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: $7,500/individual - employee only or $15,000/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, 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/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	30% coinsurance/visit 30% coinsurance/ screening 30% coinsurance/ immunizations	None None None 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

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	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); Not covered (home delivery)	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, 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.
	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); Not covered (home delivery)	
	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); Not covered (home delivery)	
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	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	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	
	Inpatient services	10% coinsurance	30% coinsurance	

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 are pregnant	Office visits	10% coinsurance	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. 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 professional services	10% coinsurance	30% coinsurance	
	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).
	Skilled nursing care	10% coinsurance	30% coinsurance	None
	Durable medical equipment	10% coinsurance	30% coinsurance	
	Hospice services	10% coinsurance/inpatient; 10% coinsurance/outpatient services	30% coinsurance/inpatient; 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.
- Private-duty nursing
- 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

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: 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Michigan Health Insurance Consumer Assistance Program (HICAP) at 877-999-6442. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,020**

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	$20
The total Joe would pay is	**$2,920**

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:** 19 **Plan ID:** 10651455

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DISCRIMINATION IS AGAINST THE LAW

Medical 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.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna 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, 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：我們可為您免費提供語言協助服務。對於 Cigna 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, 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 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, 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, 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 الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna 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 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, 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 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 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 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-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 می‌شود. برای مشتریان فعلی Cigna، 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 شماره‌گیری کنید).

ATTACHMENT “B”
Vision

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
Bloomfield Township
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision
Schedule of Vision Coverage

Coverage	In-Network Benefit	Out-of-Network Benefit	Frequency Period **
Exam Copay	$0	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$0	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $130	Up to $71	24 months

** 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. (Note: copays do not apply to contact lenses).
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.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- 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)
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.

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 Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- 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
- 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

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,"Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision 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 Cigna Vision Directory, under Additional Directories.
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 or Cigna Vision ID card 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 claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
- Go to **Cigna.com** and go to Forms, Vision Forms
- 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 1.877.478.7557 (TTY: 800.428.4833).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.877.478.7557 (TTY: 800.428.4833).

Chinese – 注意：我們可為您免費提供語言協助服務。請致電 1.877.478.7557 （聽障專線：800.428.4833）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.877.478.7557 (TTY: 800.428.4833).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.478.7557 (TTY: 800.428.4833)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.877.478.7557 (TTY: 800.428.4833).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.478.7557 (линия TTY телетайп: 800.428.4833).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.478.7557 (رقم هاتف الصم والبكم: 800.428.4833).

French Creole – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.478.7557 (TTY: 800.428.4833).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.877.478.7557 (ATS: 800.428.4833).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.877.478.7557 (TTY: 800.428.4833).

Polish – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 877 478 7557 (TTY: 800.428.4833).

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。1.877.478.7557（TTY: 800.428.4833）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.478.7557 (TTY: 800.428.4833).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.478.7557 (TTY: 800.428.4833).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. با شماره 1.877.478.7557 تماس بگیرید (شماره تلفن ویژه ناشنوایان: 800.428.4833).

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ATTACHMENT “C”
Dental

Cigna Dental Care® (*DHMO) Patient Charge Schedule

This Patient Charge Schedule lists the benefits of the Dental Plan including covered procedures and patient charges.

Important Highlights

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist, Orthodontist or Oral Surgeon. You must verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 7th birthday.
- Procedures NOT listed on this Patient Charge Schedule are NOT covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or Nitrous Oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Important Highlights *(continued)*

- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

Code	Procedure Description	Patient Charge
Diagnostic/Preventive – Oral evaluations are limited to a combined total of 4 of the following evaluations during a 12 consecutive month period: Periodic Oral Evaluations (D0120), Comprehensive Oral Evaluations (D0150), Comprehensive Periodontal Evaluations (D0180), and Oral Evaluations for Patients Under 3 Years of Age (D0145).		
D9310	Consultation (Diagnostic Service Provided by Dentist or Physician Other than Requesting Dentist or Physician)	$0.00
D9430	Office Visit for Observation – No Other Services Performed	$0.00
D9450	Case Presentation – Detailed and Extensive Treatment Planning	$0.00
D0120	Periodic Oral Evaluation – Established Patient	$0.00
D0140	Limited Oral Evaluation – Problem Focused	$0.00
D0145	Oral Evaluation for a Patient Under 3 Years of Age and Counseling with Primary Caregiver	$0.00
D0150	Comprehensive Oral Evaluation – New or Established Patient	$0.00
D0170	Re-evaluation – Limited, Problem Focused (Not Postoperative Visit)	$0.00
D0210	X-Rays Intraoral – Complete Series (Including Bitewings) *(Limit 1 Every 3 Years)*	$0.00
D0220	X-Rays Intraoral – Periapical – First Film	$0.00
D0230	X-Rays Intraoral – Periapical – Each Additional Film	$0.00
D0240	X-Rays Intraoral – Occlusal Film	$0.00
D0270	X-Rays (Bitewing) – Single Film	$0.00
D0272	X-Rays (Bitewings) – 2 Films	$0.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D0273	X-Rays (Bitewings) – 3 Films	$0.00
D0274	X-Rays (Bitewings) – 4 Films	$0.00
D0277	X-Rays (Bitewings, Vertical) – 7 to 8 Films	$0.00
D0330	X-Rays (Panoramic Film) – *(Limit 1 Every 3 Years)*	$0.00
D0431	Oral Cancer Screening Using a Special Light Source	$50.00
D0460	Pulp Vitality Tests	$13.00
D0470	Diagnostic Casts	$0.00
D0472	Pathology Report – Gross Examination of Lesion (Only When Tooth Related)	$0.00
D0473	Pathology Report – Microscopic Examination of Lesion (Only When Tooth Related)	$0.00
D0474	Pathology Report – Microscopic Examination of Lesion and Area (Only When Tooth Related)	$0.00
D1110	Prophylaxis (Cleaning) – Adult *(Limit 2 per Calendar Year)*	$0.00
	Additional Prophylaxis (Cleaning) – In Addition to the 2 Prophylaxes (Cleanings) Allowed per Calendar Year	$45.00
D1120	Prophylaxis (Cleaning) – Child *(Limit 2 per Calendar Year)*	$0.00
	Additional Prophylaxis (Cleaning) – In Addition to the 2 Prophylaxes (Cleanings) Allowed per Calendar Year	$30.00
D1203	Topical Application of Fluoride – Child *(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.*	$0.00
D1206	Topical Fluoride Varnish – Therapeutic Application for Moderate to High Caries Risk Patients – Child *(Up to 19th Birthday) (Limited to 2 per Calendar Year). There is a Combined Limit of a Total of 2 D1203s and/or D1206s per Calendar Year.*	$0.00
D1330	Oral Hygiene Instructions	$0.00
D1351	Sealant – Per Tooth	$0.00
D1352	Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth	$0.00
D1510	Space Maintainer – Fixed – Unilateral	$0.00
D1515	Space Maintainer – Fixed – Bilateral	$0.00
D1555	Removal of Fixed Space Maintainer	$0.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
Restorative (Fillings)		
D2140	Amalgam – 1 Surface, Primary or Permanent	$0.00
D2150	Amalgam – 2 Surfaces, Primary or Permanent	$0.00
D2160	Amalgam – 3 Surfaces, Primary or Permanent	$0.00
D2161	Amalgam – 4 or More Surfaces, Primary or Permanent	$0.00
D2330	Resin-Based Composite – 1 Surface, Anterior	$0.00
D2331	Resin-Based Composite – 2 Surfaces, Anterior	$0.00
D2332	Resin-Based Composite – 3 Surfaces, Anterior	$0.00
D2335	Resin-Based Composite – 4 or More Surfaces or Involving Incisal Angle, Anterior	$85.00
D2390	Resin-Based Composite Crown, Anterior	$57.00
D2391	Resin-Based Composite – 1 Surface, Posterior	$45.00
D2392	Resin-Based Composite – 2 Surfaces, Posterior	$57.00
D2393	Resin-Based Composite – 3 Surfaces, Posterior	$79.00
D2394	Resin-Based Composite – 4 or More Surfaces, Posterior	$110.00
Crown and Bridge – All charges for crown and bridge (fixed partial denture) are per unit (each replacement or supporting tooth equals 1 unit) – Replacement limit 1 every 5 years.		
D2510	Inlay – Metallic – 1 Surface	$340.00
D2520	Inlay – Metallic – 2 Surfaces	$340.00
D2530	Inlay – Metallic – 3 or More Surfaces	$340.00
D2542	Onlay – Metallic – 2 Surfaces	$390.00
D2543	Onlay – Metallic – 3 Surfaces	$390.00
D2544	Onlay – Metallic – 4 or More Surfaces	$390.00
D2740	Crown – Porcelain/Ceramic Substrate	$415.00
D2750	Crown – Porcelain Fused to High Noble Metal	$380.00
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$335.00
D2752	Crown – Porcelain Fused to Noble Metal	$355.00
D2780	Crown – 3/4 Cast High Noble Metal	$380.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D2781	Crown – 3/4 Cast Predominantly Base Metal	$335.00
D2782	Crown – 3/4 Cast Noble Metal	$355.00
D2790	Crown – Full Cast High Noble Metal	$380.00
D2791	Crown – Full Cast Predominantly Base Metal	$335.00
D2792	Crown – Full Cast Noble Metal	$355.00
D2794	Crown – Titanium	$380.00
D2910	Recement Inlay – Onlay or Partial Coverage Restoration	$11.00
D2915	Recement Cast or Prefabricated Post and Core	$11.00
D2920	Recement Crown	$11.00
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$11.00
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$11.00
D2932	Prefabricated Resin Crown	$105.00
D2933	Prefabricated Stainless Steel Crown with Resin Window	$110.00
D2934	Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth	$110.00
D2940	Protective Restoration	$12.00
D2950	Core Buildup – Including Any Pins	$91.00
D2951	Pin Retention – Per Tooth – In Addition to Restoration	$18.00
D2952	Post and Core – In Addition to Crown, Indirectly Fabricated	$130.00
D2954	Prefabricated Post and Core – In Addition to Crown	$110.00
D2960	Labial Veneer (Resin Laminate) – Chairside	$105.00
D6210	Pontic – Cast High Noble Metal	$380.00
D6211	Pontic – Cast Predominantly Base Metal	$335.00
D6212	Pontic – Cast Noble Metal	$355.00
D6214	Pontic – Titanium	$380.00
D6240	Pontic – Porcelain Fused to High Noble Metal	$380.00
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$335.00
D6242	Pontic – Porcelain Fused to Noble Metal	$355.00
D6245	Pontic – Porcelain/Ceramic	$370.00
D6602	Inlay – Cast High Noble Metal, 2 Surfaces	$380.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D6603	Inlay – Cast High Noble Metal, 3 or More Surfaces	$380.00
D6604	Inlay – Cast Predominantly Base Metal, 2 Surfaces	$335.00
D6605	Inlay – Cast Predominantly Base Metal, 3 or More Surfaces	$325.00
D6606	Inlay – Cast Noble Metal, 2 Surfaces	$345.00
D6607	Inlay – Cast Noble Metal, 3 or More Surfaces	$355.00
D6610	Onlay – Cast High Noble Metal, 2 Surfaces	$380.00
D6611	Onlay – Cast High Noble Metal, 3 or More Surfaces	$380.00
D6612	Onlay – Cast Predominantly Base Metal, 2 Surfaces	$335.00
D6613	Onlay – Cast Predominantly Base Metal, 3 or More Surfaces	$325.00
D6614	Onlay – Cast Noble Metal, 2 Surfaces	$355.00
D6615	Onlay – Cast Noble Metal, 3 or More Surfaces	$355.00
D6624	Inlay – Titanium	$380.00
D6634	Onlay – Titanium	$380.00
D6740	Crown – Porcelain/Ceramic	$415.00
D6750	Crown – Porcelain Fused to High Noble Metal	$380.00
D6751	Crown – Porcelain Fused to Predominantly Base Metal	$335.00
D6752	Crown – Porcelain Fused to Noble Metal	$355.00
D6780	Crown – 3/4 Cast High Noble Metal	$380.00
D6781	Crown – 3/4 Cast Predominantly Base Metal	$335.00
D6782	Crown – 3/4 Cast Noble Metal	$355.00
D6790	Crown – Full Cast High Noble Metal	$380.00
D6791	Crown – Full Cast Predominantly Base Metal	$335.00
D6792	Crown – Full Cast Noble Metal	$355.00
D6794	Crown – Titanium	$380.00
	Complex Rehabilitation – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
D6930	Recement Fixed Partial Denture	$11.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
Implant Supported Prosthetics – All charges for crown and bridge (fixed partial denture) are per unit (each replacement on a supporting implant(s) equals 1 unit) – Replacement limit 1 every 5 years. All charges for an implant supported denture are limited to replacement of 1 every 5 years.		
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$805.00
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	$880.00
D6058	Abutment Supported Porcelain/Ceramic Crown	$715.00
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$680.00
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$635.00
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$655.00
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$680.00
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$635.00
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$655.00
D6065	Implant Supported Porcelain/Ceramic Crown	$715.00
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$680.00
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$680.00
D6068	Abutment Supported Retainer for Porcelain/Ceramic Fixed Partial Denture	$715.00
D6069	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (High Noble Metal)	$680.00
D6070	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Predominantly Base Metal)	$635.00
D6071	Abutment Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Noble Metal)	$655.00
D6072	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (High Noble Metal)	$680.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D6073	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Predominantly Base Metal)	$635.00
D6074	Abutment Supported Retainer for Cast Metal Fixed Partial Denture (Noble Metal)	$655.00
D6075	Implant Supported Retainer for Ceramic Fixed Partial Denture	$715.00
D6076	Implant Supported Retainer for Porcelain Fused to Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$680.00
D6077	Implant Supported Retainer for Cast Metal Fixed Partial Denture (Titanium, Titanium Alloy, High Noble Metal)	$680.00
D6078	Implant/ Abutment Supported Fixed Denture for Completely Edentulous Arch	$805.00
D6079	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch	$880.00
D6092	Recement Implant/Abutment Supported Crown	$51.00
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$51.00
D6094	Abutment Supported Crown (Titanium)	$680.00
D6194	Abutment Supported Retainer Crown for Fixed Partial Denture (Titanium)	$680.00
	Complex Rehabilitation on Implant Supported Prosthetic Procedures – ADDITIONAL CHARGE PER UNIT FOR MULTIPLE CROWN UNITS/COMPLEX REHABILITATION *(6 or more units of crown and/or bridge in same treatment plan requires complex rehabilitation for each unit – ask your dentist for the guidelines)*	$135.00
Endodontics (Root Canal Treatment, Excluding Final Restorations)		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	$13.00
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	$13.00
D3220	Pulpotomy – Removal of Pulp, Not Part of a Root Canal	$19.00
D3221	Pulpal Debridement (Not to be used when root canal is done on the same day)	$19.00
D3222	Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development	$19.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D3310	Anterior Root Canal – Permanent Tooth (Excluding Final Restoration)	$12.00
D3320	Bicuspid Root Canal – Permanent Tooth (Excluding Final Restoration)	$31.00
D3330	Molar Root Canal – Permanent Tooth (Excluding Final Restoration)	$280.00
D3331	Treatment of Root Canal Obstruction – Nonsurgical Access	$13.00
D3332	Incomplete Endodontic Therapy – Inoperable, Unrestorable or Fractured Tooth	$13.00
D3333	Internal Root Repair of Perforation Defects	$13.00
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$13.00
D3347	Retreatment of Previous Root Canal Therapy – Bicuspid	$32.00
D3348	Retreatment of Previous Root Canal Therapy – Molar	$350.00
D3410	Apicoectomy/Periradicular Surgery – Anterior	$13.00
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	$44.00
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	$75.00
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$13.00
D3430	Retrograde Filling per Root	$13.00
Periodontics (Treatment of Supporting Tissues [Gum and Bone] of the Teeth) Periodontal regenerative procedures are limited to 1 regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. The Relevant Procedure Codes are D4263, D4264, D4266 and D4267. Localized delivery of antimicrobial agents is limited to 8 Teeth (or 8 sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.		
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	$17.00
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth per Quadrant	$110.00
D4211	Gingivectomy or Gingivoplasty – 1 to 3 Teeth per Quadrant	$56.00
D4240	Gingival Flap (Including Root Planing) – 4 or More Teeth per Quadrant	$135.00
D4241	Gingival Flap (Including Root Planing) – 1 to 3 Teeth per Quadrant	$69.00
D4245	Apically Positioned Flap	$135.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D4249	Clinical Crown Lengthening – Hard Tissue	$145.00
D4260	Osseous Surgery – 4 or More Teeth per Quadrant	$220.00
D4261	Osseous Surgery – 1 to 3 Teeth per Quadrant	$120.00
D4263	Bone Replacement Graft – First Site in Quadrant	$290.00
D4264	Bone Replacement Graft – Each Additional Site in Quadrant	$225.00
D4266	Guided Tissue Regeneration – Resorbable Barrier per Site	$380.00
D4267	Guided Tissue Regeneration – Nonresorbable Barrier per Site (Includes Membrane Removal)	$430.00
D4270	Pedicle Soft Tissue Graft Procedure	$175.00
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$175.00
D4275	Soft Tissue Allograft	$175.00
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth per Quadrant *(Limit 4 Quadrants per Consecutive 12 Months)*	$49.00
D4342	Periodontal Scaling and Root Planing – 1 to 3 Teeth – per Quadrant *(Limit 4 Quadrants per Consecutive 12 Months)*	$30.00
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis *(1 per Lifetime)*	$44.00
D4381	Localized Delivery of Antimicrobial Agents per Tooth – By Report	$45.00
D4910	Periodontal Maintenance *(Limited to 2 per Calendar Year) (Only Covered after Active Therapy)*	$32.00
D9940	Occlusal Guard – By Report *(Limit 1 per 24 Months)*	$110.00
D9951	Occlusal Adjustment Limited	$32.00
D9952	Occlusal Adjustment Complete	$115.00
Prosthetics (Removable Tooth Replacement – Dentures) Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years.		
D5110	Full Upper Denture	$505.00
D5120	Full Lower Denture	$505.00
D5130	Immediate Full Upper Denture	$525.00
D5140	Immediate Full Lower Denture	$525.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D5211	Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	$370.00
D5212	Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	$370.00
D5213	Upper Partial Denture – Cast Metal Famework (Including Clasps, Rests and Teeth)	$580.00
D5214	Lower Partial Denture – Cast Metal Framework (Including Clasps, Rests and Teeth)	$580.00
D5225	Upper Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	$385.00
D5226	Lower Partial Denture – Flexible Base (Including Clasps, Rests and Teeth)	$385.00
D5410	Adjust Complete Denture – Upper	$37.00
D5411	Adjust Complete Denture – Lower	$37.00
D5421	Adjust Partial Denture – Upper	$37.00
D5422	Adjust Partial Denture – Lower	$37.00
Repairs to Prosthetics		
D5510	Repair Broken Complete Denture Base	$62.00
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	$62.00
D5610	Repair Resin Denture Base	$62.00
D5630	Repair or Replace Broken Clasp	$80.00
D5640	Replace Broken Teeth – Per Tooth	$62.00
D5650	Add Tooth to Existing Partial Denture	$62.00
D5660	Add Clasp to Existing Partial Denture	$80.00
Denture Relining (Limit 1 Every 36 Months)		
D5710	Rebase Complete Upper Denture	$190.00
D5711	Rebase Complete Lower Denture	$190.00
D5720	Rebase Upper Partial Denture	$190.00
D5721	Rebase Lower Partial Denture	$190.00
D5730	Reline Complete Upper Denture – Chairside	$13.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D5731	Reline Complete Lower Denture – Chairside	$13.00
D5740	Reline Upper Partial Denture – Chairside	$13.00
D5741	Reline Lower Partial Denture – Chairside	$13.00
D5750	Reline Complete Upper Denture – Laboratory	$165.00
D5751	Reline Complete Lower Denture – Laboratory	$165.00
D5760	Reline Upper Partial Denture – Laboratory	$165.00
D5761	Reline Lower Partial Denture – Laboratory	$165.00
Interim Dentures (Limit 1 Every 5 Years)		
D5810	Interim Complete Denture – Upper	$280.00
D5811	Interim Complete Denture – Lower	$280.00
D5820	Interim Partial Denture – Upper	$225.00
D5821	Interim Partial Denture – Lower	$225.00
Oral Surgery (Includes Routine Postoperative Treatment) Surgical Removal of Impacted Tooth – Not covered for ages below 15 unless pathology (disease) exists.		
D7111	Extraction of Coronal Remnants – Deciduous Tooth	$12.00
D7140	Extraction, Erupted Tooth or Exposed Root – Elevation and/or Forceps Removal	$12.00
D7210	Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	$19.00
D7220	Removal of Impacted Tooth – Soft Tissue	$19.00
D7230	Removal of Impacted Tooth – Partially Bony	$69.00
D7240	Removal of Impacted Tooth – Completely Bony	$120.00
D7241	Removal of Impacted Tooth – Completely Bony, Unusual Complications (Narrative Required)	$125.00
D7250	Surgical Removal of Residual Tooth Roots – Cutting Procedure	$19.00
D7251	Coronectomy - Intentional Partial Tooth Removal	$69.00
D7260	Oroantral Fistula Closure	$125.00
D7261	Primary Closure of a Sinus Perforation	$125.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
D7270	Tooth Stabilization of Accidentally Evulsed or Displaced Tooth	$13.00
D7280	Surgical Access of an Unerupted Tooth *(Excluding Wisdom Teeth)*	$13.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$7.00
D7285	Biopsy of Oral Tissue – Hard (Bone, Tooth) *(Tooth Related – Not allowed when in conjunction with another surgical procedure)*	$87.00
D7286	Biopsy of Oral Tissue – Soft (All Others) *(Tooth Related – Not allowed when in conjunction with another surgical procedure)*	$75.00
D7287	Exfoliative Cytological Sample Collection	$74.00
D7288	Brush Biopsy – Transepithelial Sample Collection	$74.00
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	$13.00
D7311	Alveoloplasty in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	$7.00
D7320	Alveoloplasty Not in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces per Quadrant	$13.00
D7321	Alveoloplasty Not in Conjunction with Extractions – 1 to 3 Teeth or Tooth Spaces per Quadrant	$7.00
D7450	Removal of Benign Odontogenic Cyst or Tumor – Up to 1.25 cm	$13.00
D7451	Removal of Benign Odontogenic Cyst or Tumor – Greater than 1.25 cm	$13.00
D7471	Removal of Lateral Exostosis – Maxilla or Mandible	$13.00
D7472	Removal of Torus Palatinus	$13.00
D7473	Removal of Torus Mandibularis	$13.00
D7485	Surgical Reduction of Osseous Tuberosity	$13.00
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	$13.00
D7511	Incision and Drainage of Abscess – Intraoral Soft Tissue Complicated	$19.00
D7960	Frenulectomy – Also Known as Frenectomy or Frenotomy – Separate Procedure Not Incidental to Another	$13.00
D7963	Frenuloplasty	$19.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
Orthodontics (Tooth Movement) Orthodontic Treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)		
D8050	Interceptive Orthodontic Treatment of the Primary Dentition – Banding	$480.00
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition – Banding	$480.00
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition – Banding	$500.00
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition – Banding	$515.00
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition – Banding	$515.00
D8660	Pre-Orthodontic Treatment Visit	$68.00
D8670	Periodic Orthodontic Treatment Visit – As Part of Contract	
	Children – Up to 19th Birthday:	
	24-Month Treatment Fee	$1,575.00
	Charge per Month for 24 Months	$66.00
	Adults:	
	24-Month Treatment Fee	$2,320.00
	Charge per Month for 24 Months	$97.00
D8680	Orthodontic Retention – Removal of Appliances, Construction and Placement of Retainer(s)	$345.00
D8999	Unspecified Orthodontic Procedure – By Report *(Orthodontic Treatment Plan and Records)*	$195.00

Cigna Dental Care®
Patient Charge Schedule (F4-08)

Code	Procedure Description	Patient Charge
General Anesthesia/IV Sedation – General anesthesia is covered when performed by an Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. IV sedation is covered when performed by a Periodontist or Oral Surgeon when medically necessary for covered procedures listed on the Patient Charge Schedule. Plan limitation for this benefit is 1 hour per appointment. There is no coverage for general anesthesia or intravenous sedation when used for the purpose of anxiety control or patient management.		
D9220	General Anesthesia – First 30 Minutes	$180.00
D9221	General Anesthesia – Each Additional 15 Minutes	$80.00
D9241	IV Conscious Sedation – First 30 Minutes	$180.00
D9242	IV Conscious Sedation – Each Additional 15 Minutes	$73.00
Emergency Services		
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$0.00
D9440	Office Visit – After Regularly Scheduled Hours	$65.00
Miscellaneous Services – External Bleaching (D9972) is limited to the use of take-home bleaching trays. All other bleaching methods are not covered.		
D9972	External Bleaching per Arch	$175.00

After your enrollment is effective:

Call the dental office identified in your Welcome Kit. If you wish to change dental offices, a transfer can be arranged at no charge by calling Cigna Dental at the toll-free number listed on your ID card or plan materials.

Multiple ways to locate a *DHMO Network General Dentist:

- Online provider directory at www.Cigna.com
- Online provider directory on myCigna.com
- Call the number located on your ID card to:
  - Use the Dental Office Locator via Speech Recognition
  - Speak to a Customer Service Representative

EMERGENCY: If you have a dental emergency as defined in your group's plan documents, contact your Network General Dentist as soon as possible. If you are out of your service area or unable to contact your Network Office, emergency care can be rendered by any licensed dentist. Definitive treatment (e.g., root canal) is not considered emergency care and should be performed or referred by your Network General Dentist. Consult your group's plan documents for a complete definition of dental emergency, your emergency benefit and a listing of Exclusions and Limitations.

*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

830566 10/11

Cigna®

Cigna Dental Benefit Summary
Bloomfield Township
Plan Renewal Date: 01/01/2021

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations.
Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$1,500		$1,500	
Calendar Year Deductible Individual Family	$50 $150		$50 $150	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain	85% After Deductible	15% After Deductible	85% After Deductible	15% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible
Class IV: Orthodontia Coverage for Dependent Children to age 19 Lifetime Benefits Maximum: $3,000	75% After Deductible	25% After Deductible	75% After Deductible	25% After Deductible

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.

Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Oral Health Integration Program (OHIP)	Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with the following medical conditions: diabetes, heart disease, stroke, maternity, head and neck cancer radiation, organ transplants and chronic kidney disease. There's no additional charge for the program, those who qualify get reimbursed 100% of coinsurance for certain related dental procedures. Eligible customers can also receive guidance on behavioral issues related to oral health and discounts on prescription and non-prescription dental products. Reimbursements under this program are not subject to the annual deductible, but will be applied to and are subject to the plan annual maximum. Discounts on certain prescription and non-prescription dental products are available through Cigna Home Delivery Pharmacy only, and you are required to pay the entire discounted charge. For more information including how to enroll in this program and a complete list of program terms and eligible medical conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Oral Evaluations	2 per calendar year
X-rays (routine)	Bitewings: 2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months
Diagnostic Casts	Payable only in conjunction with orthodontic workup
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy
Fluoride Application	1 per calendar year
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months
Space Maintainers	Limited to non-orthodontic treatment for children under age 19
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;	
Periodontics: bite registrations; splinting;	
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Cigna Dental PPO plans are insured and/or administered by Cigna Health and Life Insurance Company (CHLIC) or Connecticut General Life Insurance Company (CGLIC), with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Texas, the insured dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO network.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. Policy forms (for insured dental plans) in OK: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OR: HP-POL68; TN: HP-POL69/HC-CER2V1 et al (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

Cigna Dental Benefit Summary
Bloomfield Township - DPRET
Plan Renewal Date: 01/01/2021

Administered by: Cigna Health and Life Insurance Company

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Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.

Cigna Dental PPO				
Network Options	***In-Network:*** **Total Cigna DPPO Network**		***Non-Network:*** **See Non-Network Reimbursement**	
Reimbursement Levels	Based on Contracted Fees		Maximum Reimbursable Charge	
Calendar Year Benefits Maximum Applies to: Class I, II & III expenses	$750		$750	
Calendar Year Deductible Individual Family	$100 $300		$100 $300	
Benefit Highlights	***Plan Pays***	***You Pay***	***Plan Pays***	***You Pay***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain	100% No Deductible	No Charge	100% No Deductible	No Charge
Class II: Basic Restorative Restorative: fillings Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation Repairs: Bridges, Crowns and Inlays Repairs: Dentures Denture Relines, Rebases and Adjustments Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain	85% After Deductible	15% After Deductible	85% After Deductible	15% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Bridges and Dentures	50% After Deductible	50% After Deductible	50% After Deductible	50% After Deductible

Benefit Plan Provisions:	
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Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Alternate Benefit Provision	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.

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Denture and Bridge Repairs	Reviewed if more than once
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation
Prosthesis Over Implant	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Benefit Exclusions: Covered Expenses will not include, and no payment will be made for the following:	
Procedures and services not included in the list of covered dental expenses;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;	
Periodontics: bite registrations; splinting;	
Prosthodontic: precision or semi-precision attachments; initial placement of a complete or partial denture per plan guidelines;	
Implants: implants or implant related services; Orthodontics: orthodontic treatment;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; services performed primarily for cosmetic reasons; personalization; replacement of an appliance per benefit guidelines;	
Services that are deemed to be medical in nature; services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	

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April 1, 2020 to March 31, 2026
Signature Copy

ATTACHMENT “D”
Retirement Health Savings Plan

Charter Township of Bloomfield

Retirement Health Savings Plan (RHS Plan)

SUMMARY PLAN DESCRIPTION

Original Effective Date: April 1, 2011
Restated: April 1, 2018
Amended: April 1, 2020
Plan Year is: April 1st through March 31st

Aviben

Benefits Administrator. Elevated Solutions.

Contents

ARTICLE I. INTRODUCTION

Your Employer, the Charter Township of Bloomfield (the "Employer" or "Township"), is pleased to sponsor an employee benefit program known as the Charter Township of Bloomfield Retirement Health Savings Plan (the "RHS Plan") for certain eligible employees.

This summary plan description ("SPD") describes the basic features of the RHS Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the RHS Plan, and a brief description of your rights as a participant. To make maximum use of this RHS Plan, be sure to proceed through this booklet carefully, so that you can make informed decisions that are right for you.

If, for any reason, there is an omission or misstatement in this SPD, or any difference between this SPD and the Plan document, the Plan document shall in all respects control and govern. Please note that neither the RHS Plan nor the SPD constitute a contract of employment.

In all situations involving the interpretation and clarification of a policy, procedure or application, the decision of the RHS Plan Administrator will be final and binding. However, notwithstanding the prior sentence, any claim for benefits that a Plan Administrator denies is subject to review under the RHS Plan's claims and appeals procedures, which are summarized herein.

If you have any unanswered questions after reading this SPD, please contact:

Educators Benefit Consultants, LLC
1995 E. Rum River Drive S.
Cambridge, MN 55008
Phone number: 888-507-6053

PRIVACY NOTIFICATION

The RHS Plan is a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules.

HIPAA requires that "covered entities" protect the confidentiality of your protected health information (PHI). "Electronic PHI" or "E-PHI" means PHI that is transmitted in electronic media.

PHI means health information that:

- Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse;
- Related to the past, present and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- Either identifies the individual or reasonably could be used to identify the individual

A complete description of your rights under HIPAA can be found in the RHS Plan's ***privacy notice***, distributed to you upon enrollment and available upon request from your RHS Plan Administrator.

The RHS Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment and health plan operations, expressly authorized by you or as required by law. The RHS Plan requires all of its service providers to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receiving an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the RHS Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. You may fine more information about HIPAA at the following website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/

ARTICLE II. GENERAL INFORMATION ABOUT THE PLAN

2.1 What is the purpose of the RHS Plan?

The purpose of the RHS Plan is to provide certain Employees with an opportunity to receive reimbursement for qualified Health Care Expenses as provided in this RHS Plan. You will receive contributions into the Plan as long as you are an active Employee and a Participant (as described in Sections 2.4 and 2.5, below), and you will be eligible for reimbursements after you terminate employment with the Township. It is the intention of the Adopting Employer that the benefits payable under this RHS Plan be eligible for exclusion from the gross income of Participants as provided by Code §§ 105(b) and 106. In addition, it is the intention of the Adopting Employer that the RHS Plan qualify as a Health Reimbursement Arrangement ("HRA") under IRS Revenue Ruling 2002-41, IRS Notice 2002-45, IRS Notice 2013-54, IRS Notice 2015-87 and Final Regulations jointly issued on November 18, 2015 by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration) and the Department of Health and Human Services, (i.e., Final Rules for Grandfathered RHS Plan, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections Under the Affordable Care Act.).

2.2 When did the RHS Plan take effect?

The RHS Plan became effective April 1, 2011. It operates on a Plan Year specified in the Administrative Information included at the end of this SPD.

2.3 Compliant plan models

Effective for Plan Years beginning on or after January 1, 2017, in order to comply with related legislation and regulatory guidance the Affordable Care Act ("ACA"), (which generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits), an HRA must fit into one of certain compliant designs specified in the Adoption Agreement.

Your RHS Plan falls within the Internal Revenue Service definition of a "Retiree-Only HRA" (i.e., an arrangement that has fewer than two active employees participating in the RHS Plan on the first day of the Plan Year). Although dubbed "Retiree-Only" by the IRS, the RHS Plan is actually a post-employment plan. Contributions shall be made into the RHS Plan, on your behalf, while you are actively employed. You shall become eligible for reimbursement status upon separation of employment for any reason. Age and/or retirement eligibility is not an eligibility factor.

2.4 Who can participate in the RHS Plan?

An eligible employee, the legal spouse and legal dependent(s) of the employee.

In order to participate in this RHS Plan, a person must meet the following eligibility criteria:

- Must be hired on or after May 1, 2011; and

- Must be a full-time employee
  - Regularly works 40 hours or more per week; Or
  - At library a full-time employee regularly works 37.5 or more hours per week

This RHS Plan includes union and non-union employees.

Union Employees: The Plan is maintained pursuant to various collective bargaining agreements and a copy of the relevant portions of the relevant agreement may be obtained by a Plan participant upon written request to the RHS Plan Administrator. These employees are called Eligible Employees. Those Eligible Employees who actually participate in the Plan are called "Participants." Always refer to your most recent collective bargaining agreement for eligibility and contribution information.

Non-Union Employees: The Plan is maintained pursuant to a written personnel policy or contractual agreement. A copy of the policy may be obtained by Plan participants upon written request to the RHS Plan Administrator. These employees are called Eligible Employees. Those Eligible Employees who actually participate in the Plan are called "Participants." Always refer to your most recent personnel policy for eligibility and contribution information.

"**Employee**" means a common-law employee of the Employer who is on the Employer's W-2 payroll, except that the term "Employee" does not include any common-law employee who is a leased employee (including but not limited to an individual defined in Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer, but who is paid by a temporary or other employment agency such as "Kelly Manpower," etc., or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder.

2.5 How long will I be able to participate in the RHS Plan?

There are two aspects of participation in the RHS Plan – the receipt of employer contributions and access to your RHS Plan Account to receive reimbursement of eligible Health Care Expenses.

Contributions. Contributions on your behalf cease upon the earliest of the following: (1) the date of your death; (2) the date of termination of your employment with the Employer; (3) the date of your failure to meet the eligibility requirements described in Section 2.4 above, other than the requirement that you be an employee of the Employer; or (4) the date of termination of the RHS Plan.

Access to reimbursements. Access to your RHS Plan account for purposes of reimbursing eligible Health Care Expenses cease upon the earliest of the following: (1) the date of your death; (2) the date the balance of your RHS Plan account reaches zero; or (3) the date of termination of the RHS Plan.

Please note: Termination of contributions or access to your RHS Plan does not prevent you or others covered through you from receiving continuation coverage required by applicable law. In addition, termination of access to your RHS Plan is subject to the spend down access described in Section 5.2.

2.6 How long will the RHS Plan remain in effect?

Although the Township expects to maintain the RHS Plan indefinitely, it has the right to amend or terminate the program in whole or in part at any time. It is also possible that future changes in state or federal tax laws may require that the RHS Plan be amended or terminated accordingly. In addition, future collective bargaining agreements may change or eliminate the RHS Plan with respect to certain union employees. You will be informed if changes are made to the RHS Plan.

2.7 How does reimbursement under this RHS Plan affect my tax deductions?

You should realize that any medical expense for which you are reimbursed under this RHS Plan cannot be claimed as a medical expense deduction on your income tax return.

Note: Beginning Jan. 1, 2017, all taxpayers may deduct only the amount of the total unreimbursed allowable medical care expenses for the year that exceeds 10% of your adjusted gross income. You always should check with your tax advisor for up-to-date information regarding medical expense deductions.

ARTICLE III. HEALTH CARE ACCOUNT

3.1 What is my RHS Plan account?

A RHS Plan account will be established in your name to keep a record of the benefits under this RHS Plan to which you are entitled.

Your RHS Plan account is an individual trust account established within an Integral Part Trust. Benefits are paid from the Trust account.

Elected Officials shall receive upon hire the following contributions into their RHS Plan account:

Direct Employer Contribution
An eligible employee shall receive a direct employer contribution based on the employee's years of service. The contribution shall be paid out over the twenty-six (26) biweekly pay periods.

0-5 Years	$3,000 per year	($115.38 per pay)
5-15 Years	$4,500 per year	($173.08 per pay)
15 years +	$6,000 per year	($230.77 per pay)

Mandated Employee Contribution
An eligible employee shall contribute three percent (3%) of gross wages. The mandated employee contribution shall be deducted over the twenty-six (26) biweekly pay periods.

Contribution Vesting
Mandated employee contributions are not subject to a vesting requirement. You shall have immediate access to those funds upon separation of employment. In order to vest and gain access to the direct employer contributions, you must complete three (3) years of continuous service with the Township.

Immediate vesting shall also occur upon death, or due to total and permanent disability. Total and permanent disability is defined by the RHS Plan as it is defined by the public pension plan available to the employees of the Township.

Eligible Water Department shall receive upon hire the following contributions into their RHS Plan account:

Direct Employer Contribution
An eligible employee shall receive a direct employer contribution not to exceed $2,500 for the Plan Year. The contribution shall be paid out over the twenty-six (26) biweekly pay periods.

Mandated Employee Contribution
An eligible employee shall contribute two percent (2%) of gross wages not to exceed $2,500 for the Plan Year. The mandated employee contribution shall be deducted over the twenty-six (26) biweekly pay periods.

Contribution Vesting
Mandated employee contributions are not subject to a vesting requirement. You shall have immediate access to those funds upon separation of employment. In order to vest and gain access to the direct employer contributions, you must complete three (3) years of continuous service with the Township.

Immediate vesting shall also occur upon death, or due to total and permanent disability. Total and permanent disability is defined by the RHS Plan as it is defined by the public pension plan available to the employees of the Township.

All other eligible employees shall receive upon hire the following contributions into their RHS Plan account:

Direct Employer Contribution
An eligible employee shall receive a direct employer contribution based on the employee's years of service. The contribution shall be paid out over the twenty-six (26) biweekly pay periods.

0-5 Years	$3,000 per year	($115.38 per pay)
5-15 Years	$4,500 per year	($173.08 per pay)
15 years +	$6,000 per year	($230.77 per pay)

Mandated Employee Contribution
An eligible employee shall contribute three percent (3%) of gross wages. The mandated employee contribution shall be deducted over the twenty-six (26) biweekly pay periods.

Contribution Vesting
Mandated employee contributions are not subject to a vesting requirement. You shall have immediate access to those funds upon separation of employment. Employees hired before 4/1/2020 must complete three (3) years of continuous service with the Township in order to be vested in the direct employer contribution portion. Employees hired after 4/1/2020 shall be subject to the following vesting schedule for the direct employer contribution portion.

0-3 Years	0%
3-5 Years	25%
5-7 Years	50%
7+ Years	100%

3.2 What is an "eligible" Health Care Expense?

Only eligible Health Care Expenses may be reimbursed under this Plan. An eligible Health Care Expense is an expense for the payment of medical, dental, vision and long term care premium expenses and out-of-pocket vision, dental and medical care expenses. Furthermore, to be an eligible Health Care Expense, the expense:

(a) must be "incurred" while you are a Participant; and
(b) must be "incurred" for yourself, your legal Spouse or your legal Dependent(s).

An expense is "**incurred**" when the service that gives rise to the expense has been provided, not when you are billed or when you pay the expense.

"**Spouse**" means an individual who is legally married to you and who is treated as your spouse under the Internal Revenue Code.

"**Dependent**" means a dependent for purposes of Section 105 of the Internal Revenue Code. Generally, "dependent" includes a qualifying child that has not attained age 27 in the tax year. The other relatives that may be "dependents" for purposes of the RHS Plan (IRC 152) are individuals who: (a) are your child (or a descendant of a child), brother, sister, stepbrother, or stepsister, parent (or a parent's ancestor), stepparent, brother or sister's son or daughter, parent's brother or sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or, if not such a relative, an individual who has the same principal place of abode as you and is a member of your household; (b) generally have received more than one-half of their support from you during the relevant year; and (c) are not a qualifying child of you or someone else.

3.3 How do I receive my benefits under the RHS Plan?

Once you separate employment you are eligible to submit for the reimbursement of qualified expenses. EBC shall pay out paper, fax and web claims two times a month. If you elect to make use of the Prepaid Benefits Card, the expense payment takes place at point of sale (when you swipe the card).

Paper Claims. When you incur an expense that is eligible for reimbursement, you must submit a claim to the Claims Administrator on an administrative form that will be supplied to you. The form will typically require you to provide:

(1) the amount, date and nature of the expense,
(2) the name of the person or entity to which the expense was paid,
(3) your statement that the expense has not been reimbursed or is not reimbursable through any other source, and
(4) such other information as the Claims Administrator may require.

You shall also be required to submit *copies* of bills or receipts from the provider(s) to support your claim.

Web Claim. You will also have the opportunity to submit a claim via the EBC secure web portal. Please refer to your enrollment materials for instructions on how to sign on and submit your claim for reimbursement on-line using the web portal.

Prepaid Benefits Card. You shall also have the opportunity to pay for eligible expenses uses a prepaid benefits card. The card is a voluntary payment method. The cost of the card is paid for by the Participant. Please refer to Wex Health Payment Card Frequently Asked Questions for more information on the "Benny Card".

"**Claims Administrator**" means Educators Benefit Consultants, LLC. The address for claims submission is: 3125 Airport Parkway N.E., Cambridge, MN 55008. The phone number is 1-888-507-6053.

3.4 What if my claim exceeds the balance of my RHS Plan account?

The maximum reimbursement you may receive at any time is the amount of your RHS Plan account balance at the time the reimbursement request is processed. The maximum reimbursement requirements apply to you, your Spouse, and your Dependent(s) on an aggregate basis, not an individual basis. If your claim is for an amount that is more than your current RHS Plan account balance, the excess amount of the claim will not be reimbursed.

3.5 Do I submit claims for reimbursement under my Employer's cafeteria plan first?

Yes. Claims for eligible Health Care Expenses (see Question 3.2) must first be submitted for reimbursement to your Employer's or another family member's flexible spending account under its cafeteria plan. If that claim is not fully reimbursed, the balance may then be submitted under this RHS Plan.

3.6 What happens if my claim for benefits is denied?

In most cases, within thirty (30) days after a claim for benefits is filed, the claim will either be paid or the Claims Administrator will notify you of the claim denial. If the Claims Administrator denies the claim, you will be provided with the following information in writing:

1. The specific reasons for the denial;

2. The specific reference to the RHS Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

4. Appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered.

Within one hundred eighty (180) days after you receive notice that your claim has been denied, you or your authorized representative may file a written request with the Claims Administrator appealing the denial and requesting review of it. You or your representative are entitled to review the pertinent documents and may also submit issues and comments in writing to be considered as part of the review.

"**Authorized Representative**" means a person entitled to act on your behalf and recognized by the RHS Plan Administrator. In order to be recognized by the RHS Plan Administrator, the person must have a completed "Authorized Representative Form" on file with the Claims Administrator.

The RHS Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The RHS Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection

with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

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

2. The specific RHS Plan provision(s) on which the decision is based; and

3. A statement of your right to review (on request and at no charge) relevant documents and other information

Upon completion of the internal claims and appeal process, you may request to initiate an external review of a denied internal appeal. Contact the RHS Plan Administrator or Claims Administrator for a description of applicable external review procedures. Note that an external review must be initiated within four months of your receipt from the RHS Plan Administrator of a denial of an appeal. Any request to pursue an external claim must be made in writing to the RHS Plan Administrator.

3.7 What if I am subject to a medical child support order?

Notwithstanding any provision of the RHS Plan to the contrary, the RHS Plan shall recognize ***Qualified*** Medical Child Support Orders ("QMCSOs"). To be recognized, specific procedures must be followed. If you are involved in a divorce or child custody matter, you or your legal counsel should contact the RHS Plan Administrator. Participants, spouses or dependents may request from the RHS Plan Administrator a copy of the RHS Plan's QMCSO procedures (which will be provided at no charge).

3.8 Will I have any administrative costs under the RHS Plan?

Administrative Asset Based Fee: Paid by Participant

The cost of administering this RHS Plan is paid from your account balance at a rate of 19 basis points per quarter (note: 19 basis points means 0.19%). The 19 basis points is not charged against assets in a fixed or money market account.

Prepaid Benefits Card: Paid by Participant

If you elect to use the card you will see $20.00 dollars deducted from your RHS Plan account. The $20.00 pays for the cost of two cards. One card is for you and the other is for your dependent or spouse. Additional cards cost $10.00 a card. You must reenroll in the card every year.

3.9 What happens to my RHS Plan account if I die?

If there is a balance in your RHS Plan account at the time of your death, your spouse and dependent(s) ***may*** be able to continue to access these funds until the earlier of: (a) the date on which the balance is exhausted, or (b) the date the last remaining Spouse or Dependent dies. Access to your RHS Plan account is only available in the event such access is offered and selected as an alternative to any continuation coverage that may otherwise be available.

3.10 In what situations will the balance of my RHS Plan account be forfeited?

(a) Amounts attributed to your RHS Plan account shall be forfeited upon your death if you do not have a legal spouse and/or legal dependent(s). If you have no spouse or dependent(s) your estate has eighteen (18) months from the day of your passing to submit qualified expenses for reimbursement. After your final remaining medical expenses have been reimbursed to your estate the forfeited amounts shall be placed in a forfeiture account and be used to fund future direct employer contributions into the RHS Plan.

(b) **Annual Option to Permanently Opt Out.** Each year that you are eligible for reimbursements under this RHS Plan (i.e., upon termination of employment) you have the right to

permanently opt out of participation in this RHS Plan. When you opt out you permanently forfeit your funds.

Under What Circumstance Would I Opt Out?

Answer: Being eligible for RHS Plan benefits means you are considered to be covered by an employer-sponsored health plan under federal health care rules and prevents you from being eligible for federal subsidies if you purchase health insurance coverage on the public marketplace exchange. Keep in mind that other factors, such as your household income, will impact whether you are eligible for subsidies to offset the cost of health insurance coverage you may purchase on the public marketplace exchange. If you elect to opt out of coverage under this RHS Plan, you will not be allowed to re-enroll (and receive benefits using money deposited to your account) for the duration of the time you are eligible for coverage under the RHS Plan.

For information about federal health insurance rules, the public marketplace exchange and federal subsidies see https://www.healthcare.gov/or call 1-800-318-2596. To exercise your opt-out rights under this RHS Plan, please obtain the opt out form from the Plan Administrator. Please contact the Plan Administrator with questions.

Article IV. Investments

4.1 What happens to the funds before I take them out?

All assets of the Plan will be held in a trust by the Trustee. The Trustee will administer the trust in accordance with the RHS Plan trust and plan documents.

"**Trustee"** means Charter Township of Bloomfield, Michigan

Contribution made into your RHS Plan account shall default to a Target Date Fund. You may redirect those funds if you so desire. You will receive investment information in your welcome kit.

Caution: Not FDIC insured. Earnings are not guaranteed. You may experience investment losses.

4.2 Are the earnings taxable?

No. The earnings accumulate on a tax-free basis. When the RHS Plan balance is accessed for reimbursement of a claim, there is no distinction between contribution dollars and earnings.

Article V. Continuation Coverage

A Participant, and any others who are covered through that Participant, ***may*** be entitled to elect to continue coverage under the RHS Plan in accordance with the Consolidated Omnibus Reconciliation Act of 1985, as amended ("COBRA"), or the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), as described below.

Are there other coverage options besides COBRA continuation coverage? *Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace (established by ACA), Medicaid or other group health plan options (such as a spouse's plan though what is called a "special enrollment period." It is possible that some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at* ***https://www.healthcare.gov/****.*

5.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with twenty (20) or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the cost for the continuation coverage.

This notice is intended to inform persons covered under the RHS Plan, in summary fashion, of their rights and obligations under the continuation coverage provision of the law. It is intended that no greater rights be provided than those required by this law. It does not fully describe your continuation coverage rights. The RHS Plan Administrator has developed additional policies regarding the provision of continuation coverage under the RHS Plan. For additional information about your rights and obligations under the RHS Plan and under federal law, you should contact the RHS Plan Administrator.

This notice covers only this RHS Plan.

Each person covered under the RHS Plan should read this notice carefully.

Qualifying Events. Upon the commencement of a "qualifying event" each person that loses coverage may have rights as a "qualified beneficiary."

Qualifying event. A qualifying event is the occurrence of an enumerated event (described below) that results in a loss of coverage under the terms of the group health plan.

Qualifying beneficiary. A qualified beneficiary is the employee, employee's spouse and/or employee's dependent children who on the day before the qualifying event were covered under the group health plan. A spouse whose coverage was reduced or terminated in anticipation of divorce is also a qualified beneficiary. In addition, a child born to or placed for adoption with a qualified beneficiary ***who was the employee*** is a qualified beneficiary is if he or she was covered under the group health plan on the day before the qualifying event. Furthermore, an individual for whom the employee must provide coverage under the group health plan pursuant to a medical child support order is a qualified beneficiary.

Employee Loss. If covered by any of the group health plans described above, the employee has the right to elect continuation coverage if he or she loses coverage under such plan due to termination of employment (other than for gross misconduct) or a reduction in hours of employment.

Spouse's Loss. If covered by any of the group health plans described above, a spouse has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

the employee's death; or

divorce or legal separation from the employee.

Please Note: If an employee eliminates coverage for his or her spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier.

Dependent Child's Loss. If covered by any of the group health plans described above, a dependent child has the right to elect continuation coverage if he or she loses coverage under such plan due to any of the following:

the employee's termination of employment (other than for gross misconduct) or a reduction in hours of employment;

the employee's death;

divorce or legal separation of the employee and the child's other parent; or

the child ceasing to be a "dependent child" under the terms of the plan.

Employer's Bankruptcy. Rights similar to those described above may apply to retirees (and the spouses and dependents of those retirees), if the employer commences a Chapter 11 bankruptcy proceeding.

Responsibility to Notify. In certain circumstances, you are required to provide notification to the RHS Plan in order to protect your rights under COBRA.

Notice of Qualifying Event. Under the law, the employee or a family member (or a representative acting on behalf of the employee or a family member) has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the plan within sixty (60) days of the latest of: (1) the date of the qualifying event; (2) the date coverage would be lost because of the qualifying event; or (3) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. The notification must be provided in writing and be mailed to the RHS Plan Administrator at the address identified below. Oral notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable. Your notification must be postmarked no later than the last of the sixty (60) day notice period described above. The Plan Administrator will provide the notification requirements upon request.

(1) state the name of the RHS Plan;
(2) state the name and address of the employee or former employee who is or was covered under the RHS Plan;
(3) state the name(s) and address(es) of all qualified beneficiaries who lost coverage due to the qualifying event;
(4) include a detailed description of the event;
(5) identify the effective date of the event; and
(6) be accompanied by any documentation providing proof of the event (i.e., the divorce decree).

Notice of Second Qualifying Event. In addition, the employee or a family member (or a representative acting on behalf of the employee or family member) must notify the RHS Plan of the death of the employee, divorce or separation from the employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the RHS Plan, if that event occurs within the eighteen (18) month continuation period (or an extension of that period for disability or for pre-termination Medicare entitlement). The notification must be provided within sixty (60) days after such a second qualifying event occurs in order to be entitled to an extension of the continuation period. The notification must be provided

in writing and be mailed to the RHS Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notices are not acceptable The Plan Administrator will provide the notification requirements upon request.

Notice of Disability. Also, an employee or a family member (or a representative acting on behalf of the employee or a family member) must notify the RHS Plan Administrator when a qualified beneficiary has been determined to be disabled under the Social Security Act within sixty (60) days of the latest of: (1) the date of the disability determination; (2) the date of the qualifying event; (3) the date coverage would be lost because of the qualifying event; or (4) the date on which the qualified beneficiary was informed of the responsibility to provide the notice and the procedures for doing so. (Notwithstanding the foregoing, the notice must be provided before the end of the first eighteen (18) months of continuation coverage.) The notification must be provided in writing and be mailed to the RHS Plan Administrator at the address identified below. Oral notice, including notice by telephone is not acceptable. Electronic (including emailed or faxed) or hand-delivered notifications are not acceptable. Your notification must be postmarked no later than the last day of the sixty (60) day notice period described above. The Plan Administrator will provide the notification requirements upon request.

Election Rights. When a qualifying event occurs, or when the COBRA Administrator is notified that a qualifying event has occurred in the case of those events in which the employee has an obligation to provide notice, the COBRA Administrator must notify the qualified beneficiaries of the right to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. Employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all qualified beneficiaries and parents may elect continuation coverage on behalf of their children. Furthermore, other third persons can elect continuation coverage on behalf of a qualified beneficiary.

Please Note: Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered by Medicare effective on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if he or she first becomes covered by Medicare effective after the date on which COBRA is elected.

Cost. A person electing continuation coverage may have to pay all or part of the cost of continuation coverage. You will receive additional information regarding the cost requirements following the occurrence of a qualifying event. The amount charged cannot exceed 102% of the cost to the RHS Plan of providing the coverage. The amount may be increased to 150% for the months after the eighteenth (18^{th}) month of continuation coverage when the additional months are due to a disability under the Social Security Act. Payment is generally due monthly. Payment is considered "made" on the date sent.

More Information: The Employer administers its own COBRA responsibilities. The Employer has hired a third party to administer COBRA. All questions, notices, and other communications regarding COBRA and the RHS Plan should be directed to:

Bloomfield Township
4200 Telegraph Road, PO Box 489
Bloomfield Hills, MI 48303

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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

5.2 What if I just want to spend down my account?

Following termination of employment, the RHS Plan allows you to spend down the balance of your RHS Plan account if you choose to continue to access your account in lieu of COBRA continuation coverage. If you choose to spend down your account, you may generally continue to submit claims for eligible Health Care Expenses until the date the account balance reaches zero.

Upon your death, your surviving Spouse and Dependents will be allowed to spend down the balance of your RHS Plan account if they choose to continue to access your account in lieu of COBRA continuation coverage. If they choose to spend down your account, your surviving Spouse and Dependents may generally continue to submit claims for eligible Health Care Expenses until the account balance reaches zero. (See Section 3.9 regarding other situations in which such access may terminate.)

5.3 What are my continuation rights under USERRA?

USERRA requires all employers to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "U-continuation coverage") at group rates where health coverage under employer-sponsored group health plan(s) would otherwise end because of the employee's service in the uniformed services. For more information, contact the Plan Administrator.

More Information: For information about USERRA, you may contact the 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ARTICLE VI. FAMILY AND MEDICAL LEAVE ACT OF 1993

Family and Medical Leave Act of 1993 ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") imposes certain obligations on employers with fifty (50) or more employees. Should your Employer have more than fifty (50) employees, this RHS Plan (including the component plans) shall be administered in a manner consistent with the FMLA and the Employer's FMLA Policy required thereunder. If your Employer is subject to FMLA, then you should be provided with a complete explanation of FMLA rights and responsibilities. Contact your Employer if you have questions about FMLA.

Also note that the **Newborns' and Mothers' Health Protection Act ("NMHPA")** applies to the RHS Plan. Under NMHPA, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issues may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Contact the Plan Administrator if you have questions about NMHPA and its application to this RHS Plan.

ARTICLE VII. YOUR RIGHTS

COBRA and HIPAA Rights.

As a Participant in the Plan you may be entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in coverage under the RHS Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the RHS Plan on the rules governing your COBRA continuation coverage rights.

Small Employer Exception: The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers with *twenty (20) or more employees* to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. However, your Employer is currently too small in size for COBRA coverage to apply.

Assistance with Your Questions.

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

RHS Plan Administrator: Your Employer is the RHS Plan Administrator. Aviben is the Claims Administrator and acts as your Employer's designee. All notices and other communication should be directed to:

Educators Benefit Consultants, LLC. DBA: Aviben
1995 E. Rum River Drive S.
Cambridge, MN 55008
Phone number: 888-507-6053

ADMINISTRATIVE INFORMATION

Plan:

Plan Name:	Charter Township of Bloomfield Retirement Health Savings Plan
Plan Type:	Retiree-Only Health Reimbursement Arrangement – NON ERISA
Plan Number:	
Plan Year (Start to End)	April 1 to March 31
Effective Date of Plan	April 1, 2018
Date of this SPD	February 10, 2021

Employer & Plan Administrator:

Name:	Charter Township of Bloomfield
Address:	4200 Telegraph Road, PO Box 489
City, State Zip:	Bloomfield Hills, MI 48303
Phone Number:	Phone: 248-433-7712 Fax: 248-594-2831
EIN:	38-6000242
Contact Person:	Elizabeth Parrott, HR and Benefits Manager

Agent for Service of Legal Process:

Name:	Elizabeth Parrott, HR and Benefits Manager
Address:	4200 Telegraph Road, PO Box 489
City, State Zip:	Bloomfield Hills, MI 48303
Phone/Fax Number:	Phone: 248-433-7712 Fax: 248-594-2831

Claims Administrator:

Name:	Educators Benefit Consultants, LLC. DBA: Aviben
Address:	1995 E. Rum River Drive S.
City, State Zip:	Cambridge, MN, 55008
Phone Number:	Toll-Free 888-507-6053 Metro: 763-552-6053
Fax Number:	763-552-6055

Directed Trustees:

Name:	Matrix Trust
Address:	717 17th St, Ste 1300
City, State Zip:	Denver, CO 80202
Phone Number:	1-877-610-3822

April 1, 2020 to March 31, 2026
Signature Copy

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

April 1, 2020

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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 all 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. Forfeitures will be allocated as follows:

- Forfeitures may first be used to pay any administrative expenses.
- Any remaining forfeitures will be used to reduce any Employer contribution.

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 2021 is $290,000. After 2021, 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 2021, this total cannot exceed the lesser of $58,000 or 100% of your annual compensation. After 2021, 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. The pre-amendment vesting schedule is as follows:

Vesting Schedule Pre-Amendment	
Years of Service	Percentage
1	0%
2	0%
3	100%

Special Vesting Provisions

- For those Participants with an Hour of Service on or after January 1, 2008, the following vesting schedule shall apply to Plan employer contributions, including Township contributions to a Participant's Pick-Up contribution account: Less than 3 years - 0%; 3 or more - 100%. For those Participants without an Hour of Service on or after January 1, 2008, the following vesting schedule shall apply to Plan employer contributions, including Township contributions to a Participant's Pick-Up contribution account: 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)", "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 "Water and Sewer Union (AFSCME) and "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).

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.

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 April 1, 2020.

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.

The name, address and business telephone number of the Plan's Administrator are:

Charter Township of Bloomfield
4200 Telegraph Road
Bloomfield Hills, Michigan 48303
(248) 433-7700

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)