HEALTH CARE PLAN

for

POLICE AND FIRE RETIREES OF THE CITY OF DETROIT

HEALTH CARE PLAN
for
POLICE AND FIRE RETIREES OF THE CITY OF DETROIT

Table of Contents

HEALTH CARE PLAN
for
POLICE AND FIRE RETIREES OF THE CITY OF DETROIT

Preamble

WHEREAS, the City of Detroit, Michigan filed a voluntary petition for relief under Chapter 9 of the United States Bankruptcy Code on July 18, 2013, in the United States Bankruptcy Court for the Eastern District of Michigan (the "Court"); and

WHEREAS, the Court approved the Plan for the Adjustment of Debts of the City of Detroit (the "Plan of Adjustment") with an effective date of December 10, 2014; and

WHEREAS, the Plan of Adjustment provides for the establishment of a voluntary employees beneficiary association ("VEBA") to provide health care benefits to certain eligible City of Detroit retirees and their eligible dependents as of January 1, 2015; and

WHEREAS, the Plan of Adjustment established the City of Detroit Police and Fire Retiree Health Care Trust (the "Trust") as a vehicle for funding the benefits to be provided under the VEBA; and

WHEREAS, the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust is responsible for designing, adopting, maintaining and administering the Health Care Plan for Police and Fire Retirees of the City of Detroit (the "Plan"), through which all health care benefits to the Trust's beneficiaries shall be provided; therefore be it

RESOLVED, that THIS INSTRUMENT, as made and adopted by the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust effective the 1st day of January, 2015, is hereby revised effective the 1st day of January 2017, as follows:

ARTICLE I. ESTABLISHMENT

1.01 Purpose. The Plan and Trust taken as a whole shall constitute a voluntary employees beneficiary association under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended, and is created for the exclusive purpose of providing benefits for the welfare of certain police and fire retirees of the City of Detroit, and their eligible Dependents, through policies of insurance issued by duly licensed commercial insurance companies, through a fund of self-insurance, or through any other lawful means of providing group health coverage in accordance with applicable laws.

1.02 Name. This Plan shall be known as the Health Care Plan for Police and Fire Retirees of the City of Detroit.

1.03 Structure of the Plan. Benefits under the Plan will be provided to Participants through the purchase of insurance coverage, or by reimbursement of eligible expenses, in accordance will the Plan and applicable state and federal laws. The Board reserves the right to enter into insurance agreements, and to modify, alter or amend such agreements from time to time, with commercial insurance carriers, health maintenance organizations, preferred provider organizations or any other qualified entity currently existing or created for the purpose of providing benefits under the Plan.

ARTICLE II. DEFINITIONS

The following terms as used herein shall have the following meanings, unless a different meaning is plainly required by the context:

2.01 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

2.02 "Board" or **"Board of Trustees"** means the Board of Trustees of the City of Detroit Police and Fire Retiree Health Care Trust.

2.03 "City" means the City of Detroit, Michigan.

2.04 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, as it applies through the Code and the Public Health Service Act.

2.05 "Code" means the Internal Revenue Code of 1986, as amended.

2.06 "Dependent" means any individual who is a legal dependent of the Participant within the meaning of Code section 152, without regard to subsections 152(b)(1), (b)(2), and (d)(1)(B) thereof, of a Participant, or an individual who was a legal dependent, within the meaning of Code section 152, without regard to subsections 152(b)(1), (b)(2), and (d)(1)(B) thereof, of a Participant immediately prior to the Participant's death and who would still qualify as a legal dependent of the Participant were the Participant still alive.

2.07 "Effective Date" means January 1, 2015.

2.08 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.09 "HMO" shall mean Health Maintenance Organization.

2.10 "Insurance Agreement" means the health insurance plan(s) and any amendment(s) thereto, including any substitute insurance agreement with a commercial insurance carrier, health maintenance organization, preferred provider organization, or any other qualified entity currently existing or created for the purpose of providing benefits under the Plan.

2.11 "Insurance Carrier" means a commercial health insurance carrier, health maintenance organization, preferred provider organization or other qualified entity designated by the Board to provide benefits under the Plan.

2.12 "NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

2.13 "Participant" means any eligible Retiree or eligible Spouse, who are eligible to participate under Section 3.01 of the Plan and is participating in the Plan pursuant to Section 3.02.

2.14 "Plan" means the Health Care Plan for Police and Fire Retirees of the City of Detroit and any subsequent amendments, Insurance Agreement(s), or other applicable insurance policy documents incorporated by reference into the Plan.

2.15 "Plan Administrator" means the person(s) or such other individual(s) or entity designated by the Board, to carry out the administrative services that are necessary to operate and administer the Plan.

2.16 "Plan of Adjustment" shall mean the Eighth Amended Plan for the Adjustment of Debts of the City of Detroit.

2.17 "Plan Year" means the 12-consecutive month period that begins on 1st day of January, and ends on the 31st day of December of each year.

2.18 "PPO" shall mean Preferred Provider Organization.

2.19 "Qualifying Life Event" means marriage, birth or legal adoption of a child, legal separation, divorce, legal guardianship, loss of other coverage, death, or marriage of a Dependent child.

2.20 "Retiree" means any former Employee of the City of Detroit who retired on or before December 31, 2014, and is in receipt of retirement benefits from the Police and Fire Retirement System of the City of Detroit.

2.21 "Retirement System" means the Police and Fire Retirement System of the City of Detroit, as amended.

2.22 "Spouse" means a Retiree's lawful spouse at the time of retirement or as otherwise recognized under the Plan of Adjustment, provided that in the case of a Surviving Spouse such marital status exists at the date of the Participant's death.

2.23 "Surviving Spouse" means the widow or widower of a Retiree, who is eligible for receipt of benefits under the Plan.

2.23 "Trust" means the City of Detroit Police and Fire Retiree Health Care Trust, as amended.

ARTICLE III. HEALTH CARE PLAN

3.01 Eligibility. (1) Eligibility for participation in the Plan shall be limited to Retirees and their eligible Spouses and Dependents, with an effective date of retirement on or before December 31, 2014, and who were eligible to receive retiree health care benefits from the City at the time of retirement.

(2) Specific eligibility requirements for participation in the Plan's Medicare Advantage program and Health Reimbursement Arrangement (HRA) are set forth in Addendum A attached hereto, as may be amended by the Board from time to time in its sole discretion.

(3) In all cases of doubt the Board of Trustees shall determine eligibility to participate in the Plan, provided that such decision is consistent with the provisions of the Plan and Trust and the City's Plan of Adjustment.

3.02 Participation. (1) All Eligible Retirees shall immediately become eligible to participate in the Plan as of the Plan's Effective Date. Participants may be required to contribute to the cost of coverage under the Plan in accordance with rules and procedures adopted by the Board. Contributions toward the cost of health insurance benefits provided to Participants will be deducted from the Retiree's or Surviving Spouse's monthly pension payment. In the event that a Participant's or Surviving Spouse's monthly pension, if any, is insufficient to make the required monthly contribution, such contributions shall be made in accordance with rules and procedures adopted by the Board.

(2) An Eligible Retiree or Spouse who wishes to participate in the Plan shall complete the annual open enrollment process to participate. The annual election to participate in the Plan shall be irrevocable unless the Participant otherwise becomes eligible to change his election(s) pursuant to Section 3.07 herein.

(3) If an eligible Retiree and his/her Spouse are each participating in the Plan as an eligible Participant, they may each elect individual coverage, or they may elect joint coverage if circumstances allow. Eligible Dependents may only be covered under one Participant; there will be no dual coverage under the Plan.

(4) Termination of participation in the Plan shall be in accordance with all applicable state and federal laws including, but not limited to, the ACA. No less than thirty (30) days prior to the effective date of termination, the affected individual(s) shall be provided with written notice of termination of participation, including the reason for termination. Participation in the Plan shall terminate upon occurrence of the following:

(a) Death. The date the Participant dies;

(b) Cessation of Contributions. If the Participant fails to make any contribution required under the plan, coverage shall terminate in accordance with applicable law;

(c) a Participant's election to cease coverage under the Plan;

(d) in the case of a Spouse or Dependent, the date the Spouse or Dependent ceases to be a Spouse or Dependent as defined in this Plan;

(e) Plan termination. The date the plan terminates; or

(f) As otherwise provided under the terms of the Plan and in accordance with applicable law.

3.03 Enrollment. (1) Each eligible Retiree and Spouse shall be provided timely written notice of his or her eligibility and right to enroll in coverage under the Plan. In connection with his or her enrollment for coverage, the Participant shall furnish all pertinent information requested by the Board, Plan Administrator, and/or Insurance Carrier, including but not limited to the names, relationships and birth dates of the Participant's eligible Spouse and Dependent(s).

(2) Spouses and Dependents shall be eligible for coverage as provided herein and/or any insurance agreement. Eligible Spouses and Dependents shall be enrolled for coverage under the Plan at the time the Participant enrolls for coverage under the Plan during an open enrollment period, or as provided for in subparagraph (3).

(3) Participants must report Qualifying Life Events to the Plan Administrator within thirty (30) days of the event in order to make coverage changes under the Plan. Notification beyond thirty (30) days of the Qualifying Life Event will delay the effective date of any coverage changes to the first day of the calendar month following the date on which notification was made. If failure to report a Qualifying Life Event within thirty (30) days results in additional benefit costs to the Trust due to non-termination of benefits, the Participant may be held responsible for such additional costs.

3.04 Benefits. (1) Beginning on the Effective Date, the Plan shall provide health care benefits to each eligible Participant and, if elected, to his or her eligible Dependent(s). The benefits provided under the Plan are as set forth herein or as otherwise provided in the individual plan documents and/or insurance agreements which are incorporated herein by reference. A complete description of the benefits provided under the Plan, inclusive of those set forth in the individual plan documents and/or insurance agreements, shall be maintained by the Board or Plan Administrator.

3.05 Limitation on Benefits. Participants are not entitled to cash or any other benefit in lieu of medical coverage. The benefits provided will be limited to medical care as defined by Section 213(d) of the Code.

3.06 Claims Procedure. Claims shall be handled by a third party administrator or insurance provider in accordance with the contract with such third party administrator or insurance provider.

3.07 Payment of Claims to Others. If the Plan Administrator, insurance carrier or third party administrator determines in its sole discretion that any person to which an amount is payable under the Plan is unable to care for his or her affairs because of sickness, injury, incapacity, death, or is a minor, then any payment due (unless a prior claim has been made by a duly appointed legal representative) may, if the Plan Administrator, insurance carrier or third party administrator so elects, be paid to the individual's spouse, dependent child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator, insurance carrier, or third party administrator to be a proper recipient on behalf of such person otherwise entitled to payment. The Plan Administrator, insurance carrier, or third party administrator shall not have an affirmative obligation to investigate whether a person is or is not capable of caring for his or her affairs. Any such payment shall be a complete discharge of the liability of the Plan.

3.08 Allowable Mid-Year Changes. (1) No Participant in the Plan will be allowed to alter or discontinue the Participant's annual elections during a Plan Year except when due to a Qualifying Life Event.

(2) The Plan Administrator shall be notified as soon as reasonably possible in the event of a Qualifying Life Event. The Plan Administrator may require additional documentation as evidence of the Qualifying Life Event, and completion of appropriate forms and documentation by the relevant parties.

3.09 Plan Administration. The Plan Administrator shall have the authority and responsibility for the administration of the Plan. In addition to any rights, duties, or powers specified under the Plan, the Plan Administrator shall have the following rights, duties, and powers:

(a) Procedure. Adopt and apply rules and procedures to ensure the orderly and efficient administration of the Plan;

(b) Information. Obtain from or transmit to, the Board, Participants, and any other necessary party, all information necessary for the proper administration of the Plan;

(c) Disclosure and Reporting. Make all disclosures to Participants and file all governmental reports, as required by law;

(d) Specialists or Advisors. In consultation with the Board, retain the services of such persons or entities as it may deem necessary for the proper administration of the Plan. The Plan Administrator may utilize, among others, actuaries, accountants, consultants, third party administrators, legal counsel, or any other specialist or advisor.

(e) All Other Necessary and Proper Functions. Perform any other necessary or proper functions in the operation of the Plan.

3.10 Continuation Coverage Under COBRA. (1) Notwithstanding any provision to the contrary, any Participant who is eligible for continuation coverage under the Plan pursuant to COBRA shall be allowed to continue to participate in the Plan, as long as such Participant complies with the provisions set out in COBRA.

(2) The Board shall adopt rules relating to continuation coverage, as provided under Section 4980B of the Code or applicable state law, as may be required from time to time, and shall advise affected individuals of the terms and conditions of such continuation coverage.

3.11 Women's Health and Cancer Rights Act. (1) If a Participant had or is going to have a mastectomy, such Participant may be entitled to certain benefits under the Women's Health and Rights Act of 1988, as amended. For individuals receiving mastectomy related benefits, coverage will be provided in a manner in consultation with the attending physician and the patient for:

(a) All stages of reconstruction of the breast(s) on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses; and

(d) Treatment of physical complications of the mastectomy, including lymphedema.

(2) These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

3.12 Special Rights Upon Childbirth. (1) NMHPA provides that group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length stay in connection with childbirth for the mother or the newborn to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., the physician, nurse, physician assistant, or midwife (if covered) of a Participant), after consultation with the mother, discharges the mother or newborn earlier.

(2) Also, under NMHPA, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

3.13 Interpretation and Appeal. (1) Subject to applicable state or federal law, any interpretation of any provision of the Plan made in good faith by the Board as to any Participant's rights or benefits under the Plan is final and shall be binding, subject to appeal as follows.

(2) All decisions of the Board regarding benefits provided under the Plan shall be subject to appeal in accordance with the rules and regulations adopted by the Board. The appeal shall be in writing and filed with the Board within thirty (30) days of the date the individual is notified of an adverse claim decision or determination of ineligibility. The written appeal shall, at a minimum, contain the following information:

(a) The individual's name, residence and mailing address, date of birth, daytime contact number, and service date(s);

(b) A statement of the ground(s) for appealing the decision;

(c) Specific reference to the Plan provisions on which the appeal is based;

(d) A statement of the individual's reasons for believing the decision to be improper, including a statement of the arguments and authority, if any, supporting the ground(s) for appeal; and

(e) Any other pertinent information and/or documentation which the appellant wishes to submit in support of the appeal.

(3) The Board shall not be responsible for the interpretation and/or validity of any insurance agreement issued in connection with the Plan or Trust or for the failure on the part of the insurer to make payments provided under such insurance agreement, or for the action of any person which may delay payment or render an insurance agreement null and void or unenforceable in whole or in part.

3.14 Exclusive Benefit. The Plan shall be administered solely for the benefit of the Participants, and for the exclusive purpose of providing Participants with the benefits stated herein.

ARTICLE IV. AMENDMENT AND TERMINATION

4.01 Amendment. (1) The provisions of this Plan may be amended at any time or from time to time by resolution of the Board of Trustees, and the provisions of any such amendment may be made applicable to the Plan as constituted at the time of the amendment, provided that this Plan shall not be amended in any manner which causes or allows any portion of the Trust allocable to the Plan to be used for purposes other than providing health care benefits to eligible Retirees and their eligible Spouse and/or Dependents.

(2) The Board may also remove or change insurance carriers, other benefits providers, administrators, or other service providers at any time provided that such changes would not result in the violation of any applicable laws.

4.02 Limitations. No amendment shall adversely affect the benefits of a Participant or beneficiary under the Plan on a retroactive basis, unless otherwise necessary to bring the Plan into compliance with applicable laws and regulations.

4.03 Termination of the Plan. The Board may, by resolution, terminate the Plan at any time, provided that this Plan shall nevertheless continue in effect until such time as may be necessary to carry out the provisions of the Plan and for a period of time sufficient to wind up the affairs of the Trust.

ARTICLE V. MISCELLANEOUS

5.01 No Assignment. The Plan shall not recognize any assignment, alienation, attachment, garnishment, legal process, sale, transfer, pledge, encumbrance of or charge upon any benefits payable under the Plan, and any attempt to encumber, alienate or assign any benefit payable under the Plan shall be void.

5.02 Creditors. (1) The right of a Participant to receive a benefit under the Plan shall not be subject to the claims of creditors, and shall be exempt from execution, attachment, prior assignment or any other judicial relief or order for the benefit of creditors or other third party.

5.03 Evidence. Each Participant shall cooperate with the Board or Plan Administrator by furnishing such documents, evidence, or information as the Board, insurance carrier, or third party administrator may deem necessary, and by taking such other relevant actions as may be required by the Board, insurance carrier, or third party administrator in implementing the Plan. The Board shall have no obligation under the Plan in the event of a Participant's failure to cooperate.

5.04 Withholding Taxes. To the extent required by applicable law, the Board may withhold from payments made pursuant to the Plan all federal, state, local, or other taxes as shall be required with respect to any amounts paid or payable under the Plan.

5.05 Correction of Errors. No person is entitled to any benefit under the Plan except to the extent expressly provided herein or as otherwise provided under an incorporated plan document or insurance agreement. The fact that the Plan made payment(s) in connection with a claim for benefits under the Plan does not establish the validity of the claim, a right to such benefits or a right to the continuation of benefits. Therefore, if a person is paid a benefit under the Plan and the Board, insurance company, or third party administrator determine that such benefit should not have been paid (whether or not attributable to an error by such person, the Board, insurance company, or third party administrator, or any other person), then such action may be taken as necessary or

appropriate to remedy the situation, including, but not limited to, the deduction of the amount from any succeeding payments to or on behalf of such person under the Plan or from any amounts due or owing to such person under any other plan, program or arrangement of the Plan that benefits such person. If the Board, insurance company, or third party administrator determines that an underpayment of benefits has been made under the Plan, such action may be taken as necessary or appropriate to remedy the situation, but in no event shall interest or a penalty be paid on the amount of underpayment.

5.06 Notice to Participants. Each Participant shall be responsible for informing the Board of his or her correct mailing address. Any communication, statement or notice addressed and sent via prepaid first class mail to a Participant at his or her last post office address as shown on the Board's records shall be deemed to satisfy the notice requirements under the Plan.

5.07 Construction. All terms expressed herein shall be deemed to include the feminine and neuter genders and all references to the plural shall be deemed to include the singular and vice versa, all as proper construction shall dictate.

5.08 Headings and Captions. The headings and captions herein are inserted for convenience of reference only and shall not affect the meaning or interpretation of the Plan.

5.09 Severability. If any provision of this Plan is held invalid or unenforceable, such invalidity shall not affect any other provision, and the Plan shall be construed and enforced as if such provision were omitted.

5.10 Governing Law. The Plan shall be governed and construed in accordance with the laws of the State of Michigan to the extent not preempted by federal law.

ADDENDUM A

Eligibility Rules and Regulations

1. Medicare Advantage Program

A. General

1. The Trust will sponsor one or more fully insured Medicare Advantage plans through licensed and independent insurance provider(s). The Trust's Medicare Advantage plan(s) shall include coverage for prescription drugs under Medicare Part D ("MA-PD Plan").

2. The Trust may sponsor HMO and/or PPO MA-PD Plans with one or more insurance provider(s) as determined by the Board.

B. Eligibility

1. Retirees and Spouses shall be eligible to participate in the Trust's Medicare Advantage Program for so long as the Retiree or eligible Spouse meets the following conditions:

   a. Eligible for Medicare;

   b. Enrolled in both Medicare Part A and Medicare Part B;

   c. live within a MA-PD Plan(s) service area; and

   d. do not have End-Stage Renal Disease (ESRD) such that participation in a Medicare Advantage plan is prohibited pursuant to CMS rules and regulations.

2. If an eligible Retiree elects to opt-out of participation in the Trust's Medicare Advantage Program his or her Spouse may elect to individually participate in the MA-PD plan(s) sponsored by the Trust.

2. Health Reimbursement Arrangement (HRA)

A. General

1. The Trust will sponsor a HRA for non-Medicare eligible Retirees and Spouses as detailed below.

2. The Trust will also offer a HRA benefit to Medicare eligible Retirees and Spouses electing to opt-out of coverage under the Trust's Medicare Advantage Program.

B. Eligibility

1. Medicare Eligible Opt-Out HRA

a. Medicare eligible Retirees and Spouses electing to opt-out from coverage under the Trust's Medicare Advantage program shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

2. Non-Medicare Eligible HRA

a. Non-Medicare eligible Retirees and Surviving Spouses shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit of upon enrollment.

b. Participants with a total household income of $75,000.00 or less and purchasing health insurance through a policy purchased on a public exchange may be eligible to receive an additional monthly HRA benefit.

i. Participants claiming eligibility for this HRA benefit will be required to provide verification of coverage under a health insurance policy purchased through a public exchange, along with a copy of his or her most recently filed tax return as proof of a total household income of $75,000.00 or less.

3. Over 65 Non-Medicare Eligible HRA

a. Retirees and Spouses over the age of 65 who are not eligible directly, or through his or her spouse, for free coverage under Medicare Part A shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

b. Retirees and Spouses claiming eligibility for this HRA benefit will be required to provide proof of ineligibility for Medicare through submission of a denial letter from the Centers for Medicare and Medicaid Services ("CMS").

4. Non-Medicare Eligible Duty Disabled HRA

a. Non-Medicare eligible Retirees in receipt of a duty disability pension from the Police and Fire Retirement System of the City of Detroit ("PFRS") shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit upon enrollment.

b. Retirees claiming eligibility for this HRA benefit may be required to submit proof of duty disabled status through submission of a duty disability determination letter from the PFRS.

c. Upon attaining Medicare eligibility, termination of duty disability benefits, or receipt of a service retirement allowance from PFRS, Participants shall be ineligible to participate in the Plan's non-Medicare Duty Disability HRA.

ADDENDUM A

5. Spousal HRA

   a. Spouses under the age of 65 who are not eligible to be enrolled under the Trust's Medicare Advantage Program shall be eligible to participate in the Trust's HRA and receive a monthly HRA benefit.