all payments are recovered by the Township.

3. No deductions shall be made from the Employee's Sick Leave or Annual Leave accumulations to cover payments from the Township or any time off work due to a work-related injury or illness.

B. An employee unable to return to work within the twenty-six (26) week period described in Section 4-A, shall no longer receive regular normal salary payments from the Township, nor any accrued sick time or vacation. Seniority shall continue to accrue for 48 months. However, the employee shall be eligible to receive 66 2/3% of normal salary from the following sources:

1. Workers' Compensation Insurance – payments made by the Insurance Company or the First Responders Presumed Coverage Fund under provisions of the Workers' Compensation Act, shall remain with the employee.

2. Social Security – after an employee is disabled for six months (twenty-six weeks) he may be eligible for Social Security benefits. Application for benefits must be made at a Social Security Administration office by the employee.

3. Unum Life Insurance Company – if payments from Worker's Compensation Insurance and the Social Security Administration do not total 66 2/3% of the employee's regular normal salary, the employee should apply to Unum Insurance Company for long term disability payments. Payments from Unum Insurance Company will be 66 2/3% of regular normal salary less any amount received from Workers' Compensation Insurance and Social Security.

C. Any employee injured by a work-related injury or illness deemed compensable by the Township, the Township's Workers' Compensation Company, or the First Responders Presumed Coverage Fund, shall continue to receive their pre-injury medical benefits for fifty-four (54) months. In addition, medical benefits shall continue for the employee's spouse and dependent children for fifty-four (54) months.

Section 5 – Termination of Employment While Disabled

A. Under this Article, any employee who does not return to work within six (6) months after the onset of a disability shall submit to the Township a written statement from the employee's attending physician stating: diagnostic evaluation of the disability, treatment / medication, prognosis for recovery, length of recovery, and any other information requested by the Fire Chief. Based upon the attending physician's evaluation, the time period for returning to work shall be extended to forty-eight (48) months.

B. Notwithstanding "A" above, any employee who does not return to work without restrictions shall submit from the attending physician a progress report periodically as requested by the Fire Chief.

C. Under this Article an employee unable to return to work within forty-eight (48) months of any injury or illness shall be deemed to be permanently disabled and shall be terminated from Township employment subject to review and approval of the Township.

D. A written notice of termination, and date of termination, shall be signed by the Fire Chief and the Township Supervisor and delivered to the employee.

E. All Employee and dependent insurance coverage shall cease on the date of termination (except as may be specified in other Sections of this Contract).

F. Payment in full for accumulated vacation time shall be made to the Employee. Payment shall be made at the rate the Employee was earning on the date of injury or illness.

G. Payment in full for all unused accumulated Sick Leave shall be made to the Employee. Payment shall be made at the rate the Employee was earning on the date of injury or illness.

H. For purposes of application of this Article successive periods of disability shall mean:

1. Separate periods of disability for the same injury or aggravation thereof, shall be considered one period unless separated by a return to full duty for at least six (6) months.

2. Separate periods of disability for unrelated injuries from unrelated causes shall be considered one period unless separated by a return to full duty for at least one (1) day.

3. The definition of successive periods of disability set forth in paragraphs 8(A) and 8(B) shall not apply to receipt of benefits under the Township's workers' compensation policy, the First Responders Presumed Coverage Fund, or short-term or long-term disability policies. Employees shall be able to obtain benefits under those policies by meeting the definition(s) of successive periods of disability as set forth in those policies.

Section 6 – Death While Disabled

If an Employee dies while disabled under the Workers' Compensation Act and within forty-eight (48) months of the compensable injury, the Employee's designated beneficiary shall receive the following:

A. Payment for the face amount of the Employee's life insurance policy carried by the Township.

B. Payment in full for accumulated vacation time, uniform account, and full pay for all unused accumulated Sick Leave as described in Section 5.

ARTICLE 23 - SICK LEAVE

Section 1 – Definition of Sick Leave

Sick Leave is an absence from work for which the employee is paid, just as if they were at work, when the reason for absence is covered by the provisions of this Sick Leave plan and the employee has accumulated at least as much Sick Leave as required for the absence in question. Sick Leave shall not be considered a privilege, which an employee may use at his discretion, but shall be allowed only in cases of actual illness or disability and with the approval of the Fire Chief.

Section 2 – Eligibility for Sick Leave Accumulation and Use

All employees eligible for the Sick Leave plan shall begin their accumulation from the first day of eligible Township employment. New employees will start with 24 hours of sick time.

Section 3 – Rate of Accumulation of Sick Leave

Eligible employees shall accumulate Sick Leave as follows:

Classification	Sick Leave Hours Credited Per Pay Period	Maximum Sick Leave Accumulation
Day Employees	4	No maximum limitation
Unit Employees	5.6	No maximum limitation

Section 4 – Use of Sick Leave

A. Sick Leave may be used only with the approval of the Fire Chief, such approval shall not be unreasonably withheld. This provision shall apply to all other sections of this Sick Leave Article and is subject to applicable state law.

B. An employee that misuses Sick Leave, shall be notified in advance that a physician's statement will be required before returning to work, subject to applicable state law.

C. Short Term Sick Leave means absence from work for no more than two (2) successive workdays for Unit Employees and no more than four (4) successive days for Day Employees. Long Term Sick Leave means absence from work for more than two (2) successive workdays for Unit Employees and more than four (4) successive days for Day Employees.

D. The Fire Chief shall be responsible for reviewing employee requests for Sick Leave and determining their validity. He shall refuse to allow use of Sick Leave when, in his sole judgment, there is insufficient evidence to support the employee's claim.

E. Where Short-Term sick leave is requested the employee shall:

1. Notify the Fire Chief and/or the Unit Officer in Charge as soon as the employee knows that they will be unable to work, but not less than one (1) hour before their normal workday begins. Where the Fire Chief believes that the employee has not exercised reasonable effort to promptly notify the Fire Department of their absence, Sick Leave shall be denied.

2. Provide, upon request, a physician's statement that the employee was ill and unable to work. The Fire Chief will not require a physician's statement for the use of one (1) day's Sick Leave, unless there is evidence of abuse, subject to applicable state law.

3. Abuse of the Short-Term Sick Leave or requesting Short-Term Sick Leave when the employee is able to work shall result in disciplinary action.

F. Where Long-Term Sick Leave is requested, the employee shall:

1. Obtain a statement from their physician on a form obtained from the Fire Chief: a) describing the disability or illness; b) stating the reason(s) the employee is unable to work; and c) specifying the date that the employee can return to work.

2. Abuse of Long-Term Sick Leave or obtaining Long-Term Sick Leave when the employee is able to work shall result in disciplinary action.

G. Sick Leave may not be used before it is earned.

H. Subject to the restrictions set forth above, Sick Leave may be used for the following purposes:

1. Acute personal illness or incapacity over which the employee has no reasonable control.

2. Absence from work because of exposure to contagious disease which, according to public health standards, would constitute a danger to the health of others by the employee's attendance at work.

3. For Day Employees only, medical and dental examinations or treatment.

4. The care of the employee's ill minor dependent children, spouse, parent or guardian if the employee is the only person available to render such care. Such usage is not to exceed two (2) workdays for any one illness.

I. If an employee engages in another occupation, business, job or work, while the employee is on Short-Term or Long-Term Sick Leave outside of the stated physician's restrictions, they shall be subject to the following discipline:

1. First (1st) offense, employee is suspended for (3) three consecutive work days without pay; Second (2nd) offense, employee is subject to termination.

Section 5 – Payment for Unused Accumulated Sick Leave

A. Payment while still a Township employee:

1. The number of unused Sick Leave hours in each employee's Sick Leave accumulation shall be recorded as of the pay period in which the last paycheck is received in November of each fiscal year. Each Unit Employee having more than 960 hours (600 for Day Employees) shall have a choice of:

a. Unit Employees may receive sixty percent (60%) pay for Sick Leave in excess of 960 hours up to a maximum of 496 hours per year. Day Employees may receive sixty percent (60%) pay for Sick Leave in excess of 600 hours up to a maximum of 440 hours per year.

i. All employees must fill out an annual form provided by the Fire Chief's office if an employee wishes to cash in any accumulated Sick Leave. There will be no automatic Sick Leave pay-off on an annual basis.

b. The right to keep the hours in excess of those enumerated in Section 5 (A) (1).

2. All accumulated Sick Leave hours will be indicated on an employee's paystub. An employee on Short or Long-Term Sick Leave will be advised of their Sick Leave status upon request.

B. Payment upon separation of employment with the Township:

1. Upon retirement or death, employee will be paid sixty percent (60%) pay for all of their unused accumulated Sick Leave up to 1456 hours for Unit Employees or 1040 hours for Day Employees.

2. Payment shall be made at the rate the employee is earning at the time of separation.

Section 6 – Payment for Sick Leave Used

A. Payment for Sick Leave used by an employee will be processed as a normal payroll payment. All such payments shall be subject to normal payroll deductions.

1. Upon approval of Sick Leave as explained in Section 4, the Fire Chief on the next regular payroll request shall indicate the amount of time to be

charged against the employee's accumulated Sick Leave. Charges will be made in one-quarter (1/4) hour increments.

2. Sick Leave payments will be charged against the employee's accumulated Sick Leave until all such leave is used or the buffer reached, where applicable. Payments may next be charged against the employee's accumulated Vacation until all such leave is used. At this time all payments for Sick Leave and Vacation from the Township shall cease.

3. An employee who has used all of their accumulated Sick Leave may be eligible for disability payments from Unum (see insurance handbook for details). It shall be the responsibility of the employee to apply for disability payments. Employees shall not be eligible for disability payments until the accumulated Sick Leave time is exhausted or the Sick Leave buffer reached, if applicable.

Section 7 – Effect of Sick Leave on Vacation

A. Employees on Sick Leave with pay shall continue to accumulate Vacation and Sick Leave just as if they were on the job.

B. If it is necessary for an employee to use Sick Leave during a period of Vacation usage, and if such leave is used to cover an illness of the employee, and if such Sick Leave is approved as required by Section 4, such time may be deducted from the employee's Sick Leave Accumulation, instead of from their Vacation Accumulation.

C. Legal Holidays which are counted as days off with pay by the Township shall not be deducted from a Day Employee's Sick Leave Accumulation, when they fall during a period of Sick Leave usage.

Section 8 – Effect of an Employee Leaving the Township Services on His Unused Accumulated Sick Leave

A. Former employees who return to Township service must start their accumulation of Sick Leave as new employees.

B. Employees who leave the Township service to enter the Armed Forces of the United States under provisions of the Vietnam Veterans Readjustment Act, who are members of the Armed Forces and are called to active duty, or who enlist in the Armed Forces during a declared national emergency shall, upon reemployment by the Township, have available any unused Sick Leave previously earned; provided that such reemployment takes place within ninety (90) days after the discharge or release from active duty in the Armed Forces, whichever is later.

Section 9 – Sick Time Buffer

All employees who have accrued at least one hundred forty-four (144) hours of sick leave time and who incur an injury or illness which is not compensable by worker's compensation, but which is covered by Short-Term Disability benefits, may elect to retain as a buffer, the following maximum hours: forty (40) hours for Day Employees and forty-eight (48) hours for Unit Employees. The buffer is only to be used to provide for available Sick Leave in the event the employee has an additional or recurring illness upon returning to work after the short-term disability.

Section 10 – Effect of Bereavement Leave on Sick Leave

Employees who are given permission to use Bereavement Leave during a period of approved Sick Leave usage shall not have the time spent on Bereavement Leave deducted from their Sick Leave Accumulation.

Section 11 – Effect of Sick Leave on Employment

The intent of Sick Leave is to provide the employee with protection of income during a period of illness or disability. It is hoped no employee need use all their Sick Leave, but such a possibility does exist. In the event an employee must make extended use of Sick Leave, such use cannot be considered a guarantee of employment. In order to maintain the continuity of Township operations, the Township must retain certain rights:

A. If an employee is unable to return to work within one hundred thirty (130) weeks (2 ½ years) from the date of commencement of any illness or non-service connected disability, they will be considered permanently disabled and separated from Township service. The employee shall have the right to appeal, in writing, their separation to the Township Board within two (2) weeks of their separation.

B. All employee and dependent insurance coverage shall cease on the date of separation from employment (except as may be specified in other sections of this contract).

C. Separate periods of disability for the same injury or aggravation thereof, shall be considered one period unless separated by a return to full duty for at least six (6) months.

D. Separate periods of disability for unrelated injuries from unrelated causes shall be considered one period unless separated by a return to full duty for at least one (1) day.

E. The definition of successive periods of disability set forth in Section 11(C) and 11(D) shall not apply to receipt of benefits under the Township's workers' compensation policy or short-term or long-term disability policies. Employees shall be able to obtain benefits under those policies by meeting the definition(s) of successive periods of disability as set forth in those policies.

Section 12 – Three Doctor Rule

If the Employer's doctor and the Employee's doctor do not agree on whether the Employee meets the definition of disability, a third (3rd) doctor shall be selected by the Employer after consultation with the Association. The third (3rd) doctor will be paid for by the Township.

ARTICLE 24 - PERSONAL LEAVE/FLOATING HOLIDAY

Section 1-Personal Leave

A. During each year of this Agreement, Day Employees may use twenty-four (24) hours accumulated Sick Leave time as Personal Leave and Unit Employee may use thirty-six (36) hours of their accumulated Sick Leave time as Personal Leave. Personal Leave is not cumulative from year to year and shall be taken in four (4) hour minimum increments for Unit personnel and two (2) hour minimum increments for Day personnel.

B. The Fire Chief may approve Personal Leave beyond the thirty-six (36) hour limit for Unit Employees or twenty-four (24) hour time limit for Day Employees to attend classes for continued education. Personal Leave for attending educational courses approved by the Fire Chief may be used in any necessary increments. Personal Leave time shall only be allowed in full hour increments. Partial hours beyond the minimum of four (4) hours shall be accelerated to the next hour. Personal Leave can only be used with the prior approval of the Fire Chief or Unit Officer in Charge. Additional hours for Personal Leave may be extended with the Fire Chief's approval. If there is a request for the use of Personal Leave and a request for a floating holiday for the same day, the approval of such requests shall be by seniority.

C. Requests for Personal Leave shall be granted for Unit personnel by seniority from 0700 until 0800 of the scheduled workday. After 0800 hours for Unit Personnel, Personal leave, if approved, shall be granted on a first come first serve basis.

D. Request for Personal Leave shall be granted for Day Staff by seniority the day prior from 07:00-12:00. After 12:00, personal leave, if approved, shall be granted on a first come first serve basis.

E. Personal Leave will be approved down to 15 personnel on full duty. Any reference to a certain number of "personnel" is in no way intended to establish a minimum required staffing level. Instead, the Fire Chief or his designee has sole discretion to establish staffing levels at any and all of the Township's fire stations.

Section 2- Floating Holiday

During each year of this Agreement, Unit employees will have 48 hours and Day employees will have 36 hours of time to be used as floating holiday hours. Floating holiday hours will be prorated for the calendar year of hire. Floating holiday hours can only be used as paid time off by the employee during the calendar year in which they are provided and only with prior approval. Floating holiday hours cannot be used to receive additional pay in lump sum. Should the floating holiday hours not be used by the employee before the end of the calendar year, they will be forfeited. Floating Holiday is not cumulative from year to year and shall be taken in four (4) hour minimum increments for Unit personnel and two (2) hour minimum for Day personnel.

A. Floating Holiday for unit personnel will count as one of the three paid leave spots if taken in increments of:

1. 24 Hours from 0800 hrs. to 0800 hrs.
2. 12 Hours from 0800 hrs. to 2000 hrs.
3. 12 Hours from 2000 hrs. to 0800 hrs.

B. Any requests different from Section A will be administered the same as Personal Leave Section 1(C).

C. Requests for Floating Holiday described in Section A shall be made by seniority on the day prior to scheduled workday, which the Floating Holiday is to be used, between 0900 and 1100 Hrs. After 11:00, Floating Holiday from part A, if approved, shall be granted on a first come first serve basis until 0659 hours of the scheduled workday. At this point Floating Holiday shall fall into Section B.

D. Floating Holiday described in Section B, shall be granted for Unit personnel by seniority from 0700 until 0800 of the scheduled workday. After 0800 hours for Unit personnel Floating Holiday, if approved, shall be granted on a first come first serve basis.

E. Day employees may request Floating Holiday the day prior by seniority from 07:00-12:00. After 12:00, floating holiday, if approved, shall be granted on a first come first serve basis.

F. Any reference to a certain number of "personnel" is in no way intended to establish a minimum required staffing level. Instead, the Fire Chief or his designee has sole discretion to establish staffing levels at any and all of the Township's fire stations.

ARTICLE 25 - BEREAVEMENT LEAVE

Section 1 – Definition of Bereavement Leave

A. Bereavement Leave is an absence from work, for not more than three (3) working days for Day Employees, and two (2) working day for Unit employees, for which the employee is paid just as if they were at work, because the reason for the absence is the death of a member of their immediate family or household as described by the following provisions of this plan.

B. The deceased must bear one of the following relationships to the employee (whether the relationship is natural, adoptive, step or foster in nature):

Spouse	Spouse's Grandparent
Child	Brother-in-Law
Parent	Sister-in-Law
Guardian	Son-in-Law
Grandparent	Daughter-in-Law
Brother	Sister
Grandchild	Spouse's Parent

Member of the employee's household at the time of death (must actually have resided with the employee on a year-round basis).

Section 2 – Use of Bereavement Leave

A. Bereavement Leave may be used only with the permission of the Fire Chief or his designee. Such permission shall not be unreasonably withheld.

B. Permission to use Bereavement Leave must be secured before the Bereavement Leave is used.

C. In no case shall paid leave for one (1) death be longer than three (3) working days for Day Employees and two (2) working days for Unit Employees.

Section 3 – Effect of Bereavement Leave on Sick Leave and Vacation Accumulations

A. Time taken off with pay as Bereavement Leave shall not be deducted from either the employee's Vacation accumulation or their Sick Leave accumulation.

B. An employee may use Vacation, Personal Leave or Sick Leave for attendance at a funeral not covered under this Bereavement Leave Article, but only at the Fire Chief's discretion, which shall not be unreasonably withheld.

ARTICLE 26 - MILITARY LEAVE

All leaves of absence for military leave will be granted in accordance with the Vietnam Veterans Readjustment Act and/or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). An employee must file, with the Fire Chief, the proper military papers when requesting a military leave of absence.

ARTICLE 27 - PROMOTIONS

If a new position is created in the Fire Department by the Township all the guidelines set forth in this Article shall govern its fulfillment provided there is an increase of wages and said level is below the rank of Assistant Chief.

Section 1 - UNIT LIEUTENANT

Eligibility for Lieutenant's Examination

A. An employee must have five (5) years of service with the Bloomfield Township Fire Department.

B. An employee must be a "Class A Firefighter".

C. An Employee must have a Fire Officer II Certificate or must attain a Fire Officer II certificate within eighteen (18) months of appointment or extension approved by the Fire Chief.

Promotional List

A promotional list shall be established and be effective for two (2) years from the date of posting (March 16, of every even year). A new list shall be established prior to the termination of the posted list.

Section 2 - BATTALION CHIEF/CAPTAIN

Eligibility for Battalion Chief/Captain Examination

A. A Lieutenant must have two (2) years of continuous service in the Unit Lieutenant's rank.

B. A Lieutenant must complete the promotional process and attain passing scores in all phases.

C. An employee must have a Fire Officer II Certificate and must attain a Fire Officer III Certificate within twelve (12) months of appointment or extension approved by the Fire Chief.

Promotional List

1. A promotional list shall be established and be effective for two (2) years from the date of posting. A new list shall be established prior to the termination of the posted list.

2. The Battalion Chief and Captain shall be tested and selected off of the same list. If a Captain is promoted off of the promotional list they shall remain eligible on the list for Battalion Chief.

3. Captains attaining a passing score on the Battalion Chief/Captain test shall receive two (2) bonus points applied toward their final calculated score.

4. Upon ratification of this Agreement, the current Senior Lieutenant of each shift will be paid Captain pay (Acting Wage) until the current Battalion Chief list expires. 3 Captains shall be selected off the new Battalion Chief/Captain list.

Section 3 - DAY FIRE MARSHAL

Eligibility for Day Fire Marshal Examination

A. An Officer must have two (2) years of continuous service as an officer at a Lieutenant's rank or above.

B. An employee must have a Fire Officer II Certificate and must attain a Fire Officer III Certificate within twelve (12) months of appointment or extension approved by the Fire Chief.

Promotional List

Promotional List: A promotional list will be established on an as needed basis and will be effective for two (2) years from date of posting.

Section 4 - DAY LIEUTENANT FIRE INSPECTOR

The assignment of Day Lieutenant Fire Inspector to a Unit will not circumvent Acting Pay.

The lateral move of a Day Lieutenant Fire Inspector, from Days to Unit, only after testing, placement, and promotion on current promotional list for that classification. The Day Lieutenant Fire Inspector will not be permanently assigned to a Unit unless they have taken, passed and promoted to that position.

Eligibility for Day Lieutenant Fire Inspector's Examination.

A. An employee must have five (5) years of service with the Bloomfield Township Fire Department.

B. An employee must be a "Class A Firefighter".

C. An Employee must have a Fire Officer II Certificate or must attain a Fire Officer II certificate within eighteen (18) months of appointment or an extension approved by the Fire Chief.

Promotional List

Promotional List: A promotional list will be established on an as needed basis, and will be effective for two (2) years from date of posting.

Section 4 - DAY CAPTAIN EMS COORDINATOR

The lateral moves of Day EMS Coordinator from Days to Unit only after testing, placement, and promotion on current promotional list for that classification. The Day Captain EMS Coordinator will not be permanently assigned to a Unit unless they have taken, passed and promoted to that position.

Eligibility for Day EMS Coordinator's Examination

A. An employee must have five (5) years of service with the Bloomfield Township Fire Department.

B. An employee must be a "Class A Firefighter".

C. An employee must have a Fire Officer II Certificate or must attain a Fire Officer II Certificate within eighteen (18) months of appointment, or an extension approved by the Fire Chief.

Promotional List

A promotional list will be established on an as needed basis and will be effective for two (2) years from date of posting.

Section 5 - EXAMINATION REQUIREMENTS

Examinations for Unit Lieutenant, Battalion Chief, Captain, Day Lieutenant Fire Inspector, Day Captain EMS Coordinator and Day Fire Marshal shall be conducted as follows:

A. Written Examination: A written test shall be administered by EMPCO or a testing agency agreed upon by the Association and the Township. The written test will be graded by the same agency. All test questions shall be of an objective nature to include multiple choices, true or false, matching, etc. The Standard Score of seventy percent (70%) will be used to determine passing. A passing score of seventy percent (70%) shall be required to continue the promotional process. Test questions may be challenged by employees, at the employee's expense and according to the testing agency's policy. The Township shall post a bibliography, maximum of 3 books, plus the SOP's no later than 120 days prior to the scheduled written examination date.

B. Seniority Points: Seniority points will be granted at the rate of one-tenth (1/10) of a point for each full completed month of service (1.2 points per year) calculated from the date of the test. This will allow maximum credit to all employees.

C. Oral Review Board: The oral appraisal of the candidate shall be conducted by at least two (2) members of the fire profession selected by the agency conducting the written examination. The Oral Review Board will examine the candidate's personal qualities relating to the candidate's ability to perform in the position being tested for. Consideration shall be given to appearance, attitude, communicative ability and professional qualifications. The Oral Review Board will not be informed of the scores achieved on the other sections of the examination. Any earned oral board score will be considered passing and recorded toward the promotional process.

D. Psychological Evaluation: The Fire Chief may send the top three (3) candidates on the final list for a psychological evaluation. The Township's psychological consultant will give assessment of an employee's intellectual and personality traits. The psychological assessment will consist of a series of written tests to evaluate the employee's intellectual potential, personality variables, emotional stability and leadership qualities. Assessment of the employee's intellect and personality will be given to the Township. The employees will be ranked as excellent, very well qualified, well qualified, good or poor.

E. An employee must complete the promotional process and attain a passing score of 70% or higher on the written exam.

F. All candidates may review their scores on the above sections (A, B, C, D), after all portions of the promotional examination are complete.

G. The Township Supervisor and Fire Chief reserve the right to appoint from the top three (3) finishers with the highest accumulated percentage and/or points.

H. Upon the date of appointment, the new Officer will receive the full increase in wages according to the wage scale,) and will be placed on a promotional probationary period for six (6) months.

I. In the event the classes/courses listed in the collective bargaining agreement are no longer offered, available or are no longer required by the State of Michigan, the parties agree to meet and agree upon equivalent replacement classes/courses before implementation.

J. The promotional list will be posted prior to sending any employee for a psychological evaluation.

K. The scoring of the promotional exam shall be as follows:

The written exam will be weighted at 75% of the overall score; the oral examination will be weighted at 25% of the overall score; with 1/10 point granted per month of service.

L. The Employee may “freeze” the written test score from the previous testing period, to be used as the written test score in only the next test of the same rank/position, Employee must inform the Chief’s office in writing prior to the collection of the test sign up.

M. The Department must make promotions within 12 business days of a list being posted and the position being vacant.

ARTICLE 28 - UNIFORMS

Section 1 - Account Amount

The Township agrees to credit the Fire Department Uniform Account in the following manner:

Beginning April 1, 2020 and each year thereafter:

Day Employee	$350.00
Unit Employee	$300.00

Section 2 - Use of Allowance

Use of the Fire Department Uniform Allowance must be approved by the Fire Chief prior to the purchase of any uniform or accessory item.

Approved Items are as follows:

> Department t-shirts, uniform shirts, uniform pants, job shirts (sweatshirt), uniform boots, uniform shoes, black/blue dress socks, belt, three season jacket, winter hat, baseball hat, turnout gear bag, Large (hockey size) bag, medium duffle bag, small bag for extras on truck, harness of which are available through Department vendors.

Any clothing damaged or ruined on duty may be replaced by the Department, at the discretion of the Fire Chief and at no cost to the employee.

Section 3 - Dress Uniform

All Class A Firefighters shall have a dress uniform. The Township will pay for the first dress uniform and any alterations needed throughout employment.

Section 4 - Emergency Uniform Cleaning

Emergency uniform cleaning will be approved at the discretion of the Fire Chief.

Section 5 - Protective Clothing

All protective clothing and gear for firefighting will be furnished by the Fire Department. All original badges, badges of rank and insignias will be furnished by the Fire Department. If equipment is lost due to carelessness or negligence, the employee shall replace it and the cost thereof will be charged to the employee's uniform allowance.

Section 6 - Probationary Employee

Probationary employees will receive work uniforms, paid for by the Fire Department, consisting of Six (6) uniform shirts, six (6) uniform pants, six (6) T-shirts, one (1) job shirt, one

(1) pair of shoes, belt, all season jacket, the cost of which will not be charged to the employee's uniform allowance.

Section 7 - Probation Period

At the completion of the probation period the employees Uniform Account will be credited with the appropriate funds.

Section 8 - Properly Attired

All employees shall, at all times, be properly attired in uniforms, which conform to regulations and standards set by the Fire Chief. Each fiscal year every member shall receive, at no charge to employee's uniform account, one (1) full uniform (uniform pants, uniform shirt, and uniform job shirt.

Section 9 - Overdraw

Employees shall not overdraw their uniform allowance by more than $50.00.

Section 10- Payment for unused Uniform Account Money

Upon retirement from the Township, the employee shall be paid out the full amount of their uniform account balance.

ARTICLE 29 - RESIDENCY

Employees may reside in any County of their choosing, however this may affect overtime eligibility. (See ARTICLE 13 - OVERTIME of this Agreement)

ARTICLE 30 - LATE TIME

Unit Employees starting time is 0800 hours.
Unit Employees quitting time is 0800 hours.
Day Employees starting time is 0700 hours.
Day Employees quitting time is 1730 hours.

An employee cannot leave unless they are properly relieved by the incoming employee. Any employee starting work after 0800 hours will be charged late and face the following disciplinary actions:

1. First (1st) offense (1-15 minutes late):
   The employee will receive an oral reprimand for being late.

2. Second (2nd) offense (16+ minutes late and/or second (2nd) offense):
   If the employee is more than sixteen (16) minutes late, it is automatically considered a second (2nd) offense and employee is given a written reprimand.

3. Third (3rd) offense:
   The employee will be sent home without pay.

4. Fourth (4th) offense:
   The employee will be suspended three (3) days without pay pending further disciplinary action.

Employees calling Fire Station One stipulating the reason for being late may be considered excusable by the Fire Chief.

Disciplinary actions shall be cleared off personnel records at the end of the fiscal year.

ARTICLE 31 - EDUCATION REIMBURSEMENT

Section 1 - Reimbursable Items

The Township will reimburse one-half (1/2) or (50%) the cost of formal education for an Associate's and Bachelor's degree. Reimbursable fees include tuition, books and any fees for course work completed at approved accredited colleges and universities in the field of Fire or EMS technology, fire related field or classes approved by the Fire Chief.

Section 2 - Fire Officer Courses

The Township will reimburse the tuition for any Fire Officer courses, or equivalent new state courses.

Section 3 - Other Courses

The Fire Chief, at his discretion, may before a course is taken and without prejudice or precedent to the Township's rights in the future, approve for payment by the Township, full costs of tuition and fees for any other course related to the Fire Department, its operation, and management. The Fire Chief may, at his sole discretion, select employees from a list of employees who have expressed interest in attending courses related to the Fire Department, its operation and management. If no qualified employees, as determined by the Fire Chief, have signed the list or to achieve diversification of opportunity, the Fire Chief, at his discretion, may select employees to attend the courses.

Section 4 - Books Reimbursement

The Township will reimburse the employee the full costs of all necessary books required to complete the assigned work for the course defined in Sections 1, 2, 3 and 4 of this Article, unless the books are available through other means for the Employees' use. All books paid for by the Township shall remain the property of the Township and shall be returned to the Township after the course is completed and will be maintained for future use by other employees. Any employee who does not return a book to the Township upon completion of the course must reimburse the Township for the full cost of the book.

Section 5 - Final Grade Requirement

The reimbursed costs for each course defined in Sections 1, 2, 3 and 4 of this Article will be paid to the employee at the end of each semester, or course and only after the employee has presented evidence of the satisfactory completion of the course with a final grade of "C" or above, in a form acceptable to the Fire Chief. The employee must furnish the Fire Chief with copies of the grades received and valid receipts of expenses. All books shall be transferred prior to reimbursement.

ARTICLE 32 – EMS

Section 1.

The Township Supervisor and Fire Chief, at their discretion, and without prejudice or precedent to the Township's rights in the future, may require employees to attend a Paramedic Academy to expedite obtaining their special classification of Paramedic.

Section 2.

A. Employees hired as a Basic EMT will not be assigned on a routine basis as an engine/ladder operator.

B. Any Employee who does not attain a State of Michigan Paramedic License within one (1) year of finishing Paramedic school, or within 3 years from their start date of employment, will have their employment with Bloomfield Township terminated.

C. Any Employee who has failed the State of Michigan/National Registry test program (3 tests), subsequent refresher program and (3 tests) will have their employment with Bloomfield Township terminated.

D. If conditions exist where the timeline cannot be met, The Fire Chief and the Union shall agree to an appropriate amended timeline. (i.e. class schedule issues, unforeseeable circumstances, natural disasters, etc.).

E. Any employee that is sent to a Paramedic Program and acquires a State of Michigan Paramedic License will be required to keep the Paramedic License for the remaining duration of employment with Bloomfield Township.

F. All employees, once a State of Michigan Paramedic License is attained, must maintain a Paramedic License as a condition of employment with Bloomfield Township Fire Department.

ARTICLE 33 - TRADE TIME

Section 1 - General

Trade Time is a system devised to allow an employee to be absent from their regular assigned duty by having another employee, by mutual agreement, work in their absence. The employee regularly scheduled for duty will be credited for attendance as if they were working.

Section 2 - Trade Time Criteria

An employee wishing to "Trade Time" must meet the following criteria:

A. The Trade Time is done voluntarily by the employees participating in the program and not at the request of the Fire Department.

B. The reason for Trade Time is not due to the Fire Department's business operations, but to the employee's desire or need to attend to a personal matter.

C. A record is maintained by the Fire Department of all Trade Time.

D. All Trade Time shall be paid back within three hundred sixty-five (365) calendar days of the initial trade.

E. No Employee will be allowed more than one hundred twenty (120) hours of Trade Time outstanding to be paid back.

Employees who do not follow the above criteria in Section 2 may not Trade Time.

Section 3 - Trade Time Rules

A. Any employee wishing to Trade Time shall properly fill out a Trade Time form. Each employee shall have their signature on the form and have it approved by the employee's Unit Officer in Charge. When the Trade Time form is completed, it shall be submitted to the Fire Chief and it will become a permanent attendance record. Each employee trading time shall receive a copy of the completed Trade Time form. The employees trading time must notify the Unit Officer in Charge at least twenty-four (24) hours prior to the Trade Time worked. The twenty-four (24) hour limitation may be waived, without prejudice or precedent to the rights of the Township, at the sole discretion of the Fire Chief.

B. If either of the employees involved in a Trade are on sick leave, short-term disability, long-term disability or workers compensation and it is twenty (20) calendar days prior to the scheduled Trade Time, it will be the responsibility of the employees trading time to make alternate time off arrangements.

C. Employees on light duty, short-term disability, long-term disability or workers compensation will not be eligible to schedule new Trade Time.

D. When a owed trade day is interrupted by bereavement, bereavement will be granted but the trade day will still be owed.

Section 4 - Responsibility

When an employee is scheduled to work in place of another, they shall be responsible for their own actions.

Section 5 - Holiday Trade Time

If Trade Time is utilized on a scheduled Holiday the Unit Employee regularly scheduled for duty shall be credited for attendance as if they were working.

Section 6 - Union Board Members

Union Executive Board members may utilize up to one-hundred ninety-two (192) outstanding Hours.

Section 7 - Acting Pay

Battalion Chiefs can trade with Captains or Lieutenants, but no Acting Pay will be paid for the initial trade time. Acting pay will be paid to all other employees affected as a direct result of the initial trade time.

ARTICLE 34 - LAUNDRY

The Department will provide a washer and dryer in each fire station to allow employees to wash uniforms and linens.

ARTICLE 35 - JURY DUTY

When a member of the Fire Department is required to serve on a jury, or subpoenaed as a witness for Department business, they shall be excused from their regular duties during that time that is required to and does appear in court, except that on such days the employee shall be required to work all scheduled hours during which their attendance in court is not required with reasonable travel time provided. The Township will pay said employee for time actually lost from their scheduled work hours and the employee will be required to submit their jury fees received to the Township for such time.

ARTICLE 36 - LIGHT DUTY ASSIGNMENTS

Section 1 – Work Related

A. When an employee is absent from work due to an injury or illness deemed work related, they may be placed on Light Duty by the Fire Chief. Non-work-related injuries, the employee shall choose whether they want to be placed on Light Duty or use other time off banks. Light Duty assignment shall be limited to the Fire Department and to tasks within the scope of the fire department that are appropriate and within the employee's medical restrictions.

B. The Fire Chief shall determine the need for Light Duty assignment and whether the employee has the ability to perform the Light Duty Assignment. Light Duty employees shall not be counted as shift manpower and shall not count against a vacation spot or any other time off banks. Light Duty shall first be assigned to employees on work related injury or illness (if they are the most appropriate employee for the job). If Light Duty has been assigned to an employee with a non-duty related injury, and an employee becomes disabled deemed to be work related, the Fire Chief may assign the Light Duty assignment to the employee with the work-related injury or illness.

C. If an employee does not return to full duty work within six (6) months after the onset of a disability, the employee shall submit to the Township, a written statement from the employee's attending physician stating: diagnostic evaluation of the disability, treatment/medication, prognosis for recovery, length of recovery, and any other relevant information requested by the Fire Chief. Based upon the attending physician's evaluation, the assignment for Light Duty may be extended.

D. Personnel assigned to Light Duty shall be compensated without reduction to their regular normal salary and benefits. Employees assigned to Light Duty shall be assigned to Unit and work normal shift hours. The employee will not respond to emergencies unless authorized by the Fire Chief or his designee. During the hours of 0800-1700 the employee will do work as assigned by the Fire Chief. From 1700-0800 hours, the employee will do work as assigned by the Shift Commander. The employee will receive Holiday Pay according to the contract for Unit employees. Once an employee has been medically certified as fit to return to regular duty with no restrictions, that employee will return to his normal duties.

E. Employees assigned to Light Duty shall have that time assigned to light duty applied as follows:

1. The time period assigned to Light Duty (work related) shall be counted towards the total of twenty-six (26) weeks of regular normal salary provided in ARTICLE 22 - WORK CONNECTED INJURY OR ILLNESS, Section 4.

2. The time period assigned to Light Duty (work related) shall be counted towards the total of fifty-four (54) months of pre-injury medical benefits provided in ARTICLE 22 - WORK CONNECTED INJURY OR ILLNESS, Section 4.

3. The time period assigned to Light Duty shall apply to the 48 months of leave before an employee is deemed to be permanently disabled and terminated from Township employment for a work-connected illness or injury as set forth in ARTICLE 22 - WORK CONNECTED INJURY OR ILLNESS, Section 5(3).

Section 2 – Non-Work Related

A. When an employee is absent from work due to an injury or illness, which is not work related, the employee may at any time request to be placed on Light Duty by the Fire Chief or elect to utilize sick leave, and other benefits. Light Duty assignments shall be limited to the Fire Department and to tasks within the scope of the Fire Department which are appropriate and within the employee's medical restrictions.

B. The Fire Chief shall determine the need for Light Duty assignments and whether the employee has the ability to perform the Light Duty assignment. Light Duty employees shall not be counted as shift manpower. Light Duty shall first be assigned to employees with a work related injury or illness (if they are the most appropriate employee for the assignment). In the event that an employee with a non-duty related injury or illness has been assigned a Light Duty position, the Fire Chief may reassign the work to the employee with the work-related injury or illness.

C. If an employee does not return to full duty work within six (6) months after the onset of a disability, the employee shall submit to the Township a written statement from the employee's attending physician stating: diagnostic evaluation of the disability, treatment/medication, prognosis for recovery, length of recovery, and any other relevant information requested by the Fire Chief. Based upon the attending physician's evaluation, the assignment of Light Duty may be extended.

D. Unit Employees assigned to Light Duty shall be compensated without reduction to their regular normal salary and benefits. All hours worked or assigned to Light Duty shall be adjusted and compensated by utilizing a conversion factor of 1.4

For Example:

Unit Employee Assignment	***Hours Unit Employee Credited for:***			
Unit Regular hours		=	*1.0*	*hour*
Day Regular hours	*x1.4*	=	*1.4*	*hours*
Unit Vacation hours		=	*1.0*	*hours*
Day Vacation hours	*x1.4*	=	*1.4*	*hours*

Unit Sick hours		=	*1.0*	*hours*
Day Sick hours	*x1.4*	=	*1.4*	*hours*
Unit Personal Leave hours		=	*1.0*	*hours*
Day Personal Leave hours	*x1.4*	=	*1.4*	*hours*
Unit Workers Compensation hours		=	*1.0*	*hours*
Day Workers Compensation hours	*x1.4*	=	*1.4*	*hours*
Other Unit Overtime hours		=	*1.0*	*hours*
Other Day Overtime hours	*x1.4*	=	*1.4*	*hours*

All hours utilizing a conversion factor of 1.4 shall be considered hours actually worked.

Unit Employees assigned to Light Duty for a whole pay period shall accumulate sick time at a rate of 4.0 hours per pay period. Unit Employees on Light Duty for less than a whole pay period shall accumulate sick time at a rate of 5.6 hours per pay period.

Unit Employees assigned to Light Duty shall have their sick bank hours and vacation bank hours adjusted by utilizing a conversion factor of 1.4.

For Example:

When converting Unit Hours to Day Hours for going on Light Duty, a Unit employee that has 280 hours of sick time or vacation time on Unit shall have 200 hours on Day shift.

280 Unit hours /1.4 = 200 hours of Day shift hours

When converting Day shift hours to Unit hours for an employee returning to Unit from Light Duty an employee that has 200 hours of sick time or vacation time on Days shall have 280 hours of Unit hours.

200 Day hours x 1.4 = 280 hours of Unit hours.

After the conversion the Unit Employee shall be charged one hour for every one hour used for vacation or sick time. Light Duty assignments shall be Monday through Thursday from 0700-1730 hours. Unit Employees shall remain on non-work related benefits corresponding to the employee's normal shift assignment schedule until the employee actually works a Light Duty shift. Unit Employees on Light Duty will not be required to work less than the 0700-1730 assignment. Unit Employees on Light Duty shall receive Unit-defined Holidays off. Unit Employees on non-work related Light Duty shall not receive Holiday pay for any Holiday that occurs while they are on Light Duty. The Unit Employee will not respond to emergencies unless authorized by the employee's attending physician and the Fire Chief or his designee. Once a Unit Employee has been medically certified as fit for duty, that employee shall be returned to their normal duties.

E. Day Employees assigned to Light Duty shall be assigned to work their normally scheduled work hours and will receive Holiday pay according to the Agreement. Once a Day Employee has been medically certified as fit for duty, that employee shall be returned to their normal duties.

F. The time period assigned to Light Duty shall apply toward the 130 weeks of leave before an employee is deemed to be permanently disabled and terminated from Township employment for a non-work-related injury or illness as set forth in ARTICLE 23 - SICK LEAVE, Section 11A.

ARTICLE 37 - UNION DUES

To the extent state and federal law permits, it is agreed that:

1. The current or future employment of bargaining unit employees is not contingent upon membership in the Union or the payment of union dues or fees.

2. The Employer agrees to make Union payroll deductions twice each month from the pay of the employees who have authorized that such deductions be made as set forth in Subsections 4 and 5.

3. As soon as practicable following the decision to hire a new employee into the bargaining unit, the Employer shall notify the Union of newly-hired bargaining unit employees and provide the Union an opportunity during the onboarding process to meet with newly-hired bargaining unit employees to discuss the employees' options with respect to becoming or not becoming a member of the Union.

   Each employee who becomes a member of the Union after June 27, 2018, must sign the Union's Application for Union Membership and Authorized Dues Deduction Card.

4. Deductions for any calendar month shall be remitted to the Union. In the event that a refund is due to any employee for any sums deducted from wages and paid to the Union, it shall be the responsibility of such employee to obtain the appropriate refund from the Union.

5. The Employer shall not be liable for the remittance or payment of any sums other than those constituting actual deductions made. If the Employer fails to make a deduction for any employee as provided, it shall make that deduction from the employee's next pay period in which such deduction is normally deducted after the error has been called to its attention by the employee or the Union.

6. If there is an increase or decrease in Union payroll deductions, as determined and established by the Union, such changes shall become effective upon the second pay period following notice from the Union to the Employer of the new amount(s).

ARTICLE 38 - DAILY OPERATION

Section 1- Work Schedule

A. The work schedule for Day Employees shall be (40) hours per week, (10) hours per day, four (4) days per week, Monday through Thursday, excluding all holidays or observance of holidays set forth in this Agreement.

B. Unit personnel shall maintain a fifty-six (56) hour work week. The schedule shall be worked as prescribed by Act 125, Public Acts of 1925, as amended; and under the three (3) unit system.

Section 2 – Pay Periods

A. A. The pay period for Fire Department employees shall start at 0800 hours on Saturday and run for fourteen (14) days until 0800 hours on the second successive Saturday. The wages of the employees shall be paid biweekly on Wednesday of the appropriate week. In the event this day is a holiday, either the preceding day or following day shall be payday. Pay statements shall be available online at all times, and employees shall have access to any and all previous paychecks.

All employees are required to have electronic direct deposit of paychecks. Employees shall execute any necessary documentation to effectuate direct deposit of their paychecks.

Section 3- Day Employee Working Hours

The starting time for Day Personnel shall be 07:00 and ending time shall be 17:30. The starting time for Unit personnel shall be 08:00 and ending time shall be 08:00 the following morning.

With the Fire Chief approval Day Personnel may request an alteration to the schedule of daily working hours if approved by the Fire Chief. The change of regular working hours shall not be unreasonably withheld.

Section 4- Shift Transfers

Personnel transferred to shifts shall receive a 30-day notice before any transfer.

Personnel may waive the 30-day notice at their discretion.

In the event of a transfer for any reason, vacation time already scheduled will be honored and approved even if it exceeds the maximum personnel allowed off on vacation time.

Section 5- Shift Assignments

A. Battalion Chiefs will be assigned to Central Fire and operate Command Vehicle.

B. Unit Captain will be assigned to Central Fire.

C. Lieutenants will pick station by seniority, time in rank, must pick by first week in February or be assigned by the Battalion Chief. This process to be completed every two (2) years.

Rest time and workout time will be allowed on Saturdays and Sundays.

ARTICLE 39 - ENTIRE AGREEMENT

This Agreement supersedes and cancels all previous Agreements. Any Amendment or Agreement supplemental hereto shall not be binding upon either party unless approved and executed in writing by the Association and the Township.

ARTICLE 40 - TERMINATION

Section 1 – Duration

This Agreement shall be in effect the first day of April, 2025 and shall remain in force and effect to and including March 31, 2028.

The parties understand, acknowledge and agree that employees and their Eligible Dependents (defined in Section 1(F) and (G), in ARTICLE 19 – HEALTHCARE BENEFITS) who are eligible for the defined benefit retiree health care plan, who retire or separate from service after April 1, 2020, or who have retired or separated from service prior to April 1, 2020 and are on the pre-Medicare age HRA plan, will have the same health care, prescription, dental and vision coverage for themselves, and for their Eligible Dependents, for the remainder of their respective lives (known as "Retiree Health Care for Life"). The health care, prescription, dental and vision plans that a pre-Medicare age retiree on the HRA plan and an employee retiring or separating from service under the April 1, 2020 to March 31, 2025 Collective Bargaining Agreement will have access to for the remainder of their life and/or lives in retirement is the plan that is in place in the final year of the April 1, 2020 to March 31, 2025 Collective Bargaining Agreement; not the year that they retired or separated from service. The health care, prescription, dental and vision plans that an employee retiring or separating from service under a Collective Bargaining Agreement beginning after March 31, 2025 will have access to for the remainder of their life and/or lives in retirement is the plan that is in place as of December 31 of the last full calendar year of that Collective Bargaining Agreement; not the year that they retired or separated from service. For example, if the employee retires or separates from service in 2022, they and their Eligible Dependents shall have the same health care plan, including all employee/retiree cost-sharing obligations, in effect in 2022, 2023, 2024, and 2025 and as set forth in ARTICLE 19 – HEALTHCARE BENEFITS. Under this example, the plan the employee/retiree will have for the remainder of their life and/or lives, post-2025, will be the same plan that is in place for active employees on December 31, 2024. However, there shall be no retiree cost-sharing premium obligations beyond the existing 15-25-year schedule that was established in 1999 and is within ARTICLE 19 – HEALTHCARE BENEFITS Section 2 (E) and (F). This "Retiree Health Care for Life" provision shall survive the expiration of this Agreement under the terms and conditions immediately set forth above. This "Retiree Health Care for Life" provision shall be subject to the provisions set forth in ARTICLE 19 – HEALTHCARE BENEFITS Section 2 (B) through (H) and Sections 3 and 4. Notwithstanding the forgoing, the parties understand, acknowledge and agree there may be changes to provided insurance that are out of the Township's control; for example protocol changes, network requirements, prescription formulary changes, etc. Any such changes shall be at the sole discretion of the insurance carrier.

Section 2 – Future Negotiations

The Township and the Union agree that bargaining for a new agreement for a succeeding period will commence not later than January 15, 2028.

Section 3 – Extension

In the event the negotiations extend beyond the said expiration date of this Agreement, the terms and provisions of this Agreement shall remain in full force and effect pending agreement of a new contract or an interest arbitration award establishing a new contract, or until thirty (30) days after notice is given by either party that the contract will be terminated.

BLOOMFIELD TOWNSHIP ASSOCIATION OF PROFESSIONAL FIREFIGHTERS

By:_____
Joseph McGrail, President
Date: 10/30/25

By:_____
Jeremy Koziel, Vice President
Date: 10/30/25

By:_____
Brandon Gainer, Secretary/Treasurer
Date: 10/30/25

CHARTER TOWNSHIP OF BLOOMFIELD

By:_____
Mike McCready, Township Supervisor
Date: 10/30/25

By:_____
Michael Schostak, Township Treasurer
Date: 10/30/25

By:_____
John LeRoy, Fire Chief
Date: 11-3-25

EMERGENCY MANAGER PROVISION

An emergency manager appointed under the Local Government and School District Fiscal Accountability Act may reject, modify or terminate this collective bargaining agreement as provided within the Local Government and School District Fiscal Accountability Act.

Inclusion of the foregoing language which is required under Section 15(7) of the Public Employment Relations Act does not constitute an agreement by the Union to the substantive or procedural content of the language. In addition, inclusion of the language does not constitute a waiver of the Union's right to raise Constitutional and/or other legal challenge (including contractual or administrative challenges) to the validity of: (1) appointment of an Emergency Manager; (2) P.A. 4 of 2011 (Local Government and School District Financial Accountability Act); or (3) any action of an Emergency Manager which acts to reject, modify, or terminate the collective bargaining agreement.

APPENDIX A – Wage Scales

EFFECTIVE at contract execution

CLASSIFICATION	START	HOURLY	OT	HOLIDAY OT
Probationary - Day	$54,441.65	$26.17	$39.26	$65.43
Probationary - BEMT	$54,441.65	$18.70	$28.04	$46.74
Probationary - Paramedic	$54,441.65	$18.70	$28.04	$46.74

CLASSIFICATION	1 Year	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$75,010.17	$25.76	$38.64	$64.40
Firefighter/Paramedic	$76,244.99	$26.18	$39.27	$65.46

CLASSIFICATION	2 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$79,824.10	$27.41	$41.12	$68.53
Firefighter/Paramedic	$81,855.89	$28.11	$42.16	$70.27

CLASSIFICATION	3 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$84,637.93	$29.07	$43.60	$72.66
Firefighter/Paramedic	$87,466.63	$30.04	$45.05	$75.09

					OVERTIME WITH LONGEVITY ADDED TO BASE PAY				
CLASSIFICATION	CLASS A	HOURLY	OT	HOLIDAY OT	2%	4%	6%	8%	10%
Firefighter/Paramedic	$93,567.18	$32.13	$48.20	$80.33	$49.16	$50.13	$51.09	$52.05	$53.02
Lieutenant/Paramedic	$102,281.55	$35.12	$52.69	$87.81	$53.74	$54.79	$55.85	$56.90	$57.95
Lieutenant Fire Inspector (Day)	$106,836.50	$51.36	$77.05	$128.41	$78.59	$80.13	$81.67	$83.21	$84.75
Captain/Paramedic	$107,602.26	$36.95	$55.43	$92.38	$56.54	$57.64	$58.75	$59.86	$60.97
Battalion Chief	$109,672.12	$37.66	$56.49	$94.16	$57.62	$58.75	$59.88	$61.01	$62.14
Day Captain EMS	$114,555.83	$55.07	$82.61	$137.69	$84.26	$85.92	$87.57	$89.22	$90.87
Fire Marshal (Day)	$117,621.77	$56.55	$84.82	$141.37	$86.52	$88.22	$89.91	$91.61	$93.31

	HOLIDAY OVERTIME WITH LONGEVITY				
	2%	4%	6%	8%	10%
Firefighter/Paramedic	$81.94	$83.54	$85.15	$86.76	$88.36
Lieutenant/Paramedic	$89.57	$91.32	$93.08	$94.84	$96.59
Lieutenant Fire Inspector (Day)	$130.98	$133.55	$136.11	$138.68	$141.25
Captain/Paramedic	$94.23	$96.07	$97.92	$99.77	$101.62
Battalion Chief	$96.04	$97.92	$99.80	$101.69	$103.57
Day Captain EMS	$140.44	$143.19	$145.95	$148.70	$151.46
Fire Marshal (Day)	$144.20	$147.03	$149.85	$152.68	$155.51

EFFECTIVE APRIL 11, 2026 No flat %, rescaling positions to one another

CLASSIFICATION	START	HOURLY	OT	HOLIDAY OT
Probationary - Day	$55,802.69	$26.83	$40.24	$67.07
Probationary - BEMT	$61,031.32	$20.96	$31.44	$52.40
Probationary - Paramedic	$67,134.45	$23.05	$34.58	$57.64

CLASSIFICATION	1 Year	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$74,109.46	$25.45	$38.17	$63.62
Firefighter/Paramedic	$81,520.41	$27.99	$41.99	$69.99

CLASSIFICATION	2 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$78,468.84	$26.95	$40.42	$67.37
Firefighter/Paramedic	$86,315.72	$29.64	$44.46	$74.10

CLASSIFICATION	3 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$82,828.22	$28.44	$42.67	$71.11
Firefighter/Paramedic	$91,111.04	$31.29	$46.93	$78.22

					OVERTIME WITH LONGEVITY ADDED TO BASE PAY				
CLASSIFICATION	CLASS A	HOURLY	OT	HOLIDAY OT	2%	4%	6%	8%	10%
Firefighter/Paramedic	$95,906.36	$32.93	$49.40	$82.34	$50.39	$51.38	$52.37	$53.35	$54.34
Lieutenant/Paramedic	$105,497.00	$36.23	$54.34	$90.57	$55.43	$56.52	$57.60	$58.69	$59.78
Lieutenant Fire Inspector (Day)	$109,507.41	$52.65	$78.97	$131.62	$80.55	$82.13	$83.71	$85.29	$86.87
Captain/Paramedic	$110,292.31	$37.88	$56.81	$94.69	$57.95	$59.09	$60.22	$61.36	$62.49
Battalion Chief	$115,087.63	$39.52	$59.28	$98.80	$60.47	$61.65	$62.84	$64.03	$65.21
Day Captain EMS	$117,419.72	$56.45	$84.68	$141.13	$86.37	$88.06	$89.76	$91.45	$93.15
Fire Marshal (Day)	$120,562.30	$57.96	$86.94	$144.91	$88.68	$90.42	$92.16	$93.90	$95.64

	HOLIDAY OVERTIME WITH LONGEVITY				
	2%	4%	6%	8%	10%
Firefighter/Paramedic	$83.98	$85.63	$87.28	$88.92	$90.57
Lieutenant/Paramedic	$92.38	$94.19	$96.01	$97.82	$99.63
Lieutenant Fire Inspector (Day)	$134.25	$136.88	$139.52	$142.15	$144.78
Captain/Paramedic	$96.58	$98.48	$100.37	$102.26	$104.16
Battalion Chief	$100.78	$102.76	$104.73	$106.71	$108.69
Day Captain EMS	$143.95	$146.77	$149.60	$152.42	$155.24
Fire Marshal (Day)	$147.80	$150.70	$153.60	$156.50	$159.40

EFFECTIVE APRIL 10, 2027 1.025

CLASSIFICATION	START	HOURLY	OT	HOLIDAY OT
Probationary - Day	$57,197.76	$27.50	$41.25	$68.75
Probationary - BEMT	$62,557.10	$21.48	$32.22	$53.71
Probationary - Paramedic	$68,812.81	$23.63	$35.45	$59.08

CLASSIFICATION	1 Year	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$75,962.20	$26.09	$39.13	$65.21
Firefighter/Paramedic	$83,558.42	$28.69	$43.04	$71.74

CLASSIFICATION	2 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$80,430.56	$27.62	$41.43	$69.05
Firefighter/Paramedic	$88,473.61	$30.38	$45.57	$75.96

CLASSIFICATION	3 Years	HOURLY	OT	HOLIDAY OT
Probationary Firefighter/BEMT	$84,898.93	$29.15	$43.73	$72.89
Firefighter/Paramedic	$93,388.82	$32.07	$48.11	$80.18

					OVERTIME WITH LONGEVITY ADDED TO BASE PAY				
CLASSIFICATION	CLASS A	HOURLY	OT	HOLIDAY OT	2%	4%	6%	8%	10%
Firefighter/Paramedic	$98,304.02	$33.76	$50.64	$84.40	$51.65	$52.66	$53.68	$54.69	$55.70
Lieutenant/Paramedic	$108,134.43	$37.13	$55.70	$92.84	$56.82	$57.93	$59.04	$60.16	$61.27
Lieutenant Fire Inspector (Day)	$112,245.10	$53.96	$80.95	$134.91	$82.56	$84.18	$85.80	$87.42	$89.04
Captain/Paramedic	$113,049.62	$38.82	$58.23	$97.05	$59.40	$60.56	$61.73	$62.89	$64.06
Battalion Chief	$117,964.82	$40.51	$60.76	$101.27	$61.98	$63.20	$64.41	$65.63	$66.84
Day Captain EMS	$120,355.21	$57.86	$86.79	$144.66	$88.53	$90.27	$92.00	$93.74	$95.47
Fire Marshal (Day)	$123,576.36	$59.41	$89.12	$148.53	$90.90	$92.68	$94.46	$96.25	$98.03

	HOLIDAY OVERTIME WITH LONGEVITY				
	2%	4%	6%	8%	10%
Firefighter/Paramedic	$86.08	$87.77	$89.46	$91.15	$92.84
Lieutenant/Paramedic	$94.69	$96.55	$98.41	$100.26	$102.12
Lieutenant Fire Inspector (Day)	$137.61	$140.31	$143.00	$145.70	$148.40
Captain/Paramedic	$99.00	$100.94	$102.88	$104.82	$106.76
Battalion Chief	$103.30	$105.33	$107.35	$109.38	$111.40
Day Captain EMS	$147.55	$150.44	$153.34	$156.23	$159.12
Fire Marshal (Day)	$151.50	$154.47	$157.44	$160.41	$163.38

Attachment “A” - Medical

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $4,000/individual - employee only or $8,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan. Amount your employer contributes to your account: Up to $1,500/individual or $3,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $3,000/individual - employee only or $6,000/family maximum For out-of-network providers: $6,000/individual - employee only or $12,000/family maximum Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, certain drug coupon amounts, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance/visit	30% coinsurance	None
	Specialist visit	10% coinsurance/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs (Tier 1)	30% coinsurance/prescription (retail 30 days), 30% coinsurance/prescription (retail 90 days); 30% coinsurance/prescription (home delivery 90 days)	30% coinsurance/prescription (retail 30 days); Not covered (retail and home delivery 90 days)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply,

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.cigna.com	Preferred brand drugs (Tier 2)	40% coinsurance/prescription (retail 30 days), 40% coinsurance/prescription (retail 90 days); 40% coinsurance/prescription (home delivery 90 days)	40% coinsurance/prescription (retail 30 days); Not covered (retail and home delivery 90 days)	including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Non-preferred brand drugs (Tier 3)	50% coinsurance/prescription (retail 30 days), 50% coinsurance/prescription (retail 90 days); 50% coinsurance/prescription (home delivery 90 days)	50% coinsurance/prescription (retail 30 days); Not covered (retail and home delivery 90 days)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance/office visit 10% coinsurance/all other services	30% coinsurance/office visit 30% coinsurance/all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	10% coinsurance	30% coinsurance	Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 40 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	10% coinsurance/visit	30% coinsurance/visit	None
	Habilitation services	10% coinsurance/visit	30% coinsurance/visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance/inpatient services 10% coinsurance/outpatient services	30% coinsurance/inpatient services 30% coinsurance/outpatient services	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (in-network only)
- Chiropractic care (combined with Rehabilitation Services)
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Michigan Health Insurance Consumer Assistance Program (HICAP) at (877) 999-6442.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$3,120

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$2,940

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,080

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA - Active and U65 **Ben Ver:** 33 **Plan ID:** 36722185

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

cigna healthcare

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

Cigna Healthcare
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).

Attachment “B” - Vision

Summary of Benefits **Cigna Health and Life Insurance Company**

Cigna Vision serviced by EyeMed
Bloomfield Township
C1 PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision **Coverage Effective Date:** April 1, 2025			
Vision Services and Frequency	**In-Network Plan Coverage****	**In-Network Member Cost*****	**Out-of-Network Reimbursement**
Exam and Professional Services: Frequency* : once per **12 month**			
Eye Exam	100% after $0 Copay	$0 Copay	Up to $45 Allowance
Retinal Screening	$0	Up to $39	Not Covered
Standard Eyeglass Lenses Allowances: Frequency* : one pair per **12 month**			
Lenses:	Copay: $0		
Single Vision	100%	$0 Copay	Up to $32 Allowance
Lined Bifocal	100%	$0 Copay	Up to $55 Allowance
Lined Trifocal	100%	$0 Copay	Up to $65 Allowance
Lenticular	100%	$0 Copay	Up to $80 Allowance
Lens Enhancements / Options:			
Oversize lenses	100%	$0	Not Covered
Rose #1 and #2 Solid Tints	100%	$0	Not Covered
Polycarbonate Lenses <19 years of age	100%	$0	Not Covered
Standard Polycarbonate Lenses	$0	$40	Not Covered
Standard Progressives	$0	$65	Not Covered
Plastic Dye Tints	$0	$15	Not Covered
Photochromic – Glass or Plastic	$0	$75	Not Covered
Standard Scratch Coating	$0	$15	Not Covered
Standard Ultraviolet (UV) Coating	$0	$15	Not Covered
Standard Anti-Reflective (AR) Coating	$0	$45	Not Covered
Hi-Index Lenses	$0	20% off retail	Not Covered
All other lens options, including Premium Tiers	$0	20% off retail	
Contact Lenses Retail Allowance: Frequency* : one pair or single purchase per **12 month**			
Elective	100% up to $130 Retail Allowance	Balance over $130 Allowance	Up to $105 Allowance
Therapeutic	100%	$0	Up to $210 Allowance
Frame Retail Allowance Frequency* : one per **24 month**	100% up to $130 Retail Allowance	20% off balance over $130 Allowance	Up to $71 Allowance
* Your Frequency Period begins on January 1 (Calendar year basis)			
Definitions: **Copay:** the amount you pay towards your exam and/or materials, lenses and/or frames **Coinsurance**: the percentage of charges Cigna will pay. Customer is financially responsible for the balance. **Allowance:** the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.			

In-Network Coverage Includes**:	**What's Not Covered:**
• One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses; • One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) including Oversize, Rose #1 or #2 Solid Tint and Polycarbonate lenses < 19 years of age. ○ 20% savings on all additional lens enhancements/ option you choose for your lenses, not shown on the Schedule of Vision Coverage above. • One pair of **Elective** conventional contact lenses or a single purchase of a supply of disposable contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). • Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Vision Coverage. • One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance; ** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information. *** Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.	• Orthoptic or vision training and any associated supplemental testing • Medical or surgical treatment of the eyes • Any eye examination, or any corrective eyewear, required by an employer as a condition of employment • Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related • Charges in excess of the usual and customary charge for the Service or Materials • Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy • Experimental or non-conventional treatment or device • Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage • Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses • Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage • Prescription sunglasses lens "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage • Two pair of glasses, in lieu of bifocals or trifocals • Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage • VDT (video display terminal)/computer eyeglass benefit • Claims submitted and received in excess of twelve (12) months from the original Date of Service

In-Network Value Added Savings

- Up to 40% off additional complete pairs of glasses (frame and lenses)
- 20% off any item not covered by the plan, including non-prescription sunglasses, but excluding professional services

Interested in Laser Vision Correction service such as LASIK? Visit your MyCigna.com and search for Healthy Rewards® for details.

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com, under "Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision – serviced by Eye Med Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click on Cigna Vision serviced by EyeMed Directory, from the Additional Directories drop down listing.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna Vision serviced by EyeMed information at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision service by EyeMed claim form and itemized receipt to: Cigna Vision, Claims Dept. c/oFAA PO Box 8504, Mason, OH. 45040-7111

To get a Cigna Vision serviced by EyeMed claim form:

• Go to **Cigna.com** and go to Forms, Vision Forms, select the Cigna Vision serviced by EyeMed form

• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

DISCRIMINATION IS AGAINST THE LAW

Vision coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.888.353.2653 (TTY dial 711 for operator, then dial 1-844-230-6498).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.888.353.2653 (TTY: marque 711 para hablar con un operador y luego marque 1-844-230-6498).

Chinese – 注意：我們可為您免費提供語言協助服務。請致電 1.888.353.2653（聽語障人士請撥打 711（聽語障專線）由操作人員為您服務，然後撥打 1-844-230-6498）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.888.353.2653 (TTY xin quay số 711 để kết nối với tổng đài, sau đó quay số 1-844-230-6498).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.353.2653번으로 문의하십시오(TTY는 교환원 연결을 위해 711번으로 전화하신 후, 1-844-230-6498번으로 전화하십시오).

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.888.353.2653 (Para sa TTY, i-dial ang 711 para sa operator, pagkatapos ay i-dial ang 1-844-230-6498).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.353.2653 (линия TTY: наберите 711 для соединения с оператором, затем наберите 1-844-230-6498).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.353.2653 (ينبغي لمستخدمي TTY الاتصال على الرقم 711 للتحدث إلى عامل الهاتف، ثم الاتصال على الرقم 1-844-230-6498).

French Creole – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.888.353.2653 (TTY konpoze 711 pou pale ak yon operatè, apresa konpoze 1-844-230-6498).

French – ATTENTION : Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.888.353.2653 (ATS: composez le 711 pour joindre l'opérateur, puis composez le 1-844-230-6498).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.888.353.2653 (TTY: marque 711 para o telefonista e, em seguida, marque 1-844-230-6498).

Polish – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.888.353.2653 (użytkownicy TTY powinni dzwonić pod numer 711, aby otrzymać połączenie z telefonistą, a następnie wybrać numer 1-844-230-6498).

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.888.353.2653 にお電話ください（TTYをご利用の場合は、711 をダイヤルしてオペレーターに接続してから 1-844-230-6498 におかけください）。

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.888.353.2653 (TTY: comporre il 711 per l'operatore, quindi comporre il numero 1-844-230-6498).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Rufen Sie die Nummer 1.888.353.2653 an (TTY-Benutzer wählen 711 für die Vermittlung und dann 1-844-230-6498).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. با شماره 1.888.353.2653 تماس بگیرید (YTT شماره 711 را برای اپراتور گرفته و سپس 1-844-230-6498 را شماره گیری کنید).

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Attachment “C” - Dental

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group #12241-0001, 0002, 0005, 0006, 0007, 0008, 0009, 0010, 0011, 9991
Charter Township of Bloomfield

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	**100%**	**100%**	**100%**
Palliative Treatment – to temporarily relieve pain	**100%**	**100%**	**100%**
Sealants – to prevent decay of permanent teeth	**100%**	**100%**	**100%**
Brush Biopsy – to detect oral cancer	**100%**	**100%**	**100%**
Radiographs – X-rays	**100%**	**100%**	**100%**
Basic Services			
Minor Restorative Services – fillings and crown repair	**85%**	**85%**	**85%**
Endodontic Services – root canals	**85%**	**85%**	**85%**
Periodontic Services – to treat gum disease	**85%**	**85%**	**85%**
Oral Surgery Services – extractions and dental surgery	**85%**	**85%**	**85%**
Major Restorative Services – crowns	**85%**	**85%**	**85%**
Other Basic Services – misc. services	**85%**	**85%**	**85%**
Relines and Repairs – to prosthetic appliances	**85%**	**85%**	**85%**
Major Services			
Prosthodontic Services – bridges, dentures, and crowns over implants	**50%**	**50%**	**50%**
Orthodontic Services			
Orthodontic Services – braces	**75%**	**75%**	**75%**
Orthodontic Age Limit –	**No Age Limit**	**No Age Limit**	**No Age Limit**

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable once per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable twice per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any three-year period.
- Sealants are payable once per tooth per three-year period for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.

- Composite resin (white) restorations are payable on all teeth, including posterior teeth.
- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are not Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per Member total per Benefit Year on all services except orthodontic services. $4,000 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 75% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – $50 Deductible per Member total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, sealants, and orthodontic services.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following 30 days of employment.

Eligible People – All full-time employees of the Contractor working at least 37 hours per week who choose the dental plan and all Enrollees who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar non-preempted state law ("COBRA").

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

The medical and Delta Dental plans are offered as a package. Employees enrolled in either plan are automatically enrolled in both plans with the same type of coverage. For example, employees enrolled with single coverage under the medical plan must also be enrolled with single coverage under the Delta Dental plan.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Delta Dental will use a carve-out method of coordinating Benefits for This Plan. If a Member has other coverage and that coverage is primary, This Plan's payment for Covered Services will equal the amount payable under This Plan minus the amount paid by the primary carrier. This Plan's payment will not exceed the amount that would have been paid in the absence of any other plan.

Benefits will cease on the date of termination.

Attachment "D" – IAFF Medical Expense Reimbursement Plan

SUMMARY PLAN DESCRIPTION

of the

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN (IAFF MERP)

of the

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST

Based on Plan restated effective August 1, 2023
Distributed November 2023

Including COBRA General Notice and
HIPAA Notice of Privacy Practices

Dr. 10/24/23

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN

November 2023

Dear Participants:

The IAFF Medical Expense Reimbursement Plan ("IAFF MERP" or the "Plan") was established to provide an important piece of financial support during your retirement. Your participation in IAFF MERP means you are building a fund to assist with medical costs that you will incur after you retire. Your Local has negotiated Contributions to the Trust in your Collective Bargaining Agreement.

The IAFF MERP is highly tax-favored. The contributions are pre-tax dollars; Plan earnings are not taxable; and when you begin receiving benefits in the future, they will not be taxed (unless you elect to receive a reimbursement for insurance premiums paid with pre-tax income).

The IAFF MERP is administered by a Board of Trustees, who are fellow fire fighters selected by the membership of participating Locals. We are very pleased to provide you this "Summary Plan Description" that provides general information about the operation of IAFF MERP in a Question-and-Answer format and describes the rights and protections to which you are entitled under federal law.

The Board of Trustees are committed to the successful operation of this Plan, in hopes of helping fire fighters and their families decrease the burden of retiree healthcare costs.

Please contact the Trust Office or one of the Trustees (contact info in this Summary Plan Description) if you have any questions or comments on the Plan.

Fraternally,
Greg Markley, Chairman
IAFF MERP Board of Trustees

IAFF MEDICAL EXPENSE REIMBURSEMENT PLAN

SUMMARY PLAN DESCRIPTION
Table of Contents

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NOTE: References in this Summary Plan Description to "Plan Sections" refer to the formal "IAFF Medical Expense Reimbursement Plan" of the Washington State Council of Fire Fighters Employee Benefit Trust, restated effective August 1, 2023. You may review that document by going online to **https://iaff-merp.simon365.com**.

You may also obtain a hard copy of the formal Plan document by contacting the Trust Office at:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743
Fax: (866) 676-1530
Email: iaff-merp@vimly.com

HIGHLIGHTS OF IAFF MERP

- Eligibility. Generally, Employees need five (5) years in IAFF MERP to achieve eligibility for monthly benefits from the Trust. However, for Employees who are within five years of retirement when their Local joins the Trust, there is a limited benefit – See Q&A 4 below.

- Benefits. Your benefits from this Trust come in the form of monthly reimbursement for certain medical costs, which are called "Covered Expenses,"[1] incurred after you retire, limited to the amount of your Monthly Benefit Level, Accumulated Benefit, and/or Individual Account. The "Benefit Calculator" section on the Trust's website at **https://iaff-merp.simon365.com** will give you an approximation of the amount of your Monthly Benefit Level earned thus far, or you can contact the Trust Office for information.

- Claims. You must present your claims to the Trust Office with your proof of payment of Covered Expenses, on a form approved by the Trustees, no later than March 31 of the following year from the date on which you made the payment of the Covered Expense. However, you are encouraged to submit your claims throughout the Plan year.

- Change of Address or Family Composition. If you move or have a change in mailing address, it is your responsibility to update the mailing address on file with the Trust Office. It is also your responsibility to update the information on file with the Trust Office if you have a change in family composition, e.g., marriage, divorce, or birth of a child. Failure to notify the Trust Office may result in loss or delay of benefit payments.

- Trust Office (Administrative agent of Trust). The Trust Office is a valuable resource and provides important services to the Trust. For example, to find out your Monthly Benefit Level, apply for benefits, submit any benefit claims, request a copy of the Plan or notify the Trust of a change in address, you will need to contact the Trust Office. The Trust Office may be contacted at the following:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743 or Fax: (866) 676-1530
Email: iaff-merp@vimly.com
Website: https://iaff-merp.simon365.com

[1] Capitalized terms contained herein are defined in the formal Plan document, and many are described in this Summary Plan Description ("SPD").

NOTE: The Questions & Answers in this Summary Plan Description have been designed to provide you with key information about the IAFF MERP but they do not provide all the details and limitations of the Plan. Exact specifications are provided in the "IAFF Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust," restated effective August 1, 2023, and as amended from time to time thereafter. If there is a conflict between what is contained in the Plan, and what is contained in the Summary Plan Description or any other descriptions, the terms of the Plan will prevail.

TABLE OF QUESTIONS FOR SUMMARY PLAN DESCRIPTION

Summary Plan Description

1. Who can participate in IAFF MERP (or the "Plan")?

Eligibility in IAFF MERP (or the "Plan") is generally available to all Employees who are represented by a bargaining unit of a member Local of the International Association of Fire Fighters that represents fire fighter, fire department and/or paramedic employees and for whom Contributions are made to the Plan as required by the Collective Bargaining Agreement between that Local and the Employee's Participating Employer.

NOTE re promotions: If you promote out of a participating bargaining unit and there is no agreement between the Trust and your Employer, your contributions may cease. COBRA is not available in this circumstance. Contact the Trust Office for details.

2. Who is eligible for a lifetime Monthly Benefit Level from the Plan?

An Employee described in Q&A 1 becomes an Eligible Retiree entitled to monthly benefits for his or her lifetime[2] under IAFF MERP after all of the following requirements are met:

- The Employee earns five years of Active Service in the Plan (see Q&A 3).
- Contributions are made to the Plan on behalf of the Employee for all years of Active Service.
- The Employee attains age 53 (except for those who qualify as an Eligible Retiree with Regular Pension Benefits or Disability Pension Benefits prior to age 53).
- The Employee ceases employment with all Participating Employers.

Return to any employment with a Participating Employer after retirement will cause a suspension of all benefit payments for the length of that re-employment. Benefit payments are suspended from the monthly benefit, the Individual Account, and the Accumulated Benefit. Benefit payments from all sources will resume upon separation from all employment with Participating Employers. It is the Eligible Retiree's responsibility to report re-employment with a Participating Employer to the Trust Office.

[2] IAFF MERP is currently written to provide benefits until death for Eligible Retirees with the Monthly Benefit Level. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

Age Eligibility Prior to Age 53. An Employee may become an Eligible Retiree under the Plan without attaining the age 53 requirement of Plan Section 2.1(a)(3), if an Employee attains eligibility for Regular Pension Benefits or Disability Pension Benefits prior to age 53, as long as all of the other eligibility requirements listed above are met. These Employees are entitled to start benefit payments immediately after retirement, but at a reduced Monthly Benefit Level, as determined by the Early Retirement Factors Table. The reduction to the Monthly Benefit Level depends upon the age at which the Employee separated from employment, unless the Employee defers benefits to a later date, then the Monthly Benefit Level depends upon the age when the Employee submits the first claim for reimbursement. Monthly Benefit Levels are reduced more for younger Employees because those Employees are expected to receive the monthly benefit for a longer period of time. See the Table in Appendix E at the end of this Summary. An Employee who is eligible for Disability Pension Benefits also has the option to have his/her contributions credited to an Individual Account for reimbursement of Covered Expenses until the balance of the Individual Account is exhausted, instead of a relatively small Monthly Benefit Level based on the Appendix E Table.

Disability Pension Benefits means the Employee has earned eligibility for retirement benefits from the retirement system that the Employee's employer participates in for fire fighter employees due to a work-related disability, as determined by the retirement system. The Employee must submit documentation to the Trust Office of eligibility for and receipt of retirement benefits from the retirement system.

Regular Pension Benefits means the Employee has earned eligibility for retirement benefits from the retirement system that the Employee's employer participates in for fire fighter employees by attaining the normal service and/or age requirements of that retirement system to receive routine benefit payments. The Employee must submit documentation to the Trust Office of eligibility for and receipt of retirement benefits from the retirement system.

An Eligible Retiree who is eligible for lifetime monthly benefit payments is called a "Regular Beneficiary." An Eligible Retiree who is eligible for benefit payments from an Individual Account is called an "Account Beneficiary." See Q&A 7 below regarding Individual Accounts. An Eligible Retiree can be both a Regular Beneficiary and an Account Beneficiary.

3. How do I earn Active Service?

An Employee can earn Active Service and Active Service Units in the following ways:

- Employer Contributions to the Plan from Payroll. Generally, you will receive years of Active Service credit for all periods of full-time employment during which your employer makes Contributions to the Plan on your behalf. You can also earn Active Service credit during a leave of absence, as long as Contributions are made to the Plan on your behalf during that time (either through self-pay COBRA contributions or by your Employer on your behalf pursuant to your CBA). The federal law USERRA also provides for employees on active service military leave to make contributions for up to 24 months of that leave in order to maintain their benefits. If you have questions about Contributions, please contact the Trust Office.

- Conversion of Leave Transfer, Other Lump Sum Transfers, or Individual Account Balance into Active Service and ASUs. The Plan only allows you to earn additional years of Active Service through conversion when conversion is elected at your retirement or separation from employment. When you retire or separate from employment without attaining five years of Active Service, you can use a Lump Sum Transfer received at that time to purchase additional years of Active Service through a COBRA election and/or conversion of your leave transfer (or other Lump Sum Transfer) using the age-related factors on the Lump Sum Transfer Conversion Table. You can also use your Individual Account balance (from prior Lump Sum Transfers) for COBRA payments or conversion, but you cannot use Pooled Contributions received from your former employer's payroll transfers that were credited to the Individual Account balance due to your ineligibility for the monthly benefits. (These Pooled Contributions have already been used to earn Active Service during your active employment.)

  Conversion is based on the age of the Employee on the date that the Trust Office receives the conversion election form. Note that the cost of converting a leave transfer or the Individual Account balance into ASUs is higher as the age of the Employee increases due to the decreased time for investment before drawing benefits. Please refer to Appendix C to the Plan, "Leave Conversion Table," attached hereto. The cost of a year of Active Service through leave conversion in Appendix C was actuarially calculated to be equivalent to monthly Contributions during employment.

- Contribution After Termination or Reduction of Employment (COBRA) – Including Retirement. If your Contributions to the Plan cease because your employment is terminated (including for retirement, but not for gross misconduct) or your hours are reduced to less than full-time (e.g., going on leave without contributions), you may continue to earn Active Service and Active Service Units for a maximum of eighteen months, by making monthly self-payments to the Plan

as permitted by the federal law known as COBRA,[3] and subject to rules set by the Trustees. An Employee may elect to self-pay COBRA contributions through deduction from Lump Sum Transfers (such as an accrued leave transfer) or from the Individual Account balance, or by sending check payments to the Trust Office. Benefit payments shall not commence until COBRA contributions have stopped. Active Service Units earned through COBRA self-payment cost $25 per ASU – the same as during active employment, i.e., the Leave Conversion Table does not apply. Please also see Q&A 5 for the use of leave transfers (or Other Lump Sum Transfer), or Individual Account balance to make COBRA Contributions.

COBRA self-payment enables an Employee to reach the minimum requirement of five years of Active Service and/or increase the Employee's Monthly Benefit Level. Active Service Units earned from COBRA payments are added to the Employee's total Active Service Units from other sources and used to calculate the Monthly Benefit Level. Even if the Employee has already attained eligibility for monthly benefits, the Employee can elect to make COBRA contributions to earn additional Active Service Units and a higher Monthly Benefit Level. See attached COBRA General Notice.

4. What happens if I separate from service before I earn five (5) years of Active Service?

An Employee who does not earn five years of Active Service (defined as "Short Service" under Plan Section 3.2(f)) will not be eligible to receive the lifetime[4] stream of monthly benefit payments. Instead, the total amount of Contributions made on his/her behalf, (without any allocation for investment returns thereon) will be added to the Eligible Retiree's Accumulated Benefit. If an Eligible Retiree with Short Service benefits receives a Lump Sum Transfer, that transfer will be credited to the Eligible Retiree's Individual Account, and the Eligible Retiree will have both an Accumulated Benefit and an Individual Account. This type of Eligible Retiree may submit claims for the reimbursement of Covered Expenses at any time after separation from employment as an Employee in the Plan. There is no monthly limit on the dollar amount of claims that can be reimbursed, as long as all claims are for reimbursement of Covered Expenses and the claimed amount does not exceed the balance of the Accumulated Benefit, plus any Individual Account balance. Benefits cease when the Eligible Retiree has exhausted his or her Accumulated Benefit and/or Individual Account. Please note that any Accumulated Benefit balance or Individual Account balance remaining upon the death of the Eligible Retiree and all of his

[3] The Consolidated Omnibus Budget Reconciliation Act of 1986.

[4] IAFF MERP is currently written to provide benefits until death for Eligible Retirees with the Monthly Benefit Level. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

or her Beneficiaries, or at the time the Surviving Children no longer meet the definition of Child (i.e., under age 26), will forfeit to the Plan.

5. How will mandatory transfer of accrued leave, pursuant to collective bargaining, affect my benefits?

Your Local can negotiate for mandatory transfer of accrued sick and/or vacation leave to the IAFF MERP either annually or at retirement. Individual Employees cannot elect whether to transfer and what percentage of accrued leave to transfer to the IAFF MERP. If transfer of accrued leave (or other employer Lump Sum Transfers) is included in your Local's Collective Bargaining Agreement, then you have the following options related to use of those funds within IAFF MERP:

- Election to Credit Leave Transfer to an Individual Account or Convert Lump Sum Transfer to Active Service Units. Upon receipt of an accrued leave transfer (or other Lump Sum Transfer) for an Employee, the Trust Office will send the Employee a form to elect whether to convert the leave transfer into Active Service Units, or to add the leave transfer (or other Lump Sum Transfer) to the Employee's Individual Account.

- An Employee may elect conversion only upon occurrence of the events listed below:
    - Receipt of a new Lump Sum Transfer;
    - At retirement or separation from employment;
    - During the annual investment selection period while employed and receiving contributions to the Plan, i.e., not after retirement and not during periods of re-hire without contributions.

  The rules vary for each event as to the amount of funds you can convert and whether you can receive years of Active Service (for attaining eligibility for a monthly benefit) in addition to Active Service Units (for increasing your Monthly Benefit Level). See below for the details related to each event.

    - Conversion election upon receipt of a new Lump Sum Transfer. An Employee may convert the full amount of a Lump Sum Transfer into Active Service Units. An Employee may *not* convert a portion (i.e., less than the full amount) of the Lump Sum Transfer into Active Service Units. The Employee must make this election within the deadline provided in the notice that is received from the Trust Office. The Trust Office will implement the default selection (see below) if you fail to make a timely election on a Lump

Sum Transfer. An active Employee will *not* earn additional years of Active Service toward eligibility for monthly benefits for conversion at this event. The Employee *cannot* convert the current Individual Account balance at this event.

- Conversion election upon retirement/separation from employment. An Eligible Retiree, or Eligible Retiree with Short Service, that receives a Lump Sum Transfer upon retirement/separation from employment, and/or that has an Individual Account balance upon separation from employment, may elect to convert all *or a portion* of such transfer, or all *or a portion* of their Individual Account balance into Active Service Units (i.e., the Eligible Retiree can elect to convert less than the full amount of the Individual Account balance or transfer). The Eligible Retiree must make this election within the deadline provided in the notice that is received from the Trust Office. The Trust Office will implement the default selection (see below) if you fail to make a timely election on a new Lump Sum Transfer that is received upon retirement/separation from employment.

  An Eligible Retiree with Short Service cannot use any Individual Account balance resulting from transfer of Pooled Contributions for conversion to Active Service Units. (These Pooled Contributions have already been used to earn Active Service Units during your active employment.)

- Conversion election during annual investment selection period. An active Employee, i.e., receiving Contributions, may elect to convert the full amount of the Individual Account balance during the annual investment selection period. The annual investment selection period typically occurs during April of each year. Any conversions into Active Service Units made during the annual investment selection period must be for the entire amount of the Individual Account balance (i.e., you cannot elect to convert less than the full amount of the Individual Account balance during the annual investment selection period). The Employee will *not* earn additional years of Active Service toward eligibility for monthly benefits for conversion at this event. Retirees cannot convert their Individual Account balance during the annual investment selection period; after the election period has expired following retirement or separation from employment, your conversion rights are expired.

The Trust Office will communicate the deadline to elect conversion in the notice or information packet related to the event.

If the Employee or Eligible Retiree timely submits an election form, the leave transfer (or other Lump Sum Transfer) and/or Individual Account balance is converted to Active Service Units based upon the current Lump Sum Transfer Conversion Table in effect on the date that the Trust Office receives the conversion election form. Elections are irrevocable after the Trust Office has received your completed, signed election form.

- Use of Leave Transfer (or Other Lump Sum Transfer), or Individual Account Balance to Make COBRA Contributions. If the Employee has experienced a COBRA qualifying event, such as termination or retirement from employment or reduced hours, then the Employee also has the option to use some or all of the accrued leave transfer (or other Lump Sum Transfer) and/or Individual Account balance (except for any Individual Account balance resulting from transfer of Pooled Contributions) to make COBRA contributions to purchase additional ASUs at $25 per ASU. The Employee can elect this option by selecting to pay the COBRA contributions with leave transfer or Individual Account balance on the COBRA Election Form received from the Trust Office. The COBRA Election Form must be mailed (postmarked) or delivered to the Trust Office within 60 days of the date on the COBRA Election Form. After the COBRA contributions from leave transfer (or other Lump Sum Transfer) are completed, any remaining amount of leave transfer (or other Lump Sum Transfer) is subject to the election between credit to the Individual Account or conversion to ASUs, as described above.

- Default Selection for Receipt of New Leave Transfer (or Other Lump Sum Transfer). If the Employee does not timely return a completed, signed election form to the Trust Office within the time period indicated in the notice or information packet, the Trust Office will implement the default selection for the new Lump Sum Transfer funds based upon the Employee's age on the day after the deadline for delivery of the election form.

    - If the Employee is 40 years or older, the Trust Office will credit the leave transfer (or other Lump Sum Transfer) to an Individual Account for the Employee.
    - If the Employee is under age 40, the Trust Office will use the current Lump Sum Transfer Conversion Table to convert the leave transfer (or other Lump Sum Transfer) to Active Service Units.
    - The default selection is irrevocable on the day after the election form deadline.

- The default selection does not apply to the opportunity to convert the Individual Account balance.

Note that the Leave Conversion Table may be updated from time to time. Please contact the Trust Office to request a copy of the latest conversion table.

6. Can I select the investments for my Individual Account?

Yes, effective August 1, 2023, the Trustees have implemented investment options for the investment of Individual Accounts. You are only permitted to select an investment option once annually and when your Individual Account is first established. The rules for investment selection and the descriptions of the investment Portfolio options are included in the "Informational Bulletin for Individual Account Investment Selection," which is included in a packet of documents and is distributed to you when your Individual Account is first established and annually during the annual investment selection period. Please also see Q&A 5 for the circumstances in which you can convert your Individual Account balance into Active Service Units.

If you did not receive the Bulletin or need another copy, please contact the Trust Office. The Trustees reserve the right to change or terminate the investment options for Individual Accounts at any time. We expect the first annual investment selection period from IAFF MERP to be in April 2024 with changes to investment selection effective on July 1, 2024. You must return the Investment Selection Form to the Trust Office by the deadline on the form or your Individual Account will be invested in the default investment selection. See the current Informational Bulletin for description of default investments.

Investment returns are not allocated to an Individual Account with a balance of $1,000 or less.

7. What items are credited to or debited from the Individual Account?

The following items are credited to your Individual Account balance:

- Lump Sum Transfers from employers, including leave transfers and Option C transfers for San Diego firefighters, unless conversion to Active Service Units is elected;
- Retiree Contributions, i.e., mandatory employer payments made for each retiree in a specified class pursuant to a collective bargaining agreement;

- Surplus Leave Benefits for a Surviving Spouse with termination of benefits prior to receipt of the value of a leave transfer (Q&A 25);
- Contributions for the Surviving Spouse of a Line of Duty Death who elects an Individual Account instead of a monthly benefit (Q&A 14, 16);
- The sum of any Lump Sum Transfers received for Eligible Retiree with Short Service (Q&A 4);
- Investment earnings and losses (generally credited monthly based on the monthly return received by your investment selection in the prior month), as long as the balance is above $1,000;
- Administrative expenses are deducted from the balance for the costs of administering the Individual Accounts;
- Conversions of the Individual Account balance to Active Service Units will reduce the Individual Account balance;
- Benefit payments are deducted following an Eligible Retiree's claim, including when an Eligible Retiree's claim exceeds his or her Monthly Benefit Level;
- Contributions for the Surviving Spouse of a Line of Duty Death who elects an Individual Account benefit instead of a monthly benefit (Q&A 14, 16); and
- Contributions for an Eligible Retiree with a Disability Pension Benefit who elects an Individual Account benefit instead of a monthly benefit (Q&A 2).

Note Regarding Administrative Expenses Charged to Individual Accounts. All plan participants share the cost of operating the IAFF MERP (e.g., auditing, claims administration, insurance, legal advice, etc.). The Pooled Account generally pays all operating expenses. However, Account Beneficiaries with an Individual Account who are not currently participating in the Pooled Account (either through current monthly contributions or monthly benefits) are required to pay an administrative maintenance fee deducted from the Individual Account Balance to pay for their proportionate share of operating expenses of the IAFF MERP. Based on estimated costs to operate the IAFF MERP, the Trustees have set the administrative maintenance fee for Limited Beneficiaries who do not have any participation in the Pooled Account, at $8 per month (effective August 1, 2023). Other Account Beneficiaries with an Individual Account, who are also currently participating in the Pooled Account, are required to pay and administrative maintenance fee that reflects the extra costs of administering Individual Accounts. These Account Beneficiaries with an Individual Account, who are also participating in the Pooled Account, will be assessed an administrative maintenance fee of $3 per month for the cost

of maintain the Individual Account (effective August 1, 2023).[5] The Trust Office will show the administrative maintenance fee as a line item in the Individual Account transactions on the IAFF MERP web portal.[6]

8. What items are credited to the Accumulated Benefit?

The following items are credited to the Accumulated Benefit and do not earn interest or investment returns:

- Unused monthly benefits (See Q&A 17); and
- Contributions made on behalf of an Employee who does not make the minimum years of Active Service for monthly benefit eligibility, i.e., Eligible Retiree with Short Service (Q&A 4).

9. What are the benefits from the Plan?

After meeting the eligibility requirements, Eligible Retirees are entitled to reimbursement toward the payment of Covered Expenses, which generally consist of health insurance premiums and medical expenses paid and incurred by the Employee after the Employee retires and becomes eligible for benefits under IAFF MERP. Reimbursement payments are subject to proper and timely submission of benefit claims. The amount of the reimbursement payment for a Beneficiary who qualifies for the lifetime[7] stream of benefit payments is limited to the Beneficiary's Monthly Benefit Level. See Q&A 11. However, for an Employee who does not earn the five years of Active Service, his/her benefits are limited to his or her Accumulated Benefit and/or Individual Account. See Q&A 4.

Cost Sharing. It is important to remember that IAFF MERP reimburses toward the cost of Covered Expenses, but your Monthly Benefit Level, Individual Account, or Accumulated Benefit may not cover the entire amount of the Covered Expense. If your Monthly Benefit Level, Individual Account, and/or Accumulated Benefit does not cover the entire cost of your Covered Expense, you will be responsible for the balance of any Covered Expense.

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[5] This is because participants in the Pooled Account pay their portion of the IAFF MERP operating expenses through payment of operating expenses from the Pooled Account. However, there are extra administrative expenses to operate Individual Accounts that participants in the Pooled Account, who do not have an Individual Account, are not required to subsidize.

[6] The Trustees have authority to adjust the administrative maintenance fee up or down at any time based upon the actual operating expenses of the IAFF MERP. The Trustees also have the authority to determine whether to charge the administrative maintenance fee monthly, quarterly, or annually.

[7] See footnote 2.

Benefits Limited to Reimbursement of Covered Expenses. Note that IAFF MERP is not allowed under federal law to distribute unrestricted cash; it can only reimburse for tax-deductible and verified medical expenses that meet the definition of "Covered Expense." This also means that you cannot rollover your benefit payments into an Individual Retirement Account (IRA) or other retirement plan.

10. What type of medical expenses will be reimbursed by IAFF MERP?

The following medical expenses are considered Covered Expenses, and will be reimbursed by IAFF MERP:

- Premium or contribution payments for coverage under medical, dental, or vision insurance that qualify as medical care under Internal Revenue Code ("Code") Section 213(d), including Medicare supplemental plans. As of January 1, 2024, the Plan will allow for reimbursement of premiums paid with pre-tax-income.[8] However, in this circumstance the IRS requires the Plan to issue a Form 1099 to the Plan participant to show that he or she has received taxable income from the Trust. The claim form requires that you request taxable benefit payment in order to receive reimbursement of premiums paid with pre-tax income.

- Medical expenses excludable from gross income under Code Section 213(d), i.e., costs for diagnosis, cure, mitigation, treatment, or prevention of disease or injury, including insulin, but not including other non-prescribed drugs. For a list of examples of deductible and nondeductible medical expenses, see IRS Publication 502, which you can find at **www.irs.gov/pub/irs-pdf/p502.pdf**

- Premium payment for long-term care insurance as qualified for tax deduction under Code Section 7702B.

See Plan Section 1.9 for a full definition of Covered Expenses.

Please note that a payment to a health care sharing ministry, such as Samaritan ministries, Christian Care Ministry's Medi-Share program, or Christian Healthcare Ministries, does NOT qualify as a Covered Expense. This is because a payment, contribution or gift to a health care sharing ministry does not fit within the IRS rules for a tax-deductible insurance

[8] For example, your spouse's employer deducted the premium from your spouse's salary or wages prior to calculating the spouse's taxable income (like from a cafeteria plan). Thus, the amount of your spouse's income deducted for premium payment will not be reported on a W-2 form and will not be taxable income to you or your spouse.

premium or medical expense. The Trust must comply with these rules in order to preserve the tax benefits of IAFF MERP for all participants.

If you have a question about whether an expense will qualify for reimbursement, you may contact the Trust Office at (425) 367-0743.

11. How is my Monthly Benefit Level calculated?

An Eligible Retiree's Monthly Benefit Level is determined by the number of Active Service Units he/she has accrued during his/her employment (or has accrued because of conversion of leave transfer, other Lump Sum Transfer, or Individual Account balance) and the Unit Multiplier that is operative, as set forth in Appendix B (at the end of this Summary).

- An Employee earns Active Service Units for each Contribution to the Plan. Each monthly Contribution of $25 is equal to one Active Service Unit. For example, if your Local's monthly Contribution rate is $75, you will earn three Active Service Units per month.

- The Unit Multiplier is a factor set by the Trustees, with actuarial advice, which allows the Plan to pay benefits for the lifetime of all Eligible Retirees who qualify for the lifetime stream of benefits.[9]

After retirement, the Trust Office will calculate your Monthly Benefit Level by the following methodology (as further described in Plan Section 3.2, and illustrated in Appendix A of the Plan and attached hereto):

- Determine your total number of Active Service Units, and

- Multiply your total number of Active Service Units by the Unit Multiplier that is operative, as set forth in Appendix B (at the end of this Summary).

From time to time, the Trustees will determine the Unit Multiplier, as defined in Plan Section 1.34, with the assistance of professional actuarial advice. You may contact the Trust Office to find out the current Unit Multiplier, which may increase or decrease from time to time.

[9] See footnote 2.

12. What is the difference between "Active Service" and "Active Service Units" (or ASUs)?

- Active Service reflects periods of employment when your employer transfers Contributions to the Plan on your behalf. Your length of Active Service is one of the factors that determine your eligibility for monthly benefits as an Eligible Retiree.

- "Active Service Units" reflect the number of $25 Contributions made on your behalf to the Plan. The number of Active Service Units is a factor in determining the amount of your Monthly Benefit Level.

13. Why are there differences in the Monthly Benefit Level between participants?

An Eligible Retiree's Monthly Benefit Level is calculated by the methodology described in Q&A 11 above. Each Eligible Retiree's Monthly Benefit Level will be affected by the number of Active Service Units earned by that Employee over his or her career (and by any conversions of Lump Sum Transfers and/or Individual Account balance to Active Service Units). An Employee earns one Active Service Unit for each monthly Contribution of $25 to the Plan on his or her behalf. The monthly Contribution rate is negotiated by the Employee's bargaining unit. For example, a monthly Contribution rate of $75 will provide to each employee in that bargaining unit three Active Service Units per month, whereas a monthly Contribution rate of $100 will earn four Active Service Units per month. Thus, Eligible Retirees from different Locals will have different Monthly Benefit Levels, depending upon what Contribution rate their Local selected and negotiated, or whether accrued leave (or other Lump Sum Transfer) was transferred to the Plan and converted to ASUs. Even within the same Local, Monthly Benefit Levels may vary based on the Employee's period of Active Service in the Plan, or how much leave (or other Lump Sum Transfer) he/she may have contributed to the Plan.

14. Will my Monthly Benefit Level remain constant for my lifetime?

The Trustees reserve the right and power to adjust the Monthly Benefit Levels and/or the Unit Multiplier up or down. Such adjustments may apply to some or all current and/or future Beneficiaries. This could occur, generally, after the Trustees conduct a periodic review of the investment and demographic experience of the Plan. That is, if the investment returns or the demographic experience (e.g., life span, retirement age, etc.) are significantly different than projected, then the Unit Multiplier may be adjusted up or down.

Choices on Retirement: Monthly Benefit Level Options.

Application for Your Benefits. You should receive a retirement packet of forms within two (2) weeks of your employer's notification to the Trust Office of your retirement or separation from employment. Eligible Retirees who become eligible *on or after* August 20, 2014, may select from four different Monthly Benefit Level options at the time that they first apply for benefits. Option 1 provides a constant Monthly Benefit Level for your lifetime using the basic benefit level formula provided above (See Q&A 11). Each of the next three options allows you to select a higher Monthly Benefit Level immediately after you first apply for IAFF MERP benefits until age 65 and a reduced Monthly Benefit Level after age 65. Option 4 has the highest Monthly Benefit Level before age 65 and the lowest Monthly Benefit Level after age 65.

Specifically, the four options for an Eligible Retiree are as follows:

- OPTION 1: A constant Monthly Benefit Level for life. Option 1 provides the highest Monthly Benefit Level after age 65.

- OPTION 2: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Option 1. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than the Option 1 Monthly Benefit Level that he/she would receive after age 65.

- OPTION 3: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Options 1 and 2. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than either the Option 1 or 2 Monthly Benefit Levels that he/she would receive after age 65.

- OPTION 4: A Monthly Benefit Level until age 65 that is higher than the Monthly Benefit Level prior to age sixty-five under Options 1, 2, and 3. The Monthly Benefit Level decreases after the Eligible Retiree attains age 65 and is lower than the Options 1, 2, or 3 Monthly Benefit Levels that he/she would receive after age 65. Option 4 provides the highest Monthly Benefit Level before age 65, but results in the lowest Monthly Benefit Level after age 65.

In Options 2-4, your Monthly Benefit Level will be reduced at age 65, with Option 2 having the lowest percent reduction at age 65 and Option 4 having the highest

percent reduction at age 65. You will be asked to select from among these options when you commence your benefits. Once you make your selection, you cannot change that selection and the selection will apply to any survivor's benefit as well.

Your selection will depend upon your own unique circumstances. Factors to consider include, but are not limited to, your financial needs and goals, as well as those of your beneficiary(ies), sources of income in your retirement, and your health and age at retirement.

- Default Option. If you do not make a choice within the deadline included in the retirement packet, then you will automatically be defaulted into Option 1, which is the constant Monthly Benefit Level for life.

As with all decisions related to retirement, we suggest you consult with an independent financial advisor, prior to making this decision. Although it may seem like a good idea to have a higher amount right away when you retire until age 65, we suggest you bear in mind the following:

- You may need the money more after age 65;
- You may not be able to work as much after age 65;
- Medigap policies (which many retirees purchase to supplement coverage under Medicare) may increase in price;
- You may live a long time after age 65, and a higher benefit could come in handy.

If you die before you make a selection (and before the default option is implemented), your Beneficiary will have the opportunity to select from Options 1-4 for calculation of the Monthly Benefit Level and to select the length of the Surviving Spouse benefit, i.e., a benefit that ends at Medicare eligibility or a lifetime benefit (See Q&A 16). The Surviving Spouse of a Line of Duty Death has the option of a Monthly Benefit Level (See Q&A 16) or an Individual Account benefit, i.e., to elect to have the Contributions made on behalf of the Employee added to an Individual Account.

The Trust Office will provide you information with the specific amounts in each Option when you reach retirement age and apply for benefits from the Plan. For examples illustrating the four options, see Appendix D to the Plan, attached hereto.

15. How long will benefits continue for my Surviving Spouse and Children?

Regular Beneficiaries, who retire or terminate employment on or after March 15, 2023, have the choice at retirement of whether their Surviving Spouse will have a monthly benefit for the spouse's lifetime or until the spouse attains Medicare Eligibility. If the Eligible Retiree elects a lifetime Surviving Spouse benefit, the Eligible Retiree's Monthly Benefit Level (under all Options 1-4) will be actuarially reduced. If the Eligible Retiree and spouse elect a Surviving Spouse benefit that terminates at Medicare Eligibility, the Eligible Retiree's Monthly Benefit Level (under all Options 1-4) will be higher than if the lifetime Surviving Spouse benefit is elected (i.e., the actuarial reduction is not applied).

The Trust Office will send you a retirement packet that quotes your Monthly Benefit Level under each Option 1-4 with and without a lifetime Surviving Spouse benefit. If you are electing a Surviving Spouse benefit terminating at Medicare Eligibility and you are married, your spouse must sign the Election Form in front of a notary public. If you do not return the Election Form to the Trust Office by the deadline stated in the packet, or you return the packet but do not make a valid election on Surviving Spouse benefits, you will receive the default election, which is a lifetime Surviving Spouse benefit, and your Monthly Benefit Level will be actuarially reduced accordingly.

If the Employee attained age 53 prior to death, the Surviving Spouse and Child benefits commence the month after the death of the Eligible Retiree or Employee. The Surviving Child, or his or her legal guardian, is entitled to submit his or her own claims for benefits if there is no Surviving Spouse. If the Employee did not attain age 53 prior to his or her death, then the Surviving Spouse and/or Child shall be entitled to benefits for 24 consecutive months starting the month after the death (or he/she may elect a later start date). After 24 consecutive months have passed since the benefit start date (whether benefits are paid each month or not), the benefit payments will be suspended until the date that the Employee would have attained age 53. If that date occurs during the 24-month period of benefit eligibility, then the benefit payments will not be suspended. This suspension of benefits does not apply to benefits of a Surviving Spouse of an Eligible Retiree who had an actuarially reduced Monthly Benefit Level due to starting benefit payments prior to age 53 (for Employees who are eligible for Regular Pension Benefits or Disability Pension Benefits prior to age 53). In this circumstance, the Surviving Spouse benefit payments will start the month after the death of the Eligible Retiree calculated based upon the Eligible Retiree's actuarially reduced Monthly Benefit Level. If the Employee suffered a Line of Duty Death, then the benefit payments will also not be suspended after 24 months. Line of Duty Death is defined as a death that the applicable IAFF District Vice President has approved as a line of duty death. See Plan Section 1.17.

Benefits from a Surviving Spouse's or Surviving Child's Accumulated Benefit or Individual Account cease when the Surviving Spouse or Surviving Child has exhausted his or her Accumulated Benefit or Individual Account balance, or at the time that the Surviving Children no longer meet the definition of Child (i.e., under age 26).

16. What will the Monthly Benefit Level be for my spouse and children in the event of my death?

The Monthly Benefit Level for a Surviving Spouse is equal to 50% of the Monthly Benefit Level of the deceased Eligible Retiree. If there is no Surviving Spouse, the Monthly Benefit Level for Surviving Children will be 50% of the Monthly Benefit Level for the deceased Eligible Retiree (to be divided among the Children). The deceased Eligible Retiree's Monthly Benefit Level is determined based upon the Option and Surviving Spouse benefit length that he or she selected at eligibility.

If the Employee or Eligible Retiree died before selecting an Option and/or Surviving Spouse benefit length, and before the deadline for election resulted in a default election, the Trust Office will send the Surviving Spouse a retirement packet offering the Surviving Spouse the right to make an election among Options 1-4 and the right to make an election of Surviving Spouse benefit length. A Surviving Spouse of an Employee who suffered a Line of Duty Death may elect among the same Options 1-4 and Surviving Spouse benefit length; or elect to credit the total Contributions made on the Employee's behalf to an Individual Account. Any Surviving Spouse who does not make an election within the time period provided in the retirement packet will receive a Monthly Benefit Level calculated based upon the default of Option 1 with a lifetime Surviving Spouse benefit.

Additionally, any Accumulated Benefit or Individual Account balance remaining upon a Beneficiary's death will be available to the Surviving Spouse and/or Surviving Children.

A Surviving Spouse or Surviving Child also has the option to use his or her monthly benefits to reimburse the Covered Expenses incurred by a deceased Beneficiary prior to the Beneficiary's death.

Children include the natural children, adopted children, and stepchildren of the Eligible Retiree who are under the age of 26. Children who are over the age of 26 and who are legally dependent upon the Eligible Retiree and determined to be permanently and totally disabled by the Social Security Administration are also eligible Beneficiaries at any age. Spouse includes all lawful spouses, same or opposite sex. Surviving Spouse means a

lawful spouse to whom the deceased Employee or Eligible Retiree had been married for at least 12 months on the date of his or her death.

Note that the Surviving Spouse or Surviving Child of an Eligible Retiree who did not qualify for the lifetime stream of monthly benefits will not be entitled to a monthly benefit. Instead, such Surviving Spouse or Surviving Child will be entitled to reimbursement of Covered Expenses as an Account Beneficiary from the Individual Account balance or from the remaining Accumulated Benefit following the death of the Eligible Retiree. The benefits will continue until the Accumulated Benefit and/or Individual Account balance has been exhausted. The Surviving Spouse and/or Surviving Child of an Employee who suffered a Line of Duty Death has the option to elect a Monthly Benefit Level for benefit payments or an Individual Account equal to the total Contributions made on the deceased Employee's behalf (without any allocation for prior investment returns thereon) plus any mandatory transfer of sick and/or vacation leave.

Please note: The Plan provides benefits for legal spouses, who are either opposite or same sex. Due to the cost of compliance with federal tax regulations regarding domestic partners, the Plan does not provide benefits for domestic partners or surviving domestic partners.

17. What happens if I don't use my full Monthly Benefit Level each month?

If an Eligible Retiree does not use his/her entire Monthly Benefit Level for one month, then the unused amount of his/her Monthly Benefit Level, including unused benefits from periods when an Eligible Retiree's monthly benefits are suspended due to return to employment with a Participating Employer, will be added to what is known as the Accumulated Benefit (see Plan Section 1.3 for the definition of Accumulated Benefit). The Accumulated Benefit represents a total dollar amount of benefits that the Eligible Retiree and his/her surviving Beneficiaries can use for reimbursement of Covered Expenses in addition to his/her Monthly Benefit Level and/or Individual Account.

Please note that the Accumulated Benefit does not earn interest and it is available until the Accumulated Benefit amount is exhausted, i.e., there is no age requirement for Accumulated Benefit reimbursements, except that a Surviving Child must qualify as a Child (i.e., under age 26 or disabled, as defined in the Plan).

18. What happens if I have high monthly Covered Expenses in one month? Can I get the excess Covered Expenses reimbursed in a later month?

Yes. If you submit a claim for Covered Expenses that exceeds your Monthly Benefit Level plus Accumulated Benefit and Individual Account, the Trust Office will reimburse you for those excess expenses in a subsequent month when you have not submitted claims sufficient to use all of your Monthly Benefit Level. Monthly reimbursement cannot exceed the Monthly Benefit Level plus the Accumulated Benefit and Individual Account balance of the Beneficiary. For example, if your Monthly Benefit Level is $200 and you submit a claim for a Covered Expense of $300, then you would receive payment for that claim at $200 in the first month, and $100 in the next month (provided your Accumulated Benefit balance is $0). If you submit claims of $300 in the first month, $200 in the second month, and no claims in the third month, then you will receive reimbursement for the excess $100 in the third month (provided your Accumulated Benefit balance is $0). If you have an Accumulated Benefit of $100 because you only used a portion of your prior Monthly Benefit Level, then a claim of $300 would be reimbursed $200 from your Monthly Benefit Level and $100 from your Accumulated Benefit in the first month – leaving a new Accumulated Benefit of $0. Any excess Covered Expense is carried over and reimbursed in a month when you have not submitted claims equal to your Monthly Benefit Level plus Accumulated Benefit and Individual Account.

This claim carryover from month to month provides an option for Eligible Retirees to submit proof of premium payment less frequently that monthly. If the proof of premium payment shows payment of a premium amount that exceeds the Eligible Retiree's monthly Benefit Level, the Eligible Retiree may be able to wait a couple of months before submitting another proof of premium payment. For example, if an Eligible Retiree's monthly Benefit Level is $300 and he/she submits proof of payment of a monthly premium of $1,800, the Eligible Retiree would receive reimbursement of that premium for up to 6 months without submitting another proof of premium payment. After the $1,800 is fully reimbursed, the Eligible Retiree will need to submit another proof of premium payment in order to continue receiving his/her benefit payment monthly.

19. How do I submit my claims for benefits?

To present a claim for benefits under this Plan, a Beneficiary must submit a claim on a form approved by the Trustees to the Trust Office no later than March 31st of the year following the year in which the Beneficiary paid the Covered Expense. For example, all Covered Expenses which the Beneficiary paid in the calendar year 2023 must be submitted for reimbursement no later than March 31, 2024. (While the Trust Office may waive the

deadline for good cause shown, please do not assume that any circumstances will constitute good cause.) The Plan encourages you to submit claims and receive reimbursements throughout the plan year.

Please note that, in accordance with the rules of the Plan, the Trust Office requires that you provide third-party documentation of the type and amount of the expense and proof of payment by a Beneficiary before issuing a reimbursement benefit payment. Beneficiaries may contact the Trust Office to request an approved claim form. You must submit your claim to the Trust office at:

IAFF Medical Expense Reimbursement Plan
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Fax: (866) 676-1530
Email: **iaff-merp@vimly.com**
Website: **https://iaff-merp.simon365.com**

Documentation Needed For Each Claim.

For medical expense claims that are not insurance premium payments, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates that medical services or supplies were provided (which date must be prior to submission of the claim);
- A description of the medical services or supplies, which must qualify as a tax-deductible expense;
- Proof of the Beneficiary's payment of the medical expense, which can include one of the following or other proof approved by the Board of Trustees:

    - Canceled check drawn to the name of the medical services or supplies provider, bank statement showing check payment, or credit card statement showing payment;
    - Copy of confirmation of electronic payment to the medical services or supplies provider; or
    - Receipt for payment from the medical services or supplies provider.

For insurance premium payment claims, at least annually, you must submit a completed, signed claim form supplied by the Trust Office, accompanied by documentation from an independent third party, which includes the following:

- The dates of coverage for insurance premiums.
- A description of the insurance premiums, i.e., type of insurance provided.

The annual claim form will advise the Trust Office of the premium amount that you will be paying for the upcoming year, and the amount that you are claiming for reimbursement from the Plan for those monthly premiums. If you have a change in premium amount before the next annual claim form collection date (e.g., due to eligibility for Medicare or adding/deleting a family member to/from your policy), then you need to submit a new claim form to the Trust Office. If you want reimbursement of premiums that you paid with pre-tax income, e.g., premiums deducted by an employer from your spouse's wages, you must indicate this request on the claim form and acknowledge that you want a taxable benefit payment. Please contact the Trust Office for a claim form or download a copy on the Trust's website.

Documentation Needed for Each Premium Reimbursement (Monthly). To receive reimbursement of recurring monthly premiums (except for Medicare premiums deducted from Social Security payments), you must also submit the following information each time you want reimbursement. This is in addition to the annual documentation with the claim form described above. Generally, you must submit proof that a Beneficiary has paid the premium each month, and the payment amount must match the amount claimed on your annual claim form.

Examples of proof of payment are: cancelled check to insurance carrier, insurance carrier statement showing premium paid, pension statement showing deduction of premium, bank statement or credit card statement showing premium payment amount.

You can send proof of your payment monthly, or you can batch proof of payment documentation less frequently, as long as you comply with the annual claims deadline. However, you will only be reimbursed for months for which the Trust Office has received your proof of payment. If your premium amount changes before the next annual verification request from the Trust Office (most likely due to Medicare eligibility), you must submit the annual claim form and third-party insurance documentation of your premiums.

Claim Payments Must Reimburse Prior Covered Expense Payments. All reimbursement payments must reimburse your prior Covered Expense payment, not a prospective payment. If you request reimbursement of insurance premiums, you may be reimbursed in the month following the month in which you paid the insurance premium depending upon the date in the month that you pay your premiums.

You may *not* submit claims for medical expenses that have been paid, or you expect to be paid, by another source, such as Medicare, a supplemental health insurance plan, or a Health Savings Account (HSA). If such double coverage is discovered, the Trust may pursue recoupment, penalties and interest against you.

In the event the Trust overpays you for benefits, the Trust Office will deduct the overpaid amount from subsequent benefit payments until the Trust has recouped the total overpaid amount, or the Trust may seek repayment of the total overpaid amount from you directly to the Trust.

Beneficiaries may also make a written request to the Trust Office for an eligibility determination, clarification of rights under the Plan or enforcement of rights under the Plan. Details for claim submission and appeal of claim denial are set forth in Section 3.6 and Section 4 of the Plan. Note that the appeal procedures apply to any complaint that you may have regarding the Plan, i.e., not just a claim denial.

20. What are the appeal procedures for denied claims and other complaints?

To appeal a claim denial, eligibility determination or response on clarification or enforcement of Plan rights, a Beneficiary must submit a written request to the Trust Office within 181 calendar days after the date of the Trust Office's notification of denial of benefits or determination. An appeal is considered submitted and filed with the Trust Office on the date that it is received/date stamped at the Trust Office. The Board of Trustees will hold a hearing on the appeal, and the Beneficiary will be entitled to present his or her position and any evidence in support of his or her appeal at the hearing. The Board of Trustees will then make a decision affirming, modifying or setting aside the Trust Office decision.

The Trustees have broad discretionary authority to determine eligibility for benefits, to grant or deny claims for benefits, to interpret and apply the provisions of this Plan, or of their own motions, resolutions and administrative rules and regulations, or of any contract, instruments, or writings they may have entered into or adopted. The Trustees' decision is binding and conclusive.

You must first exhaust the internal appeal procedures of the Plan before filing a claim in court.

21. What is a Qualified Domestic Relations Order ("QDRO") or Qualified Medical Child Support Order ("QMCSO") and who pays the costs of evaluating and implementing a QDRO or QMCSO?

The parties to a divorce proceeding can divide the Monthly Benefit Level, Individual Account, and Accumulated Benefit earned during the marital period, but that division can only be implemented pursuant to a valid QDRO, as determined by the Plan. The Plan reserves the right to determine whether a domestic relations order is a QDRO. The Trustees have adopted procedures and a model QDRO for this purpose.

Upon notice of the intent to secure a QDRO, the Plan will segregate 50% of the community property benefits that the Employee earned during the marriage, and set those funds aside for potential future payment to the Alternate Payee (Employee's ex-spouse) after the QDRO is approved. The Plan will segregate the Alternate Payee's share of the Monthly Benefit Level, Individual Account, and Accumulated Benefit for no more than 18 months from the date that this segregation begins. If the Alternate Payee obtains a QDRO prior to the end of the 18-month period, the Plan will pay the Alternate Payee his or her share of the segregated benefits in accordance with the Plan's rules. If the Alternate Payee fails to obtain a QDRO within this 18-month period, the Plan will pay the segregated benefits to the Employee in accordance with the Plan's rules and will stop segregating future benefits.

A former spouse of an Employee under a QDRO, known as an Alternate Payee, may commence receiving his or her portion of the Monthly Benefit Level, Individual Account, and Accumulated Benefit at a time specified in the QDRO, but no earlier than the earliest date that the Employee would be eligible to begin receiving benefits, if the Employee ceased employment with the Participating Employer on such date. An Alternate Payee's monthly benefits will not be suspended if the Employee returns to employment with a Participating Employer. An Alternate Payee's monthly benefits will terminate on the first of the month following the Alternate Payee's death.

The Surviving Children of the marriage of the Eligible Retiree and Alternate Payee may begin receiving benefits starting the month after the death of the Alternate Payee and such Surviving Children's benefits will terminate on the date the last Surviving Child no longer meets the definition of Child or the date of death of the last Surviving Child.

Beneficiaries can obtain from the Trust Office, without charge, a written explanation of such procedures and a copy of the model QDRO with their benefit information inserted, including the actuarially adjusted Monthly Benefit Level of the ex-spouse of the

Participant. (You may also submit your own proposed QDRO, but it will be subject to review and approval by the Plan.)

A QMCSO is an order issued by a state court or agency that may require a health plan subject to ERISA to provide health benefits to children.

The Eligible Retiree and ex-spouse pay for the costs of dividing benefits pursuant to a QDRO or QMCSO issued in divorce proceedings. Because these services only benefit the beneficiaries involved, the Trustees have directed the Trust Office to charge the costs of that process to the Eligible Retiree and ex-spouse as a deduction applied to the Monthly Benefit Level, Individual Account, or Accumulated Benefit. The costs may vary from one divorce situation to another and may be spread amongst several months of benefit payments.

22. If my appeal is denied, is there a time limit for filing a lawsuit against the Plan for review of the denial?

Yes. The time limit for a Beneficiary to bring action in federal court pursuant to ERISA Section 502(a) is no later than one year after the exhaustion of administrative remedies (i.e., the appeal process in Q&A 20), which means the date of the written decision by the Board of Trustees on an appeal of a denied benefit claim or other complaint. You must first exhaust the internal appeal procedures of the Plan before filing a claim in court. The Board of Trustees has broad discretionary authority to interpret the terms of the Plan and to grant or deny claims for benefits, and the Trustees anticipate that an action brought in federal court challenging the Trustees' exercise of their discretionary authority will be subject to a deferential standard of review.

23. What is the Plan Year?

The Plan Year runs from July 1 through June 30.

24. What should I do if I change my address, spouse or children?

You should contact the Trust Office with any changes you experience that might affect your benefits or rights from the Plan, including but not limited to, the following:

- Changes in your mailing address, cell phone number and personal email address;
- Changes in your employment status (e.g., retirement, lay-off, or reduction in hours);
- Changes in your spouse (e.g., divorce, marriage, or death); and

- New children (e.g., by birth or adoption).

It is important for the Trust Office to have an up-to-date record of any personal information that might affect your benefits and rights under the Plan. Failure to notify the Trust Office of such changes may result in the loss or delay of benefits under this Plan.

25. What are the circumstances that may result in ineligibility or denial of benefits; or amendment or termination of the Plan?

Circumstances which may result in disqualification, ineligibility, denial, or the loss of benefits include failure by the Employee or employer to make required Contributions, failure to properly submit expense receipts, failure to meet the eligibility requirements, death, or termination of the Plan. Also, note the following events will cause termination of benefits:

- An Eligible Retiree's benefits under this Plan will be suspended upon return to employment with a Participating Employer; provided, however, that benefit payments will resume after the Eligible Retiree ceases all employment with Participating Employers.

- An Eligible Retiree's benefits under this Plan will terminate upon his/her death.

- A Surviving Spouse's benefits under this Plan will terminate on the date of death of the Surviving Spouse, unless the Eligible Retiree elected a Surviving Spouse benefit terminating at Medicare Eligibility. However, there is one exception to this termination at Medicare Eligibility in regard to Lump Sum Transfers , as follows:

    - Transfer of sick/vacation leave into Plan – Surplus Leave Benefits. If the former employer of the Eligible Retiree transferred a Lump Sum Transfer, such as accrued sick or vacation leave, into the Plan, the Eligible Retiree elected to convert that leave into Active Service Units, and the Eligible Retiree elected a Surviving Spouse benefit terminating at Medicare Eligibility, there may be a Surplus Leave Benefit for the Surviving Spouse on the Eligible Retiree's death. In this circumstance, the Trust Office will determine whether the Retiree received the full value of his/her sick leave transfer prior to death. If the value of benefits received was less than the Lump Sum Transfer, then the Trust Office will calculate the Surplus Leave Benefits, using actuarial factors, and the Surviving Spouse can receive benefits after Medicare Eligibility up to the

amount of Surplus Leave Benefits. The Trust Office will add the Surplus Leave Benefits to the Individual Account.

For example, the Trust Office received a leave conversion of $4,000, which added $50 per month to the monthly benefit. If the Eligible Retiree and Surviving Spouse received that extra $50 per month for only 10 months, then they received only $500 in added value from that leave transfer, and the Surviving Spouse will be entitled to Surplus Leave Benefits. The Surplus Leave Benefits will be actuarially calculated and may not equal $3,500, but the Surviving Spouse will receive some added benefits in an Individual Account after Medicare Eligibility in order to receive the value of the leave transfer. See Plan Section 3.4(b)(2).

- A Surviving Child's benefits under this Plan will terminate upon the loss of Child status or death, whichever occurs first.

- A Beneficiary's Individual Account or Accumulated Benefit will terminate when the amount of the Individual Account or Accumulated Benefit reaches zero or on the death of all Beneficiaries, whichever occurs first, except that the Individual Account or Accumulated Benefit of a Surviving Child will terminate upon loss of Child status.

Benefit coverage and benefit levels may be modified or terminated pursuant to Section 6 of the Plan and such changes may apply to all or some current and/or future Beneficiaries.

26. Can my benefits be reduced by Plan amendment or termination?

Yes. The Trustees reserve the right to modify benefit coverage and Monthly Benefit Levels, any other provision of the Plan or terminate the Plan, and such changes may apply to current and/or future Beneficiaries. In the event the Plan is terminated, any Plan assets that remain after payment of expenses associated with termination will be allocated and distributed to the Beneficiaries in accordance with Section 501(c)(9) of the Internal Revenue Code.

27. Can I assign or transfer my benefits and rights under the Plan to a medical provider or other entity?

No. The Trust Office will pay benefits only to a Beneficiary. As a Beneficiary, you determine what Covered Expenses you will submit to the Plan for payment. The Plan will

not honor any attempt to transfer any of your benefits or rights under the Plan to another entity, and the Plan will not approve any claim or request received from an individual or entity who is not a Beneficiary of the Plan. Details of this restriction are in Plan Section 3.7. (There is an exception for incompetent Beneficiaries with a court appointed representative. See Plan Section 3.6(f).)

28. What are the names and addresses of the Trustees?

Greg Markley, Chair	Mike Frainier, IAFF Trustee
Dennis Lawson, Secretary	Matt Martens
Mike Westland	Craig Soucy
Bill Dodds	Jeff Wainwright
Ricky Walsh	Judson McCauley
Greg Wilson	Mike Detoy

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Drive, #105
P.O. Box 6
Mukilteo, WA 98275

29. Is there any other information about the Plan I should know?

A. The name of the Plan and Trust.

This Plan is known as the "IAFF Medical Expense Reimbursement Plan of the Washington State Council of Fire Fighters Employee Benefit Trust," restated effective August 1, 2023, and as amended from time to time thereafter (the "Plan," *Dr. 3/3/23*). The Plan is governed by the "Trust Agreement Governing the Washington State Council of Fire Fighters Employee Benefit Trust," restated effective July 1, 2018, and as amended thereafter (the "Trust Agreement" *7/28/18 Ed.*). For a copy of the Plan or Trust Agreement, please contact the Trust Office.

B. The name, address and telephone number of the employee organization that established this Plan.

The Plan was established by the Washington State Council of Fire Fighters ("WSCFF'), which is an organization located within the state of Washington that represents affiliated local fire fighter unions of the IAFF.

The name, address and telephone number of the WSCFF is as follows:

Washington State Council of Fire Fighters
1069 Adams Street Southeast
Olympia, WA 98501
(360) 943-3030

C. The identification numbers of the Trust and Plan.

The Employer Tax Identification Number assigned to the Trust by the Internal Revenue Service is EIN 91-2009771. The Plan number is 501.

D. The type of plan.

The Plan is a welfare benefit plan providing reimbursement for health insurance premiums and medical expenses to retirees. Beneficiaries may refer to Internal Revenue Service Publication 502, or check with the Trust Office to determine if a premium and/or medical expense is a Covered Expense under the Plan, eligible for reimbursement under the Plan.

E. The type of administration/trust office.

The Plan is administered by the Board of Trustees of the WSCFF Employee Benefit Trust. The Board has retained the services of a contract administrator to assist in recordkeeping, claims payments, etc. You may contact the Board of Trustees in care of the Trust Office. The contact information of the Trust Office is:

IAFF Medical Expense Reimbursement Plan Trust Office
c/o Vimly Benefit Solutions, Inc.
P.O. Box 6
Mukilteo, WA 98275
Phone: (425) 367-0743
Fax: (866) 676-1530
Email: **iaff-merp@vimly.com**
Website: **https://iaff-merp.simon365.com**

F. The identity of the Plan Administrator.

The Plan Administrator (fiduciary) is the Board of Trustees IAFF Medical Expense Reimbursement Plan of the WSCFF Employee Benefit Trust. The Trustees may be contacted in care of the Trust Office.

G. The existence of a bargaining agreement that addresses this Plan and Trust.

The Plan is maintained pursuant to various collective bargaining agreements and successor agreements between the participating Locals and their respective employers. Beneficiaries of the Plan (i.e., employees, eligible retirees, surviving spouses, and children), as defined in the Plan and Trust documents, may obtain copies of these collective bargaining agreements upon written request to the Trust Office. Further, these agreements are available for examination by Beneficiaries at the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing copies of the collective bargaining agreements. Beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

H. Information regarding the Family Medical Leave Act.

Please contact the Trust Office and/or your Employer if you would like to learn more about the right to self-pay contributions during Family and Medical Leave Act ("FMLA") leave authorized by your Employer. If Contributions on behalf of an Employee are suspended during FMLA leave, then the Employee may have the opportunity to make self-pay contributions. Please contact the Trust Office for more information if this situation applies to you.

I. Information regarding Veterans' Rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If your Contributions to this Plan cease due to a leave of absence for active-duty military service, you have the right under USERRA to self-pay contributions for up to 24 months of that period of leave. If you would like to take advantage of your rights under USERRA, contact the Trust Office for details. Regardless of whether or not you elect to self-pay contributions under USERRA, the Plan will preserve all Active Service that you earned prior to your period of leave and that Active Service will be added to any future Active Service that you earn after return to employment with a Participating Employer following your leave of absence.

J. Information regarding COBRA.

The General COBRA Notice is attached hereto. However, if you would like to request a separate copy of the General COBRA Notice, please contact the Trust Office.

The Employee or a family member, who is a Qualified Beneficiary, has the responsibility to provide written notice, within the time limits described in Section 4 of the General COBRA Notice, to the Trust Office of the occurrence of any of the following Qualifying Events:

i) Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan;
ii) Divorce of the Employee and spouse;
iii) The occurrence of a second Qualifying Event;
iv) Determination of Disability by Social Security Administration; or
v) Change of Disability Status.

The period of time for providing notice to the Trust Office of a Qualifying Event, is from the date of the Qualifying Event to sixty (60) days after the latest of:

i) Qualifying Event. The date that the Qualifying Event occurs;

ii) Contributions to the Trust Cease. The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

iii) The Date You Receive Notice. The date that you are informed through the General COBRA Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 of the General COBRA Notice).

Please see Section 4 of the General COBRA Notice attached to this SPD for the notice deadlines related to specific Qualifying Events.

If you do not timely notify the Trust Office of the Qualifying Events, you will surrender your right to make COBRA contributions. The contact information for the Trust Office is as follows:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Fax: 866-601-4397
Email: **iaff-merp@vimly.com**

Your notice of the Qualifying Event should include:

i) Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

ii) Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

iii) Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

K. The source of Contributions to the Plan.

Contributions to this Plan must be non-elective; i.e., no individual employee election. Instead, they must be required by a collective bargaining agreement. They may be employer and/or employee Contributions. Further, under certain limited circumstances required by federal law, Beneficiaries may elect to make self-payment contributions.

L. The method that is used for the accumulation of assets.

Contributions are received and held in trust by the Trust and are invested with the assistance of a professional investment manager, using investment policies and methods consistent with objectives of this Plan and Employee Retirement Income Security Act of 1974 (ERISA) requirements.

M. The procedures governing Qualified Medical Child Support Order Determinations (QMCSO).

Beneficiaries can obtain, without charge, a copy of such procedures from the Trust Office.

N. The name and address of the agent for service of process.

Each member of the Board of Trustees is an agent for purposes of accepting service of legal process on behalf of the Plan. Service of legal process may be made upon a Trustee or the Trust Office at the following address:

IAFF Medical Expense Reimbursement Plan Trust Office
c/o Vimly Benefit Solutions, Inc.
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

O. Statement of Legal Rights.

- Rights of Plan Participants. Beneficiaries of the IAFF MERP are entitled to certain rights and protection under the federal 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 this Plan, including collective bargaining agreements, insurance contracts and a copy of the latest annual report 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 this Plan, including insurance contracts, collective bargaining agreements, a copy of the latest annual report, and an 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 enrollee with a copy of this summary annual report.

- If there is a cessation of Contributions to the Plan as a result of a COBRA qualifying event, you or your Spouse or your Children may be allowed to continue such contributions by self-payment. Review the General COBRA Notice and Plan Sections 2.2(c) and 2.2(d), for rules governing your COBRA continuation coverage rights.

- Prudent Actions by Plan Fiduciaries. In addition to creating rights for Trust beneficiaries, ERISA imposes obligations upon the persons who are responsible for the operation of this employee welfare benefit plan.

  These persons who operate your Plan and Trust are called "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan Beneficiaries and they must exercise reasonable prudence in the performance of their Plan and Trust duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Trust. No one, including an employer, may fire or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- Enforce Your Rights. If a claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, 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 that can be taken 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 thirty (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, or 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 a state or federal court after exhausting the Plan's administrative procedures. If a Plan fiduciary misuses 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 the court finds your claim to be frivolous.

- Assistance With Your Questions. If you have any questions about this Plan, you should contact the Plan Administrator or Trust Office. 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 Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington DC 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 at (866) 444-EBSA (3272). You may find answers to your questions at **http://www.dol.gov/ebsa/welcome.html**.

- Privacy Rights. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires special precautions of health benefit plans to protect the privacy of "protected health information." In the course of providing benefits to you under this Plan, the Trust Office may acquire protected health information. Accordingly, the Plan has developed procedures to restrict access to protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. If you would like more details about your privacy rights, please contact the Trust Office, or see the HIPAA notice attached hereto.

APPENDIX A to IAFF Medical Expense Reimbursement Plan
Examples of Calculation of Benefit Level

These examples illustrate how to calculate the Monthly Benefit Level for an Eligible Retiree who elects Option 1 under the Plan, i.e., a Monthly Benefit Level that remains constant for the life of the Eligible Retiree. For examples of how to calculate the Monthly Benefit Level for an Eligible Retiree who selects one of the other options, see Appendix D. Please note that these are examples only – your monthly Contribution rate and length of participation will differ, so your Monthly Benefit Level will be different than in these examples.

$25 monthly Contribution = 1 Active Service Unit
Unit Multiplier for all eligible Beneficiaries = $0.41*

Example #1 – 6 years in Plan: A Local has a Contribution rate of $100/month, and Employee #1 participates for two years (or 24 months) at that amount. Then the Local increases the Contribution rate to $150/month, and Employee #1 participates for four years (or 48 months) at that amount, and then retires. Employee #1's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.
$100/month = 4 Active Service Units/Month
$150/month = 6 Active Service Units/Month

Step 2: Find number Active Service Units.
4 Active Service Units x 24 months = 96 Active Service Units
6 Active Service Units x 48 months = 288 Active Service Units
Total = 384 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 384 x $0.41 = $157.44

Example #2 – 13 years in Plan: A Local selects a Contribution rate of $100/month, and Employee #2 participates for seven years (or 84 months) at that amount. Then the Local increases the Contribution rate to $200/month, and Employee #2 participates for five years (or 60 months) at that amount, and then retires. Employee #2's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.
$100/month = 4 Active Service Units/Month
$200/month = 8 Active Service Units/Month

Step 2: Find number Active Service Units.
4 Active Service Units x 84 months = 336 Active Service Units
8 Active Service Units x 60 months = 480 Active Service Units
Total = 816 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 816 x $0.41 = $334.56

Example #3 – Career Employee - 20 years in Plan: A Local has a Contribution rate of $100/month, and Employee #3 participates for seven years (or 84 months) at that amount. Then the Local increases the Contribution rate to $200/month, and Employee #3 participates for thirteen years (or 156 months) at that amount, and then retires. Employee #3's Monthly Benefit Level for medical expense reimbursement will be calculated as follows:

Step 1: Convert monthly Contributions to Active Service Units.
$100/month = 4 Active Service Units/Month
$200/month = 8 Active Service Units/Month

Step 2: Find number Active Service Units.
4 Active Service Units x 84 months = 336 Active Service Units
8 Active Service Units x 156 months = 1248 Active Service Units
Total = 1584 Active Service Units

Step 3: Multiply number Active Service Units by Unit Multiplier.
Monthly Benefit Level: 1584 x $0.41 = $649.44

These are examples. The Trustees reserve the right to modify the Unit Multiplier and the formula used to calculate Monthly Benefit Levels at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Plan. For more details, please contact the Trust Office: Vimly Benefit Solutions, (425) 367-0743.

APPENDIX B to IAFF Medical Expense Reimbursement Plan
Chart of Unit Multiplier Value

Operative Date*	Unit Multiplier (UM)**
September 1, 2009 to June 30, 2012	$0.42
July 1, 2012 to June 30, 2015	$0.39
On or after July 1, 2015	$0.41

**For the three Unit Multipliers used by the Plan to date, the Operative Date refers to the date that the Trust Office paid a claim.*

*** The Unit Multiplier for Eligible Retirees may be adjusted by the Trustees from time to time (see Section 3.2 of the Plan). The amount reimbursed to the Eligible Retiree may not exceed the actual Covered Expense paid by the Beneficiary.*

APPENDIX C to IAFF Medical Expense Reimbursement Plan
Lump Sum Transfer Conversion Table
Effective July 1, 2015

Section 2.2(b) of IAFF MERP sets forth the terms and conditions under which Lump Sum Transfers, including accrued sick and/or vacation leave, and the Individual Account balance, are converted into Active Service Units ("ASUs"). This table provides the cost of each ASU when converting a leave transfer to ASUs.

- The number of ASUs an Employee earns as a result of the Lump Sum Transfer is calculated by the following formula:

  Dollar amount transferred divided by the applicable cost for one ASU, as shown in the table below.

- The cost for one ASU depends on a number of factors, including the age of the Employee at the time of the Lump Sum Transfer, the date of election to convert the Individual Account balance, the current Unit Multiplier (see Appendix B above), and other actuarial factors, as determined by the professional actuarial firm engaged by the Trustees.

- This leave conversion table provides a sample calculation for a Lump Sum Transfer of $1,000 in the 3rd column. Note for comparison purposes that each $25 monthly Contribution made during active employment gives an Employee one ASU. Thus, $1,000 in monthly Contributions during active employment would be equivalent to 40 ASUs.

Note that you pay **no taxes** on leave that is transferred into IAFF MERP, and you pay **no taxes** on the reimbursement benefits received from the Plan.

Age on date of receipt of election or default	**Cost for One Active Service Unit ("x")**	**Number of ASUs Purchased with each $1,000 Transfer (truncated to whole number)**
Age 20	$7.60	132
Age 21	$8.11	123

Age 22	$8.65	116
Age 23	$9.22	108
Age 24	$9.84	102
Age 25	$10.49	95
Age 26	$11.19	89
Age 27	$11.94	84
Age 28	$12.73	79
Age 29	$13.58	74
Age 30	$14.48	69
Age 31	$15.45	65
Age 32	$16.48	61
Age 33	$17.57	57
Age 34	$18.74	53
Age 35	$19.99	50
Age 36	$21.32	47
Age 37	$22.74	44
Age 38	$24.25	41
Age 39	$25.87	39
Age 40	$27.59	36
Age 41	$29.43	34
Age 42	$31.38	32
Age 43	$33.47	30
Age 44	$35.70	28
Age 45	$38.07	26
Age 46	$40.60	25
Age 47	$43.30	23
Age 48	$46.18	22
Age 49	$49.26	20
Age 50	$52.53	19
Age 51	$56.02	18
Age 52	$59.75	17
Age 53	$63.72	16
Age 54	$63.00	16
Age 55	$62.23	16
Age 56	$61.42	16
Age 57	$60.57	17
Age 58	$59.68	17
Age 59	$58.74	17

Age 60	$57.78	17
Age 61	$56.77	18
Age 62	$55.74	18
Age 63	$54.67	18
Age 64	$53.56	19
Age 65	$52.41	19
Age 66	$51.22	20
Age 67	$49.99	20
Age 68	$48.73	21
Age 69	$47.45	21
Age 70	$46.13	22

**The Trustees have the authority to modify this table from time to time for future leave transfers.*

APPENDIX D to IAFF Medical Expense Reimbursement Plan
Examples of Calculation of Benefit Level Options

To calculate the adjusted Monthly Benefit Level, you multiply the flat Monthly Benefit Level (Option 1) by the applicable actuarial factor for the Eligible Retiree's age in the Actuarial Factor Table.

Eligible Retirees, who have a retirement date on or after March 15, 2023, must elect between: (a) a lifetime Surviving Spouse benefit with an actuarial reduction to the Eligible Retiree's Monthly Benefit Level under Options 1-4, or (b) a Surviving Spouse benefit that terminates upon the Surviving Spouse attaining Medicare Eligibility with no actuarial reduction to the Eligible Retiree's Monthly Benefit Level under Options 1-4. To calculate the adjusted Monthly Benefit Level with a lifetime Surviving Spouse benefit, you multiply the flat Monthly Benefit Level (Option 1) by the applicable actuarial factor for the Eligible Retiree's age in the Actuarial Factor with Lifetime Surviving Spouse Benefit Table.

A Surviving Spouse benefit that terminates at Medicare Eligibility will still terminate upon the Surviving Spouse's Medicare Eligibility even if the Eligible Retiree is not deceased on the date that the Surviving Spouse has attained Medicare Eligibility.

The Monthly Benefit Levels under Options 2, 3 and 4 depend on a participant's age when he or she retires. The following examples are for a participant who retires under IAFF MERP at age 55. The examples below provide sample calculations of each Option 1-4 with selection of a Surviving Spouse benefit terminating at Medicare Eligibility and the corresponding actuarially reduced benefit option for a lifetime Surviving Spouse benefit. Selection of the Surviving Spouse benefit terminating at Medicare Eligibility requires a notarized signature from the spouse.

Please note: The Eligible Retiree (or surviving Beneficiary if selection not made by Eligible Retiree before death) is provided a retirement packet with information on their own individualized Benefit Levels under all Options and Surviving Spouse benefit combinations and a Benefit Election Form. If the Eligible Retiree does not timely select an Option and Surviving Spouse benefit, by returning the Benefit Election Form to the Trust Office by the deadline, the Trust Office will implement the default selection, which is Option 1 with lifetime Surviving Spouse benefits.

Example #1 – 6 years in IAFF MERP:[10] Consider a 6-year participant at age 55 whose Monthly Benefit Level under Option 1 would be $157.44 (based on the facts in Appendix A). Here are this participant's Options:

[10] These are examples; each Eligible Retiree's Monthly Benefit Level under these Options will be different. The Trustees reserve the right to modify the Options for the Monthly Benefit Levels and the factors used to calculate the

Option 1: $157.44 Monthly Benefit Level under IAFF MERP for lifetime*[11]
$150.67 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

Option 2: pre-65 Monthly Benefit Level = $157.44 x 1.16493 = $183.41
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $175.52

post-65 Monthly Benefit Level= $157.44 x 0.77662 = $122.27
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $117.01

Option 3: pre-65 Monthly Benefit Level= $157.44 x 1.26963 = $199.89
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $191.29

post-65 Monthly Benefit Level= $157.44 x 0.63482 = $99.95
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $95.65

Option 4: pre-65 Monthly Benefit Level= $157.44 x 1.39501 = $219.63
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $210.19

post-65 Monthly Benefit Level= $157.44 x 0.46500 = $73.21
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $70.06

Example #2 – 12 years in IAFF MERP: Consider a 12-year participant at age 55 whose Monthly Benefit Level under Option 1 would be $334.56 (based on facts in Appendix A). Here are this participant's Options:

Option 1: $334.56 Monthly Benefit Level under IAFF MERP for lifetime
$320.17 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

amount of such Options at any time for both existing and future Beneficiaries. Such a modification is most frequently attributable to favorable or adverse demographic or financial experience of the Plan. For more details, please contact the Trust Office: Vimly Benefit Solutions, (425) 367-0743.

[11] IAFF MERP is currently written to generally provide benefits for Eligible Retirees until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of IAFF MERP.

Option 2: pre-65 Monthly Benefit Level= $334.56 x 1.16493 = $389.74
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $372.98

post-65 Monthly Benefit Level= $334.56 x 0.77662 = $259.83
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $248.66

Option 3: pre-65 Monthly Benefit Level = $334.56 x 1.26963 = $424.77
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit= $406.50

post-65 Monthly Benefit Level= $334.56 x 0.63482 = $212.39
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $203.26

Option 4: pre-65 Monthly Benefit Level= $334.56 x 1.39501 = $466.71
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $446.65

post-65 Monthly Benefit Level= $334.56 x 0.46500 = $155.57
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $148.88

Example #3 – 20 years in IAFF MERP: Consider a 20-year participant at age 55 whose Monthly Benefit Level under Option 1 would be $649.44 (based on the facts in Appendix A). Here are this participant's Options:

Option 1: $649.44 Monthly Benefit Level under IAFF MERP for lifetime
$621.51 Monthly Benefit Level with Lifetime Surviving Spouse Benefit

Option 2: pre-65 Monthly Benefit Level= $649.44 x 1.16493 = $756.55
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $724.02

post-65 Monthly Benefit Level= $649.44 x 0.77662 = $504.37
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $482.68

Option 3: pre-65 Monthly Benefit Level= $649.55 x 1.26963 = $824.69
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $789.23

post-65 Monthly Benefit Level= $649.44 x 0.63482 = $412.28
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $394.55

Option 4: pre-65 Monthly Benefit Level= $649.44 x 1.39501 = $905.98
pre-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $867.02

post-65 Monthly Benefit Level= $649.44 x 0.46500 = $301.99
post-65 Monthly Benefit Level with Lifetime Surviving Spouse Benefit = $289.00

Actuarial Factors Table[12]

Age	Option 2 Pre-65 Factor	Option 2 Post-65 Factor	Option 3 Pre-65 Factor	Option 3 Post-65 Factor	Option 4 Pre-65 Factor	Option 4 Post-65 Factor
39	1.044	0.696	1.067	0.533	1.091	0.364
41	1.051	0.701	1.078	0.539	1.107	0.369
43	1.059	0.706	1.092	0.546	1.126	0.375
45	1.069	0.713	1.108	0.554	1.149	0.383
47	1.081	0.721	1.127	0.564	1.177	0.392
49	1.096	0.731	1.151	0.576	1.212	0.404
51	1.113	0.743	1.181	0.590	1.257	0.419
53	1.136	0.757	1.218	0.609	1.314	0.438
55	1.163	0.775	1.266	0.633	1.389	0.463
57	1.197	0.798	1.328	0.664	1.491	0.497
59	1.242	0.828	1.414	0.707	1.638	0.546
61	1.302	0.868	1.532	0.766	1.863	0.621
63	1.383	0.922	1.710	0.855	2.241	0.747

[12] This Table is a portion of the full Table, which is available from the Trust Office. The factors in this table will vary with each month added to your age. The Trust Office has the full table based on your age in months.

Lifetime Surviving Spouse Benefit Actuarial Factors Table[13]

Factor to Calculate Eligible Retiree Benefit Level with Lifetime Surviving Spouse Benefit	
Retiree's Age in Years At Retirement[14]	Factor (Applied to Retiree Benefit Level under Option Selected)
40	0.985
41	0.984
42	0.983
43	0.982
44	0.980
45	0.979
46	0.977
47	0.976
48	0.974
49	0.972
50	0.970
51	0.968
52	0.965
53	0.963
54	0.960
55	0.957
56	0.953
57	0.950
58	0.946
59	0.942
60	0.938
61	0.933
62	0.929
63	0.924
64	0.919
65	0.913
66	0.908
67	0.902
68	0.897
69	0.891
70	0.886
71	0.880
72	0.874
73	0.868
74	0.861
75	0.854
76	0.848

[13] These factors were based on the actuarial assumptions used in the benefit level study of the Plan as of 12/31/20.

[14] Age is calculated based upon the Eligible Retiree's closest age on the date of retirement, i.e., 6 months after the birthdate the age is rounded up to the next year.

Factor to Calculate Eligible Retiree Benefit Level with Lifetime Surviving Spouse Benefit	
Retiree's Age in Years At Retirement[14]	Factor (Applied to Retiree Benefit Level under Option Selected)
77	0.840
78	0.833
79	0.826
80	0.818

APPENDIX E to IAFF Medical Expense Reimbursement Plan
Early Retirement Factors Table

COBRA GENERAL NOTICE

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
EMPLOYEE BENEFIT TRUST

COBRA General Notice

<< IMPORTANT COBRA INFORMATION >>
THIS COBRA INFORMATION WILL INFORM YOU OF YOUR RIGHTS AND OBLIGATIONS UNDER COBRA. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

Under this type of health plan, i.e., a retiree medical expense reimbursement plan, COBRA benefits mean the right to continue contributions to the Plan, in order to obtain certain Plan benefits after attaining the eligibility age. This Plan gives the Employee (or family member) the right to self-pay contributions into the Plan, which were formerly paid pursuant to a Collective Bargaining Agreement or other special agreement while the Employee was working. If you have questions regarding the eligibility requirements under the Plan, or are in doubt about the application of COBRA under this Plan, please contact the Trust Office.

It is important to note that the type of continuation coverage under this Plan is unusual. Under this Plan, self-paid contributions (if sufficient, as explained below) would entitle the Qualified Beneficiary to reimbursement of a portion of his or her health premium or medical expense costs after separation from employment and attainment of the eligibility age (currently 53)[15] rather than health benefits insurance coverage for former employees of any age. That is, this Plan is for retiree reimbursement health care expense, not insurance coverage.

1. COBRA Generally.

You are a participant in the IAFF Medical Expense Reimbursement Plan (hereafter the "Plan") of the Washington State Council of Fire Fighters Employee Benefit Trust (hereafter the "Trust"), which provides reimbursement towards certain medical expenses, as defined in the Plan, after reaching the eligibility age and other eligibility requirements. Continued participation in any health plan is a right governed by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA."[16]

[15] In a typical health plan, the COBRA right entitles the Employee to self-pay contributions to continue to receive health coverage immediately following loss of employment. In contrast, this Plan does not pay reimbursements for premiums or medical expense to terminated Employees until attainment of age 53, and the COBRA right entitles the Qualified Beneficiary to self-pay contributions to earn additional Active Service and Active Service Units.

[16] Public Law 99-272, Title X.

THIS NOTICE GENERALLY EXPLAINS YOUR RIGHTS AND OBLIGATIONS UNDER COBRA, WHEN THE RIGHT TO SELF-PAYMENT OF CONTRIBUTIONS UNDER COBRA MAY BECOME AVAILABLE TO YOU AND WHAT YOU NEED TO DO TO PROTECT YOUR RIGHT TO MAKE COBRA SELF-PAYMENTS. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO REACH THIS CAREFULLY.

THIS NOTICE DOES NOT FULLY DESCRIBE THE CONTINUATION COVERAGE OR OTHER RIGHTS UNDER THE PLAN. MORE COMPLETE INFORMATION REGARDING SUCH RIGHTS IS AVAILABLE FROM THE TRUST OFFICE AND IN THE SUMMARY PLAN DESCRIPTION, AND YOU MAY CONTACT THE TRUST OFFICE AT CONTACT INFORMATION IN SECTION 5 HEREOF FOR SUCH INFORMATION.

2. COBRA Coverage Means the Right to Self-Pay Continued Contributions to Plan for Benefits After Retirement.

A. The Application of COBRA to this Plan. Under this Plan, COBRA continuation coverage is the right to continue contributions to the Plan by self-payment, when contributions to the Plan would otherwise have ceased because of a certain life event known as a "Qualifying Event." After a Qualifying Event, the Plan must offer each person who is a "Qualified Beneficiary" the COBRA right to self-pay contributions, which were formerly being forwarded pursuant to a Collective Bargaining Agreement or special agreement. By offering a Qualified Beneficiary this right, generally, the Plan is offering that individual the ability to increase his or her benefits from the Plan in one of three ways:

i) The ability to meet the eligibility requirement to become a Regular Beneficiary and receive a lifetime[17] monthly reimbursement benefit from the Plan after retirement, which he/she may not otherwise have been able to meet (see **Section 2(B)** below);

ii) To augment their monthly post-retirement benefit, if the person had already met the eligibility requirements to become a Regular Beneficiary; and/or

[17] The Plan is currently written to provide benefits for Regular Beneficiaries until death. However, this is not guaranteed. The Trustees reserve the right to modify or terminate benefits as necessary to preserve the financial soundness of the Plan.

iii) To augment the total benefit amount available under Section 3.2(f) to a participant who does not earn five (5) years of Active Service as defined in Section 2.2.

You, your spouse, and your Children could become Qualified Beneficiaries if contributions to the Plan on behalf of the covered employee cease due to a Qualifying Event.

B. Plan Eligibility Requirements. To be eligible to receive these monthly medical expense reimbursement benefits after attaining eligibility age, this Plan requires that the Employee earn five (5) years of Active Service as defined in Section 2.2 of the Plan. Therefore, making COBRA self-payments could enable you to meet the Active Service requirement and become eligible for monthly benefits, depending on how many years of Active Service you have earned at the time of the Qualifying Event. An Employee may elect to self-pay COBRA contributions through deduction from a mandatory transfer of accrued leave.

Further, since the Plan also provides for a gradually increasing level of benefits based on the amount of your contributions, you may be able to increase your Monthly Benefit Level if you make additional contributions. It is important for you to determine whether making these additional contributions makes sense in your particular situation. If you choose to continue making contributions to this Plan, the number of your self-pay contributions is limited to the number allowed by COBRA, as stated in **Section 7** below. Finally, if you cannot become eligible for the monthly lifetime benefits, you will be eligible for an Accumulated Benefit under Section 3.2(f) of the Plan, which you can access upon separation from employment. (Note that if you make COBRA self-payments under this circumstance, benefit payments will not commence until you have finished making COBRA contributions.)

C. Consequence of Non-Election. If you do not choose to continue contributions to this Plan and have not earned five (5) years of Active Service, you will not qualify for monthly benefits as a Regular Beneficiary. Instead, you will be eligible to receive the amount of the total contributions submitted on your behalf (without any allocation for investment returns thereon) credited to an Accumulated Benefit, plus any mandatory transfer of sick and/or vacation leave credited to your Individual Account in accordance with Sections 3.2 and 3.5 of the Plan.

D. Widowed Spouses and Children. Widowed spouses and Children may also have the right to continue self-payment under certain circumstances. Contact the Trust Office at the address in Section 5 below for details.

3. Qualifying Events and Qualified Beneficiaries.

A. An Employee as a Qualified Beneficiary. If you are an Employee, you will become a Qualified Beneficiary and have the right to self-pay contributions for yourself (and your beneficiaries), if contributions to the Plan on your behalf cease due to any of the following "Qualifying Events":

i) Termination of Employment. Your employment is terminated for any reason other than gross misconduct; or

ii) Reduction of Work Hours. Your hours of employment are reduced.

Either of these Qualifying Events generally gives you the right to continue self-payment of contributions to this Plan.

B. The Spouse as a Qualified Beneficiary. If you are the spouse of an Employee covered by this Plan, you will become a Qualified Beneficiary and may have the right to self-pay contributions for yourself if contributions to the Plan on your spouse's behalf cease due to any of the following "Qualifying Events,"[18] and provided that the Employee does not elect to self-pay contributions under COBRA*:

i) Spouse's Death. The death of your spouse; or

ii) Termination of Spouse's Employment. A termination of your spouse's employment (for reasons other than gross misconduct);

iii) Reduction of Spouse's Work Hours. A reduction in your spouse's hours of employment, provided that your spouse does not elect to self-pay contributions under COBRA; or

iv) Divorce. If the Employee and spouse divorce during contributions or during benefit payments, a QDRO will provide more rights to ongoing and future benefit payments than COBRA, but this is a Qualifying Event for COBRA.

[18] Some health plans recognize the following Qualifying Events: 1) your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), and 2) you become divorced or legally separated from your spouse. However, due to the structure of this Plan, these are not recognized Qualifying Events.

In order to preserve your right to make COBRA contributions, if the Qualifying Event is a divorce, you must notify the Trust Office of your divorce, in writing, within 60 days of the date that your divorce becomes final. If you do not timely notify the Trust Office of your divorce, you will surrender your right to make COBRA contributions.

*Note. Only one member of a family may make self-payment contributions in this type of health plan. If there are multiple Qualified Beneficiaries, for example a former employee and a spouse, you should confer together and decide whether electing to make COBRA self-pay contributions makes sense in your case, and which of you will make the election. It is important to note that due to the nature of this type of Plan, you do not each have independent rights to elect self-payment. This means that only one Qualified Beneficiary can self-pay.

C. A Child as a Qualified Beneficiary. If you are a Child of an Employee covered by this Plan, and neither of your parents elects to self-pay contributions under COBRA, you may become a Qualified Beneficiary and have rights to self-pay contributions to this Plan if contributions to the Plan on your parent's behalf cease due to any of the following Qualifying Events, and provided that the Employee parent or spouse does not elect to self-pay contributions under COBRA*:

i) Death of Parent. The death of the covered parent; or

ii) Termination of Parent's Employment. The termination of the covered parent's employment (for reasons other than gross misconduct);

iii) Reduction of Parent's Work Hours. A reduction in the parent's hours of employment, where neither the employee parent nor spouse elect to self-pay contributions under COBRA; or

iv) Loss of Child Status. If a Child attains age 26 and loses current reimbursement benefits under the Plan because he/she no longer qualifies as a Child under the Plan.

In order to preserve your right to make COBRA contributions, if the Qualifying Event is the loss of Child status under the Plan, you must notify the Trust Office of your 26th birthday and loss of benefits, in writing, within 60 days after your 26th birthday. If you do not timely notify the Trust Office of your birthday and loss of benefits, you will surrender your right to make COBRA contributions.

*See "Note" under **Section 3(B)** above.

4. Notification of Qualifying Event.

A. Employer's Notification Responsibility. The Plan will offer the COBRA option to self-pay contributions to Qualified Beneficiaries only after the Trust Office has been notified that a Qualifying Event has occurred. When the Qualifying Event is the termination of employment, reduction of hours of employment, or death of the employee, your **employer** must notify the Trust Office of the Qualifying Event. However, we urge the employee to also give notice to the Plan, in case the employer fails to do so.

B. Qualified Beneficiary's Notification Responsibility. Under COBRA, the Employee or a family member has the responsibility to provide written notice, within the time limits described in Section 4(C) below, to the Trust Office of the occurrence of any of the following Qualifying Events:

i) Child attaining age 26 and no longer qualifying as a Beneficiary under the Plan;

ii) Divorce of the Employee and spouse;

iii) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to self-pay contributions under COBRA for a maximum period of eighteen (18) months (or twenty-nine (29) months in the case of a disability, as described in Section 6 below); or

iv) A determination by the Social Security Administration that a Qualified Beneficiary has become disabled at any time prior to or during the first sixty (60) days of self-payment contributions; or

v) A determination by the Social Security Administration that a Qualified Beneficiary who was determined as disabled is no longer disabled.

C. Timing Requirements for Qualified Beneficiaries to Notify the Trust Office of Qualifying Events.

i) Qualifying Events Other Than Disability, Divorce, Loss of Child Status. The period of time for providing notice to the Trust Office of a Qualifying

Event is from the date of the Qualifying Event to sixty (60) days after the latest of:

a) *Qualifying Event*. The date that the Qualifying Event occurs; or

b) *Contributions to the Plan cease*. The date that contributions to the Plan cease or should cease as a result of the Qualifying Event; or

c) *The date you receive notice*. The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 below).

ii) Qualifying Event of Divorce. You must notify the Trust Office of your divorce, in writing, within the latest of the following time periods:

a) You must notify the Trust Office of your divorce, in writing, within the latest of the following time periods; or

b) Within 60 days of the date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 below).

If you do not timely notify the Trust Office of your divorce, you surrender your right to make COBRA contributions.

iii) Qualifying Event of Loss of Child Status. You must notify the Trust Office by 60 days after the latest of the following time periods, provided that you incur a loss of eligibility for current benefits:

a) Your 26th birthday; or

b) The date that you are informed through this Notice of your responsibility to provide notice to the Trust Office and the Plan's procedures for providing such notice (see Section 5 below)

If you do not timely notify the Trust Office of your birthday and loss of benefits, you surrender your right to make COBRA contributions.

iv) Notice re Qualifying Event of Disability. If the Qualifying Event is a determination that a beneficiary is disabled, the Employee or other Qualified Beneficiary must notify the Trust Office no later than sixty (60) days after the latest of the following events (but no later than the end of the first eighteen (18) months of self-payment contributions):

a) *Determination by Social Security Administration.* The date of the disability determination by the Social Security Administration;

b) *Disability.* The date that the disability occurs;

c) C*ontributions to the Trust Cease.* The date that contributions to the Trust cease or should cease as a result of the Qualifying Event; or

v) Change of Disability Status. The period of time for providing notice to the Trust Office of a change in disability is thirty (30) days after the latest of:

a) Determination by Social Security Administration. The date the Social Security Administration determines that you are no longer disabled; or

b) Notice of Responsibility and Procedure. The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice to the Trust Office (see Section 5 below).

5. Procedures for Notifying Plan of Qualifying Event.

Subject to the time limits in **Section 4(C)** above, a Qualified Beneficiary must provide written notice of the Qualifying Event(s), described in **Section 4(B)** above, to the Trust Office by either first class mail or facsimile (fax) or email. The contact information for the Trust Office is as follows:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Fax: 866-601-4397

Email: **iaff-merp@vimly.com**

The notice of the Qualifying Event should include:

A. Identifying Information of the Employee and Qualified Beneficiary. The name and social security number of the Employee and of the Qualified Beneficiary;

B. Contact Information of the Filing Beneficiary. The current address and phone number of the Qualified Beneficiary who is filing the notice; and

C. Information Relating to the Qualifying Event. The nature of the Qualifying Event and the date on which the Qualifying Event occurred.

When the Plan is notified that one of these Qualifying Events has occurred, it will, in turn, notify you about details concerning your election to continue your contributions to the Plan for the right to receive future benefits.

6. Maximum Length of COBRA Payments.

You have sixty (60) days from the date on the COBRA Election Form to mail (postmark) or deliver your COBRA Election Form to the Trust Office. Once you have timely elected to take advantage of your COBRA right to self-pay contributions, your initial payment is due within forty-five (45) days of your election. Subsequent periodic payments must be made on a monthly basis and are due on the first of each month, but no later than thirty (30) days following the first of the month. **You will not receive monthly reminders that payment is due.**

A. First Qualifying Event. COBRA continuation coverage is a temporary continuation of self-payment of contributions to the Plan.

i) 18-month period. When the Qualifying Event is a termination of employment or reduction in hours of employment, the law requires that you be given the opportunity to self-pay contributions for eighteen (18) months.

ii) 36-month period. When the Qualifying Event is death of the covered employee, the COBRA law requires that you be given the opportunity to continue to make contributions to the Plan by self-payment for thirty-six (36) months (three years).

B. Second Qualifying Event Extension (18-month extension of the initial 18-month period). If a second Qualifying Event, other than termination of employment,

occurs during the 18-month period of self-payment of contributions, the Plan beneficiaries may be eligible to receive an extension of up to 18 months of self-payment contributions, for a maximum of 36 months. See **Sections 4 and 5** relating to notification requirements and procedure in the case of a second Qualifying Event.

C. Disability Extension (11-month extension of the initial 18-month period). If a Qualified Beneficiary under the Plan is determined by the Social Security Administration to be disabled, the Plan beneficiaries may be eligible to self-pay for an additional eleven (11) months, for a total of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of the COBRA self-payment contributions and must last at least until the end of the 18-month period of self-payment contributions. See **Sections 4 and 5** relating to notification requirements and procedure in the case of disability.

Please note the cost you pay for the additional eleven (11) months may be approximately 50% higher than the amount of the first eighteen (18) months if the self-payment contributions include a disabled beneficiary and the extension of period for self-payment contributions would not be available in the absence of a disability.

7. Termination of COBRA Payments.

The COBRA law provides that your right to continue COBRA payments may be terminated prior to the full self-payment period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

A. The Trust no longer maintains the Plan; or

B. Your employer no longer contributes to the Plan on behalf of employees; or

C. The monthly self-pay contribution to the Plan under COBRA is not paid timely; or

D. You qualified to make an extra eleven (11) months of self-pay contributions based on disability, but there has been a final determination that you are no longer disabled.

You do not have to show that you are insurable to choose continued participation.

8. Refund of Contributions Erroneously Paid.

Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Trust Office and shall not confer upon you any rights under the Plan if it is determined that you are ineligible to self-pay contributions. Any Active Service or Active Service Units granted based on an erroneous contribution will be rescinded or returned, as the case may be.

9. Questions about COBRA.

If you have any questions about the Plan or your COBRA continuation self-payment rights, you should contact the Trust Office at the mail or email address, or phone number appearing below:

Washington State Council of Fire Fighters
Employee Benefit Trust
c/o Vimly Benefit Solutions
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (425) 367-0743
Email: **iaff-merp@vimly.com**

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**.

10. Address Changes.

In order to protect your family's rights, you should keep the Trust Office informed of any changes in marital status or address of yourself and family members. Send all address changes to the Trust Office address stated in **Section 9** above. You should also keep a copy for your records of any notices you send to the Trust Office.

HIPAA NOTICE OF PRIVACY PRACTICES

WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST

NOTICE OF PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION

Introduction: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a Privacy Rule pertaining to "protected health information" ("PHI"), which is information that identifies a particular individual and relates to (1) the past, present or future physical or medical condition of the individual; (2) provision of health care to the individual; or (3) payment for the provision of health care to the individual. The Washington State Council of Fire Fighters Employee Benefit Trust ("Trust") is required to provide you with this Notice describing our duties and your rights with respect to protected health information and the manner in which it may be used or disclosed.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

1. Our Duties Concerning Protected Health Information:

As the administrative agent for the Board of Trustees of the Trust, we are required by law to maintain the privacy of protected health information according to the terms of the Privacy Rule and other applicable laws. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your protected health information. We are also required to abide at all times by the terms of this Notice. Your rights and our duties as set forth herein are governed by extensive regulations, and you can obtain further information by contacting the Privacy Contact Person identified in Section 7 of this Notice.

If any applicable state or federal law imposes limitations upon uses and disclosures of protected health information that are more stringent than the limitations imposed under the Privacy Rule, we are required to adhere to those more stringent limitations.

2. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

Except with respect to uses or disclosures of PHI that require an authorization as described in Section 4 of this Notice, we may use or disclose protected health information for purposes of treatment, payment or health care operations, as set forth in Paragraphs 2.A – 2.D below, without your consent. We may elect to obtain your consent to use or disclose protected health information for such purposes, although we are not required to do so. Moreover, such consent shall not be

effective to permit a use or disclosure of protected health care information that requires an authorization as described in Section 4 of this Notice.

A. Uses and Disclosures for Payment of Medical Expense and Premium Reimbursement Claims. "Payment" includes, but is not limited to, actions concerning eligibility, coverage determinations (including appeals), and billing and collection. For example, the Trust may inform a provider or insurer whether a Trust beneficiary is entitled to medical expense or premium reimbursement.

B. Uses and Disclosures for the Payment Activities of Another "Covered Entity." PHI may be shared with other "covered entities," which include health care providers and health plans, in certain circumstances. For example, the Trust may disclose its payment on a claim to another health plan, to coordinate payment of claims.

C. Disclosures to Another Covered Entity for Health Care Fraud and Abuse Detection or Compliance or Health Care Operations. For example, the Trust may disclose payment history to another reimbursement plan to investigate, and to perform related functions that do not involve treatment, provided that each entity has or had a relationship with the individual to whom the information pertains, and the information disclosed pertains to that relationship.

D. Disclosures to the Board of Trustees of the Trust, as the Plan Fiduciary, as Necessary for Trust Administration. The Board has signed a certification, agreeing not to use or disclose PHI other than as permitted by the Plan documents, or as required by law.

3. Other Uses and Disclosures Permitted or Required Without Authorization:

We may, by complying with the requirements specified in the Privacy Rule, use or disclose protected health information without your written consent or authorization, and without providing you the opportunity to agree or object to such use or disclosure, in the following circumstances:

A. When and to the extent such use or disclosure is required by law.

B. For public health activities or public health oversight authorized by law.

C. When and to the extent required or authorized by law or authorized by you regarding child abuse, neglect, or domestic violence.

D. To the extent authorized by order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process in a judicial or administrative proceeding.

E. For law enforcement purposes, subject to appropriate safeguards, when required by law or by a judicial or administrative order, or in other circumstances involving the provision of information to law enforcement officials for the purpose of locating an individual, determining whether the individual has been the victim of a crime, or reporting crime in emergencies; or if the information constitutes evidence of criminal conduct on our premises.

F. For coroners, medical examiners, and funeral directors to perform their legal duties.

G. For procurement, banking, or transplantation of cadaveric organs, eyes, or tissue.

H. For research purposes, where there is appropriate documentation of an alteration to or waiver of the individual authorization required for such use or disclosure of protected health information, and the researcher represents that the use of such information is necessary for the research and will be limited as required by the Privacy Rule.

I. To prevent or lessen a serious and imminent threat to health or safety or enable law enforcement authorities to identify or apprehend an individual.

J. For specialized government functions related to military personnel, veteran's benefits, national security, protective services, medical suitability determinations, law enforcement custodial situations, and public benefits programs.

K. For compliance with workers' compensation and similar programs that provide benefits for work-related injury or illness regardless of fault.

L. De-identified information, i.e., the Trust may disclose a Beneficiary's health information, if it does not identify the Beneficiary, and with respect to which there is no reasonable basis to believe the information can be used to identify the Beneficiary.

4. Authorization Required for Other Uses and Disclosures:

Uses and disclosures of protected health information other than those identified above will be made only with your written authorization. You may revoke such authorization at any time,

provided that the revocation is in writing, except to the extent that we have taken action in reliance thereon or, if the authorization was obtained as a condition of obtaining insurance coverage, some other law provides the insurer with the right to contest a claim under the policy or contest the policy itself.

5. Individual Rights:

All participants have the following rights with respect to protected health information that the Plan maintains about them:

A. Restrictions on Uses and Disclosures. You may request that we restrict uses or disclosures of protected health information under circumstances in which we would be entitled to use or disclose it for the purpose of carrying out treatment, payment, or health care operations or locating and providing information to persons involved with your care or payment for your care. We are only required to agree to your request if you seek to prevent disclosure to a health plan for the purposes of carrying out payment or health care operations (not for the purpose of treatment), and the protected health information pertains only to a health care item or service for which the plan participant has paid the health care provider out-of-pocket and in full.

Except as described above, we are not required to agree to your request. If we agree, we will be entitled to terminate our agreement to restrict certain uses and disclosures with respect to protected health information created or received after notifying you of the termination. Until then, we will be required to abide by the restriction, unless the information is required for purposes such as: giving you emergency treatment; assisting the Secretary of Health and Human Services to investigate privacy complaints; including your name in a health care facility directory if you are incapacitated or in emergency circumstances; or responding to those circumstances described in Section 3 of this Notice, in which an opportunity to agree or object need not be provided.

B. Confidential Communications. We must accommodate reasonable requests to have protected health information communicated to you in confidence by alternative means or at alternate locations. We may require your request to be in writing, to state (if appropriate) how payment for the accommodation will be handled, to specify an alternative method of contacting you, or to state that disclosure of all or part of the protected health information could endanger you.

C. Access for Inspection and Copying. You may request access to inspect or copy protected health information that is maintained about you in a designated record

set. If we grant your request, we may provide the information requested or, with your consent, furnish an explanation or summary of the information. We may impose a reasonable fee for the costs of copying and mailing the information you have requested and the costs to which you have agreed in advance for preparing an explanation or summary. If we deny your request, in whole or in part, we must, after excluding the information to which access is denied, provide access insofar as possible to other protected health information subject to your request.

We may in some circumstances deny your request without providing an opportunity for review, as when the information consists of psychotherapy notes or was compiled for use in a legal or administrative proceeding, or in certain other circumstances. There are other circumstances in which we must provide an opportunity for review of our denial, as when the denial is based upon a determination that provision of the information is likely to cause substantial harm to you or another person. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health and Human Services or the Privacy Contract Officer identified in Section 7 of this Notice, if you believe our denial was improper.

D. Amendments. You may request amendments to protected health information maintained about you in a designated record set. If we accept your request in whole or in part, we must identify the information affected thereby, provide a link to the amendment, and make reasonable efforts to notify within a reasonable time persons disclosed by you or known to us who might foreseeably rely on the information to your detriment. We may deny your request if we determine that the information subject to your request is already accurate and complete, is not part of the designated record set, would not be available for inspection as described in Paragraph 3.C above, was not created by us, and in certain other circumstances.

If we deny your request in whole or in part, you will be entitled to submit a written statement of disagreement. We may submit a rebuttal statement. We will be required to identify the information subject to your request and provide a link to the request, our denial, and any statements of disagreement and rebuttal. We will also be required if asked by you to include your request for amendment and our denial with any further disclosures of the information subject to your request. If you submit a statement of disagreement, we will be required to include your request for amendment, our denial, your statement of disagreement, and any rebuttal statement with any subsequent disclosure of the information to which the disagreement relates. We must in all cases inform you in plain language of the basis for our denial and the means by which you can file a complaint with the Department of Health

and Human Services or the Privacy Contact Office identified in Section 7 of this Notice, if you believe our denial was improper.

E. Accountings of Disclosures. You may obtain an accounting of certain of our disclosures of protected health information about you during any period up to six years before the date of your request. There are certain disclosures to which this right does not apply, such as disclosures made to you or for the purpose of carrying out treatment, payment, and health care operations. In addition, we are required to suspend this right for disclosures to a health oversight agency or law enforcement official if the accounting might impede their activities. The first accounting will be provided without charge. A reasonable cost-based fee may be imposed for subsequent accountings within the same 12-month period. You will be entitled to avoid or reduce the fee by withdrawing or modifying your request.

F. Paper Copies of this Notice. Regardless of the form in which you have chosen to receive this Notice from us, you may receive a paper copy at any time from the Privacy Contact Officer identified in Section 7.

6. Changes to Privacy Practices.

We must change our privacy practices when required by changes in the law. We reserve the right to make other changes to our privacy practices or to this Notice that comply with the law. Whenever a change to our privacy practices materially affects the contents of this Notice, we will prepare a revised Notice and send it within 60 days to individuals then covered by the Plan. The Privacy Contact Officer identified in Section 7 will also provide a current copy of this Notice upon request. A change to our privacy practices that requires a revision of this Notice may not be implemented before the effective date of the revised Notice. However, we reserve the right to make the terms of any revised Notice effective for all protected health information that we maintain.

7. Additional Information and Complaints.

You may as specified below obtain additional information and/or submit complaints regarding our duties and your rights with respect to protected health information:

A. Privacy Contact Person. The rights and duties described in this Notice are subject to detailed regulations in the Privacy Rule. We have appointed a Privacy Contact Person, whom you may contact at any time to obtain further information and assistance or a current paper copy of this Notice. You can reach the Privacy Contact Person at the following phone and address:

Washington State Council of Fire Fighters Employee Benefit Trust
c/o Vimly Benefit Solutions
Attn: Privacy Contact Person
P.O. Box 6
Mukilteo, WA 98275-0006
Phone: (206) 859-2600
Email: **iaff-merp@vimly.com**

B. Privacy Complaints. You may file a Privacy Complaint whenever you believe that we are not complying with the Privacy Rule or the terms of this Notice. Complaints may be filed with the Privacy Contact Person or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

C. No Intimidation or Retaliation. No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a privacy Complaint.

8. Effective Date:

This Notice shall become effective on July 6, 2015, and shall remain in effect until it is amended and a revised Notice is provided to you as described in Section 6.

PHI use and disclosure is regulated by federal law. 45 CFR parts 160 and 164 subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.

FROM:
BOARD OF TRUSTEES
WASHINGTON STATE COUNCIL OF FIRE FIGHTERS EMPLOYEE BENEFIT TRUST
Privacy Contact Person phone number: (206) 859-2600

Attachment “E” - Defined Benefit Pension Plan

January 1, 2013

Summary Plan Description
for
Township of Bloomfield
Retirement Income Plan

Employer Identification Number: 38-6000242

Plan Number: 001

This is only a summary intended to familiarize you with the major provisions of the Plan. You should read this summary closely. If you have any questions and before you make any important decisions based on your understanding of the Plan from this summary, you should contact the Plan Administrator.

TABLE OF CONTENTS

INTRODUCTION

Like so many other important events in life, retirement has a way of getting here sooner than we expect. That's why it's never too early to start planning for those years when you no longer have a regular paycheck.

Where will the money come from to support a secure retirement? Social Security, designed to provide for the basic necessities of life, will be one source of income. Both you and your employer contribute to Social Security during your working years. Another major source will be your own savings -- money that you set aside specifically for retirement in vehicles such as bank accounts, individual retirement accounts, and savings bonds.

We're pleased to tell you that a third source will be the Township of Bloomfield Retirement Income Plan (called the "Plan" throughout this booklet). This valuable benefit, funded by you and by Township of Bloomfield (called the "Employer" throughout this booklet), is intended to supplement Social Security and your personal savings in meeting your post-retirement needs. Subject to the Plan's terms and conditions, the Plan offers you:

- A monthly Plan Benefit for life starting at your Normal Retirement Date
- Optional early retirement once you've satisfied the applicable requirements
- The right to future Plan Benefits you have earned under the Plan -- whether or not you continue to work for the Employer
- Survivor Plan Benefits for your Spouse or another Beneficiary, even if you die before you retire
- A choice of ways to receive your monthly Plan Benefit, to help you better plan for your later years

Since the Plan Benefits provided by the Plan play a key role in your future financial security, we urge you to read this summarized description of the Plan carefully. This description summarizes the Plan in effect on January 1, 2013 and updates and replaces any prior descriptions. Employees whose employment terminated before January 1, 2013 may be subject to different Plan provisions.

Please remember, however, that this information is only an overview of the Plan's important provisions. Full details can be found in the legal Plan document which is available for your review in the Bloomfield Township Office during regular business hours. You should consult the Plan document itself if you have any questions about the Plan or your Plan Benefits that are not answered by this booklet.

If you would like your own copy of the Plan document, you may obtain a copy by writing to the Plan Administrator whose location is listed in this booklet's section entitled *"Getting Your Questions Answered"*. There may be a small charge for this service.

PLAN HIGHLIGHTS

WHO IS COVERED

You are covered under the Plan if you are employed in a covered class. Generally, the covered class under the Plan is any employee of the Employer who is any employee of the Employer who is customarily employed for more than 32 hours per week and for more than 5 months per year and who is in one of the following categories:

Division 000 - General Administrative Employees.
Division 001 - Library Employees.
Division 002 Fire Department Bargaining Members.
Division 003 Police Department Civilian.
Division 004 Police Department Command Officers.
Division 005 Police Department Bargaining Members.
Division 006 Bloomfield Village Police.
Division 007 - Fire Department Command Officers.

WHEN YOU CAN RETIRE

- Your Normal Retirement Date is determined in accordance with your Division Schedule; however in no event will your Normal Retirement Date be later than age 65.

- Early Retirement Date: You may retire before your Normal Retirement Date if you have reached age 50 and are 100% vested in your benefit.

- Late Retirement Date: generally, any time after your Normal Retirement Date

PLAN BENEFIT PAYMENT OPTIONS

The Plan offers you a choice of different forms of payment to meet your needs and those of your Beneficiaries:

- Single Life Annuity

- Qualified Joint and Survivor Annuity

- Joint and Survivor Annuity (sometimes called Contingent Pensioner Option)

SURVIVOR PLAN BENEFITS

In addition to those payment options which provide a Survivor Plan Benefit in the event of your death after your Annuity Starting Date, the Plan offers a Preretirement Spouse Benefit if you have a Spouse or a survivor benefit for a Beneficiary if you do not have a Spouse and you die *before* your Annuity Starting Date.

WHEN AND HOW YOU BECOME A PARTICIPANT

If you are already a Participant in the Plan on the day before January 1, 2013, you will continue as a Participant until you are no longer in a class of employees covered under the Plan.

If you were not a Participant on the day before January 1, 2013 you will not become a Participant on or after January 1, 2013. Plan participation is closed to new employees and rehired employees on the dates below:

- Employees hired under Divisions 000 and 003 as of June 1, 2005;
- Employees hired under Divisions 004 and 005 as of June 7, 2006;
- Employees hired under Divisions 002 and 007as of June 18, 2008;
- Employees hired under Divisions 001 as of January 1, 2013.

In the event that you transfer from one Division to another, your Plan Benefit will be determined by applying the specific provisions applicable to the Division under which you are covered at the time your employment ceases. In no event, will your benefit be less than what you would have received in accordance with the terms (at the time of your transfer) of the Plan applicable to the Division you transferred out of and based on your Final Earnings and Credited Service at the time of your transfer.

DIVISION SCHEDULE

With respect to each Division covered under the Plan, the term "Division Schedule" shall refer to the specific provisions and definitions contained in the appropriate schedule for that Division as outlined at the end of this booklet.

YOUR SERVICE

The term Servicer refers to your years of employment with Township of Bloomfield used to determine your eligibility to receive a Plan Benefit.

Although you earn a Plan Benefit while you are covered by the Plan, you are not entitled to that Plan Benefit until you become vested. To be vested simply means that you have earned a non-forfeitable right to your Plan Benefit.

HOW YOU EARN SERVICE

You earn Service from the date you are hired until your Severance Date (the earlier of the date your employment terminates or the date you are absent from work for 12 months). Service is credited in whole years and full months.

Any interruption in your active employment may be considered an interruption in your Service and is called a Break in Service. Breaks in Service can impact previously earned Service if you terminate employment and later return to active employment.

ABSENCES THAT QUALIFY AS SERVICE FOR VESTING PURPOSES

The following absences are still counted as Service for purposes of determining your vested interest:

- absence after your Service ends if you return to work within a year.
- an authorized leave of absence up to two years, if you return to employment when your leave is over. If you don't return, Service won't be counted after the first 12 months of leave.
- absence because of active duty with the Armed Forces of the United States, provided you apply to return to active employment after you are eligible for release from active duty.
- absence due to disability while you are receiving payroll checks from the Township or receiving disability benefits in accordance with the terms of your Division Schedule.

Periods of time during which you were eligible to contribute and elected not to contribute are NOT counted as Service.

YOUR CREDITED SERVICE

Credited Service is the portion of your employment with the Employer that is used in calculating the amount of your Plan Benefit. The amount of your Credited Service may differ from your Service.

HOW YOU EARN CREDITED SERVICE

Credited Service consists of the whole years and full months you have been employed regardless of the number of hours worked. Credited Service includes all periods of employment except the following:

- Periods of employment after you are eligible for participation in the Plan, but during which you do not make contributions.
- Service before August 1, 1961, if you were not a Participant on that date.
- Service while you are receiving disability benefits, unless otherwise specified in your Division Schedule.

YOUR EARNINGS

The term "Earnings" means your basic compensation received from the Township of Bloomfield including longevity payments, but excluding overtime payments, commissions, bonuses and any other additional compensation unless specifically indicated in your Division Schedule.

The term "Rate of Earnings" means your basic rate of compensation received from the Township of Bloomfield determined as of each May 1. Unless specified in your Division Schedule, your Rate of Earnings but does not include any other form of additional pay that you may receive.

The yearly amount of Earnings that may be used in determining your Plan Benefit cannot exceed the limit imposed by the federal government. The government increased the annual maximum compensation that can be considered for plan purposes from $170,000 to $200,000 in 2002. This limit is subject to future cost of living adjustments, and was increased to $255,000 in 2013.

The term Average Annual Earnings (or "Final Earnings") is defined in your Division Schedule.

HOW YOUR PLAN BENEFIT IS CALCULATED

NORMAL RETIREMENT BENEFIT

If you are a Participant and retire on or after your Normal Retirement Date, your Plan Benefit will be determined as outlined in your Division Schedule.

Your Normal Retirement Date is determined in accordance with your Division Schedule; however in no event will your Normal Retirement Date be later than age 65.

If you retire on your Normal Retirement Date, your Plan Benefit will begin on the first day of the month on or after that date. As an alternative, you may remain employed beyond your Normal Retirement Date and continue to accrue Credited Service

EARLY RETIREMENT BENEFIT

You may retire before your Normal Retirement Date if you have reached age 50 and are 100% vested. Thus, your Early Retirement Date can be any date after you are age 50 and before your Normal Retirement Date. Your Early Retirement Benefit payments may begin as early as the first day of the month following the month you actually cease employment. However, payments must begin no later than your Normal Retirement Date.

The Early Retirement Benefit calculation is basically the same as the Normal Retirement Benefit calculation, but includes adjustments made by an Early Commencement Factor. The Early Commencement Factor, based on the age at which you start to receive benefit

payments, reduces your monthly Plan Benefit to account for the additional years during which you'll receive payments.

Early Commencement Factor For Early Retirees

Your monthly Plan Benefit is reduced by .5% for each month that your Annuity Starting Date precedes your Normal Retirement Date.

LATE RETIREMENT BENEFIT

If you continue to work after your Normal Retirement Date, the day on which you finally do retire is called your Late Retirement Date. Generally, you continue to earn benefits under the Plan as long as you are employed.

Your Plan Benefit will begin on the first day of the month coinciding with or next following the calendar month in which you actually cease employment.

WHEN YOU TERMINATE EMPLOYMENT

The Plan provides a retirement benefit for Participants who terminate employment with the Township before they are eligible to retire, provided they are vested. To be vested is to have earned a non-forfeitable right to a portion or all of your Accrued Plan Benefit.

The amount of Plan Benefit to which you are entitled is called your Vested Plan Benefit.

Your Vested Plan Benefit will be a percentage of the Plan Benefit described under the heading "*Normal Retirement*". The percentage applicable to your benefit is taken from the vesting schedule shown below.

*If you are a Participant under Division 004 or Division 005, the following **Vesting Schedule** applies to you.*

Years of Service	Vested Interest
less than 10	0%
10 or more	100%

*If you are a Participant under Divisions 000, 001, 002, 003, 006, or 007, the following **Vesting Schedule** applies to you.*

Years of Service	Vested Interest
less than 8	0%
8 or more	100%

Payment of Your Vested Plan Benefit

Unless your Vested Plan Benefit is cashed out as described in "*Cashouts*" below, it will be paid beginning on your Normal Retirement Date.

Instead of waiting until your Normal Retirement Date to begin receiving benefit payments, you may choose to start receiving your Vested Plan Benefit the first day of any month after you reach age 50.

If you do choose to begin receiving your Vested Plan Benefit before your Normal Retirement Date, your Vested Plan Benefit will be adjusted by an Early Commencement Factor (see the information under the heading "*Early Commencement Factor For Early Retirees*").

Cashouts

If the present value of your Vested Plan Benefit is greater than $5,000, payment of your Vested Plan Benefit will begin on your Normal Retirement Date (or earlier if you are eligible and elect to start payments early). If it is less than $5,000, it will be paid out in a single sum cash payment (see "*Single Sum Cash Payment*" below) as soon as administratively practicable following your termination of employment.

SINGLE SUM CASH PAYMENT

WHEN THE VALUE OF YOUR PLAN BENEFIT IS $5,000 OR LESS

If the value of your Vested Plan Benefit is $5,000 or less you will automatically receive your Vested Plan Benefit in a single sum cash payment. You may elect to receive such payment at any time after your employment terminates. The single sum payment will be equal to the full value of your Vested Plan Benefit at that time. You cannot elect another form of payment. Please refer to the section "*Direct Rollover Distributions*" for important information regarding single sum cash payments.

Similarly, if the value of the Survivor Plan Benefit payable to your Spouse or other Beneficiary is $5,000 or less, payment may be made in a single sum cash payment as soon as administratively practicable following your death.

TAX TREATMENT

If you terminate employment before being eligible to retire and receive a single sum cash payment of your Plan Benefit, your Plan Benefit may be subject to both ordinary income tax and a 10% additional tax. However, the 10% additional tax will ***not*** apply to taxable Plan Benefit payments that are:

- Made after you reach age 59 1/2; or

- Made to your Beneficiary when you die; or

- Used to pay unreimbursed medical expenses for you or your dependent in excess of 7.5% of your adjusted gross income as reported on your Form 1040 federal tax return; or

- Made under the terms of a Qualified Domestic Relations Order.

The taxable Plan Benefit is the amount left after your own contributions are disregarded. You already paid taxes on your own contributions at the time you contributed them to the Plan, so they are not taxable now. The Plan Administrator will provide you with information regarding the tax consequences of your distribution, when it is made. However, you should consult your own tax advisor for more complete information regarding your own situation. For the most current tax information, pick up a free copy of IRS Publication 575 "Pension and Annuity Income" at your local IRS office.

DIRECT ROLLOVER DISTRIBUTIONS

If you receive your Plan Benefit in a single sum cash payment, you may choose to have all or part of such payment rolled over to another qualified plan that accepts rollovers, a tax-sheltered annuity under Code Section 403(b) that accepts rollovers, a deferred compensation plan under Code Section 457(b) maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state, or to an IRA (including a Roth IRA). The portion of your Plan Benefit that is directly rolled over will be exempt from the mandatory 20% tax withholding rules that are otherwise applicable to single sum cash payments.

If your Spouse or other Beneficiary receives payment of a Survivor Plan Benefit in a single sum, he or she may also be eligible to have all or part of such payment directly rolled over to another eligible plan or IRA. Generally, your Spouse (as defined under Federal law) or a former Spouse who is an alternate payee under a qualified domestic relations order may roll over an eligible distribution to an IRA (including a Roth IRA) or to any other eligible plan, as described above. Your non-Spouse Beneficiary (who is your designated beneficiary under IRS rules) may also elect a direct rollover. However, he or she may only direct a rollover to an IRA (including a Roth IRA). The IRA must be identified as an inherited IRA and is subject to special distribution rules.

The Plan Administrator will provide you with more detailed information as to how to elect a direct rollover. However, for more information as to the tax consequences related to single sum cash payments that are <u>not</u> directly rolled over to a qualified defined contribution plan or IRA, you should consult your own tax advisor.

EMPLOYEE CONTRIBUTIONS

After you join the Plan, each year you contribute to the Plan in the amount shown in your Division Schedule.

The balance needed for your accrued Plan Benefit is contributed by the Township of Bloomfield (referred to as Employer contributions).

Upon termination of employment, the following special rules apply to the amount of your employee contributions. You may choose either Option 1 or Option 2:

> Option 1--Elect to receive a cash refund of your total employee contributions, with credited interest as provided in the Plan. ***However, if you elect this option, you'll lose all your Plan Benefit attributable to your Employer's contributions;***
>
> Option 2--Leave your employee contributions in the Plan to provide a Plan Benefit beginning on the first day of the month on or after your early or Normal Retirement Date. If you are 100% vested in your Employer's contributions, you will receive Plan a Benefit based on your employee contributions **and** your Employer's contributions.

If you are later re-employed and had elected Option 1, you may return your cash refund, plus interest, within one year after re-employment and have your years of Credited Service re-instated.

In any event, if you choose Option 2, you will always be provided with a minimum benefit equal to the amount that can be provided by your employee contributions.

If the present value of your Vested Plan Benefit $5,000 or less, your Vested Plan Benefit be paid as a single cash payment at the time you terminate employment if you elect to receive this payment at this time. If you receive such a payment, you will not have a right to any further benefit under the Plan unless you are later rehired and earn additional benefits under the Plan.

FORMS OF BENEFIT PAYMENT

If the value of your Vested Plan Benefit is $5,000 or less at the time you retire, your Plan Benefit will be distributed in a single sum cash payment. If, however, the value of your Vested Plan Benefit is over $5,000, distribution of your Plan Benefit will automatically take the form of an Annuity.

An Annuity is the payment of a benefit in equal installments, usually monthly, over a period of time. The amount of these installments is usually based on life expectancy. You may choose among several different Annuity arrangements. Depending on your choice, you can even provide a lifetime monthly income to your Spouse or another Beneficiary if you die after your Annuity Starting Date.

NORMAL FORM OF PAYMENT

If you are married, payment will be made on the "joint and survivor" basis. This provides a benefit for you and your Spouse, so long as he or she is the same person to whom you are married at your Annuity Starting Date. Your benefit will be paid to you as long as you live. If you die after your Annuity Starting Date, your Spouse will receive a lifetime income equal to 50% of what you were receiving when you died.

If after you and your Spouse die the total amount of Plan Benefits paid to you and your Spouse is less than the value of your required employee contributions, plus interest, on your Annuity Starting Date, your designated Beneficiary will receive the remaining amount at the time of the death of you or your Spouse, whoever survives longer. However, if the total amount of Plan Benefits paid to you and your Spouse before death is more than the value of your required employee contributions, plus interest, on your Annuity Starting Date, your designated Beneficiary will not receive any payment.

The Plan Administrator will give you information about the joint and survivor benefit and your other retirement options before your benefit payments begin. If you don't want the joint and survivor coverage, you must notify the Plan Administrator in writing before your Annuity Starting Date.

If you are not married, your Plan Benefit will be paid to you in a level amount as long as you live. However, if after you die the total amount of Plan Benefits paid to you is less than the value of your required employee contributions, plus interest, on your Annuity Starting Date, your designated Beneficiary will receive the remaining amount at the time of your death. If the total amount of Plan Benefits paid to you before your death is more than the value of your required employee contributions, plus interest, your designated Beneficiary will not receive any payment.

OTHER PAYMENT OPTIONS

The Plan also offers additional payment options which may suit your needs better than the normal forms just described.

JOINT AND SURVIVOR ANNUITY

The Joint and Survivor Annuity (sometimes called the “Contingent Pensioner Option”)will provide you with reduced monthly payments for life but, at your death after your Annuity Starting Date, payments will continue to your primary Beneficiary (any person you choose) for as long as that person lives. These payments may be 100%, 66 2/3% or 50% of your reduced Plan Benefit.

If after you and your primary Beneficiary die the total amount of Plan Benefits paid to you and your primary Beneficiary is less than the value of your required employee contributions, plus interest, on your Annuity Starting Date, your designated secondary Beneficiary will receive the remaining amount at the time of the death of you or your primary Beneficiary,

whoever survives longer. However, if the total amount of Plan Benefits paid to you and your primary Beneficiary before death is more than the value of your required employee contributions, plus interest, on your Annuity Starting Date, your designated secondary Beneficiary will not receive any payment.

ELECTING YOUR FORM OF BENEFIT PAYMENT

TIMING

Generally, you will receive information from the Plan Administrator regarding your retirement payment options, and when you wish to commence payment before your Annuity Starting Date.

Once your payments begin, your election is final and cannot be changed.

PRERETIREMENT SPOUSE BENEFIT

SPOUSAL BENEFITS BEFORE YOUR ANNUITY STARTING DATE

If you have a Spouse and you die before your Annuity Starting Date, your Spouse may be eligible to receive the Preretirement Spouse Benefit which provides financial support to your Spouse if you die before your Annuity Starting Date.

ELIGIBILITY CRITERIA FOR THE PRERETIREMENT SPOUSE BENEFIT

Your Spouse will be eligible to receive a Preretirement Spouse Benefit if you meet all the conditions described in (1) or (2) below.

(1) Your Spouse will be eligible for benefits if you die and:

- You were vested and had at least one hour of service on and after the effective date shown in the appropriate Division Schedule, and
- Your Annuity Starting Date has not occurred.

Your spouse will receive 50% of your Vested Plan Benefit (based on your years of Credited Service to your date of death). However, if your Spouse is more is more than 10 years younger than you, the percentage of your Vested Plan Benefit will be reduced by 2% for each full year by which your Spouse is younger than you.

Note: If you are a Participant in either Division 001 or 006, your Spouse is eligible for this benefit only if you were eligible for an early retirement benefit at the time of your death **and** if your termination of employment had not occurred.

(2) Your Spouse will be eligible for the enhanced benefits if you die and:

- You were an active employee,
- Your Annuity Starting Date has not occurred, and
- You had met the requirements for early retirement on the date of your death.

Your Spouse will receive 100% of your Vest Plan Benefit you would have received on your date of death, reduced by actuarial factors which consider, among other things, your age and the age of your Spouse. However, this benefit will be calculated *without* adjustment by the Early Commencement Factor for early commencement. (This benefit is sometimes referred to as the "100% surviving spouse option").

When your Spouse dies, your designated Beneficiary will receive a refund of the remainder, if any, of the amount of your contributions to the Plan, with interest, on your date of death.

If you are married but not eligible for one of the benefits described above and die before your Annuity Starting Date, your Spouse will receive the amount of your contributions to the Plan, with interest.

The *Preretirement Spouse Benefit* payments described in (1) or (2) above will start on the first day of the month following your death. This *Preretirement Spouse Benefit* coverage is paid for by the Township of Bloomfield.

NON-SPOUSE SURVIVOR BENEFIT

If you do not have a Spouse and you die before your Annuity Starting Date, your designated Beneficiary will receive a non-Spouse Survivor Benefit if you were vested and had at least one hour of service on and after the effective date shown in the appropriate Division Schedule.

Essentially, your Beneficiary will receive the same payments he or she would have received as your Spouse under one of the Preretirement Spouse Benefits described above. The benefit must commence within 12-months of your date of death.

If the total non-Spouse Survivor Benefit paid to your primary Beneficiary at the time of his or her death is less than the amount of your contributions to the Plan, with interest, on your date of death, your secondary Beneficiary will receive a refund of the remaining amount in a single sum payment.

In the event no Beneficiary is named or there are multiple beneficiaries, it will be assumed that the Beneficiary is the same age and no reduction will apply. In addition, if the preceding sentence is true, this benefit will be paid as a lump sum.

Note: If you are a Participant in either Division 001 or 006, your Beneficiary is not eligible for non-Spouse Survivor Benefits described above. Your Beneficiary will receive a refund of your employee contributions, plus interest, instead.

IF YOU BECOME DISABLED

If you become disabled while actively employed, and you are eligible for benefits from your Employer's disability program, you will continue to receive Service (for vesting) while you are collecting these disability benefits. However, you may not receive Credited Service (for benefit purposes) during this period unless you meet certain criteria.

If you are an employee in Division 002, 004, 005, or 007, see your Division Schedule for additional information on disability benefits.

COST OF LIVING BENEFIT

This benefit helps your Plan Benefit payments keep up with inflation. After you retire, you will receive a cost-of-living adjustment to your monthly payments on such dates as may be determined by the Plan Administrator.

If you are currently receiving retirement income because you retired between April 1, 2002 and March 31, 2005 under Divisions 002 or 007, you (or your surviving spouse or other payee) will continue to receive each January 1 an increase in your annual retirement income.

If you are currently receiving retirement income because you retired between April 1, 2005 and December 30, 2007 under Divisions 002 or 007, you (or your surviving spouse or other payee) will continue to receive each January 1 an increase in your annual retirement

If you retire between April 1, 2005 and March 31, 2009, and you are a Participant in Division 000, 001, 003, or 006, you (or your surviving spouse or other payee) will be eligible as of the January 1 following your retirement and each January 1 thereafter, to receive an increase in your annual retirement income.

If you retire between April 1, 2005 and March 31, 2010, and you are a Participant in Division 004 or 005, you (or your surviving spouse or other payee) will be eligible as of the January 1 following your retirement and each January 1 thereafter, to receive an increase in your annual retirement income.

The annual increase in retirement income will be equal to 1% of the annual retirement income you were receiving on the previous December 31. If you do not retire on a January 1, in the first year that you receive an increase, you will receive a ratable portion of the 1%.

SPECIAL RULES APPLICABLE TO PARTICIPANTS WHO DIE DURING MILITARY ABSENCE

If you are absent from employment with the Employer because of military service and die after December 31, 2006, while performing qualified military service (as defined under the Internal Revenue Code), you will be treated as having returned to employment with the Employer on the day before your death for purposes of determining your Vested Plan Benefit and your Beneficiary's eligibility for a Survivor Plan Benefit. Notwithstanding the foregoing, you will not earn additional benefits with respect to your period of military leave.

CIRCUMSTANCES THAT MAY AFFECT YOUR PLAN BENEFIT

Here is a summary of some of the more common circumstances which may affect your Plan Benefit, with references to any sections of the booklet, which describe these situations in more depth.

The following conditions may cause your benefit to be denied or reduced:

- If you don't return to work within 12 months of the date your Service ends, it may be a break in service. This could affect the amount of your retirement benefit.

- If you are disabled, your retirement benefit may be based only on the Credited Service you earned before the disability.

- If you withdraw your required employee contributions, you will lose your Plan benefit.

- If you terminate employment before you are vested, you will not be eligible for a Vested Plan Benefit. However, you will receive a Plan Benefit payable to you at Normal Retirement Date based on the amount of your employee contributions, with interest, on your Annuity Starting Date. See the section "*When You Terminate Employment*".

- If the value of your benefit is $5,000 or less, your benefit may be paid as a single cash payment at the time you terminate employment if you elect to receive this payment at this time. If you receive such a payment, you will not have a right to any further benefit under the Plan unless you are later rehired and earn additional benefits under the Plan.

- The amount of your actual Plan Benefit may not exceed the maximum set by federal law. See the heading "*Legal Limitations And Requirements*".

- If you get divorced, the court may direct that all or part of your benefit be paid to an alternate payee. This alternate payee will generally be your ex-spouse or your children. The Plan Administrator will notify you upon receiving such an order and will tell you what effect it has on your benefit.

The above circumstances will not affect the benefit due from your required employee contributions, unless you elect a refund of your required employee contributions.

RECEIVING YOUR PLAN BENEFIT

APPLYING FOR YOUR BENEFIT

You or your Beneficiary will need to complete a benefit claim form available from the Plan Administrator. This form will allow the Plan Administrator to calculate your benefit and begin to process it.

PAYMENT OF YOUR BENEFIT

If your claim for benefits is approved, payments will be mailed to you monthly. Again, if the value of your Vested Plan Benefit is $5,000 or less, payment will be made in a single sum cash payment.

IF YOUR APPLICATION IS DENIED

If your claim is denied, the Plan Administrator will notify you in writing within 90 days after receiving your claim. The notice will state the following:

- the specific reason(s) for denial;
- the Plan provisions that support the denial;
- additional information needed to complete your claim request;
- explain why this information is needed; and
- tell you what to do if you want to have the claim denial reviewed.

REQUESTING A REVIEW OF THE DENIAL

You have 60 days after the denial date to make a written request for review. If you wish, you (or your representative) may review the appropriate Plan documents, and submit written information supporting your claim to the Plan Administrator or other person (fiduciary) responsible for reviewing denied claims.

The Plan Administrator or fiduciary will give you a written decision of the review of your denied claim within 60 days. This will tell you the specific reasons for the decision and state the Plan provisions on which the decision is based.

IMPORTANT NOTE: The 90 and 60-day periods mentioned above may be extended if there are special circumstances. You will be informed in writing of the extension before the end of the 90 (or 60) days. The extension notice will state the special circumstances requiring an extension of time and the date by which you may expect a decision. In no event will a 90-day period be extended beyond another 90 days, or the 60-day period be extended beyond another 60 days.

GETTING YOUR QUESTIONS ANSWERED

The Plan Administrator is Township of Bloomfield. The Plan Administrator is responsible for administration of the Plan. In addition to administering the Plan, the Plan Administrator is responsible for benefit information and the Plan's adherence to legal requirements. Service of legal process may be made upon the Plan Administrator. The Plan Administrator may be contacted at:

- Address: 4200 Telegraph Road; P.O. Box 489
Bloomfield Hills, MI 48304-0489
- Phone number: (248) 433-7700

ADDITIONAL INFORMATION

- Plan Name: Township of Bloomfield Retirement Income Plan
- Effective Date: The Plan was established effective August 1, 1961 and most recently revised effective January 1, 2013.
- Plan Year: The Plan Year is the 12-month period ending on each December 31st.
- Recordkeeping Period: Records for the Plan are kept on a Plan Year basis.
- Plan Sponsor: Township of Bloomfield
4200 Telegraph Road; P.O. Box 489
Bloomfield Hills, MI 48304-0489
- Phone number: (248) 433-7700
- Plan Sponsor's EIN: 38-6000242
- Plan Number: 001
- Type Of Plan: This is a defined benefit pension plan. Under a defined benefit plan, your retirement benefit is earned over the period of your covered employment and the amount of your retirement benefit is determined by a formula that is defined in the plan document. Ongoing contributions to provide this benefit to you are made to a fund held by Prudential Retirement Insurance and Annuity Company. The amount of the contribution is actuarially determined.

- Type Of Administration: Contract Administration. Plan assets are held in a group annuity contract issued by Prudential Retirement Insurance and Annuity Company, P.O. Box 2975, Hartford, CT 06104. The Plan Administrator is responsible for administering the contract.

- Plan Costs: Both you and the Township of Bloomfield share the cost of your Plan Benefit.

CONTINUATION OF THE PLAN

While the Employer fully intends to continue the Plan indefinitely, it does reserve the right to modify, suspend or terminate the Plan at any time. However, no modification, suspension or termination of the Plan may reduce any Plan Benefits you have already accrued.

Should the Plan be terminated, you will not earn any additional benefits, but you will be 100% vested in your Accrued Plan Benefit at the time of the Plan's termination. The assets of the Plan will be allocated to provide all Accrued Plan Benefits and meet any other legal requirements. After such allocation is completed, any remaining assets will be paid to the Employer.

Assets are allocated to provide Accrued Plan Benefits according to a schedule mandated by law.

DIVISION SCHEDULE 000

General Administrative

Effective as of June 1, 2005

In accordance with and subject to the terms of the Plan, the following definitions and provisions apply to Division 000 Participants who have not terminated, died or retired prior to June 1, 2005. Such definitions and provisions shall remain effective during the period from June 1, 2005 to the date preceding the effective date of an amended Division 000 Schedule.

1. Definitions:

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any three consecutive Earnings Computation Periods (May 1's) during the last ten years before your Annuity Starting Date (Retirement Date); or if Service ceases more than three years before Normal Retirement Date, the term Average Annual Earnings means the average Rate of Earnings as of the last three May 1's before Service ceases.

If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date- for benefit eligibility and vesting purposes, the day on which you attain age 52 and have completed 8 years of Service, or the date you complete 30 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such date.

2. Normal Retirement Benefit:

Effective June 1, 2005, 2.85% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 90% of your Average Annual Earnings.

3. Yearly Amount of Participant's Contributions:

June 1, 2005, 2% of your Earnings

4. Preretirement Death Benefit Coverage

The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit",* is effective April 1, 1996**.**

DIVISION SCHEDULE 001

Library

Effective as of April 1, 1996

The following definitions and provisions shall apply to Division 001 Participants who have not terminated, died or retired prior to April 1, 1996. Such definitions and provisions shall remain effective during the period from April 1, 1996 to the date preceding the effective date of an amended Division 001 Schedule.

1. Definitions:

   Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any five consecutive Earnings Computation Periods (May 1's) during the last ten years before your Annuity Starting Date (Retirement Date); or if Service ceases more than five years before Normal Retirement Date, the term Average Annual Earnings means the average Rate of Earnings as of the last five May 1's before Service ceases.

   If less than five years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

   Normal Retirement Date - for benefit eligibility and vesting purposes, the day on which you attain age 55 and have completed 8 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

   2.1% of your Average Annual Earnings multiplied by the number of your years of Credited Service.

3. Yearly Amount of Participant's Contributions:

   5% of your Earnings

DIVISION SCHEDULE 002

Fire Department Bargaining Members

Effective as of March 25, 2000

The following definitions and provisions shall apply to Division 002 Participants who have not terminated, died or retired prior to March 25, 2000. Such definitions and provisions shall remain effective during the period from March 25, 2000 to the date preceding the effective date of an amended Division 002 Schedule.

1. Definitions:

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any three Earnings Computation Periods (May 1's) during the last ten years before your Annuity Starting Date (Retirement Date); or if Service ceases more than three years before Normal Retirement Date, the term Final Earnings means the average Rate of Earnings as of the last three May 1's before Service ceases.

If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date - for benefit eligibility and vesting purposes, the day on which you attain age 52 and have completed 8 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

2.75% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 80% of your Average Annual Earnings.

3. Yearly Amount of Participant's Contributions:

1% of your Earnings

4. Preretirement Death Benefit Coverage

The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit",* is effective December 18, 1996.

5. Disability

For the purposes of calculating the retirement benefit described in (a) or (b) below, a fire department employee will be considered disabled only if because of injury or

sickness he is unable to perform the essential duties of any occupation for which he or she is or may reasonably become qualified for based upon his or her training, education and experience.

The determination of whether the employee meets the definition of disability will be made by a doctor selected by the Employer. The individual will be subject to reexamination annually for the first five years of disability and every third year thereafter by a doctor designated by the Employer.

a. Duty Disability Benefit-

The yearly amount of retirement income payable on account of a duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service from employment date to the earlier of the date you are no longer considered disabled or Normal Retirement Date. Final Earnings will be equal to the Rate of Earnings immediately prior to disablement, adjusted by the increases negotiated for your job classification between the date of disablement and the earlier of the date you are no longer disabled, or your Normal Retirement Date.

b. Non-Duty Disability Benefit-

The yearly amount of retirement income payable on account of a non-duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service and Final Earnings as of your date of disablement.

DIVISION SCHEDULE 003

Police Department Civilian

Effective as of June 1, 2005

The following definitions and provisions shall apply to Division 003 Participants who have not terminated, died or retired prior to June 1, 2005. Such definitions and provisions shall remain effective during the period from June 1, 2005 to the date preceding the effective date of an amended Division 003 Schedule.

1. Definitions:

   Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any three consecutive Earnings Computation Periods (May 1's) during the last ten years before your Annuity Starting Date (Retirement Date); or if Service ceases more than three years before Normal Retirement Date, the term Average Annual Earnings means the average Rate of Earnings as of the last three May 1's before Service ceases.

   If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

   Normal Retirement Date- for benefit eligibility and vesting purposes, the day on which you attain age 52 and have completed 8 years of Service, or the date you complete 30 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

   Effective June 1, 2005, 2.85% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 90% of your Average Annual Earnings.

3. Yearly Amount of Participant's Contributions:

   Effective June 1, 2005, 2% of your Earnings

4. Preretirement Death Benefit Coverage

   The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit*", is effective April 1, 1996.

DIVISION SCHEDULE 004

Police Department Command Officers

Effective as of June 7, 2006

The following definitions and provisions shall apply to Division 004 Participants who have not terminated, died or retired prior to June 7, 2006. Such definitions and provisions shall remain effective during the period from June 7, 2006 to the date preceding the effective date of an amended Division 004 Schedule.

1. Definitions:

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings for three Earnings Computation Periods May 1's) before your Annuity Starting Date (Retirement Date); or if Service ceases more than three years before Normal Retirement Date, the term Average Annual means the average Rate of Earnings as of the last three May 1's before Service ceases.

If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date- for benefit eligibility and vesting purposes, the day on which you attain age 52 and have completed 10 years of Service or the date you attain age 50 and have 25 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

Effective May 30, 2003 through June 6, 2006, 2.85% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 90% of your Final Earnings.

Effective on and after June 7, 2006, 3% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 90% of your Final Earnings.

3. Yearly Amount of Participant's Contributions:

Effective June 7, 2006, 3.5% of your Earnings

4. Preretirement Death Benefit Coverage

The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit*", is effective July 2, 1996.

5. Disability

For the purposes of calculating the retirement benefit described in (a) or (b) below, an officer will be considered disabled only if because of injury or sickness he is unable to perform the essential duties of any occupation for which he or she is or may reasonably become qualified for based upon his or her training, education and experience.

The determination of whether an officer meets the definition of disability will be made by a doctor selected by the Employer. The individual will be subject to reexamination annually for the first five years of disability and every third year thereafter by a doctor designated by the Employer.

a. Duty Disability Benefit-

The yearly amount of retirement income payable on account of a duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service from employment date to the earlier of the date you are no longer considered disabled or Normal Retirement Date. Final Earnings will be equal to the Rate of Earnings immediately prior to disablement adjusted by the increases negotiated for your job classification between the date of disablement and the earlier of the date you are no longer disabled, or your Normal Retirement Date.

b. Non-Duty Disability Benefit-

The yearly amount of retirement income payable on account of a non-duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service and Final Earnings as of your date of disablement.

DIVISION SCHEDULE 005

Police Department Bargaining Members

Effective as of June 7, 2006

The following definitions and provisions shall apply to Division 005 Participants who have not terminated, died or retired prior to June 7, 2006. Such definitions and provisions shall remain effective during the period from June 7, 2006 to the date preceding the effective date of an amended Division 005 Schedule.

1. Definitions:

Earnings/ Rate of Earnings- the Earnings/ Rate of Earnings definitions **no longer** includes Holiday Pay as defined in the Collective Bargaining Agreement dated April 1, 1990 through March 31, 1993.

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any three Earnings Computation Periods (May 1's) before your Annuity Starting Date (Retirement Date); or if Service ceases more than three years before Normal Retirement Date, the term Average Annual Earnings means the highest average Rate of Earnings as of any three May 1's before Service ceases.

If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date- effective June 7, 2006, for benefit eligibility and vesting purposes, the earlier of the day on which you attain age 52 and have completed 10 years of Service or the date on which you attain age 50 and have completed 25 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

Effective June 23, 2003 through June 6, 2006, 2.85% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 85% of your Average Annual Earnings.

Effective on and after June 7, 2006, 3% of your Average Annual Earnings multiplied by the number of your years of Credited Service ;provided, however, the yearly amount of your retirement income will not exceed 85% of your Average Annual Earnings.

3. Yearly Amount of Participant's Contributions:

Effective June 7, 2006, 3.5% of your Earnings

4. Preretirement Death Benefit Coverage

The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit*", is effective June 3, 1996.

5. Disability

For the purposes of calculating the retirement benefit described in (a) or (b) below, an officer will be considered disabled only if because of injury or sickness he is unable to perform the essential duties of any occupation for which he or she is or may reasonably become qualified for based upon his or her training, education and experience.

The determination of whether an officer meets the definition of disability will be made by a doctor selected by the Employer. The individual will be subject to reexamination annually for the first five years of disability and every third year thereafter by a doctor designated by the Employer.

a. Duty Disability Benefit

The yearly amount of retirement income payable on account of a duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service from employment date to the earlier of the date you are no longer considered disabled or Normal Retirement Date. Final Earnings will be equal to the Rate of Earnings immediately prior to disablement adjusted by the increases negotiated for your job classification between the date of disablement and the earlier of the date you are no longer disabled, or your Normal Retirement Date.

b. Non-Duty Disability Benefit

The yearly amount of retirement income payable on account of a non-duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service and Final Earnings as of your date of disablement.

DIVISION SCHEDULE 006

Bloomfield Village Police

Effective as of April 1, 1996

The following definitions and provisions shall apply to Division 006 Participants who have not terminated, died or retired prior to April 1, 1996. Such definitions and provisions shall remain effective during the period from April 1, 1996 to the date preceding the effective date of an amended Division 006 Schedule.

1. Definitions:

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any five consecutive Earnings Computation Periods (May 1's) during the last ten years before your Retirement Date; or if Service ceases more than five years before Normal Retirement Date, the term Average Annual Earnings means the average Rate of Earnings as of the last five May 1's before Service ceases.

If less than five years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date - for benefit eligibility and vesting purposes, the day on which you attain age 55 and have completed 10 years of Service, or the day on which you attain age 60 and have completed 8 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

2.1% of your Average Annual Earnings multiplied by the number of your years of Credited Service.

3. Yearly Amount of Participant's Contributions:

5% of your Earnings

DIVISION SCHEDULE 007

Fire Department Command Officers

Effective as of March 25, 2000

The following definitions and provisions shall apply to Division 007 Participants who have not terminated, died or retired prior to March 25, 2000. Such definitions and provisions shall remain effective during the period from March 25, 2000 to the date preceding the effective date of an amended Division 007 Schedule.

1. Definitions:

Average Annual Earnings (or Final Earnings) - the highest average Rate of Earnings as of any three Earnings Computation Periods (May 1's) before your Retirement Date; or if Service ceases more than three years before Normal Retirement Date, the term Average Annual Earnings means the average Rate of Earnings as of the last three May 1's before Service ceases.

If less than three years of Rates of Earnings are available, the average will be determined using the Rates of Earnings that are available.

Normal Retirement Date - for benefit eligibility and vesting purposes, the day on which you attain age 52 and have completed 8 years of Service. For all other purposes, Normal Retirement Date is the first day of the month coinciding with or next following such day.

2. Normal Retirement Benefit:

Effective March 25, 2000, 2.75% of your Average Annual Earnings multiplied by the number of your years of Credited Service; provided, however, the yearly amount of your retirement income will not exceed 80% of your Average Annual Earnings.

Yearly Amount of Participant's Contributions:

1% of your Earnings

3. Preretirement Death Benefit Coverage

The preretirement death benefit coverage if you do not have a Spouse, as outlined in the section entitled "*Non-Spouse Survivor Benefit*", is effective December 18, 1996.

4. Disability

For the purposes of calculating the retirement benefit described in (a) or (b) below, an officer will be considered disabled only if because of injury or sickness he is unable to perform the essential duties of any occupation for which he or she is or may reasonably become qualified for based upon his or her training, education and experience.

The determination of whether an officer meets the definition of disability will be made by a doctor selected by the Employer. The individual will be subject to reexamination annually for the first five years of disability and every third year thereafter by a doctor designated by the Employer.

a. Duty Disability Benefit-

The yearly amount of retirement income payable on account of a duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service from employment date to the earlier of the date you are no longer considered disabled or Normal Retirement Date. Final Earnings will be equal to the Rate of Earnings immediately prior to disablement adjusted by the increases negotiated for your job classification between the date of disablement and the earlier of the date you are no longer disabled, or your Normal Retirement Date.

b. Non-Duty Disability Benefit-

The yearly amount of retirement income payable on account of a non-duty disability will be equal to that calculated in accordance with the section entitled *Normal Retirement Benefit* using Credited Service and Final Earnings as of your date of disablement.

Attachment “F” - Defined Contribution 401(a) Plan

CHARTER TOWNSHIP OF BLOOMFIELD 401(A) PLAN AND TRUST

SUMMARY OF PLAN PROVISIONS

January 1, 2022

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CHARTER TOWNSHIP OF BLOOMFIELD 401(A) PLAN AND TRUST

SUMMARY OF PLAN PROVISIONS

INTRODUCTION TO YOUR PLAN

What kind of Plan is this?

Charter Township of Bloomfield 401(a) Plan and Trust ("Plan") has been adopted to provide you with the opportunity to save for retirement on a tax-advantaged basis. This Plan is a type of qualified retirement plan. Generally you are not taxed on the amounts we contribute to the Plan until you withdraw these amounts from the Plan.

What information does this Summary provide?

This Summary of Plan Provisions contains information regarding your Plan benefits, your distribution options, and many other features of the Plan. You should take the time to read this summary to get a better understanding of your rights and obligations under the Plan.

If you have any questions about the Plan, please contact the Administrator or other plan representative. The Administrator is responsible for responding to questions and making determinations related to the administration, interpretation, and application of the Plan. The name and address of the Administrator can be found at the end of this summary in the Article entitled "General Information About the Plan."

This summary describes the Plan's benefits and obligations as contained in the legal Plan document, which governs the operation of the Plan. The Plan document is written in much more technical and precise language and is designed to comply with applicable legal requirements. If the non-technical language in this summary conflicts with the language of the Plan document, then the Plan document always governs.

The Plan and your rights under the Plan are subject to various laws, including the Internal Revenue Code. The provisions of the Plan are subject to revision due to a change in laws. Your Employer may also amend or terminate this Plan.

Types of Contributions. The Plan includes provisions for the following types of contributions:

- Employer nonelective contributions
- Mandatory employee contributions
- Employee rollover contributions

ARTICLE I
PARTICIPATION IN THE PLAN

How do I participate in the Plan?

Provided you are not an Excluded Employee, you may begin participating under the Plan once you have satisfied the eligibility requirements and reached your "Entry Date." The following describes the eligibility requirements and Entry Dates that apply. You should contact the Administrator if you have questions about the timing of your Plan participation.

Excluded Employees. If you are a member of a class of employees identified below, you are an Excluded Employee and you are not entitled to participate in the Plan. The Excluded Employees are:

- certain nonresident aliens who have no earned income from sources within the United States
- leased employees
- independent contractors
- temporary
- casual employees
- any employee who has retired under the Retirement System of the Charter Township of Bloomfield
- employees for whom the Township pays less than 30% of all compensation for the year received by the employee from all governmental units of the State of Michigan, including the State of Michigan. Only those Employees of the Charter Township of Bloomfield hired on or after April 1, 2005 and only those Employees of the Bloomfield Township Library hired on or after April 2, 2011, may become Participants in the Plan. Bargained Employees shall become eligible as provided for in the applicable Collective Bargaining Agreement in effect with the Township.

Eligibility Conditions. You will be eligible to participate in the Plan when you have satisfied the following eligibility condition(s). However, you will actually become a Participant in the Plan once you reach the Entry Date as described below.

- attainment of age 21.
- completion of 1 month of service.

Entry Date. Your Entry Date will be the first day of the month coinciding with or next following the date you satisfy the eligibility requirements.

What happens if I'm a participant, terminate employment and then I'm rehired?

If you are no longer a participant because you terminated employment, and you are rehired, then you will be able to participate in the Plan on your date of rehire provided you are otherwise eligible to participate in the Plan.

ARTICLE II
EMPLOYEE CONTRIBUTIONS

What are rollover contributions?

Rollover contributions. At the discretion of the Administrator, if you are a Participant who is currently employed or an Eligible Employee, you may be permitted to deposit into the Plan distributions you have received from other retirement plans and certain IRAs. Such a deposit is called a "rollover" and may result in tax savings to you. You may ask the Administrator or Trustee of the other plan or IRA to directly transfer (a "direct rollover") to this Plan all or a portion of any amount that you are entitled to receive as a distribution from such plan. Alternatively, you may elect to deposit any amount eligible to be rolled over within 60 days of your receipt of the distribution. You should consult qualified counsel to determine if a rollover is in your best interest.

Rollover account. Your rollover will be accounted for in a "rollover account." You will always be 100% vested in your "rollover account" (see the Article in this summary entitled "Vesting"). This means that you will always be entitled to all amounts in your rollover account. Rollover contributions will be affected by any investment gains or losses.

Withdrawal of rollover contributions. You may withdraw the amounts in your "rollover account" only when you are otherwise entitled to a distribution under the Plan. See "When can I get money out of the Plan?"

What are mandatory employee contributions?

Mandatory contributions. As a condition of employment, you must agree to contribute 3.5% of Compensation if you are part of the Police Patrol Union or Police Command Union.

The mandatory employee contribution does not apply to dispatchers, dispatch supervisor, or police captains.

Fire Union Employees must, prior to his or her first Entry Date, make a one-time irrevocable election to contribute to the Plan from 1% to 3.5% of Compensation to the Plan.

All other employees are not required to make contributions to the Plan. You will always be 100% vested (your ownership rights) in any required amounts you contribute to the Plan.

Withdrawal of mandatory contributions. You may not withdraw required contributions prior to your termination of employment.

Treatment as Employer contributions. The mandatory contribution you make is considered, for purposes of federal taxes, to be an Employer contribution (many people refer to these as pick-up contributions because the Employer is picking up the contribution as though it were making the contribution). This means that the mandatory contribution is not subject to federal income taxes, and in most cases, will not be subject to Social Security and Medicare taxes. This summary still refers to these contributions as mandatory employee contributions in order to avoid confusion with respect to other Employer contributions that may be made under the Plan.

ARTICLE III
EMPLOYER CONTRIBUTIONS

This Article describes Employer contributions that will be made to the Plan.

What is the Employer nonelective contribution and how is it allocated?

Nonelective contribution. Your Employer will contribute 14% of each Participants' Base Compensation for each Plan Year for those Participants in the Police Command Union, except for Participants occupying the positions of either Captain or Dispatch Supervisor which

shall receive a contribution of 10%. 14% of each Participants' Base Compensation for each Plan Year for those Participants in the Police Patrol Union, except for Participants occupying the position of Dispatcher which shall receive a contribution of 10%. 14% of each Participants' Base Compensation for each Plan Year for those Participants in the Fire Union. 10% of each Participants' Base Compensation for each Plan Year for all other Bloomfield Township Participants, Bloomfield Township Library Participants, and Bloomfield Township Elected Official Participants.

Allocation conditions. You will always share in the nonelective contribution regardless of the amount of service you complete during the Plan Year.

What are forfeitures and how are they allocated?

Definition of forfeitures. In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that your Employer makes to the Plan. This means that you will not be "vested" in (entitled to) all of the contributions until you have been employed with the Employer for a specified period of time (see the Article entitled "Vesting"). If a participant terminates employment before being fully vested, then the non-vested portion of the terminated participant's account balance remains in the Plan and is called a forfeiture.

Allocation of forfeitures. The Employer may use forfeitures to pay Plan expenses or to reduce amounts otherwise required to be contributed to the Plan. In some cases, remaining forfeitures will be used to reduce Employer contributions.

ARTICLE IV
COMPENSATION AND ACCOUNT BALANCE

What compensation is used to determine my Plan benefits?

Definition of compensation. For the purposes of the Plan, compensation has a special meaning. Compensation is generally defined as your total compensation that is subject to income tax and paid to you by your Employer during the Plan Year.

Adjustments to compensation. The following adjustments to compensation will be made:

- Compensation is intended to include only Participants' base wages or base salary and would exclude any overtime pay, buyouts or sick, personal or vacation days, bonuses or any other non-earned income

- compensation paid after you terminate is generally excluded for Plan purposes. However, the following amounts will be included in compensation even though they are paid after you terminate employment, provided these amounts would otherwise have been considered compensation as described above and provided they are paid within 2 1/2 months after you terminate employment, or if later, the last day of the Plan Year in which you terminate employment:

    - compensation for services performed during your regular working hours, or for services outside your regular working hours (such as overtime or shift differential) or other similar payments that would have been made to you had you continued employment

Is there a limit on the amount of compensation which can be considered?

The Plan, by law, cannot recognize annual compensation in excess of a certain dollar limit. The limit for the Plan Year beginning in 2022 is $305,000. After 2022, the dollar limit may increase for cost-of-living adjustments.

Is there a limit on how much can be contributed to my account each year?

Generally, the law imposes a maximum limit on the amount of contributions that may be made to your account and any other amounts allocated to any of your accounts during the Plan Year, excluding earnings. Beginning in 2022, this total cannot exceed the lesser of $61,000 or 100% of your annual compensation. After 2022, the dollar limit may increase for cost-of-living adjustments.

How is the money in the Plan invested?

Participant directed investments. You will be able to direct the investment of your entire interest in the Plan. The Administrator will provide you with information on the investment choices available to you, the procedures for making investment elections, the frequency with which you can change your investment choices and other important information. You need to follow the procedures for making investment elections and you should carefully review the information provided to you before you give investment directions. If you do not direct the investment of your applicable Plan accounts, then your accounts will be invested in accordance with the default investment alternatives established under the Plan.

Earnings or losses. When you direct investments, your accounts are segregated for purposes of determining the earnings or losses on these investments. Your account does not share in the investment performance of other participants who have directed their own investments. You should remember that the amount of your benefits under the Plan will depend in part upon your choice of investments. Gains as well

as losses can occur and your Employer, the Administrator, and the Trustee will not provide investment advice or guarantee the performance of any investment you choose.

Will Plan expenses be deducted from my account balance?

Expenses allocated to all accounts. The Plan permits the payment of Plan expenses to be made from the Plan's assets. The method of allocating the expenses depends on the nature of the expense itself. For example, certain administrative (or recordkeeping) expenses would typically be allocated proportionately to each participant. If the Plan pays $1,000 in expenses and there are 100 participants, your account balance would be charged $10 ($1,000/100) of the expense.

Terminated employee. After you terminate employment, your Employer reserves the right to charge your account for your pro rata share of the Plan's administration expenses, regardless of whether your Employer pays some of these expenses on behalf of current employees.

Expenses allocated to individual accounts. There are certain other expenses that may be paid just from your account. These are expenses that are specifically incurred by, or attributable to, you. For example, if you are married and get divorced, the Plan may incur additional expenses if a court mandates that a portion of your account be paid to your ex-spouse. These additional expenses may be paid directly from your account (and not the accounts of other participants) because they are directly attributable to you under the Plan. The Administrator can inform you when there will be a charge (or charges) directly to your account.

Your Employer may, from time to time, change the manner in which expenses are allocated.

ARTICLE V
VESTING

What is my vested interest in my account?

In order to reward employees who remain employed with the Employer for a long period of time, the law permits a "vesting schedule" to be applied to certain contributions that your Employer makes to the Plan. This means that you will not be entitled ("vested") in all of the contributions until you have been employed with the Employer for a specified period of time.

100% vested contributions. You are always 100% vested (which means that you are entitled to all of the amounts) in your accounts attributable to the following contributions:

- mandatory employee contributions
- rollover contributions
- pick up

Vesting schedules. Your "vested percentage" for certain Employer contributions is based on vesting Years of Service. This means at the time you stop working, your account balance attributable to contributions subject to a vesting schedule is multiplied by your vested percentage. The result, when added to the amounts that are always 100% vested as shown above, is your vested interest in the Plan, which is what you will actually receive from the Plan.

Employer Contributions

Your "vested percentage" in your account attributable to Employer contributions is determined under the following schedule. You will always, however, be 100% vested in these contributions if you are employed on or after your Normal Retirement Age.

Vesting Schedule
Nonelective Contributions

Years of Service	Percentage
3	25%
5	50%
7	100%

Pre-Amendment Schedule. However, the vesting schedule in the Plan has been amended. If you have completed 3 Years of Service with your Employer as of the expiration of the election period, you may elect to have your "vested percentage" determined under the pre-amendment vesting schedule. Your election period will commence on the adoption date of the amendment changing vesting and will end 60 days after the later of (a) the adoption date of the amendment, (b) the effective date of the amendment, or (c) the date you receive written notice of the amendment from your Employer or Administrator. However, if the vesting pre-amendment vesting schedule below applies to any Participants, then the schedules above under "Vesting schedules" will only apply to Participants (even if not an Employee) in the Plan on or after April 1, 2020.

Special Vesting Provisions

- For eligible Participants hired on or after January 1, 2008, the following vesting schedule shall apply to Plan employer contributions: Less than 3 years - 0%; 3 or more - 100%. For those eligible Participants hired before January 1, 2008, the following vesting schedule shall apply to Plan employer contributions: Less than 4 - 0%; 4 or more - 100%. Employees hired on or after April 1, 2020 classified by the Employer as "Police Command Union (POLC)", "Police Patrol Union (POLC)", "DPW Foreman and Supervisor Union (GELC)", "DPW Maintenance Employees Union (GELC)", "Department Head and Deputy Union (GELC)", "General Employees Union (GELC)", "Fire Union (IAFF)", “Water and Sewer Union (AFSCME)”, "Library" and "Other non-union individuals who are full-time and qualify for this benefit" will be subject to the following vesting schedule: 0-2 Years of Service - 0%, 3 Years of Service - 25%, 5 Years of Service - 50%, 7 Years of Service - 100%. Employees hired on or after April 1, 2020 classified by the Employer as "Elected Officials" will remain on the 3-year cliff vesting schedule.

How is my service determined for vesting purposes?

Year of Service. To earn a Year of Service, you must be credited with at least 1,000 Hours of Service during a Plan Year. The Plan contains specific rules for crediting Hours of Service for vesting purposes. The Administrator will track your service and will credit you with a Year of Service for each Plan Year in which you are credited with the required Hours of Service, in accordance with the terms of the Plan. If you have any questions regarding your vesting service, you should contact the Administrator.

Hour of Service. You will be credited with your actual Hours of Service for:

(a) each hour for which you are directly or indirectly compensated by the Employer for the performance of duties during the Plan Year;

(b) each hour for which you are directly or indirectly compensated by the Employer for reasons other than the performance of duties (such as vacation, holidays, sickness, disability, lay-off, military duty, jury duty or leave of absence during the Plan Year); and

(c) each hour for back pay awarded or agreed to by the Employer.

You will not be credited for the same Hours of Service both under (a) or (b), as the case may be, and under (c). For Employees for whom records of actual Hours of Service are not maintained or available (e.g., salaried Employees) the monthly equivalency method (190 hours per month) will be used.

What service is counted for vesting purposes?

Service with the Employer. In calculating your vested percentage, all service you perform for the Employer will generally be counted.

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. If you may be affected by this law, ask the Administrator for further details.

When will the non-vested portion of my account balance be forfeited?

If you are partially vested in your account balance when you leave, the non-vested portion of your account balance will be forfeited on the earlier of the date:

(a) of the distribution of your vested account balance, or

(b) when you incur five consecutive 1-year Breaks in Service.

ARTICLE VI
BENEFITS AND DISTRIBUTIONS UPON TERMINATION OF EMPLOYMENT

When can I get money out of the Plan?

You may receive a distribution of the vested portion of some or all of your accounts in the Plan for the following reasons:

- termination of employment for reasons other than death, disability or retirement
- normal retirement
- disability
- death

This Plan is designed to provide you with retirement benefits. However, distributions are permitted if you die or become disabled. In addition, certain payments are permitted when you terminate employment for any other reason. The rules under which you can receive a distribution are described in this Article. The rules regarding the payment of death benefits to your beneficiary are described in "Benefits and Distributions Upon Death."

Military Service. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994, your qualified military service may be considered service with the Employer. There may also be benefits for employees who die or become disabled while on active duty. Employees who receive wage continuation payments while in the military may benefit from various changes in the law. If you think you may be affected by these rules, ask the Administrator for further details.

Distributions for deemed severance of employment. If you are on active duty for more than 30 days, then the Plan generally treats you as having severed employment for distribution purposes. This means that you may request a distribution from the Plan.

What happens if I terminate employment before death, disability or retirement?

If your employment terminates for reasons other than normal retirement, you will be entitled to receive only the "vested percentage" of your account balance.

If your vested account balance exceeds $5,000, you may elect to have your vested account balance distributed to you as soon as administratively feasible following your termination of employment.

If your vested account balance does not exceed $5,000, a distribution of your vested account balance may be made to you as soon as administratively feasible following your termination of employment. However, if the value of your vested account balance does not exceed $1,000, the distribution will be made to you regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these amounts will be paid.)

Treatment of rollovers for consent to distribution. In determining if the value of your vested account balance exceeds the $1,000 threshold described above used to determine whether you must consent to a distribution, your rollover account will be considered as part of your benefit.

Treatment of rollovers for timing of payments. In determining whether the $5,000 threshold described above for timing of payments has been exceeded, amounts in your rollover account will be considered as part of your benefit.

What happens if I terminate employment at Normal Retirement Date?

Normal Retirement Date. You will attain your Normal Retirement Age when you reach age 52. However, if you are a public safety employee (as defined in the Internal Revenue Code) then your Normal Retirement Age is 52. Your Normal Retirement Date is the date on which you attain your Normal Retirement Age.

Normal Retirement Date. You will attain your Normal Retirement Age when 52. Your Normal Retirement Date is the date on which you attain your Normal Retirement Age.

Payment of benefits. You will become 100% vested in all of your accounts under the Plan if you retire on or after your Normal Retirement Age. However, the actual payment of benefits generally will not begin until you have terminated employment and reached your Normal Retirement Date. In such event, a distribution will be made, at your election, as soon as administratively feasible. If you remain employed past your Normal Retirement Date, you may generally defer the receipt of benefits until you actually terminate employment. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

What happens if I terminate employment due to disability?

Definition of disability. Under the Plan, disability is defined as determination by the SSA that the Participant is disabled for purposes of determining federal Social Security benefits. Notwithstanding anything to the contrary herein and with respect to Participants who are covered by a collective bargaining agreement with the Township as part of either the Police Patrol Union, Police Command Union or Fire Union, except for dispatchers, dispatch supervisor, and police captains ("Designated Participants"), a Designated Participant who becomes permanently and totally disabled (as defined in Section 22(e)(3) of the code) while an Employee shall be deemed to receive, after becoming permanently and totally disabled, Compensation equal to the Compensation the Designated Participant would have received if the Designated Participant were paid at the rate of Compensation paid to such Designated Participant immediately before becoming permanently and totally disabled or, if greater, at the rate of Compensation to which such Designated Participant would have been entitled if still employed continuously from the date of such permanent and total disability and paid at the rate prescribed in the appropriate collective bargaining agreement ("Deemed Compensation"). Such Deemed Compensation shall continue, for a Designated Participant who was a Fire Employee at the onset of such permanent and total disability, until the later of (i) the date the Designated Participant attains age 52 or (ii) the date the Designated Participant completes 8 Years of Service or, for a Designated Participant who was a Police Employee at the onset of such permanent and total disability, until the earlier to occur of (1) the later of (i) the date on which the Designated Participant completes 10 Years of Service or (2) the later of (i) the date on which the Designated Participant attains age 50 , or (ii) the date the Designated Participant completes 25 Years of Service, in all cases considering such period of permanent and total disability as continuous service.

Payment of benefits. If you become disabled while an employee, you will be entitled to your vested account balance under the Plan. Payment of your disability benefits will be made to you as if you had retired. However, if the value of your vested account balance does not exceed $1,000, then a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it. (See the question entitled "How will my benefits be paid to me?" for an explanation of how these benefits will be paid.)

How will my benefits be paid to me?

Lump-sum distributions. All distributions from the Plan will be made in a single lump-sum payment. If your vested account balance exceeds $1,000, you must consent to the distribution before it may be made.

Delaying distributions. You may delay the distribution of your vested account balance unless a distribution is required to be made, as explained earlier, because your vested account balance does not exceed $1,000. However, if you elect to delay the distribution of your vested account balance, there are rules that require that certain minimum distributions be made from the Plan. Distributions are required to begin not later than the April 1st following the later of the end of the year in which you reach age 70 1/2 or retire.

Medium of payment. Benefits under the Plan will generally be paid to you in cash only.

ARTICLE VII
BENEFITS AND DISTRIBUTIONS UPON DEATH

What happens if I die while working for the Employer?

If you die while still employed by the Employer, then your vested account balance will be used to provide your beneficiary with a death benefit.

Who is the beneficiary of my death benefit?

Beneficiary designation. You may designate a beneficiary for your death benefit. The designation must be made in accordance with the procedures set forth by the Administrator. You should periodically review your designation to ensure it continues to meet your goals.

Divorce. If you have designated your spouse as your beneficiary for all or a part of your death benefit, then upon your divorce, the designation is no longer valid. This means that if you do not select a new beneficiary after your divorce, then you are treated as not having a beneficiary for that portion of the death benefit (unless you have remarried).

No beneficiary designation. At the time of your death, if you have not designated a beneficiary or your beneficiary is also not alive, the death benefit will be paid in the following order of priority to:

(a) your surviving spouse

(b) your children, including adopted children in equal shares (and if a child is not living, that child's share will be distributed to that child's heirs)

(c) your surviving parents, in equal shares

(d) your estate

How will the death benefit be paid to my beneficiary?

Lump-sum distributions. The death benefit will be paid to your beneficiary in a single lump-sum payment.

When must the last payment be made to my beneficiary?

The law generally restricts the ability of a retirement plan to be used as a method of retaining money for purposes of your death estate. Thus, there are rules that are designed to ensure that death benefits are distributable to beneficiaries within certain time periods.

Your death benefit must generally be paid to your beneficiary by the end of the fifth year following the year of your death. However, if your spouse is your designated beneficiary, then your spouse can elect to delay the payment until the year in which you would have attained age 70 1/2.

What happens if I'm a participant, terminate employment and die before receiving all my benefits?

If you terminate employment with the Employer and subsequently die, your beneficiary will be entitled to your remaining interest in the Plan at the time of your death.

ARTICLE VIII
TAX TREATMENT OF DISTRIBUTIONS

What are my tax consequences when I receive a distribution from the Plan?

Generally, you must include any Plan distribution in your taxable income in the year in which you receive the distribution. The tax treatment may also depend on your age when you receive the distribution. Certain distributions made to you when you are under age 59 1/2 could be subject to an additional 10% tax.

Can I elect a rollover to reduce or defer tax on my distribution?

Rollover or Direct Transfer. You may reduce, or defer entirely, the tax due on your distribution through use of one of the following methods:

(a) **60-day rollover.** The rollover of all or a portion of the distribution to an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the rollover. This will result in no tax being due until you begin withdrawing funds from the IRA or other qualified employer plan. The rollover of the distribution, however, MUST be made within strict time frames (normally, within 60 days after you receive your distribution). Under certain circumstances, all or a portion of a distribution may not qualify for this rollover treatment. In addition, most distributions will be subject to mandatory federal income tax withholding at a rate of 20%. This will reduce the amount you actually receive. For this reason, if you wish to roll over all or a portion of your distribution amount, then the direct transfer option described in paragraph (b) below would be the better choice.

(b) **Direct rollover.** For most distributions, you may request that a direct transfer (sometimes referred to as a direct rollover) of all or a portion of a distribution be made to either an Individual Retirement Account or Annuity (IRA) or another employer retirement plan willing to accept the transfer. A direct transfer will result in no tax being due until you withdraw funds from the IRA or other employer plan. Like the rollover, under certain circumstances all or a portion of the amount to be distributed may not qualify for this direct transfer. If you elect to actually receive the distribution rather than request a direct transfer, then in most cases 20% of the distribution amount will be withheld for federal income tax purposes.

Tax Notice. WHENEVER YOU RECEIVE A DISTRIBUTION THAT IS AN ELIGIBLE ROLLOVER DISTRIBUTION, THE ADMINISTRATOR WILL DELIVER TO YOU A MORE DETAILED EXPLANATION OF THESE OPTIONS. HOWEVER, THE RULES WHICH DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. YOU SHOULD CONSULT WITH QUALIFIED TAX COUNSEL BEFORE MAKING A CHOICE.

ARTICLE IX
PROTECTED BENEFITS AND CLAIMS PROCEDURES

Are my benefits protected?

As a general rule, your interest in your account, including your "vested interest," may not be alienated. This means that your interest may not be sold, used as collateral for a loan, given away or otherwise transferred. In addition, your creditors (other than the IRS) may not attach, garnish or otherwise interfere with your benefits under the Plan.

Are there any exceptions to the general rule?

There are three exceptions to this general rule. The Administrator must honor a "qualified domestic relations order." A "qualified domestic relations order" is defined as a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, children or other dependents. If a qualified domestic relations order is received by the Administrator, all or a portion of your benefits may be used to satisfy that obligation. The Administrator will determine the validity of any domestic relations order received. You and your beneficiaries can obtain from the Administrator, without charge, a copy of the procedure used by the Administrator to determine whether a qualified domestic relations order is valid.

The second exception applies if you are involved with the Plan's operation. If you are found liable for any action that adversely affects the Plan, the Administrator can offset your benefits by the amount that you are ordered or required by a court to pay the Plan. All or a portion of your benefits may be used to satisfy any such obligation to the Plan.

The last exception applies to Federal tax levies and judgments. The Federal government is able to use your interest in the Plan to enforce a Federal tax levy and to collect a judgment resulting from an unpaid tax assessment.

Can the Plan be amended?

Your Employer has the right to amend the Plan at any time. In no event, however, will any amendment authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of participants or their beneficiaries. Additionally, no amendment will cause any reduction in the amount credited to your account.

What happens if the Plan is discontinued or terminated?

Although your Employer intends to maintain the Plan indefinitely, your Employer reserves the right to terminate the Plan at any time. Upon termination, no further contributions will be made to the Plan and all amounts credited to your accounts will become 100% vested. Your Employer will direct the distribution of your accounts in a manner permitted by the Plan as soon as practicable. (See the question entitled "How will my benefits be paid to me?" for a further explanation.) You will be notified if the Plan is terminated.

How do I submit a claim for Plan benefits?

Benefits will generally be paid to you and your beneficiaries without the necessity for formal claims. Contact the Administrator if you are entitled to benefits or if you think an error has been made in determining your benefits. Any such request should be in writing.

If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

What if my benefits are denied?

Your request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will provide you with notification of the Plan's adverse determination. This written or electronic notification will be provided to you within a reasonable period of time.

ARTICLE X
GENERAL INFORMATION ABOUT THE PLAN

There is certain general information which you may need to know about the Plan. This information has been summarized for you in this Article.

Plan Name

The full name of the Plan is Charter Township of Bloomfield 401(a) Plan and Trust.

Plan Effective Dates

This Plan was originally effective on April 1, 2005. The amended and restated provisions of the Plan become effective on January 1, 2022. However, this restatement was made to conform the Plan to new tax laws and some provisions may be retroactively effective.

Other Plan Information

Valuations of the Plan assets are generally made every business day. Certain distributions are based on the Anniversary Date of the Plan. This date is the last day of the Plan Year.

The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

Employer Information

Your Employer's name, address and identification number are:

Charter Township of Bloomfield
4200 Telegraph Road
Bloomfield Hills, Michigan 48303

38-6000242

Administrator Information

The Administrator is responsible for the day-to-day administration and operation of the Plan. For example, the Administrator maintains the Plan records, including your account information, provides you with the forms you need to complete for Plan participation, and directs the payment of your account at the appropriate time. The Administrator will also allow you to review the formal Plan document and certain other materials related to the Plan. If you have any questions about the Plan or your participation, you should contact the Administrator. The Administrator may designate other parties to perform some duties of the Administrator.

The Administrator has the complete power, in its sole discretion, to determine all questions arising in connection with the administration, interpretation, and application of the Plan (and any related documents and underlying policies). Any such determination by the Administrator is conclusive and binding upon all persons.

Your Administrator's name and contact information are:

Charter Township of Bloomfield
4200 Telegraph Road
Bloomfield Hills, Michigan 48303

(248) 433-7700

AMENDMENT NUMBER TWO

CHARTER TOWNSHIP OF BLOOMFIELD 401(A) PLAN AND TRUST

SUMMARY OF PLAN PROVISIONS
MATERIAL MODIFICATIONS

I
INTRODUCTION

This is a Summary of Material Modifications regarding the Charter Township of Bloomfield 401(a) Plan and Trust ("Plan"). Unless stated otherwise, the modifications described in this summary are effective as of January 1, 2026. This is merely a summary of the most important changes to the Plan and information contained in the Summary Plan Description ("SPD") previously provided to you. It supplements and amends that SPD so you should retain a copy of this document with your copy of the SPD. If you have any questions, contact the Administrator. If there is any discrepancy between the terms of the Plan, as modified, and this Summary of Material Modifications, the provisions of the Plan will control.

II
SUMMARY OF CHANGES

1. Mandatory Employee Contributions

As a condition of employment, you must agree to contribute 5% of your compensation to the Plan. You will always be 100% vested (your ownership rights) in any required amounts you elect to contribute to the Plan.

5% of Compensation if you are part of the Police Patrol Union or Police Command Union. The mandatory employee contribution does not apply to dispatchers, dispatch supervisor, or police captains. Fire Union Employees must, prior to his or her first Entry Date, make a one-time irrevocable election to contribute to the Plan 5% of Compensation to the Plan. All other employees are not required to make contributions to the Plan.

You may not withdraw required contributions prior to your termination of employment.

The mandatory contribution you make is considered, for purposes of federal taxes, to be an Employer contribution (many people refer to these as pick-up contributions because the Employer is picking up the contribution as though it were making the contribution). This means that the mandatory contribution is not subject to federal income taxes, and in most cases, will not be subject to Social Security and Medicare taxes. This summary still refers to these contributions as mandatory employee contributions in order to avoid confusion with respect to other Employer contributions that may be made under the Plan.

2. Employer Nonelective Contribution

Your Employer will contribute 20% of each Participants' Base Compensation for each Plan Year for those Participants in the Police Command Union, except for Participants occupying the positions of either Captain or Dispatch Supervisor which shall receive a contribution of 13%. 20% of each Participants' Base Compensation for each Plan Year for those Participants in the Police Patrol Union, except for Participants occupying the position of Dispatcher which shall receive a contribution of 13%. 20% of each Participants' Base Compensation for each Plan Year for those Participants in the Fire Union. 13% of each Participants' Base Compensation for each Plan Year for all other Bloomfield Township Participants, Bloomfield Township Library Participants, and Bloomfield Township Elected Official Participants.

3. Vesting

Your "vested percentage" in your account attributable to Employer contributions is determined under the following schedule.

Vesting Schedule
Nonelective Contributions

Years of Service	Percentage
5	25%
8	100%

4. Special Vesting Provisions

- For eligible Participants hired on or after January 1, 2008, the following vesting schedule shall apply to Plan employer contributions: Less than 3 years - 0%; 3 or more - 100%. For those eligible Participants hired before January 1, 2008, the following vesting schedule shall apply to Plan employer contributions: Less than 4 - 0%; 4 or more - 100%. Employees hired on or after April 1,

2020 classified by the Employer as "Police Command Union (POLC)", "Police Patrol Union (POLC)", "DPW Foreman and Supervisor Union (GELC)", "DPW Maintenance Employees Union (GELC)", "Department Head and Deputy Union (GELC)", "General Employees Union (GELC)", "Fire Union (IAFF)", "Water and Sewer Union (AFSCME)", "Library" and "Other non-union individuals who are full-time and qualify for this benefit" will be subject to the following vesting schedule: 0-2 Years of Service - 0%, 3 Years of Service - 25%, 5 Years of Service - 50%, 7 Years of Service - 100%. Employees hired on or after January 1, 2026 classified by the Employer as "Police Command Union (POLC)", "Police Patrol Union (POLC)", "DPW Foreman and Supervisor Union (GELC)", "DPW Maintenance Employees Union (GELC)", "Department Head and Deputy Union (GELC)", "General Employees Union (GELC)", "Fire Union (IAFF)", "Water and Sewer Union (AFSCME)", "Library" and "Other non-union individuals who are full-time and qualify for this benefit" will be subject to the following vesting schedule: 0-4 Years of Service - 0%, 5 Years of Service - 25%, 8 Years of Service - 100%. Employees hired on or after April 1, 2020 classified by the Employer as "Elected Officials" will remain on the 3-year cliff vesting schedule. Employees hired on or after January 1, 2026 classified by the Employer as "Elected Officials" will remain on the 3-year cliff vesting schedule.

Attachment "G" – Life Insurance and AD&D

AMENDMENT NO. 1

This amendment forms a part of Group Identification No. 147520 001 issued to the Employer/Applicant:

Charter Township of Bloomfield

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is July 1, 2009. The changes only apply to deaths and covered losses that occur and disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on February 17, 2010.

Unum Life Insurance Company of America

By 

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of February 17, 2010.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Charter Township of Bloomfield

By _____
Signature and Title of Officer

GROUP INSURANCE
SUMMARY OF BENEFITS
NON-PARTICIPATING

IDENTIFICATION NUMBER: 147520 001

EFFECTIVE DATE OF COVERAGE: July 1, 2009

ANNIVERSARY DATE: July 1

GOVERNING JURISDICTION: Maine

Unum Life Insurance Company of America
insures the lives of

Charter Township of Bloomfield

under the
Select Group Insurance Trust
Policy No. 292000

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all of this Summary of Benefits' provisions.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.

President Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: July 1, 2009

IDENTIFICATION NUMBER: 147520 001

ELIGIBLE GROUP(S):

All Employees

For retirees, certain terms and conditions in this life insurance plan are affected as follows:
- references to "employee" will read "retiree" as it applies
- references to "active employment" will not apply
- the "life insurance premium waiver" provision will not apply

MINIMUM HOURS REQUIREMENT:

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group

Employees must be working at least 32 hours per week.

WAITING PERIOD:

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group

For employees in an eligible group on or before July 1, 2009: 1 month of continuous active employment

For employees entering an eligible group after July 1, 2009: 1 month of continuous active employment

REHIRE:

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

Your Employer pays the cost of your coverage.

For Your Dependents:

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
Your Employer pays the cost of your dependent coverage.

ELIMINATION PERIOD:

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Library Employees, Department Head Employees, All Employees not eligible in another group
$50,000

Village Police Union Employees, Village Fire Employees
$20,000

Elected Officials
$75,000

On or after November 1, 2005:	50% of your Life Insurance Benefit in effect on the day prior to your reaching age 70.
On or after January 1, 1995 but prior to November 1, 2005:	$35,000
On or after January 1, 1984 but prior to January 1, 1995:	$25,000

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU RETIRE

Union Fire Retirees, Union Police Retirees, Village Union Police Retirees, Village Fire Retirees, All Retirees, not eligible in another group, with a retirement date prior to April 1, 1993
$6,000

Union Police Command Office Retirees, Police Captain Retiree, Fire Department Operations Officer Retirees, Library Retirees, All Retirees not eligible in another group, All Retirees, not eligible in another group, with a retirement date April 1, 1993 or later
$8,000

Department Head Retirees
$15,000

Retired Elected Officials

On or after November 1, 2005:	50% of your Life Insurance Benefit in effect on the day prior to your retirement
On or after January 1, 1995 but	

prior to November 1, 2005:	$35,000
On or after January 1, 1984 but prior to January 1, 1995:	$25,000

Note: If you are age 70 or older on the day prior to your retirement, your retiree benefit amount is the amount for which you were insured at age 70.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

Union Fire Employees, Union Police Employees, Village Police Union Employees, Village Fire Employees
If you have reached age 70, your amount of life insurance will be:
- $6,000; or
- $6,000 if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Library Employees, All Employees not eligible in another group
If you have reached age 70, your amount of life insurance will be:
- $8,000; or
- $8,000 if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

Elected Officials

On or after November 1, 2005:	50% of the Life Insurance Benefit in effect on the day prior to your reaching age 70.
On or after January 1, 1995 but prior to November 1, 2005:	$35,000
On or after January 1, 1984 but prior to January 1, 1995:	$25,000

Department Head Employees
If you have reached age 70, your amount of life insurance will be:
- $15,000; or
- $15,000 if you become insured on or after age 70.

There will be no further increases in your amount of life insurance.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

For all Spouse's under age 70

Union Fire Employees, Union Police Employees, Village Police Union Employees, Village Fire Employees
$5,000

Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
$10,000

For all Spouse's age 70 or older:

No coverage

Children:

Union Fire Employees, Union Police Employees, Village Police Union Employees, Village Fire Employees

15 days to 6 months:	$500
6 months to age 19:	$2,500

Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group

15 days to 6 months:	$1,000
6 months to age 19:	$5,000

THE AMOUNT OF LIFE INSURANCE FOR A DEPENDENT WILL NOT BE MORE THAN 100% OF YOUR AMOUNT OF LIFE INSURANCE.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

Survivor Income Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: July 1, 2009

IDENTIFICATION NUMBER: 147520 001

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 32 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2009: 1 month of continuous active employment

For employees entering an eligible group after July 1, 2009: 1 month of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees
$50,000

Village Police Union Employees, Village Fire Employees, Library Employees
$20,000

Elected Officials
$75,000

Department Head Employees
$40,000

All Employees not eligible in another group
$25,000

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

Union Fire Employees, Union Police Employees, Village Police Union Employees, Village Fire Employees
If you have reached age 70, your amount of AD&D insurance will be:
- $6,000; or
- $6,000 if you become insured on or after age 70.

There will be no further increases in your amount of AD&D insurance.

Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Library Employees, All Employees not eligible in another group
If you have reached age 70, your amount of AD&D insurance will be:
- $8,000; or
- $8,000 if you become insured on or after age 70.

There will be no further increases in your amount of AD&D insurance.

Department Head Employees
If you have reached age 70, your amount of AD&D insurance will be:
- $15,000; or
- $15,000 if you become insured on or after age 70.

Elected Officials

On or after November 1, 2005:	50% of the AD&D Insurance Benefit in effect on the day prior to your reaching age 70.
On or after January 1, 1995 but prior to November 1, 2005:	$35,000
On or after January 1, 1984 but prior to January 1, 1995:	$25,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

Union Fire Retirees, Union Police Retirees, Village Union Police Retirees, Village Fire Retirees, All Retirees not eligible in another group with a retirement date prior to April 1, 1993, Union Police Command Office Retirees, Police Captain Retiree, Fire Department Operations Officer Retirees, Library Retirees, All Retirees not eligible in another group with a retirement date of April 1, 1993, or later, Department Head Retirees, Retired Elected Officials
We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within this time limit, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized

representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies

before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any **hospital or institution** where treatment was received, including all attending **physicians**.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative's expense, must show:

- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

EMPLOYER PROVISIONS

WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?

This Summary of Benefits consists of:

- all Summary of Benefits' provisions and any amendments and/or attachments issued;
- the Employer's Participation Agreement;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 9 months. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

Also, Unum does not require premium payments for dependents when Unum approves an insured employee's claim for premium waiver of life insurance. Unum does not require further premium payments for dependents during the period the life insurance premium is waived.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during an insurance month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?

The Employer must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum; or

- by the Employer.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies this Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel this Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel this Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels this Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR LIFE INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the Summary of Benefits, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the Summary of Benefits.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the latest of:

- the plan effective date; or
- the day after you complete your **waiting period**; or
- the date you retire.

WHEN DOES YOUR COVERAGE BEGIN?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library, Elected Officials, Department Heads, All Employees not eligible in another group
When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

Union Fire Retirees, Union Police Retirees, Village Union Police Retirees, Village Fire Retirees, Union Police Command Office Retirees, Police Captain Retiree, Fire Department Operations Officer Retirees, Library Retirees, Department Head Retirees, Retired Elected Officials, All Retirees not eligible in another group
Your Employer pays 100% of the cost of your retiree coverage. You will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Department Head Employees, All Employees not eligible in another group
If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

Elected Officials
If you are absent from work due to injury, sickness or temporary layoff, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library, Elected Officials, Department Heads, All Employees not eligible in another group
If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
If you are on a temporary **layoff**, and if premium is paid, you will be covered for up to 2 months following the date your temporary layoff begins.

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Department Head Employees, All Employees not eligible in another group
If you are on a **leave of absence**, and if premium is paid, you will be covered for up to 2 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library, Elected Officials, Department Heads, All Employees not eligible in another group
Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library, Elected Officials, Department Heads, All Employees not eligible in another group
Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness or due to retirement, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

Union Fire Retirees, Union Police Retirees, Village Union Police Retirees, Village Fire Retirees, Union Police Command Office Retirees, Police Captain Retiree, Fire Department Operations Officer Retirees, Library Retirees, Department Head Retirees, Retired Elected Officials, All Retirees not eligible in another group
Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered; or
- the last day of the period for which any required contributions are made.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, not legally separated or divorced from, or widowed by the Employee. The spouse must be under age 70 to be eligible. You may not cover

your spouse as a dependent if your spouse is enrolled for coverage as an employee.

- Your unmarried children from birth but less than age 19.

- Your unmarried dependent children age 19 or over are eligible, provided they are unable to earn a living because of a physical or mental disability and you are the main source of support and maintenance.

Unum must receive proof within 31 days of the date the child attains age 19 and as required during the first two years. After the first two years Unum will ask for proof when needed but not more than once a year.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

WHEN DOES YOUR DEPENDENT COVERAGE BEGIN?

When your Employer pays 100% of the cost of your dependent coverage under a plan, your dependent will be covered at 12:01 a.m. on the date they are eligible for coverage.

WILL COVERAGE CONTINUE FOR A CHILD AGE 19 OR OVER WHO BECAME DISABLED WHILE COVERED UNDER THE PLAN?

Coverage will continue for a child age 19 or over who became physically or mentally disabled while covered under the plan provided:

- the child is unmarried;
- the disability was acquired before the child's coverage would have ended;
- the child is incapable of self-support and remains so incapable;
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the date the child attains age 19 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

WHAT IF YOUR SPOUSE IS TOTALLY DISABLED ON THE DATE YOUR SPOUSE'S COVERAGE WOULD NORMALLY BEGIN?

If your eligible spouse is **totally disabled**, your spouse's coverage will begin on the date your eligible spouse no longer is totally disabled.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT'S COVERAGE END?

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness or due to retirement, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment;
- for a spouse, the date your spouse reaches age 70.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT'S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
You must be disabled through your **elimination period**.

Your elimination period is 9 months.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States. You will be considered to reside outside the United States

when you have been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

Union Fire Employees, Union Police Employees, Union Police in Command Office Employees, Police Captain Employees, Fire Department Operations Officer Employees, Village Police Union Employees, Village Fire Employees, Library Employees, Elected Officials, Department Head Employees, All Employees not eligible in another group
You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 100% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $250,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

ADDING PORTABLE COVERAGE FOR DEPENDENTS

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or

- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

SURVIVOR INCOME INSURANCE BENEFIT

Nothing contained in this Survivor Income Insurance Benefit will be held to affect any of the terms of the Summary of Benefits other than as stated herein.

This Survivor Income Insurance Benefit will not be effective: (1) with respect to any Employee not in active employment on its effective date until such Employee is again in active employment; or (2) with respect to any Employee whose insurance is being continued in accordance with any continuance of insurance provision on the effective date of this Survivor Income Insurance Benefit.

If we receive Proof that you died while your Life Insurance under the Summary of Benefits was in force and that you had at least one Eligible Survivor on the date of your death, we will pay a Survivor Income Benefit. We will pay such benefit to your Eligible Survivor(s) subject to all the terms and conditions of the Summary of Benefits.

The Spouse Only Benefit will be payable for each Benefit Month that there is a Class 1 Survivor. The Child(ren) only Benefit will be payable for each Benefit Month that there is at least one Class II Survivor. The Spouse and Child(ren) Benefit will be payable for each Benefit Month that there is a Class 1 Survivor and Class II Survivor. No benefit will be payable on or after the date that there is no Eligible Survivor who is eligible for that benefit.

If there is no Class 1 Survivor, or at least one Class II Survivor, for only part of a Benefit Month, the monthly benefit will be payable on a pro-rata basis. In this case 1/30 of the monthly benefit will be payable for each day of the Benefit Month that there was an Eligible Survivor.

Amount of Benefits
The Survivor Income Benefit payable will be whichever one of the following is applicable:

Spouse Benefit – An amount equal to $300 monthly, payable for 24 months .

Child(ren) Benefit - An amount equal to $300 monthly, payable for 24 months.

Payment of Benefits
When we receive Proof of the death of the Employee, benefits will be paid monthly beginning on the first of the month following the Empoyee's death for up to 24 months to the Class 1 Survivor. If there is no Class I Survivor, benefits will be paid monthly for up to 24 months in equal shares to the Class II Survivors's surviving parent or legal guardian. If a Class II Survivor ceases to be an Eligible Survivor during a Benefit Month, the monthly benefit will be pro-rated according to the number of days in each portion of the Benefit Month when there are a different number of Class II Survivors, before determining the equal shares payable to the Class II Survivors for that portion of the Benefit Month.

After 24 months of payments, an additional monthly income benefit of $300 will be paid to the Class I Survivor provided the Class I Survivor was at least 50 but less than 60 years old at the time of the Employee's death.

Child
The term :Child::

1. means a child who is unmarried and under 21 years of age.
2. is limited to:
- your natural born child; and
- your legally adopted child who has been adopted for at least one year.

A child becomes an eligible survivor immediately following birth. In the event of an adoption, an adopted child becomes an eligible survivor on the first day of the month coincident with or next following one year after the date of adoption.

Class I Survivor
Means your surviving Spouse who has not remarried. If the surviving Spouse has remarried, that spouse will be considered to be a Class I Survivor until the date of remarriage. However, if the Spouse notifies Unum of the spouse's remarriage within 60 days of the date of remarriage, then an additional benefit will be paid in a lump sum equal to twelve times the Spouse Only Benefit.

Class II Survivor
Means any surviving Child of yours who is not married and had not attained the Limiting Age for Class II Survivors.

Eligible Survivor
Means a Class I Survivor or Class II Survivor. In no event will an Eligible Survivor include any person who has died or whose status as an Eligible Survivor has previously terminated.

Spouse
Means your lawful spouse on the day before your death. Your spouse must be married to you for at least one year and may not be legally separated or divorced from you at the time of your death and must be under age 62. If your spouse is not currently an eligible survivor then your spouse will become an eligible survivor on the last day of the month coincident with or next following one year of marriage.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an **accidental bodily injury** results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

Covered Losses	**Benefit Amounts**
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Quadriplegia	The Full Amount
Paraplegia	Half The Full Amount

One Hand or One Foot One	Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Hemiplegia	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a **Private Passenger Car**, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child; and

- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:
- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT **"BENEFITS AT A GLANCE"** page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being **intoxicated**.
- war, declared or undeclared, or any act of war.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE **"BENEFITS AT A GLANCE"** page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

ACTIVITIES OF DAILY LIVING means:

- Bathing - the ability to wash oneself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet; to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

A person is considered unable to perform an activity of daily living if the task cannot be performed safely without another person's stand-by assistance or verbal cueing.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

COGNITIVELY IMPAIRED means a person has a deterioration or loss in intellectual capacity resulting from injury, sickness, advanced age, Alzheimer's disease or similar forms of irreversible dementia and needs another person's assistance or verbal cueing for his or her own protection or for the protection of others.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIFE INSURANCE BENEFIT means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

LIFE THREATENING CONDITION is a critical health condition that possibly could result in your dependent's loss of life.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD is any of your unmarried dependent children under age 19.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

RETIREE means a person who was in active employment in the United States with the Employer just prior to their date of retirement.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder, your spouse:

- is confined in a hospital or similar institution;
- is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;
- is cognitively impaired; or
- has a life threatening condition.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, US and **OUR** means Unum Life Insurance Company of America.

YOU means an employee who is eligible for Unum coverage.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Summary of Benefits, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

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

If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by

which Unum 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 will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of

extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

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

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

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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

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

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the Summary of Benefits. You agree that Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.

Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. *When legally necessary, we ask your permission before sharing NPI about you*. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. *When required by law, we ask your permission before we share NPI for marketing purposes.*

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

Access to Information

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information

If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us

For additional information about Unum's commitment to privacy, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance

Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

A-32442 (4-07)

Attachment "H" – STD and LTD

AMENDMENT NO. 11

This amendment forms a part of Group Policy No. 147520 002 issued to the Policyholder:

Charter Township of Bloomfield

The entire policy is replaced by the policy attached to this amendment.

The effective date of these changes is October 1, 2016. The changes only apply to disabilities which start on or after the effective date.

The policy's terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on February 8, 2018.

Unum Life Insurance Company of America

By 

Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of February 8, 2018.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Charter Township of Bloomfield

By _____
Signature and Title of Officer

GROUP INSURANCE POLICY
NON-PARTICIPATING

POLICYHOLDER: Charter Township of Bloomfield

POLICY NUMBER: 147520 002

POLICY EFFECTIVE DATE: July 1, 2009

POLICY ANNIVERSARY DATE: July 1

GOVERNING JURISDICTION: Michigan

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

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BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: July 1, 2009

POLICY NUMBER: 147520 002

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 32 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2009: None

For employees entering an eligible group after July 1, 2009: 1 month of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

The later of:

- the date the injury occurs for disability due to an injury; or
- 7 days for disability due to a sickness; or
- the date your accumulated sick leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

All Police and Fire Employees
70% of weekly earnings to a maximum benefit of $1,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

All Employees not eligible in another group
70% of weekly earnings to a maximum benefit of $1,000 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

MAXIMUM PERIOD OF PAYMENT:

26 weeks

Premium payments are required for your coverage while you are receiving payments under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $250 per week.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

OTHER FEATURES:

Minimum Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: July 1, 2009

POLICY NUMBER: 147520 002

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 32 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before July 1, 2009: None

For employees entering an eligible group after July 1, 2009: 1 month of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

The later of:

- 180 days; or
- the date your accumulated sick leave or insured Short Term Disability or paid time off (PTO) payments end, if applicable.

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

All Employees not eligible in another group
66.6667% of monthly earnings to a maximum benefit of $4,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

All Police and Fire Union Employees
66.6667% of monthly earnings to a maximum benefit of $6,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Continuity of Coverage

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

CLAIM INFORMATION

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the appropriate documentation of your weekly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

CLAIM INFORMATION

LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the appropriate documentation of your monthly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

SHORT TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

Premium payments are required for an insured while he or she is receiving Short Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

LONG TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an insured while he or she is receiving Long Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Policyholder** must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 31 day **grace period**.

If Unum cancels or modifies this policy or a plan for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a **payable claim**.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the policyholder's Human Resource policy on family and medical leaves of absence if premium payments continue and the policyholder approved the employee's leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the policyholder's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR SHORT TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

None

FOR LONG TERM DISABILITY:

NAME/LOCATION (CITY AND STATE)

None

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if **evidence of insurability** is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

If you have a Cesarean section, you will be considered disabled for a minimum period of 8 weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the 8 weeks.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, benefits begin on the later of:

- the date the injury occurs; or
- the date your **accumulated sick leave** payments end, if applicable.

If your disability is the result of a sickness, your elimination period is the later of:

- 7 days; or
- the date your accumulated sick leave payments end, if applicable.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

After the elimination period, if you are disabled for less than 1 week, we will send you 1/7th of your payment for each day of disability.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

All Police and Fire Employees
1. Multiply your weekly earnings by 70%.
2. The maximum **weekly benefit** is $1,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

All Employees not eligible in another group
1. Multiply your weekly earnings by 70%.
2. The maximum **weekly benefit** is $1,000.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

WHAT ARE YOUR WEEKLY EARNINGS?

All Employees not eligible in another group
"Weekly Earnings" means your gross weekly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

Firefighters
"Weekly Earnings" means your gross weekly base pay from your Employer in effect just prior to your date of disability. Gross weekly base pay is computed based on your base rate of pay in effect just prior to your disability multiplied by your regularly scheduled work hours (not to exceed 56 hours per week). It includes your total base pay before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly disability earnings, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly **disability earnings** are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings routinely fluctuate widely from week to week, Unum may average your disability earnings over the most recent 3 weeks to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 weeks exceeds 80% of weekly earnings.

We will not pay you for any week during which disability earnings exceed 80% of weekly earnings.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income payments under any:

   - state compulsory benefit **act** or **law**.
   - other group insurance plan.

2. The amount that you receive:

   - under the mandatory portion of any "no fault" motor vehicle **plan**.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or

otherwise.

3. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

   Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- **salary continuation** or **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: $25.

Unum may apply this amount toward an outstanding overpayment.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment.** Your maximum period of payment is 26 weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** but you choose not to;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;

- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in your **indexed monthly earnings** due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is the later of:

- 180 days; or
- the date your **accumulated sick leave** or insured Short Term Disability or **paid time off (PTO)** payments end, if applicable.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

All Employees not eligible in another group

1. Multiply your monthly earnings by 66.6667%.
2. The maximum **monthly benefit** is $4,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

All Police and Fire Union Employees

1. Multiply your monthly earnings by 66.6667%.
2. The maximum **monthly benefit** is $6,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

All Employees not eligible in another group

"Monthly Earnings" means your gross monthly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

Firefighters

"Monthly Earnings" means your gross monthly base pay from your Employer in effect just prior to your date of disability. Gross monthly base pay is computed based on your base rate of pay in effect just prior to your disability multiplied by your regularly scheduled work hours (not to exceed 56 hours per week). It includes your total base pay before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the monthly payment if you are disabled and your monthly **disability earnings**, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

Unum may require you to send proof of your monthly disability earnings at least quarterly. We will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings routinely fluctuate widely from month to month, Unum may average your disability earnings over the most recent 3 months to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings.

We will not pay you for any month during which disability earnings exceed 80% of indexed monthly earnings.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:

   - a workers' compensation law.
   - an occupational disease law.
   - any other **act** or **law** with similar intent.

2. The amount that you receive or are entitled to receive as disability income payments under any:

   - state compulsory benefit **act** or **law**.
   - other group insurance plan.
   - governmental retirement system as a result of your job with your Employer.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

   - the United States Social Security Act.
   - the Canada Pension **Plan**.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you:

   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal

retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **salary continuation** or **accumulated sick leave** or **paid time off (PTO)** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months

Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** but you choose not to;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

Unum will continue to send you payments beyond the 24 month period if you meet one or both of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that

additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

Unum will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

ARE INCREASES IN COVERAGE SUBJECT TO A PRE-EXISTING CONDITION?

All Police and Fire Union Employees
Your plan will not provide a maximum monthly benefit in excess of $4,000 which becomes effective on October 1, 2016 for any disability caused by, contributed to by, or resulting from the following pre-existing condition.

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to October 1, 2016; and
- the disability begins in the first 12 months after October 1, 2016.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a **recurrent disability**, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your **eligible survivor** a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per **dependent**; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.

OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

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

- For Short Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

- For Long Term Disability:

MAXIMUM CAPACITY means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

- For Short Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

- For Long Term Disability:

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:

- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a Long Term Disability payment.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

- For Short Term Disability:

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

- For Long Term Disability:

SALARY CONTINUATION, ACCUMULATED SICK LEAVE OR PAID TIME OFF (PTO) means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation, accumulated sick leave or paid time off (PTO) does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SELF-REPORTED SYMPTOMS means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

TOTAL COVERED PAYROLL means the total amount of monthly earnings for which employees are insured under this plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, **US** and **OUR** means Unum Life Insurance Company of America.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means an employee who is eligible for Unum coverage.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum 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 will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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

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

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.

Our Commitment to Privacy

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

Attachment "I" – FMLA Policy

FAMILY AND MEDICAL LEAVE

General Policy

Notwithstanding any other policy, any eligible employee is entitled to 12 weeks of unpaid leave to attend to a variety of medical and parental responsibilities allowed under the Federal Family and Medical Leave Act.

Eligible Employee: In order to be eligible for family or medical leave, an employee must meet three requirements:

1. Has been employed by the Township for at least 12 months;

2. Has been employed for at least 1,250 hours during the previous 12-month period immediately preceding the commencement of the leave;

3. Is employed at a location where there are at least 50 employees within 75 miles.

Available Leaves

Each eligible employee is entitled to a total of 12 weeks of unpaid leave[1] calculated using a "rolling" 12 month period measured backward from the date an employee uses any FMLA leave for one or more of the following reasons:

A. For birth of a child and/or for the purpose of caring for the newborn child. The right to leave on this basis expires at the end of the 12-month period after such birth and must be concluded within this one-year period;

B. For placement of a child with an employee for adoption or foster care. The right to leave on this basis expires at the end of the 12-month period after such placement and must be concluded within this one-year period;

C. To care for the employee's spouse, child or parent if such person has a serious health condition, illness, injury, impairment or physical or mental condition that involves in-patient care in a hospital, hospice or residential medical care facility or which requires continuing treatment by a health care provider. Intermittent leave or a reduced leave schedule will be permitted in place of 12 straight weeks where medically necessary; or

D. Because of the employee's own serious health condition, illness, injury, impairment or physical or mental condition that involves in-patient care in a hospital, hospice or residential medical care facility or which requires continuing treatment by a health care provider that renders the employee unable to perform the functions of their position. Intermittent leave or a reduced leave schedule will be permitted when medically

[1] See section entitled "Use of Paid Leave" concerning required use of sick leave, vacation time and personal time while on FMLA leave.

necessary. If the treatment is foreseeable, the employee is required to make a reasonable effort to schedule treatment so as not to disrupt Township operations any more than necessary.

E. For qualifying exigency arising out of the fact that the employee's spouse; son; daughter or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation. An eligible spouse, child or parent of a service member is entitled to a maximum of twelve (12) week leave. This qualifying exigency leave does not apply to family members of the Regular Armed Forces.

F. If you are the spouse, son, daughter, parent or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness the employee is entitled to a combined maximum of 26 weeks military caregiver leave during a 12-month period. A covered service member is a member of the Armed Forces including members of the National Guard or Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, on the temporary disability retired list for a serious injury or illness, or a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

For the purposes of this Policy, a parent means a biological parent of an employee or an individual who stands or stood in the place of a parent to an employee when the employee was a child. A child means a biological, adopted or foster child, a step-child, a legal ward, or a child of a person standing in *loco parentis*, who is under 18 years of age or 18 years of age or older and incapable of self-care because of a mental or physical disability.

If a situation should occur where a husband and a wife, who are both employed by the Township, are entitled to leave under this policy, each are limited in the amount of family leave they may take for the birth and care of a newborn child, placement of a child for foster care or adoption, or to care for a parent who has a serious health condition to a combined total of twelve workweeks arising under subsection A, B and C (or a combined total of 26 workweeks if leave to care for a covered service member with a serious injury or illness is also used in subsection F). Leave for birth and care, or placement for adoption or foster care, must conclude within 12 months of the birth or placement.

Intermittent Leave: An intermittent or reduced leave schedule may be taken under certain circumstances. Where the leave is taken because of a birth or placement of a child for adoption or foster care, an employee may take an intermittent or reduced leave schedule only if agreed to by the Township. Where the leave is taken for an employee's own serious health condition or to take care of a sick family member, leave may be taken intermittently or on a reduced leave schedule when medically necessary.

Use of Paid Leave

Family and Medical Leave is unpaid except that any employee using leave pursuant to this policy must apply all available vacation leave, sick days or other available paid leave toward this 12-week period prior to using unpaid leave, except that the employee may retain forty (40) hours of accrued vacation time and forty (40) hours of accrued sick time. Some employees may be eligible for short term disability insurance or workers' compensation benefits. Contact the Accounting Department in this regard.

Notice of Leave and Verification of Medical Reason

All employees must give the Township notice of upcoming leave requirements 30 days prior to the date leave is to begin, if possible, and if it is not possible to give such notice, as soon as practicable.

An application for leave based on the serious health condition of the employee or the employee's spouse, child or parent must also be accompanied by a "Medical Certification Statement" completed by a health care provider. The certification must state the date on which the health condition commenced, the probable duration of the condition, and the appropriate medical facts regarding the condition.

If the employee is needed to care for a spouse, child or parent, the certification must so state, along with an estimate of the amount of time the employee will be needed. If the employee has a serious health condition, the certification must state that the employee cannot perform the functions of their job.

The Township retains the right to request, at its expense, a second opinion by a physician to be designated by the Township. If the first and second opinions conflict then the Township and the employee shall designate a third physician whose opinion shall be binding. If the employee refuses to take part in the selection process of the third independent physician, the Township selection shall be deemed controlling.

During the leave, employees may be required to provide the Township with subsequent certification every 30 days. The Township shall have the right to request such certification in its sole discretion.

Failure of an employee to provide certification as to the reasons for the leave will result in a denial of the leave. If the employee has already begun the leave, they will be expected to return to work immediately upon the Township informing the employee of their failure to provide acceptable certification. Failure to return to work will result in the termination of the employee's employment. Further, any time away from work which is not authorized by a proper medical certification will be treated as unexcused absences and will subject the employee to all discipline authorized by the Township's attendance policy and/or work rules.

Return from Leave

Upon return from any leave covered by this policy, the employee will be restored to the position held by them prior to the leave or to a position equivalent in benefits, pay and other conditions and

terms of employment. An employee making use of this policy will not lose any employment benefits which have accrued prior to the leave. However, no seniority, sick time, benefit time, vacation time, holidays, personal time or bonus days will accrue during the period of time covered by the leave, except when the employee is using sick leave, leave for work connected injury or illness, or vacation time and in these instances the accrued provisions of those policies shall control.

The Township requires that a Fitness for Duty Statement be provided by the employee's doctor before the employee may return to work. This statement should specify if there are restrictions.

Health Care Benefits

An employee's health care benefits will be continued by the Township for the entire period of the leave. If the employee fails to return from a leave, the employee will be required to reimburse the Township for the monies expended incident to the purchase of those health care benefits unless the employee does not return because of a continuation, recurrence, or onset of a serious health condition which would entitle the employee to a leave or other circumstances beyond the control of the employee. A medical certification may be required for this exemption to apply and the certificate must be returned in 30 days.

Exemption for Highly Paid Key Employees

The Township may deny restoration to a former position to highly compensated employees where the denial is necessary to prevent substantial and grievous economic injury to the Township's operations. Highly compensated employees are those employees who are among the highest paid 10 percent of the Township's employees. The Township will notify such employee of its intent to deny reinstatement on this basis as soon as the Township determines that such injury would occur. If the leave has already begun when such notice is given, and the employee elects not to return to work immediately, the employee gives up all rights to restoration.

Relationship to the Family and Medical Leave Act of 1993:

This policy has been developed to comply with the requirements of the Family and Medical Leave Act of 1993. Should this policy conflict with the Act, the Act shall be deemed controlling. The Township also retains all rights under the Act and regulations even though they may not be incorporated into this policy.